Knowledge, Attitudes, and Practices among Men in the Gaza Strip Related to Sexual and Reproductive Health and Rights and Child-rearing

Nadia Al Bayoumi, Riyad Diab and Bassam Abu Hamad

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Authors of this report

Nadia Al Bayoumi, MPH, Independent Consultant, Qualitative Lead

Riyad Diab, MPH, Independent Consultant, Quantitative Lead

Bassam Abu Hamad, PhD, Associate Professor of Public Health- Al-Quds University, Team Leader

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List of abbreviations

AFD	Agence Française de Développement
ANC	Antenatal Care
ARA	Access Restricted Areas
BF	Breast Feeding
CBOs	community-based organizations
CSE	Comprehensive Sexuality Education
ECD	Early Childhood Development
FGD	Focus Group Discussion
FP	Family Planning
GBV	Gender-Based Violence
GDP	Gross Domestic Product
GEM	Gender Equitable Men
HH	Household
HIV	Human Immunodeficiency Virus
ICT	Information and Communication Technology
ILS	Israeli shekel
IUD	Intrauterine device
IVF	In vitro Fertilization
KAP	Knowledge, Attitudes, and Practices
KII	Key Informant Interview
MENA	Middle East and North Africa
MICS	Multiple Indicator Cluster Survey
MMR	Maternal Mortality Ratio
MoH	Ministry of Health
MoE	Ministry of Education
M&E	Monitoring and Evaluation
NC	Natal Care
NGO	Non-Governmental Organization
PCBS	Palestinian Central Bureau of Statistics
PESTELE	Political, Economic, Social, Technological, Environmental, Legal, Ethical
PHC	Primary Health Care
PMRS	Palestinian Medical Relief Society
PNC	Postnatal Care
PSS	Psychosocial Support
PWD	Persons with Disability
SDGs	Sustainable Development Goals
SPSS	Statistical Package for the Social Sciences
SRHR	Sexual and Reproductive Health and Rights
SRMNCHAH	Sexual, Reproductive, Maternal, Neonatal, Child, and Youth and Adolescent Health
STI	Sexually Transmitted Infection
TFR	Total Fertility Rate
TOR	Terms of Reference
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund

UNRWA	United Nations Relief and Works Agency for Palestine Refugees in the Near East
WHO	World Health Organization

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Executive summary

Background and objectives

There is growing global evidence that male engagement initiatives on sexual and reproductive health, maternal health, gender-based violence (GBV), and child-rearing can have positive behavioural and health outcomes for their partners and children, in addition to supporting the realization of human rights for all. As with the literature specifically on Palestine, there is a dearth of research on men's involvement in sexual and reproductive health and rights (SRHR) and child-rearing. Driven by the politics of the Israeli occupation and concerns about its implications for the ongoing Palestinian-Israeli conflict including the continuous Israeli aggression against Gaza, the available literature on violence in Palestine mainly focuses on political violence, and on men and older male adolescents; and GBV is almost absent from policy frameworks. Many unanswered questions hence remain about men's involvement in SRHR and child-rearing and what drives versus constrains their participation.

This study is part of a larger three-year joint programme implemented by the United Nations Children's Fund (UNICEF), the UNFPA, and the World Health Organization (WHO) aiming to improve access to quality and sustainable SRHR, child health, nutrition, and early childhood development (ECD) services in Gaza. The study ascertains knowledge, attitudes, and practices (KAP) among men and male youth on SRHR and childrearing, in order to inform future polices and programming.

Methods and design

This study used a mixed-methods approach involving a literature review, empirical quantitative Knowledge attitudes, and practices survey collected in March/April 2021, and qualitative data collection taking place during the same period. The quantitative findings were drawn from a clustered random household (HH) survey with 476 HHs, proportionately distributed across the five governorates of the Gaza Strip. From each HH, we interviewed an adult male, an adult female (952 total adults) and an adolescent (270 males and 206 females). The sample parameters were congruent with the Gaza Strip population, for example, 67% were refugees and 84% were living in nuclear families. We deliberately oversampled some groups of particularly marginalized subpopulations, including those with disabilities (13.3% of the HHs are having at least one member with disability) and early married girls.

Twelve female enumerators living in the targeted governorates and the field supervisors attended a 4-day training course to orient them on the quantitative data collection processes and tools. Then field piloting was conducted with 30 HHs and resulted in further modifications to the tool which was implemented in Arabic. The response rate was high (87.5%). Field supervisors also conducted validation visits and call-backs (100 calls). The qualitative component included conducting 41 focus group discussions (FGDs) with adults and young males and females, diverse in socio-economic backgrounds as well as 18 Key Informant Interviews (KIIs). In total, the qualitative part included talking to 335 participants, of them, there were 18 KIIs (9 males and 9 females), 31 service providers and 20 male and female community leaders who participated in 7 FGDs, and 266 community

members (112 Females, 154 Males) who participated in 34 FGDs with purposively selected community members from all areas in the Gaza Strip including access restricted areas (ARA).

A purposive sampling technique was used to recruit the participants for the FGDs. The team also ensured a mix composing different socioeconomic backgrounds, including youth and adults, adolescent mothers, child brides, divorced/separated, unmarried women, and people with disabilities. To ensure scientific rigor, a two-day training session was provided to the 7 qualitative researchers assigned to collect the qualitative data followed by piloting and refinement of the tools in addition to standard approaches to enhance scientific rigor including standardizations of administering the tools, daily checking and members and peer check. Qualitative meetings were conducted at non-governmental organizations (NGOs) in a convenient non-threatening environment. The average duration of FGDs was 110 minutes, the average duration for KIIs was 52 minutes and the average number of participants per FGD was around 8 members.

The research team adhered to stringent ethical measures to protect participants as per the international ethical principles. Permission was sought, and given, from Gaza's Helsinki Committee (PHRC/HC/792/20). To protect the rights of the participants, each of them received a complete, standardized explanation of the purpose and parameters of the research, and informed consent for adults and assent for young people 17 years and under was sought.

The quantitative data were entered, cleaned, and analysed using Statistical Package for the Social Sciences (SPSS) 26. Descriptive statistics were conducted first, followed by inferential analysis to examine the statistical differences among the variables. P-value was regarded as statistically significant when it falls below 0.05. Qualitative interviews were double-recorded, listened to and then detailed minutes were taken, reviewed, carefully read several times (immersion), and then thematically coded.

The limitations of this study are those common in cross-sectional surveys. Cross-sectional studies (snap-shot) assess the situation at a particular time, while perspectives and behaviours could be influenced by time, circumstances, and so on. Additionally, the collected data was solely reliant on self-reported responses. It is possible that self-reported responses could be inaccurate as participants are sometimes unwilling to describe accurately their experiences, attitudes, or feelings, especially around culturally sensitive issues, like SRH. Moreover, the Covid-19 pandemic constituted a major barrier to engage more with beneficiaries and to use more participatory interactive qualitative methods.

Key findings

Perspectives and awareness about sexual and reproductive health and rights and child-rearing

The surveyed participants reported being familiar with the term SRH (66% of men, 80% of women, 46% of boys, and 67% of girls). Gender differences are in favour of females and adults. Among males who reported being familiar with the SRH term, antenatal care (ANC) (reported by 62% of men and 58% of boys), family planning (FP) (reported by 49%

of men and 37% of boys), and natal care (NC) (41% by men and 45% by boys) were more frequently cited than other non-maternity related aspects such as sexually transmitted infections (STIs) and adolescent health. The responses overlooked important aspects such as preconception counselling where only one in four men reported knowing about it compared to 33% among women. Care during menopause, information and counselling services, pre-marital examination, and adolescent health are areas were less known, as less than one in ten men referred to, while percentages of less than 2% of men and close to 0% of women were reported regarding the awareness about STIs and GBV. Similarly, despite reporting familiarity with the SRH term, a lot of our FGD participants were confused about what the term entails. The most common perceptions about SRH evolved around some concepts such as childbearing and delivery besides making this happen or the socio-physical aspects of the marital relationship. This observation resonates with the inputs of KIIs and service providers who were concerned about the low level and/or the inaccurate information among males, particularly youngsters. When we asked our respondents about their familiarity with SRHR specifically for men, only a small proportion of respondents were familiar with what this term entails (39% of men, 20% of boys, 36% of women and 17% of girls). Even those who are familiar with men-specific SRHR possess a limited knowledge mainly concentrated around infertility (45% reported by men, 47% by women, 41% of boys and 60% of girls), sexual dysfunction (39% by men, 56% by women, 50% of boys and 46% of girls), and the need for contraception (38% of men, 30% of women, 30% of boys and 34% of girls). Despite its particular importance, prevention of STIs was rarely cited (only by 11% of men, 5% of women, 4% of boys and 3% of girls). Men's knowledge of pregnancy signs is relatively high; 82% of men mentioned nausea and 79% mentioned vomiting. The awareness about danger signs of pregnancy was alarmingly low. For instance, while half of the men (51%) knew that bleeding is a danger sign during pregnancy, only 3% of men recognized convulsions and shortness of breath as danger signs. Moreover, less than 2% of adult males were able to name three danger signs or more and only 3% of women correctly named three or more danger signs of pregnancy.

Our discussions highlight great variations in the sources of information about puberty, across the different generations as young adults and male adolescents rely on online sources and peer exchange of information while older men and women's groups, in addition to girls, receive information from more classic sources such as schools, parents (mainly mothers), and other's personal experiences. Similar to their inputs in the FGDs, for male adults themselves, the main sources of information about puberty-when they were young were friends (33%) followed by schools (29%), previous experiences (23%), online sources (21%) and health workers (14%). Females were more informed, by their mothers, while fathers played a limited role in informing their sons about puberty. On the other hand, with few differences in comparison with the qualitative inputs, the main source of information about puberty for boys were schools/counsellors (80%), followed by friends (29%), parents (fathers 18%, mothers 16%) and internet sources (13%). As for girls, the main sources of information about puberty were their schools (87%), mothers (79%), friends (14%), and books (11%). It was noticed that the sources of information for males are mainly non-family related, but for females, sources are largely nested within the families due to social taboos around puberty and sexuality. When asked about the needs of women and girls during menstruation, generally, women's responses reflect more understanding of the needs during menstruation than men. The most prominently reported need was hygiene supplies and sanitary pads at more than 90% by both men and women. Understanding other physiological and psychological issues like sleep, change in

psychological status, and the need for pain killers was reported by only 30% of the male participants.

Overall knowledge around sexual and reproductive health and rights

To assess the level of knowledge about SRHR in general, a proxy indicator was constructed based on 14 knowledge-related questions and the mean percentage of the overall knowledge among men stands at 47.6% (low). Among men, findings showed that some men have greater levels of knowledge – for instance, refugees compared to non-refugees (49% vs 45%), residents of Khanyounis governorate compared to other governorates (57% for Khanyounis, 49% for Rafah and Dier Al-Balah, 44% for Gaza, and 43% for North Gaza), more educated men (56%) compared to less-educated men (40%), and men who earn a higher monthly income (52% among men with income above Israeli shekel (ILS) 2,000; 45% among men with monthly income less than ILS 500).

Our findings confirm that familiarity with SRHR in general and for men in specific is limited among males in the Gaza Strip, particularly among young people. Indeed, amongst males and females, both our qualitative and quantitative analysis conclude that knowledge level differs by age; women in their 30s and men in their 40s are more likely informed about SRHR related topics, especially about men-specific topics. Generally, our survey concluded that, higher level of knowledge was reported among females than males and those who belong to a smaller size, and/or nuclear family. Differences in levels of knowledge about SRHR and child-rearing are most likely attributed to socio-cultural and economic variations among respondents. For example, educated and better-off participants enjoy better access to SRHR information, resources, and services. Therefore, they have greater opportunities than their less educated and poorer counterparts. Furthermore, variations across governorates could be attributed to the demographic structure of different areas, whereby governorates with higher concentrations of refugees (especially in the southern areas) and refugees, in general, have higher levels of knowledge about SRHR and child-rearing (this is possibly the legacy of United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) standardized primary health care (PHC) services that were launched three decades earlier than governmental services). UNRWA services are, to a greater extent, more accessible, and also more gender- and age-sensitive than governmental services. Moreover, the presence of NGOs focusing on gender and women's health in the south and Deir Al-Balah governorate proved to be able to contribute to men's greater knowledge about SRHR and child-rearing in these areas. Demographic characteristics of refugees include a greater tendency to join university education (especially for girls), better utilization of FP, and smaller size families. On the other hand, non-refugee families tend to wed their daughters early and to have larger families. For farmers (who are mostly non-refugees), having a large family is a necessity.

Attitudes and decision making around sexual and reproductive health and rights

Son preference and number of children

Of the total adults surveyed, 19% indicated that within their families, husbands alone decide on the number of children. As for their perspectives about who inside the family – in the general community in the Gaza Strip – normally decides about the number of children a family should have, 44% of men respondents indicated that the HHs are the ones who decide, while only 8% of men and women respondents reported that the wife decides on the number of children. The preferable mean number of girls reported by men respondents was 1.95, and by female respondents, it was 2. Regarding boys, both males and females demonstrated the preference of having more boys than girls (2.2 by men and 2.17 by women). Similarly, male and female adolescent respondents showed a similar slight preference for boys over girls (2.1 for boys and 1.9 for females) and the differences are statistically significant. Indeed, the study found that around a third of men and almost 40% of women knew a female friend or relative who had been humiliated by their husband after giving birth to a girl in the last year. In the qualitative discussions, men were also regarded as one-sided decision-makers. However, younger, unmarried participants (especially girls), referred to a slight generational change and a desire to navigate a mutual decision-making norm in their future families.

Marriage related decisions

When it comes to decisions around marriage, 37% of adult respondents reported not being ready for marriage at the time of the survey. Moreover, 11% of men and 13% of women reported that they were subjected to family pressure when they married. Influenced by cultural norms, 29% of men respondents and 24% of women respondents disagreed that a woman should decide free of any pressure or influence about the time of marriage.

Gender-based violence

Regarding GBV, which is widely spread in the Gaza Strip, a considerable proportion of male (32%) and female (39%) respondents reported knowing a friend or a relative in the last 12 months who were humiliated by their husbands after giving birth to a baby girl. A quarter of women respondents reported being pressured by their parents to accept maltreatment from their husbands or in-laws. More men (22%) than women (18%) think that parents should approve that a brother disciplines his sister, even if she is of the same age or even older than him.

Availability of and access to services and information

Nearly one third of men (37%) and women (31%) believe that unmarried girls don't need to attend sessions on SRH. Very concerningly, some 44% of men and 53% of women reported that in their community –regardless of their own or personal thoughts- performing a necessary invasive medical examination for an unmarried girl is considered completely unacceptable. Our survey underscores that half of the male respondents think

that husbands usually consider the emerging needs of their wives at the menopausal stage. Similarly, nearly 50% of males and females either agreed or somewhat agreed that menopause is the end of female SRH life. This has been reflected in the finding that around one third (35%) of men reported that the husband thinks of a second marriage when his wife reaches menopause. Challenges facing women during menopause are further complicated by the absence of services as half of the respondents reported a lack of services for females during menopause. The service providers confirmed that in almost all clinics, they close women's files after one year of no menstruation, regardless of who the provider is. This indicates a perception that SRHR is exclusively applicable to women of childbearing age. When it comes to menopausal or post-menopausal women requiring a service, only the doors of non-communicable disease care or outpatient clinics are opened to them. This reality reflects in part the scarcity of resources but more importantly the mindset behind the design of service provision. This finding highlights a need to emphasize the SRHR needs over the entire life course of both men and women.

Time use

Our findings confirm that the use of time is also gendered. In a typical day, men reported spending 1.3 hours on doing domestic-related work, while women reported spending around 4 hours daily doing the same (boys reported 1.4 and girls 1.9 hours). Men spent more time surfing social media and communicating with others (2 hours) and watching TV (1.9) than women (1.4). Similarly, girls spent more time in domestic chores (1.9 hours) than males (1.2) and in child care (males 0.7 for males and 1.1 for females). Boys spent more time surfing social media (3 hours) than girls (1.9). Our discussions concluded that the prevailed patterns of time use are highly impacted by how people are raised (cultural factor) and are linked to the perceived traditional male and female roles in the community.

Gender Equitable Men

Our survey included a module entitled "the Gender Equitable Men (GEM)"; a three-point scale from 0 to 2 to measure participants' attitudes and perspectives related to supporting equitable versus inequitable gender norms. More than half (55%) of men and boys (56%) reported that a woman's most important role is to take care of her home and cook. Other participants, 38% of men, 23% of boys agreed or somewhat agreed that there are times when a woman deserves to be beaten. Similarly, 76% of men, 70% of women, 73% of boys, and 53% of girls strongly agreed and somewhat agreed that a woman should tolerate domestic violence, in order to keep her family together. The percentage of agreement with the statement *'to be a man, you need to be tough'* was as follows; 18% by men, 7% by women, 16% by boys, and 5% by girls either agreed or strongly agreed with the notion.

Three-quarters of men and women, 72% of boys, and 69% of girls strongly agreed that changing diapers, bathing the children, and feeding them are solely a mother's responsibility. Nearly 40% of men, 48% of women, 57% of boys, 54% of girls agreed (strongly or somewhat) that it is a woman's responsibility to avoid falling pregnant. More than three-quarters (78%) of men, 61% of women, 77% of boys, and 62% of girls reported that a man should have the final word when it comes to decisions within the family.

The vast majority of participants of all categories (more than 96%) strongly agreed or somewhat agreed that both the man and the woman should decide together about the type of contraceptive to be used, that a father's participation is important in raising children and that couples should decide together if they want to have children or not. In general, equitable positions by men and women respondents were cited when it came to child-rearing, rejecting tough practices as a demonstration of power, and in participatory decisions between couples – regardless of whether they practice that in reality or not. On the other hand, the majority of participants (more than 70% of males) remain to hold inequitable positions around women's role in the community and within the HH and that men should have the final word on family issues.

Mean score "GEM Scale"

In total, men scored 1.28 (64%) which is close to 10% less than women, who scored 1.38 out of 2 (69%). Similarly, girls elicited higher scores than boys and the differences are statistically significant. Also, adult males elicited higher scores than adolescent males. The lower score among adolescents could be attributed to the effects of cultural norms which they learn while growing up. It also links to inappropriate and untrusted information they obtain at the onset of puberty. An important driver of the overall perceptions and attitudes of adolescents regarding SRHR could be the prevailing insecurity and uncertainty due to the political and economic turbulence at the macro level. Our key informants pointed out that the community members, especially groups who lived the largest part of their lives under such conditions tend to hold more conservative attitudes as their needs of protection have been stretched greatly. Findings confirm that as part of the insecurities assured and the influence of norms partially fades out (as indicated by the difference between persons who live in extended families versus nuclear families), the supportive attitudes manifest clearer. For instance, for adults who are married, it seems the experiences they went through have somewhat promoted their gender attitudes. Being a refugee, living in nuclear families, educated, economically better off, belonging to a small size family were associated with higher scores indicating more gender-equitable attitudes than their counterparts from other groups.

Male participation in sexual and reproductive health and rights and child-rearing

The vast majority of participants strongly agreed that male participation in SRH is limited (68% of men and 72% of women), whereas, only 12% of men and 10% of women disagreed. Likewise, participants of the FGDs provided rough estimates of the percentage of males who actively participate in child-rearing to be around 20% to 30% in the best-case scenario. This is also true for service utilization, even when services are home-based such as participation in the postnatal (PNC) visits which the nurses/midwives conduct in certain cases. Concerning the participation in child care, almost two-thirds of men (64%), and 71% of women agreed or somewhat agreed that men are not actively engaged in childcare; more men (36%) disagreed with this assumption than their female counterparts (29%). Our survey also indicates that in general, the proportion of men who reported being engaged or supportive to SRHR components was higher than the reported proportion by women, regarding male engagement. These differences in the estimated level of participation were even clearer during the FGDs at it seems that men overestimate their

engagement or women don't feel that men are deeply engaged or that supportive to SRHR. This is particularly true for parents of children with disabilities. Not only that, participants in this survey agreed/somewhat that 60% of men restrict women's access to SRH services. Our discussions with service providers and women themselves underscored restrictions imposed on young women when it comes to attending health education sessions, deciding to use and/or to remove or stop using a contraceptive. A nurse from UNRWA clinics clarified that in some situations when allowed to be present for the services, young women are accompanied by their mothers'-in-law who attempt to guarantee that husbands' decisions are being respected. One of the providers said '*Mothers-in-law are key in FP, they come with their daughters' in-law and talk on their behalf. I realized that once and when the mother-in-law asked me to insert an Intrauterine device (IUD) for her daughter-in-law, I asked her to leave the room during the procedure. The lady told me then she doesn't want it and I had to lie saying that there is a problem that the IUD insertion is not possible, so I sent them back at that time*.' Restricting access to SRHR may also be associated with practicing violence. Although it was not frequently mentioned during the discussions, some service providers shared how some men, regardless of their education level, hurt their wives and prevented their access to healthcare. A healthcare provider shared that she has received a pregnant woman in her 7th month of pregnancy and was shocked by the signs of beating and bleeding from some parts of her body. The staff said '*She came to us and was wounded. We dressed her wounds quickly and called the ambulance to get her to the hospital since she was in bad status and she is 7 months pregnant. Her husband followed her to the clinic and forced her to get off the ambulance. He then kicked her and took her in a private car. By law and by norms, he has the right to stop her and prevent her from going to the hospital! Of course, we reported the incident to the protection department who followed up with her through home visits. We learned later that her husband is a school headmaster!! That is why I don't think violence or domination is linked a lot to education level*'.

Features of men participation

Male engagement is culturally gendered, as they are more engaged or supportive during the delivery process (75%), or when they experience personal sensitive issues, like sexual dysfunction (73%). Men faced with that sensitive issue do their best to pursue all possible methods to resolve their dysfunction and are ready to '*Burn the earth*' (as stated by one male focus group participant) and when it comes to fertility care (72%). One of the explanations of why men give sexual dysfunction issues a great value is the cultural link between sexual potency and real manhood/virility and of being a decision-maker within the family and powerful as perceived in the larger community. On the other hand, attending the materialized SRHR services (like FP, preconception care, ANC, PNC) by men is highly stigmatized, therefore, in many cases, mothers and in-laws accompany the wives since their presence at healthcare and child care facilities is regarded as normal and acceptable. Some of them (the mothers-in-law) also contribute to assuring men that services such as FP do not contradict their decisions.

Despite experiencing multiple pregnancies (median at 6), less than 40% of women reported ever receiving preconception care; only 17% of men indicated being involved in preconception services. Only around 7% of respondents from the two genders reported that men highly participate in preconception counselling services and another 26%

indicated that men participate to some extent. When asked if they had ever participated in ANC, 32% of men said yes (often), however, only 19% of women reported that their husbands often participate in ANC, mostly accompanying their wives to the clinic (over 90%), and less likely participating in the care sessions (63%) or counselling (51%). Our survey confirms that male contribution to delivery services is mainly manifested in facilitating access to delivery services as reported by 93% of men and providing better food and hygiene supplies. During the discussions, a man from North Gaza described men's role saying '*Like a concierge'*, another participant added '*A concierge who also pays'*. Men were not allowed in most of the cases to attend deliveries and were waiting outside the delivery room despite the desire shown by some of them to attend along with their wives as they reported during the discussions. A 32 years old male from Jabalia - who had previous unfavourable event happened with his wives indicated that he fought to attend with her the other time, he said "*I entered with her by force, I fought them [medical team] who prevented me and expelled me out but I insisted and called them to tell I am not leaving and will not allow more mistakes to happen. That is how I was allowed there. She had an easier labour process and was very much assured while I was there. I was assured as well*." Other roles reported by men during the childbirth process are providing psychological support (84%) and securing financial resources (93%). Men's responses indicate that only around one in ten were involved in any PNC session at home or at a health facility, which echoes the voice of a first-line service provider, stating that men welcome them for a home visit and then leave the room or the entire house, except for only 10 to 15% of cases where men attend the PNC home visit. Moreover, when couples are unable to conceive and want to access fertility services, husbands provided financial support (reported by 78%) and facilitated timely access to health care of women as reported by 74% of men. The pressure of securing the financial resources required for fertility care combined with the feeling of being abused due to their pressing need to have children – since, for many families, being infertile or impotent is equated with *'being useless'* – is a major source of stress and violent situations between couples, as reported by men and women during FGDs. Females also reported receiving part of the blame for unsuccessful procedures even when the medical condition that leads to subfertility is entirely men-related.

Prevalence of contraceptive use

While 58% of women stated that they received health information about FP, only 17% reported participating in such sessions. Among men who have had heard about any FP method (96% of the respondents), 91% of them mentioned IUD (50% among boys), 90% heard about pills (82% of boys), followed by male condom 67% (14% only by boys). Even for male-related methods like withdrawal, standard days, and male condoms, males' knowledge is significantly lower than females. The prevalence of current contraception used by couples in this study as reported by men was 58%, slightly less than what was reported by their wives (64%). This suggests that some men are either disengaged from the process or perhaps are unaware of their wives' use of contraceptives. This finding should be considered in the light of–regardless of having a written guideline or not – the common practice at both UNRWA and Ministry of Health (MoH) facilities conditions husband's approval for using FP methods, as women are usually asked about that according to the inputs of service providers themselves. Despite that 92% of men and 88% of women reporting a joint decision about the FP method used by them, 34% of men and 39% of women regarded FP as a female responsibility. Further explanation comes from

the same men who said in the FGD that they agree together on FP issues and provided supportive examples, yet, these examples pointed out that the discussions between some couples tacitly assume male decision rules. Men also mentioned they don't focus on the means their wives use for FP unless it causes them health problems or annoys the man. A young husband from Jabalia said about the contraceptive means '*According to her comfort, she decides*' while another added '*When there is a problem, I should go with her, because it is me who decides if the IUD does not work or annoys me. I should go with her to the clinic to decide'*. In general, our findings conclude that men leave it to women or the health provider to decide the contraception method as women who are supposed to use it while they retain the decision about whether to accept it or not and when women should use FP services. These crosscuts with the reported unmet needs for FP were, of the total women surveyed, 15% indicated that they were prevented from using the FP method they wanted to use. When asked about who prohibited women from using the FP method they wanted, two-thirds (66%) stated that husbands are the ones who practiced that.

Support by males during stressful periods

Another gap between knowledge and practice manifested in support during menstruation where despite that 92% of male adults indicated that they know when a female in the HH is in the menstruation days and that 90% of male adults have indicated that men should support women during menstruation, their practices on the ground were different, only 73% of women agreed that men do support them during that stressful period; indeed, 15% reported that their husbands are not supportive. One man in a focus group said '*I hate her {his wife} when she is in menses'* because she is not ready for sexual intercourse during that period.

For girls, generally, the type of support men provided evolves around the provision of hygiene commodities (99%) and in some cases provision of pain killers (57%), decrease the demands from their daughters or allowing more rest –provided that another female in the HH performs the needed tasks such as housekeeping or cooking. Girls indicated doing fewer HH chores or having rest as needed (90%) and receiving emotional support from any family member (89%). Girls, possibly because they were not prepared or adequately informed, experienced anxiety (61%) at menarche (median age in our sample was 14 years). Around three-quarters of boys (77%) and girls (74%) agreed that it is important that male members of the family show support to females during their menstruation days. While around 90% of girls enjoy a certain level of privacy, our qualitative findings refer to particular difficulties for girls living in camps and belonging to large families where this group of girls reported more frequent mood changes and stress. One of them said about this stage '*It is full of awful days and bad mood during the menses*".

Sexually transmitted infections

With regards to STIs, 74% of adults (male and female) and 45% of boys 50% of girls had heard about them before especially Human Immunodeficiency Virus (HIV) (more than 91%), nevertheless, other STIs, were less frequently mentioned, as inflammation was mentioned only by 21% of men and 33% of women. Only 15% of men and 31% of women reported ever attending any session about STIs; indicating that this area is not given adequate priority in Gaza by health services. This was confirmed by some of the

healthcare providers including key informants, who referred to STIs and GBV being as neglected topics. Service providers also highlighted the uncertainty felt by service providers due to fluid or absence of guidelines for the management of STIs. They also referred to the disinterest of men to attend STIs treatment even after they were called by the health providers, as stated by several women during FGDs.

Men experiences with sexual and reproductive health services

With regards to male experiences, when they seek SRH services, 18% of women and men reported knowing a man who felt embarrassed, 10% of men and women reported knowing a man who has been maltreated or mocked, and a similar proportion reported knowing a man who has been maltreated or embarrassed while visiting SRH services, during the last 12 months. Moreover, 13% of men and 15% of women reported knowing a man who was turned away, without receiving the SRH services that he came to receive in the last 12 months. Almost all participants mentioned that attending services by men is not acceptable at all by the community members and by the service providers themselves, they also highlighted the poor ability of providers to communicate with men, they have concerns about the privacy and quality of services in UNRWA and governmental clinics, and have serious comments on the appropriateness of the physical setting according to them. All that and the inconvenience to female clients are factors that reduce male participation in service utilization.

Impact of cultural norms on men contribution to childrearing

Our analysis suggests that there is a dissonance between what men say versus what they do, as although the majority of men (90%) reported that adult males should have a good share of childcare, their practices on the ground are different. This indicated that cultural norms strongly determine what they do, regardless of their convictions. Some of the key informants attributed the large gap between attitudes and practices in part to the influence of culture, where going against cultural norms is risky, and in part to the information ambiguity and the modest level of information communicated to men about their roles and how to perform them. For instance, only 27% of men respondents reported contributing to taking care of younger children including feeding and taking care of his/her hygiene, only 16% of men indicated that they take part in the routine check-up of their children, which are perceived more as female tasks. Interestingly, no differences were noticed across the two genders inappropriate (making a child smile) or even inappropriate practices (leaving the child alone with young siblings), that are not strongly culturally gendered. Concerning positive rearing practices, overall, mothers performed (weekly) more positive child-rearing practices (mean 16.3) than fathers (mean 14.8), and the differences between the two categories are statistically significant. Again, male participation in child-rearing is culturally underpinned, as they participate more in playing with children (4.4 times per week) and taking the children outside the house (2.1 per week). Some men consider the mothers as more patient and caring by nature, and therefore feel that even with the best of efforts, they will fall short of the standard set by women. Meanwhile, both males and females see a greater role for men in disciplining children and securing the financial resources for them, according to their qualitative inputs. A 62-year-old grandfather described a man who does everything-including taking care of children-while his wife is sitting, relaxed (with her legs crossed) saying '*This man deserves to be burnt!*'.

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Who participates the most?

When certain participation aspects (such as attending services, support to wives, taking part in child care) were complied, only 42.9% of men were somehow or actively participating in SRHR and child-rearing activities (mean score 6 out of 14 selected participation questions). Findings indicate that among men, educated (46,5% for highest educated versus 39,5% for the least educated), economically better off (47% versus 41% noting that groups whose income is higher than ILS 2000 did not show greater participation than the group with income between ILS 1000 and 2000), and those residing in the southern part of the Gaza Strip are more progressive (Rafah 50% and Gaza is the least 41%) in participation than other categories and differences among the groups are statistically significant. Education and income frequently showed up during FGDs with key KIs mentioning that educated and financially better off tend to participate more in SRH activities, use FP services more, and have less size family members as they have high aspirations for their children in terms of education and future opportunities. Also, the KIs referred to a greater role of women in these families and more awareness in general. On the other hand, participants from the poorest groups retain the norms that more sons equate to better social protection of older parents under an inadequate welfare/social protection system at the national level.

Reasons for non-participation

Men, women, boys, and girls hold similar perceptions about the possible factors which prevent men from actively participating in SRHR. The key reasons given were feeling shy and embarrassed (reported by 59% of men, 51% of women, 55% of boys, and 54% of girls), followed by gendered perceptions that SRH is more of a female business (reported by 68% of women, 51% of men, 36% of boys and 48% of girls), lack of awareness about the importance of male participation was also cited by 42% of both men and women and by 40% of boys and 46% of girls.

Inappropriate perceptions about masculinity were reported by 27% of men and by 36% of women, 22% of boys, and 25% of girls. Moreover, around 13% of men and women reported fear of being stigmatized by the community, which was also reported by 10% of boys and 6% of girls. Men (20%) and boys (19%) slightly more than women (16%) and girls (17%) think that men don't participate because they are busy at work. Other structural factors at the supply side also constrain men's participation, as only 9% of men and 4% of boys reported that service providers don't engage them, gender of service providers (8% of men), and the provided services either don't target or even exclude them (reported by 6% of men and 3% of boys), 4% of men and 2% of boys reported that they don't know about the existence of SRHR services and 3% of men reported that service providers are not trained to serve them. Reasons for not participating in child care were very similar as detailed later in this report.

Our FGDs sought further understanding of the barriers towards more engagement of men and concludes that a combination of deficiency on the supply side - including weak access to information - along with restraining cultural norms are the two main obstacles that impede male participation. Also, financial hardships prevent some men from seeking

services since the majority of them approach private physicians to assure their privacy concerns and adequacy of services. Although not generalizable, some of the men reported reasons indicating that they are focusing on their own issues (such as sexual dysfunction or varicoceles) so their service utilization manifests the most if the issues they are facing are solely related to their potency or a lesser extent, their fertility. On the other side, some women, as well as service providers, attributed lowered level of participation in some services such as STIs management and FP to men's reliance on women to solve the issue as long as they are not bothered. As for the limited role of men in child-rearing, most of the participants linked that to the cultural preferences and perceptions of manhood. Generally, cultural norms – despite a slow favourable change towards equitable roles of men and women – remain among the major restricting factors towards men's involvement in SRHR. These norms are sustained by the existing legal frames and by the reliance on the tribal mechanisms of problem-solving especially problems related to marital life and family issues.

Comprehensive sexuality education

Parents concerns around comprehensive sexuality education

In general, almost half of our adult respondents think that comprehensive sexuality education (CSE) is a social taboo and parents won't go against prevailed norms, with women agreeing more on that than men (58%). Nearly three-quarters (73%) of men and 80% of women reported concerns about the age-appropriateness of the contents (agreed and somewhat agreed). Concerns about gender-appropriateness of the contents were reported by 73% of male respondents and by 75% of female respondents. Although only 38% of men and 40% of women think that boys have appropriate information about SRH and a similar percentage were reported about girls, many are still sceptical about CSE to their children due to the cultural stigma around sexuality. This is true even when parents are assured about the content of CSE and the competencies of providers. For instance, less than half of them would like their child to learn CSE at a young age (49% of men are supportive and 46% of women are supportive). In congruence with that, only 28% of men and 13% of women are willing to discuss SRHR topics with male adolescents within their families. The proportion who are willing to openly discuss these issues with a female adolescent within their families is even lower as only 11% of males and 28% of females are willing to do that.

The most requested topics about comprehensive sexuality education

Interestingly, when adolescents were asked to nominate topics, they are interested to learn more about the cited prevention of undesired pregnancies and STIs (72% by boys and 78% of girls), prevention of and protection from GBV (72% of boys and 84% of girls), gender issues and relationships between males and females (60% of boys and 67% of girls) and puberty and its associated changes and self-care (Reported by 54% of boys and 63% of girls). In all the mentioned topics, girls reported a higher level of interest than boys.

Considering the views of parents around the comprehensive sexuality education

Our qualitative findings were somehow different than the survey results, probably because of the interactions among the group members and the exchange of views; it is common for participants in FGDs to recalibrate their positions somewhat in order not to contradict the input of others in ways that may be considered socially undesirable. A lot of men - including the significant number of them who reported being exposed to this topic in a group setting for the first time in their entire life – acknowledge the need for adolescents to have access to appropriate information and many parents said that this generation '*knows everything'* but were deeply concerned about the accuracy and appropriateness of this information. Therefore, they agreed, despite some concerns, to expose adolescents to age and gender-sensitive information that respects cultural and religious boundaries. Some of them deemed family sources as the right channels. Therefore, educating parents to convey accurate messages to their offspring would be accepted. More groups including KIs mentioned a greater role for schools and healthcare providers. Adolescents and young males, who were not happy at all about the quality and quantity of information provided at schools, reported (except for the most conservative groups) a need for a clearer and deeper level of information at schools and healthcare facilities but doubted the willingness of service providers to do so. Girls on the other hand took a different position to SRHR education at schools: many girls expressed interest in learning about issues relating to women's SRHR only; meanwhile a few girls indicated the importance to learn about SRHR issues related to men as this would be helpful for them in their future marital life. On the community leader side, a sense of no objection rather than enthusiasm around SRHR education to adolescents has been expressed. It also came with conditions that educational programmes align to religious values, reject inappropriate wording or meanings, and serve what they described as "good purposes", such as teaching boys and girls about puberty changes, their limits, self-awareness, and prepare them for future roles. They further proposed to provide this information at an older age than that proposed by parents and service providers.

Appropriate age for introducing information on sexual and reproductive health at schools

Our findings collected different views around the appropriate age at which comprehensive sexual education would be acceptable; adult survey respondents indicated 16.3 years as mean age for boys and 15.9 years for girls (16 years old was the median age for both boys and girls according to the views of their parents and adult family members). Adolescents themselves indicated a slightly younger age with a mean age of 15.6 years for male and female students according to boys' views and 15.8 years according to girl's views (grade 10). However, during the discussion, both boys and girls mentioned that it is either necessary or at least acceptable to start with information around puberty for girls in the 7th grade (age around 12 to 13 years. Mothers, some fathers, and the majority of service providers also agreed that as of 11 years old, girls could start to receive –gradually - puberty-related information. Some men (the older participants mainly older than 40 years) and most of the community leaders indicated older age to introduce information about the SRH at schools as they considered 14 to 16 years as the appropriate age for girls and 16 to 18 years for boys. The most common responses focused on grade 8 for girls and grade 10 for boys.

Conclusions and action points

Our findings confirmed several perceived red flags about a suboptimal level of male engagement and participation in SRHR and childrearing activities. Most of the participation barriers have a cultural origin and are enforced by oppression, insecurities, financial hardships, and poor access to information among the male community in the Gaza Strip. The nature and modalities of service provision at schools and healthcare facilities contribute largely to a lowered level of both acceptability and possibility of service utilization by men and their support to service utilization by women. The good news, however, is that an increasing number of men are sensitized about the importance of their participation and about the need to inform the younger generations about SRHR and childrearing aspects despite that channelling this information was not an area of consensus. Both survey results and qualitative findings refer to more equitable attitudes among younger married adults (females in their 30s and males in their 40s) who also possess a higher level of information and reflect more participatory practices. Also, the service providers gave examples of increased men's participation in recent years. Our findings did not quantify the current level of men participation due to the unavailability of baselines or tracking of service utilization by male clients. This report underscores the essential need for such information at least at healthcare facilities. An important issue that the report concludes relates to the non-equitable attitudes that young adult and adolescent males hold around men and women roles in SRHR and child-rearing activities. The authors of this report share the views of some KIs that explain such attitudes primarily by lack of/inaccessibility to accurate information or possessing misleading ideas around SRH. In addition to that, the alarming level of reported insecurity and uncertainty about the future and decision-making capacity – that is largely impacted by possessing or not possessing reliable sufficient financial resources according to them- could possibly prevent young male participants from reflecting equitable positions towards men and women roles.

While it is clear that the contextual and cultural barriers that impede greater engagement of men and young males in SRHR and childrearing activities are enormous and deeply rooted, our report attempts to collect and present evidence about interventions for a breakthrough to support and sustain positive changes. Most of that mirrors and/or builds on the inputs of the study participants and intersects with the international evidence and previous national studies. Part of the recommended interventions aims at achieving "quick-wins" - small but durable wins that feed and go alongside more fundamental/structural improvements and policy actions to sustain and scale up male engagement in SRHR and childrearing as the table below shows. In doing so, the authors of this report stress the overlapping nature of these interventions and the need for multidisciplinary cooperation mainly among MoH, Ministry of Education (MoE), Ministry of Social Development, other healthcare providers, relief and development partners, media, and religious figures. It is necessary to track and monitor male users with appropriate and proactive monitoring and evaluation (M&E) systems.

Area of intervention	**Quick wins/short-term actions**	**Longer-term actions**
Overarching interventions		
Advocate on and strive to	● The ongoing political conflict and repeated outbreaks of intense fighting,	● Delivering improvements in male participation is closely

address the contextual factors that hinder male involvement (men and boys) in SRHR and child-rearing	alongside economic and social challenges, reinforce deeply rooted conservative norms, including inappropriate masculinities, increased GBV and social inequalities. Therefore, during crises, proactively target and support the most affected groups. ● Advocate on the socioeconomic determinants of SRHR, including monitoring the effects of the blockade and economic collapse on increasing vulnerabilities, especially in relation to SRHR. ● Provide assistance to mitigate the impact of political turbulence, economic collapse, and increasingly conservative norms through effective social protection programmes that go beyond the traditional relief model, such as the 'Cash-Plus' approach.	linked to other contextual issues such as ending the occupation and its de-development policies, political resolution of the Palestinian case, economic growth, community empowerment, civil peace, democracy, social justice, gender equity, decent employment opportunities, access to university education, and women's empowerment – which all need to be constantly strived for by all actors. ● Ending the occupation and political resolution of the Palestinian case. ● Supporting economic growth at HH and community level. ● Addressing restrictive cultural norms by reforming discriminatory laws, raising awareness and inducing social change. ● Tackling other determinants for SRHR such as women's empowerment, promoting access to university education, civil peace, democracy and social justice.
Launch a national multi-sectoral strategy to increase male involvement in SRHR and child-rearing	● Advocate for the development of a multi-sectoral strategy for male involvement in SRHR and child-rearing. ● Conduct stakeholder mapping and PESTELE analysis (political, economic, social, technological, environmental, legal, ethical) to identify and liaise with interested and influential actors. ● Develop agreement on the process, scoping and vision for the intended strategy. ● Launch the development of the designated strategy as soon as possible.	● Develop a multi-sectoral strategy for male involvement in SRHR and child-rearing and translate this strategy into practical programmes with assigned responsibilities and budget. It is essential to involve men and male youth in these efforts and promote positive masculinities. ● Track and monitor male service users with appropriate and proactive M&E systems.
Induce change towards more age- and gender-equitable social norms (age-tailored	● Conduct mapping to identify target audiences/ beneficiaries and address them through appropriate channels. ● Use different approaches to change norms, including social media, peer-to-peer approaches, community mobilization programmes, awareness	● Social and cultural norms play a key role in driving male involvement, so it is vital to work towards gradual and progressive social change that promotes more

messages are needed)	programmes implemented in schools, by NGOs, media channels and religious organizations. ● Utilize the large number of social workers in social protection programmes like the PNCTP, teachers, health workers and youth groups like Y-peer to influence social norms, targeting poor and uneducated population groups. ● Involve mass media, community-based organizations (CBOs), NGOs, religious institutions, schools and universities to influence social norms and address inequalities.	egalitarian age and gender norms. ● Reform laws and policies to eliminate discrimination and promote age and gender equity. ● Awareness efforts should pay greater attention to people with disabilities, divorced women, older unmarried women and women going through menopause.
Reforming the personal status and family laws and legal framework, and activating social protection systems	● Support a community-based non-provoking dialogue around GBV, gender equity, legal age of marriage, social norms, and cultural preferences pertaining to SRHR and child-rearing to advocate for changes in family and personal laws. ● Liaise with influential stakeholders including parliamentarians, human rights activists, women's organizations and religious leaders to change discriminatory laws and policies. ● Raise awareness about the positive impact of adopting gender- and age-equitable policies and also the negative consequences of social inequalities.	● Reforming the personal status law must be a key priority in tackling gender inequality as it shapes so much of what men and women can (and can't) do. Efforts are also needed to tackle discriminatory laws and norms, including educating parents and raising community awareness. ● Ensure that social protection systems are development-oriented, effective and sensitive to address people's social and economic vulnerabilities, particularly the most disadvantaged groups, including people with disabilities and elderly people, as they are being left behind. They should not have to rely on more children and sons to be their source of social security.
Encourage programmes to comply with evidence-based policies	● SRHR programmes should comply with policies and plans, including setting of priorities, standards, codes of conduct, and a robust M&E system that allows for reflection and learning. ● Develop standard policies/frameworks for SRHR services to enhance the quality of services and promote better governance. ● Enhance licensing processes, supervisory functions and M&E according to the developed standards.	● Stakeholders, including regulators, service providers and donors, should advocate for adopting policy research and evidence-based programming. ● Funds should be channelled based on clear SRHR and child-rearing improvement strategies, based on a clear framework with maximum of coordination efforts in place. ● Invest in developing effective systems for monitoring, evaluation, accountability and

		learning (MEAL) in the SRHR domain.
Information and services for adolescents and youth		
Ensure access to appropriate information	• Health and education sectors should be more engaged in designing and implementing age- and gender-appropriate packages of information to be delivered to young people at schools, universities, health centres and community spaces. • Establish counselling units at health facilities and counselling services at schools and universities. • Liaise with health education and school health teams to focus more on SRHR and child-rearing as part of their routine work. • Scale up the roles and responsibilities of social workers within social protection programmes and health facilities to go beyond focusing on economic issues and engage more in addressing non-economic social inequalities. • Train service providers, including health staff, school teachers and counsellors, social workers and staff working at NGOs and CBOs, to deliver age- and gender-appropriate messages. • Involve religious leaders, youth leaders, youth groups and media professionals. • Make greater use of information and communication technology (ICT) and mass media using adolescent-friendly approaches to reach and engage adolescents and youth. • Communicate the positive impact of accurate information.	• Invest in creating a more supportive culture within the HH, in schools and the wider community to support boys and girls as they go through puberty, particularly with issues around menstruation and sexual relationships. • Initiate a long-term programme at the MoH and MoE to inform adolescents about SRHR and child-rearing issues.
Collective efforts for community buy-in to CSE	• MoE, in coordination with MoH and other relevant sectors, should build a consolidated vision on CSE. It should be able to clarify the intentions and content of the CSE curriculum. • MoE should begin conversations among parents focusing on those who have more progressive positions on CSE to create a critical mass for change. • Information should be presented gradually, starting with physical and psychological changes at the onset of	• Engaging religious leaders (after they are exposed to appropriate training), clubs and NGOs will be necessary to support community dialogue around CSE. • Enhancing internal disciplinary policies at schools will help dismiss suppressive measures and reinforce supportive interventions by counsellors, such as greater privacy and

	puberty, through till marital life and FP, as students are about to finish their schooling. This requires putting in sufficient time, and assigning and training staff and school counsellors. ● There is a need to recruit and allocate resources for an optional class on CSE within Palestinian universities.	more adolescent-friendly conversations with counsellors, and guidance/manuals for counsellors and teachers to tackle SRHR issues with boys and girls in an appropriate manner. ● Perform routine evaluations around CSE among students and their families and update interventions accordingly. ● Universities should start to think about orienting final - year students who will graduate as teachers and counsellors on CSE.
Scale up school health services	● Encourage school health teams to provide age- and gender-appropriate SRHR information. ● Train and involve teachers and counsellors in school health activities. ● Scale up school health screening (currently testes examination only) to incorporate a comprehensive SRHR health check-up, nutrition, and psychosocial support (PSS). ● Strengthen appropriate referrals for boys and girls who need specialized services. ● Produce and disseminate brochures, pamphlets and other educational materials, including messages that can be posted using ICT and social media. ● Involve parents in awareness sessions and orient them about common health issues affecting adolescents and how to manage them.	● Reform the current package of school health services, which is currently not sensitive enough to SRHR issues. ● Improve school infrastructure, to provide adolescent- friendly spaces and services for boys and girls, especially access to menstrual hygiene resources. ● Develop a protocol for school health services.
Augment support to adolescent health services and information	● Continue to support plans to establish an adolescent health department within health services. ● Introduce adolescent counselling services at PHC centres. ● Train health providers to provide age- and gender-sensitive services for adolescents. ● Utilize the family medicine and family health team model to target the entire family, including adolescents. ● Provide more information for adolescents on puberty experiences,	● Develop adolescent health services package that are integrated within PHC services. ● Increase coordination among different actors to frame the provision of adolescent health services. ● Redesign services to support non-maternity services, and services for unmarried girls.

	menstrual hygiene management, negative health aspects and consequences of frequent masturbation, prevention and management of STIs, prevention and protection from GBV, anti-harassment (including cyber harassment) or self-protection guidance, promotion of other services such as pre-marital counselling, FP and preconception care, safe sexual relationships, basics of positive parenting, and PSS during the transition to adulthood.	● Develop guidelines and protocols for adolescent health.
Greater participation by men and boys in SRHR and child-rearing		
Promote male accessibility to SRHR services and information Redesign service provision at healthcare facilities	● Remove any unwelcoming signs or behaviours. There should be welcoming and engaging messages for men to take up SRHR services on their own or with their wives. ● Communicate the change in policies to encourage male participation to a wide spectrum of audiences. ● Urgently adapt physical spaces to allow more privacy and a conducive environment for men to access SRHR services. ● Train service providers to show welcoming attitudes to men taking up SRHR services.	● Redesign physical spaces at service delivery points to facilitate men's greater engagement and participation. ● Ensure that male staff are available at SRHR service delivery points as much as possible. ● Ensure availability of commodities and supplies needed to meet men's SRHR needs.
Introduce and link 'male specific and age-tailored' SRHR needs to existing programmes	● Provide pre-marital screening, support treatment of sexual dysfunctions, and introduce fertility care at least at the counselling stage. ● Invest in more male staff to be present in waiting areas or during home visits to demonstrate small tasks for baby care and mother support. ● During contact with men, counsel them on SRHR issues, including danger signs during pregnancy and postpartum issues; inform men about the types of support and needs of women/ consequences of unmet needs for women and men and children, or for women during pregnancy. ● Counsel men about the positive impact of their engagement with the health status of the entire family. ● Engage positive role models to advertise and promote men's	● Acknowledge and respond to male SRHR needs as a key factor and entry point to increase service utilization. Partial or full services are required at fertility care, providing pre-marital screening and treating dysfunction. Regulate private sector fertility care (both quality and safety of interventions). Agree a formula to subsidize a number of interventions such as covering the costs of fertility management for the poorest families. ● Spreading information on men's SRHR needs not only serves the best outcomes of SRHR care but also builds client–provider relationships and enhances the overall client experience.

	participation in SRHR and child-rearing. ● Utilize community pharmacists as first-line contact with men to raise awareness about SRHR topics. ● Offer SRHR orientation and training to recent graduates of health colleges and those doing an internship.	
Revisit technical instructions and guidelines and enhance healthcare providers' competencies on men's engagement	● Update technical instructions and guidelines to incorporate men's involvement as an integral component of SRHR. ● Train front-line staff and supervisors on updated guidelines, including on issues related to FP, GBV, STIs, sexual dysfunction, and men's role in SRHR. ● Develop supervisory tools like checklists to monitor staff adherence to protocols. ● Support service providers as they transition from an unwelcoming to a welcoming strategy for men and boys to access services.	● Stakeholders should develop a long-term strategy for male engagement in SRHR and child-rearing. ● Introduce guidelines and technical instructions in the curricula of health colleges. ● Alongside developing guidelines, introduce essential services that are not currently provided for men's SRHR needs such as counselling, infertility management and management for sexual dysfunctions. ● Strengthen referral networks and the continuum of care. ● Ensure complementarity and effective coordination among different actors. ● Develop national indicators with clear targets and an M&E system to track men's engagement with SRHR services.
Greater investments in raising awareness about SRHR for males and females	● Beside investment in CSE, it is critical to raise awareness about SRHR and child-rearing strategically at different levels, as a basic human right, through a wide range of formal and informal platforms. ● Men, boys, community leaders, religious leaders and staff working in the social sector (including health, education and welfare services) should be proactively targeted through a range of communication channels including mass media, online platforms and social media. ● Because girls and boys have limited access to information and services at health facilities, there should be more opportunities within schools, universities and the wider community for adolescents to have access to	● Develop a behavioural change and communication strategy with clear and consistent messages to raise awareness and disseminate information about the benefits of male engagement in SRHR and child-rearing. ● Increase coordination among the different actors involved in disseminating information on SRHR. ● Develop a monitoring plan to assess the impact of the communication strategy in encouraging men's participation.

	appropriate information about their SRHR issues and rights, and parents and community leaders should be involved in outreach efforts. ● Revise the content of educational materials to ensure that they promote men's participation and engagement in SRHR. Ensure that educational materials incorporate specific components about men's participation. ● Build on progressive religious values that encourage positive masculinities, caring and non-violent male behaviours. ● Better utilize outreach activities to disseminate awareness messages, including through midwives carrying out PNC home visits, social workers employed by social protection programmes, and community animators from CBOs/NGOs.	
Introduce and promote pre-marital counselling, preconception care counselling, and resource centres (under acceptable names/shapes)	● Design and advertise pre-marital counselling services, for couples planning to marry. ● Enhance preconception care for male and female youth at universities, healthcare facilities, through social media, in high schools, in preschools when parents attend for registration of children, and in mosques. ● Share an invitation for services and/or training course the day of performing the thalassemia test (which is a requirement for the marriage certificate). ● To encourage participation in pre-marital training, a symbolic marriage/wedding gift may be presented upon completion of the courses and/or when the participant invites another couple to attend upcoming courses. ● Create an online module for those planning to marry (possibly via sending a link to the mobile phone of groom/bride if their information is obtained through the thalassemia test form) so that they can complete the module in their own time, gaining a certificate after a short quiz. This can be linked to social media promotion to make the courses	● Gradual advocacy for a mandatory pre-marital training course for male and female youth contemplating marriage. ● Outsource pre-marital sessions to youth groups (small entrepreneur groups) in the long term. They will be able to design age-appropriate messages to deliver to new couples or youth peers. ● Continue to support and scale up mobile apps and other ICT ideas for pre-marital counselling and preconception care and counselling.

	popular and fashionable among the youth community, in ways that will not be considered in appropriate by older generations.	
Adopt a life-cycle approach for provision of SRHR services		
Support access to SRHR services for all people, men and women, boys and girls, of all ages	● Technical guidelines should consider the SRHR needs of all groups, including currently overlooked categories (adolescents, menopausal women, older unmarried women, divorced women, sub-fertile couples and people with disabilities). ● The practice of closing women's personal health files when they cease menstruation should be ended, and replaced by provision of age-appropriate SRHR counselling and services.	● Revisit policies to address safe and joyful sexuality for elderly people, especially women at and after the end of childbearing age, and men and women with disabilities, to accommodate their needs (focus on physical access and effective communication with providers). ● Proactively target neglected groups such as people with disabilities, sub-fertile couples and unmarried women.
Encourage more roles for men in child-rearing and promote positive parenting in general		
Provide, scale up and support positive parenting practices among men to encourage greater male involvement in child-rearing activities	● Reinforce positive parenting within existing ECD programmes targeting caregivers at PHC centres, preschools, schools, NGOs and community entities, and scale up these programmes to target parents of older children and adolescents. ● Caregivers should receive training and awareness on child-rearing, and non-violent discipline practices to make these practices socially acceptable. ● Train service providers (health staff, teachers and counsellors) to recognize, report and manage exposure to violence. ● Break the vicious circle of violence practiced within the HH, community and institutions through awareness, efforts to change norms and provide safe platforms for reporting child abuse.	● Develop policies for child protection (safeguarding policies) and ensure their implementation. ● Promoting positive parenting practices should not be the responsibility of ECD and preschool actors only, it should extend to other service providers. ● Develop a national surveillance system to register and report safeguarding cases. ● Strengthen referral services to support survivors of violence and inappropriate disciplining practices.
Programmes should be driven by policies, rather than the other way around	● Programmes should adapt to and comply with policies and plans, which include setting of priorities, codes of conduct, sound MEAL functions, and continuous learning.	● Stakeholders (including regulators, service providers and donors) should advocate for the adoption of policy research and evidence-based programming. Funds should be channelled based on clear SRHR and child-rearing improvement strategies, with maximum coordination in place.

1. Background

The United Nations Population Fund (UNFPA), UNICEF, and WHO are implementing a three-year joint programme (2020 - 2023) on sexual, reproductive, maternal, neonatal, child, and youth and adolescent health (SRMNCHAH) in Gaza, funded by Agence Française de Dévelopement (AFD). The programme aims to improve access to quality and sustainable SRHR, child health, nutrition, and ECD services in Gaza. As a part of the SRMNCHAH programme, UNFPA is commissioning a consultancy team to carry out a study on KAP on SRHR and childrearing among men and boys in Gaza in order to inform future policies and programming. The study builds on the existing knowledge on the subject and contributes to providing answers to many unanswered questions around male adults' and boys' perspectives around SRHR. Global evidence indicates that male engagement initiatives on SRH, including maternal health and GBV, and child-rearing can have positive behavioural and health outcomes for their partners and children, in addition to supporting the realization of human rights for all (Fayoyin, 2014). There is growing global evidence that male engagement initiatives on SRHR and positive parenting can have significant health outcomes for their families (Davis et al, 2016) including adopting appropriate parenting behaviours, promoting demand and utilization of SRH services, and greater support for women, children and young boys and girls (Mohammed et al, 2019).

1.1 Purpose and the main objective

The purpose of this study is to generate reliable evidence on KAP among men in the Gaza Strip related to SRHR and child-rearing (see Terms of Reference (TOR) in Annex 1). The study collected in-depth qualitative and quantitative information on the underlying social, cultural, and economic factors that drive prevailing social norms on SRHR and child-rearing, in order to inform future interventions and to contribute to national goals and strategies. The study findings provide policymakers and programmes implementers working on SRHR and positive parenting including the SRMNCHAH programme, with wider balanced evidence upon which to develop more effective interventions to involve men and boys in SRHR and child-rearing, which resonate with families and communities and are perceived as legitimate. Findings might inform interventions to support women's voice and agency in decisions regarding their own SRHR and wellbeing.

1.2 Context

Gaza is a narrow strip of land (45 kilometres long) between Israel, Egypt, and the Mediterranean Sea, home to around 2 million people, making it one of the world's most densely populated areas. Once a thriving centre of culture, economy, education, and tourism, over the past 70 years Gaza has witnessed a cycle of military incursions by Israel and prolonged blockade since June 2006. The never-ending battle for statehood, exacerbated by the Israeli blockade and the struggle for subsistence are thus the main preoccupations of Gaza's inhabitants, 66% of whom are refugees (Palestinian Central Bureau of Statistics-PCBS, 2018). In Gaza, nearly 42% of refugees live in one of eight camps operated by the UNRWA (PCBS, 2018). Expropriation of land has created a condition of dispossession that has further compromised Palestinians' abilities to withstand the deliberate de-development strategy pursued by Israel, through punitive

economic, blockade and isolation, and military policies. Israel still has overall sovereignty of Gaza, controlling its borders, economy, movement of goods and people, electricity, communications, and security – the key aspects of Palestinians' lives. A combination of economic, political, cultural, social, and legal factors is shaping perceptions and perspectives of the population, mostly pushing the social norms in Gaza towards a more conservative society (Abu Hamad, et al 2017; Jones and Abu Hamad, 2016).

Since 1948, the Palestinian people have experienced many clashes with Israel, including four recent consecutive aggressions on Gaza (2008/2009, 2012, 2014, and 2021) and multiple confrontations between Israeli forces and Palestinian fighters. These conflicts have contributed to the loss of life, land, livelihoods, and economic resources, driving further displacement, violence, and vulnerabilities whereby, women and children are the most affected. This has weakened social networks, increased the incidence of psychological and emotional difficulties, and exacerbated poor housing and sanitation (Samuel et al, 2017). It has also led to high poverty levels (more than 60% of Gazans are poor or extremely poor) and high unemployment rates (around 70% among youth and women) (Abu Hamad, et al 2019). The UN has predicted that Gaza may be uninhabitable by 2020. It has described the situation as a 'human dignity crisis and considers it as a 'collective punishment' in clear violation of international humanitarian law (UN, 2017).

Since 2006, Gaza's gross domestic product (GDP) has been cut in half, with the World Bank estimating that its GDP should be four times larger today than it is (World Bank, 2019). Due to this combination of depressed economic growth and rising population, the GDP per capita in Gaza is only around $1000 (PCBS, 2018). Humanitarian assistance has become essential for approximately 80% of Gaza's population. Operated through the Ministry of Social Affairs, the Palestinian National Cash Transfer Programme helps the most impoverished Palestinians – about 75,000 HHs in Gaza– access nutritious food, basic education, and health care; however, the programme is far away from being an effective social protection programme as it doesn't address multi-faceted vulnerabilities that the people are facing especially these related to age and gender hierarchies including GBV (Samuel et al, 2017). Additional demographic data is available in Table 1.

Table 1: Key demographic characteristics of Gaza

Variable	Value	Variable	Value
Total population	2 million	Population density	5,500 per sq km
Average household size	5.7	Total fertility rate per woman	Around 4
Women at Reproductive age	22.5%	Gross domestic product (GDP) per capita	$1,000
Adolescent fertility rate	66 per 1,000	Women's participation in the workforce	19
Population density in camps	50,000	Adult literacy rate	96.4%
The proportion of the population who are refugees	66%	Youth bulge	30%
Poverty rate	60%	Relying on food assistance	80%
Unemployment rate	50%	Receiving social assistance from the Ministry of Social Development	75,000

Food insecurity	55%		Receiving assistance from UNRWA	22,000
Females' median age of marriage	19 years		Desire to migrate among youth	37%
The proportion of population with a disability	8%		Municipality water suitable for drinking	3%

Sources: PCBS, 2015; PCBS, 2019a; PCBS, 2019b; PCBS, 2020; UNICEF, 2014; World Bank, 2019.

1.2.1 Education and women employment

The Palestinian culture largely values education (literacy rate is above 95%) including girls' education, and this value is based on both improved economic prospects and improved preparation for marriage and motherhood (Jones and Abu Hamad, 2016; PCBS, 2020). On the contrary, with scarce resources, families often prefer to invest in sending their sons to universities (UNFPA, 2016). Also, early marriage (which is more prominent in rural areas), restricts girls' access to university education (ibid). Palestinian culture largely supports girls' education not only for the way it fosters girls' agency and voice but more noticeably for how it prepares them to be economically better off and also, to prepare girls to be better wives and mothers (Jones and Abu Hamad, 2016). However, despite high levels of education, female participation in the labour force is limited, and women comprise just 19% of formal workers (PCBS, 2020).

1.2.2 Decision-making dynamics

To understand the male involvement in SRHR which is largely associated with positive outcomes to everyone, it is crucial to look at the frame of cultural norms around SRHR (Sarvar and Sonavane, 2018). Traditionally, the Arabic culture reflects a strong hierarchy of people with sacred obedience for the figurehead, older age people especially males (Jones, Abu Hamad, 2016). This narrows the space provided to younger people, youth and women in particular. The same applies to the HH decision-making process where the paternal authorities are usually unchallengeable. The traditional, and still prevalent Palestinian family model, sees men as the HH's main breadwinner and source of protection, and women as dependent housewives and the primary caregivers and nurturers (ibid). Girls, in one study, for example, repeatedly lamented that they were not accorded the same value as their male counterparts by family and community members alike (Samuels, Jones, and Abu Hamad, 2017). Similarly, girls reported feeling less valued than boys when it comes to sharing opinions and thoughts.

1.2.3 Health and health services

The four major healthcare providers in Gaza are the government, UNRWA, NGOs, and private for-profit operators. The MoH is responsible for a significant portion of health care delivery including SRH, in addition to performing the role of the regulator and the supervisor of the entire health system. In Gaza, MoH operates 14 hospitals and 58 PHC centres (MoH, 2020). Reproductive health services are available in some of these PHC centres for example, FP services are available at only 15 governmental PHC centres (ibid).

UNRWA plays an important role in providing PHC services, including SRH services through its 22 centres and buying secondary and tertiary services for registered Palestinian

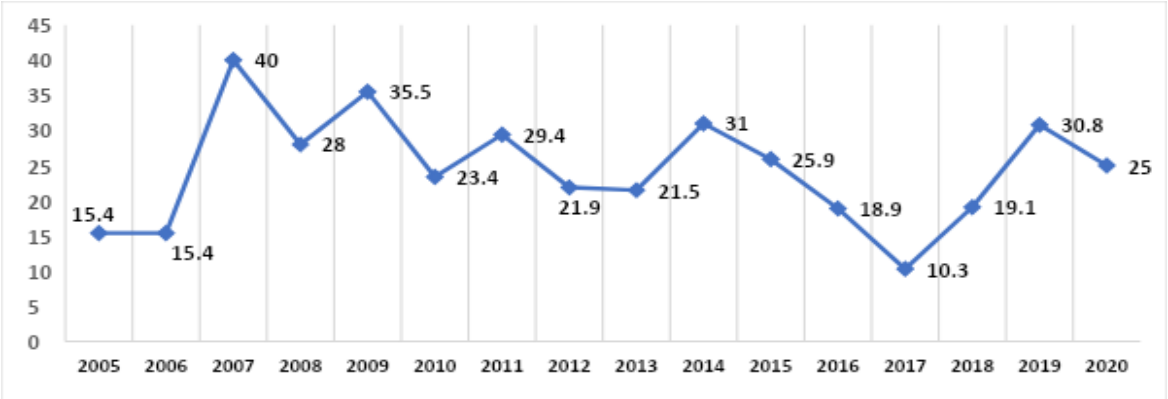
refugees (UNRWA, 2020). NGOs play a complementing role in supporting vulnerable groups, particularly for people living with disabilities, youth, and women's health services. The private sector is largely unregulated and tends to focus on services which generate high revenue such as obstetrics and surgical interventions (Abu Hamad et al, 2017). The private sector follows direct, market-based, non-contractual interactions between beneficiaries and providers. Generally, the distribution of health personnel per population in Gaza is reasonable with more than 22 doctors and 40 nurses per 10,000 population (UNFPA, 2016). However, specialty and subspecialty areas, including midwifery and neonatology, are greatly under-represented. There is a reasonable gender balance among health personnel, and women are more likely to participate in the health workforce in the future as they are currently participating in training programmes in higher numbers than their male counterparts (ibid). Also, health services including SRH services are hyper-medicalized (Samuel et al, 2017).

1.2.4 Sexual and reproductive health indicators

Maternal mortality ratio

Maternal Mortality Ratio (MMR) is a widely used proxy outcome indicator that reflects the interplay of many factors including socioeconomic, contextual, political, cultural, and healthcare system-related factors. However, the officially reported figures indicate that the overall MMR in Gaza has significantly improved from more than 55 per 100,000 live births in 1999 to around 10.3 in 2017, then it increased again to 31 in 2019, and 24.8 in 2020 which is better than the acceptable global range recommended by the WHO and the Sustainable Development Goals (SDGs) (50 and 70 per 100,000 live births consecutively). From January to mid-September 2021 (although the data has not been officially published yet), 21 maternity deaths were recorded (including 13 cases with Covid-19), compared to just 10 cases recorded for the same period in 2020, which suggests a pessimistic picture for the full year 2021. Still, the analysis of MMR tells us that intensive support is needed to accelerate the reduction at the country level to achieve the SDGs recommended reduction by 2/3 by 2030. The analysis of maternal deaths indicates that most of these are preventable if women were more supported at HH, community, and health facility level, particularly ensuring adequate birth spacing.

Figure 1: MMR trends in Gaza between the years 2005 through 2019



Antenatal care

PCBS report (2020) indicates that 95% of women aged 15-49 years received ANC at least four times by a health care provider during pregnancy; about 73% of women received eight ANC sessions or more during pregnancy; 20% attended their first ANC visit after 4 months of their pregnancies. Timely utilization varies by social and cultural reasons, for example, it was more prominent among the younger (less than 20 years), educated and wealthy as well as residents of rural areas. Despite the high coverage, the noticeable quality gaps in ANC include lack of adequate preconception care, weak counselling, and inadequate access to information (UNFPA, 2016).

Natal Care

Annually, in Gaza, there are between 55,000 to 58,000 deliveries. Almost all Gazans women deliver at health facilities and their deliveries are attended by skilled birth attendants usually a doctor and/or a nurse/midwife. Contrarily, problems during delivery include, weak counselling, inadequate access to information, lack of privacy, and sometimes GBV practiced by service providers (Ahu Hamad, 2017). Concerning the mode of delivery, nearly 22% of births were performed through caesarean section (PCBS, 2020); it is more than the WHO recommended standard (less than 15%).

Post Natal Care

PNC remains unsatisfactory, with many women post-delivery not receiving timely appropriate care for themselves. PCBS Multiple Indicator Cluster Survey (MICS) study (2020) showed that 87% of women received a sort of PNC after birth during their stay in the health facility or at home. The average stay of a woman in the hospital after normal birth is usually very limited; 47% stated that they stayed less than 6 hours (PCBS, 2020), influenced by family pressure and cultural norms. Family and social norms contribute to the lack of effective universal PNC coverage. Most of the attention goes to the newly-born babies rather than the mother herself.

Abortion and STDs

Little is known about abortion which is an important component of RH; there is no available credible data on unsafe abortion or cases that have been prosecuted as a result. Some women put their lives at risk by trying to terminate their unwanted pregnancies by using herbs, violent exercises, and other risky methods. However, measuring the level of unsafe abortion in Gaza where pertinent laws are highly restrictive remains difficult. Procedures are often carried out outside the formal health system and are not reflected in health records. A recent study conducted in Palestine (Shahawy and Diamond, 2018) showed that the main themes arising from the interviews were; the centrality of religion in affecting women's choices and views on abortion; the importance of community norms in regulating perspectives on elective abortion. MDM-France assessment in the middle area of Gaza in 2013 showed that many women faced with an unintended (unwanted or mistimed) pregnancy, and some of them had resorted to unsafe abortions exposing their health at risk such as inserting traditional concoction into the uterus, application of external force (Jar of gas on lower abdomen) or by using drugs as Misoprostol (Cytotec).

Of more than 300 university students surveyed in 2018, about 12% reported that they or any of their friends ever suffered or are still suffering from STDs particularly Hepatitis B, Candida, and gonorrhoea (Sayej, 2018). The protective role of condoms in HIV prevention was not known by an overwhelming majority (64.4% for all surveyed), with youth ages 15-19 far less aware (58%) than their older peers aged 20-24 (68.1%) and 25-29 (70%) (Miftah, 2015). UNFPA reported that 25% of older (19-24) unmarried male youth in the West Bank and 22% of younger (17-18) male youth report having had any sexual experiences, with generally similar rates for females. Reported rates for sexual intercourse remain lower (9.5% of older unmarried males and 7% of females) (UNFPA, 2017).

Fertility

As shown in the demographic overview in Table 1, local measures of fertility in Gaza are quite high, with the total fertility rate (TFR) reaching 4 children per woman, despite the significant reduction in the past two decades (UNFPA, 2016). Both the total high fertility rate and the structure of fertility should also be a matter of concern with the concentration of births at young ages. In 2020, the PCBS MICS Survey found an adolescent fertility rate of 48 per 1,000. Influenced by cultural norms, mothers tend to have the number of children they prefer and to have them all within a limited period of time. High fertility rates in Gaza could also be related to many factors including, cultural, educational, political, tribal, and religious factors. More importantly, female secondary education and employment are strong determinants of infertility whereby educated and working women tend to conceive less (UNFPA, 2016).

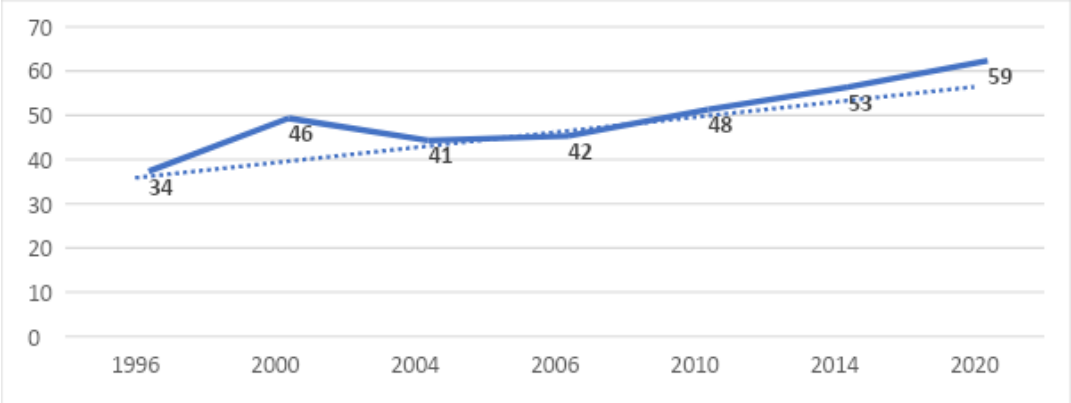
Although it is part of the SRH package of services, sub-fertile couples are usually not served by the public services and most of them seek expensive poorly regulated infertility treatment at private centres. A recent study (S Abu Hamad, 2021) reported that couples start seeking infertility management too early, with 40% doing that within less than 1 year of marriage. On average, sub-fertile couples, approach 5 doctors for infertility management and try two IVF centres (ibid). Strangely, 56.9% of the respondents in the latter study confirmed visiting a traditional healer. The vast majority of sub-fertile couples reported exposure to social pressure (89.4%), especially by in-laws to conceive which increased their stress. In addition, they faced financial difficulties (91.6%), discrimination (76.6%) especially my in-laws, psychosocial stress (53.1%), and complaints from the side effects of hormonal therapy (20.6%) (ibid).

Contraception use

The prevalence of contraception use rate is used as a proxy indicator that reflects the interplay of many factors at both the demand and supply sides, it is the most widely reported measure of outcome for FP programmes at the population level. Influenced by the described above context, trends of using FP methods in the past years show a slow increase in the contraceptive prevalence rate; 51% in 2000 which increased to 53% in 2010, 57% in 2014, and finally 59.4% in 2020 (PCBS, 2020); with 42.8% reported using modern methods and 16.6% using traditional methods. The annual increase rate of contraception use of all methods in the past 20 years in Gaza is at 1.2%. Worth noting that younger adolescent women are far less likely to use contraception than older women, only about 15% of married women aged 15-19 currently use contraception (PCBS 2020). FP is usually initiated late; first contraceptive use (ever-use) tends to have begun only after the

4th or 5th child and after having a 'satisfactory' number of children, especially boys (UNFPA 2016).

Figure 2: Prevalence of contraception use in Gaza



Women's education is associated with higher use of contraception. Social and economic development to reduce the demand for children is essential particularly through the education and employment of mothers. The most commonly used methods are female methods including Intra-uterine devices (IUDs) (used by 23% of married women) followed by pills (8,5%) and male condoms (6.7%) (PCBS 2020). Condom use was more reported among couples with higher education (ibid). As a result of social, cultural, political, economic, and legal pitfalls, women and girls often face particular challenges to their enjoyment of their full SRHR which includes autonomous access and utilization of FP. For instance, by practice, the consent of the partner on using the FP by women is a prerequisite for receiving the services at both the MoH and UNRWA (UNFPA, 2016).

According to the most recent PCBS (2020), only 60% of married women of reproductive age had met their need for modern FP methods. Unmet need is often portrayed as a problem of access, leaving the perception that women do not use contraceptives because they cannot find or afford them. But while access is an issue, women have many other reasons for not using FP, including personal, cultural, or religious objections, fear of side effects, health concerns and lack of knowledge or lack of permission from husband.

1.2.5 Violence and child marriage

Girls in Gaza are vulnerable to child marriage and early pregnancy. They are not only poorly protected by national law—which permits the marriage of girls as young as 16—but they face considerable pressure from their families to marry early in order to uphold 'honour' and also, because of economic hardship. PCBS (2020) report indicates that 17% of women in Gaza aged 20-24 years got married for the first time before reaching the age of 18 years. Overall, one in four Gazan females (25.7%) report having been sexually harassed at some point in their lives (PCBS, 2016). Not only is the law largely silent on GBV (UN-Women 2015), but given that victims can be perceived as having violated 'honour', most girls and women are afraid to report their experiences, often even to their own families. At the HH level, fathers usually show more leniency in tolerating opposition of their decisions by their older sons more than their daughters or even wives. The PCBS most

recent survey on violence (2019) shows that more than one third of married women had experienced violence by their HH in the past year, and the prevalence of violence against non-married youth by HH members was even higher. Just 1% of victims seek formal assistance at a legal or woman centre (PCBS, 2019b). Divorced women are arguably exposed to the most severe social sanctions due to the 'social stigma' surrounding divorced women, who are often viewed as the cause of their own misfortune, with divorce largely considered 'shameful' for women, but not for men (Jones and Abu Hamad, 2016).

1.2.6 Accessibility barriers

The barriers preventing boys accessing health care services are financial rather than social, in addition to restrictions on movement outside Gaza and lack of resources at health facilities, especially drugs (Abu Hamad, 2017). The findings underscore that gender norms especially those pertaining to adolescent girls' sexual 'purity'– shape adolescent health in multiple ways. Girls face increasing restrictions on their mobility and social interactions, leaving them with limited opportunities for leisure or exercise, socializing with peers or seeking health (including SRH) services. UNFPA and Sharek Youth Forum (Sarras, 2020) has conducted a study which aimed to explore the social norms and attitudes hindering youth in Palestine from accessing SRH services and reported that males need to access more information about "physical puberty", safe sex, sexual identity, and STIs. While females' informational needs focused on building relationships and relating to the other gender-related topics, domestic violence, harassment, as well as FP methods, and reproductive health needs of people with disability (Sarras, 2020). As in many conservative contexts access to the SRH services and information is very limited and stigmatized for unmarried young people (Abu Hamad, et al 2017); the system targets only married women particularly around maternity issues, and indeed post-menopausal women are also excluded from services.

2. Literature review

2.1 Male involvement in SRHR

A small but growing body of research on men's involvement in SRHR globally calls for gender-transformative programming that works with men and boys in addressing gender inequalities as being key to improving SRHR for everyone (Gupta 2000; Greaves et al 2014; Ricardo et al 2011; Dworkin et al 2015; Sarvar and Sonavane, 2018). Gender-transformative interventions largely focus on violence against women and girls (Dworkin et al 2013; Anderson et al 2013). As with the literature specifically on Palestine, there is much less research on adolescent SRHR or sexual health promotion, despite these being top priorities for SRHR interventions in general. A systematic review of the quality and impact of gender-transformative interventions, however, finds that they tend to be of low quality and have an inconclusive impact (Ruane-McAteer et al 2019). The authors suggest that the assumption that simply involving men and boys in SRHR in and of itself is enough to promote gender equality, is false; unless there is more attention paid to male privilege, power, and positionality, the status quo is likely to continue. They argue that for interventions engaging men and boys to challenge gender inequality, there is a need to be explicit about how the change is meant to occur, go beyond 'self-reported measures of attitudinal shifts and to look at the behavioural changes driven by interventions, and monitor these over a longer period of time (Ruane-McAteer et al, 2019).

Whilst research with reproductive health experts in Palestine on their priorities for work on sexual and reproductive health finds that understanding community attitudes towards, amongst other concerns, the role of men in FP was ranked as a top priority (Abu-Rmeileh et al 2018), a 2019 review of the landscape of reproductive health research in Palestine found that there has been no research as yet in this context on men's role or involvement in sexual and reproductive health rights (Shalash et al 2019). Where Palestinian men's relationship to SRHR is considered, they are largely positioned within the literature as perpetrators of violence and rights infringements against women and girls and the implications for their SRHR (Shalhoub-Kevorkian 2005; CSW 2010; Baloushah et al 2019). Little attention is given to exploring how these dynamics might be addressed to promote SRHR.

2.2 Youth male involvement in SRH

A recent descriptive feasibility study commissioned by UNFPA in 2018 on 325 university students (15–29 years) in East Jerusalem, West Bank and Gaza to deliver evidence-based information that will form a road map for successful and sustainable Youth-Friendly Health Services delivery points and to strengthen the capacities of all relevant stakeholders to meet young peoples' needs. One third of both male and female respondents think that educating people about SRH issues can help individuals to develop more positive attitudes and greater maturity toward SRH issues; as 28.6% think that it can help to gain appropriate information related to SRH and 15.1% think that it can help to protect young people from unsafe sexual experiences (Sayej, 2018). Generally, studies argue that greater participation of youth is in itself a prerequisite and output of improved

SRHR services (Nair et al, 2015). It also requires working on the attitudes and competencies of healthcare providers, appropriate physical setting of health facilities, encouraging and non-discriminatory services and sound outreach programmes in order to operationalize the 8 standards of WHO towards adolescent health (ibid).

2.3 Male knowledge and awareness about SRHR

The available limited literature indicates that only 33.5% of both males and females' university students in East Jerusalem, West Bank and Gaza have had heard about SRH issues (Sayej, 2018). In a similar but more recent study, a higher percentage of males (41%) reported that they have good knowledge about health issues and reliable resources than females (30%). Similarly, about 39% and 46% of males and females, respectively, reported that they have some knowledge, but they still have some questions that need to be answered. Correspondingly, around 17% of the females and 15% of the males don't know much about SRH matters, and they need to know more, while about 5% of the males and 7% of the females don't know much about SRH issues, and do not have a need to know more now (Sarras, 2020). The participants indicated their need for more information about puberty, the human body, reproductive health system, safe sex, sexual identity and STIs. On the other hand, females requested more information about building relationships and relating to the other, gender-related topics, domestic violence, harassment, as well as FP, and reproductive health needs of people with disabilities (ibid). In relation to their attitudes towards SRH, youth were highly progressive. For instance, the later study shows that about 92% of all male and female respondents agreed that SRH health awareness contributes to a healthier and better future for all, 87% of males and females (1.2 value for males and 1.2 for females) agreed that lack of SRH information may lead to marital problems and 95% of males and females agreed that FP is a joint responsibility of both partners and it is not the sole responsibility of only the women. One third of female youth and a quarter of male youth reported that they are in favour of including CSE curricula in school curricula at least starting at 4 years of age (Sarras, 2020). The sections below describe experiences regarding specific SRHR related components.

2.4 Menstruation and puberty

The literature shows that the main source of information about puberty for boys in Palestine is friends (UNFPA, 2013). Abu Hamad and colleagues (2017) confirmed that boys know only a little about SRH and they are completely unprepared for puberty changes. According to the latter study, most Palestinian boys defined puberty as growing up and linked it with the ability to marry. While the majority of boys focus on physical changes only, the same source indicates that some Palestinian boys had anxiety feeling about going through puberty and the prospect of the 'scary adulthood' stage. These feelings reflect young males' concerns over their sexual ability or ability to father children. As menstruation is considered a taboo topic, surrounded by stigma within the Palestinian community, families including the boys are not aware of menstruation and they don't support girls/women during it (Abu Hamad et al., 2017). Indeed, in the latter study, boys did not mention anything about girls' menstruation. Similarly, the majority of girls reported that they are exposed to embarrassing comments or teasing from family members. Moreover, fathers don't communicate with daughters directly concerning menstruation, while, the mothers usually tell the fathers when their girls get the period (ibid).

2.5 Maternity services

The literature shows that about three-quarters of Palestinian men had accompanied their wives to any ANC visits, 30% of men reported that they attended every ANC visit (El-Feki et al., 2017). Younger men, those with more education, those with greater wealth, and those who were employed were more likely to have accompanied their wives to an ANC visit (ibid). The same source indicates that around three-quarters of the Palestinian husbands were present during the birth of their most recent or youngest child – at the hospital, but only rarely in the delivery room. Palestinian delivery rooms are usually occupied by more than one woman, and as such, it is not culturally acceptable – nor, often, is it possible in terms of physical space- for men to be present during childbirth (El-Feki et al., 2017; UNFPA, 2016). The Palestinian figures do not differ largely from the figures in Egypt (very similar) and Lebanon (a bit better), (El-Feki et al., 2017).

2.6 Decisions about the use of contraceptives

A study conducted on 325 university students (15–29 years) in East Jerusalem, West Bank and Gaza shows that 78.6% of both males and females university students already familiar with contraceptive methods as follows; pills (62.8%), male condoms (53%), natural methods (41%) and injectable (34%). Interestingly, among university students, 48% are aware that male condoms are used for protection from STIs besides their birth control role (Sayej, 2018). Barbour & Salameh (2009) reported that all university Lebanese male students knew about the condom, but 2.8% of females had never heard of it, about three-quarters of males (72.5%) had heard about the IUD in comparison with 88.6% of females. One third of respondents thought that an IUD was placed in the vagina, 10.7% thought it could be used by any woman, and 15.0% did not know how it is used. More females than males knew that IUDs have side effects and contraindications (Barbour & Salameh, 2009). Of the Palestinian refugee women in Lebanon, 77% reported that decision about contraception was shared, and 71% of the men women reported that decision about contraception was shared, while 25% of the Palestinian men reported that the men should decide about contraception (El-Feki et al., 2017). On the other hand, 78% of the Lebanese women reported that the decision about contraception was shared, while, 18% of the women reported that men decided about the use of the contraception (ibid). With regard to correlates related to involvement in FP, Wondim and colleagues (2020) revealed that Ethiopian men's level of education was positively associated with male involvement in FP. Men with a favourable attitude towards FP were approximately 2 times more likely to be involved in FP than those having unfavourable attitudes. Also, men who had good knowledge of FP were 2 times more likely involved in FP utilization than those who have poor knowledge. Also, men who ever discussed with their wives were 2.51 times more likely to be involved than those who do not discuss (Wondim et al., 2020).

2.7 Sexually Transmitted Infections

Regarding knowledge about STIs transmission, the literature highlights that only 52% of both males and female university students in East Jerusalem, West Bank, and Gaza know about STIs transmission, 20% indicated that STIs are transferred through sexual relationships, 9.2% reported via body fluids, 4.9% through homosexuality and 3.1% via blood transfusion (Sayej, 2018). The same study indicated that 12% of the university

students in East Jerusalem, West Bank and Gaza had experienced a sort of STIs with hepatitis (5.5%) (Candida 3.7%) and gonorrhoea 3.4% are the most commonly reported. Moreover, 14% admitted that they are aware that their friends were engaged in pre-marital sexual relationships. This is an alarming finding and calls to improve access to appropriate SRHR services and information for young people (Sayej, 2018). Of teens aged 15-17 in Palestine, 40% had not heard about STIs (other than HIV) and 20% even had not heard of HIV (MIFTAH et al., 2015).

Despite the social stigma and taboos associated with sexuality, 25% of the unmarried male youth 19-24 years and 22% of the younger group (17-18) in the West Bank and East Jerusalem reported engagement in any sexual experiences, with generally similar rates for females. Rates for sexual intercourse remain lower (9.5% of older (20-24) unmarried males and 7% of females) (Glick et al., 2016). Phone and internet sex involving another person is relatively common among unmarried youth of both genders; up to 38% among male youth and up to 30% among older female youth (Glick et al., 2016). Young people's limited access to SRHR services and education may hinder their healthy development and increase the risk of unintended pregnancies, HIV/AIDS, and STIs (ibid).

2.8 Inequitable gender norms

To a large extent, social norms in Gaza are not gender-equitable. For example, these norms dictate that it is not acceptable for a woman to leave a sub-fertile husband, although it is acceptable for a man to leave a sub-fertile wife. These social norms are not only driven by the prevailing gender inequalities, but it also contributes to exacerbating those prevailing gender inequalities (Abu Hamad et al, 2017). Additionally, women are blamed if they miscarry or produce female offspring. Preference for a male child tends to prohibit FP, since mothers often have more babies hoping for a boy, fearing that their husband might marry again to have male offspring (Jones and Abu Hamad, 2016). Ironically, while Abu Hamad (2020) concluded that family was the main source of support for the sub-fertile couples, as 81.9% reported being supported by their husbands, the same study indicates *that 23% of the sub-fertile women reported experiencing discrimination because of infertility, of them, 38.7% reported that they were exposed to discrimination by their husbands. Aspects of discrimination were mainly showing sympathy and sorrow (73.3%), verbal abuse (33.3%), and uncertainty about the sustainability of marriage (21.3%) (Abu Hamad, 2020).* Some 23% of sub-fertile women reported that they had experienced negative reactions due to their infertility, including discrimination at the hands of their husbands. Verbal abuse was reported by 33.3%, and uncertainty about the sustainability of the marriage was common, reported by 21.3%. Over 73% of sub-fertile women also reported that their husbands responded with sympathy and sorrow.

El-Feki and colleagues (2017) revealed that inequitable gender attitudes remain common in Palestine. Using a specifically adapted GEM scale, the average GEM score for men was 1.17/out of 3 (39%), while women's average score was 1.52 (51%) (El-Feki et al., 2017). In Egypt, the average GEM score for men was very low at 0.9 (30%), and women reported higher at 1.3 (43%) (ibid). The average GEM score for men in Lebanon was 1.69 (56%), while the women's average score was 1.92 (64%). Syrian respondents' GEM scale scores were slightly lower than Lebanese respondents' scores, for both men and women (ibid).

2.9 Parenting practices

The PCBS MICS study (2020) reveals that Gazan parents almost universally use corporal punishment against their children, only 5.6% reported using non-violent disciplining practices. Although boys more commonly experience physical abuse, girls either experience or witness physical and psychological aggression that creates expectations about their own prospects as adult women. The use of corporal discipline was more common among the poorest quintile, camp residents, parents with lower education, and male respondents (PCBS, 2020). As they become older, exposure to violence among children decreases, though still more than half (56%) of adolescents aged 12–17 had experienced violence from caregivers in the past year (PCBS, 2019b). The same survey shows that nearly half of boys aged 12–17 and 17% of girls the same age reported experiencing some form of violence at school.

Although it is physically and emotionally harmful, 26.9% of caregivers reported using physical punishment regularly with their pre-schoolers and 53.1% reported occasionally using such punishments (Abu Hamad and Melehat, 2014). Another study shows that in Palestine, more than 80% of men and 94% of women reported verbally disciplining their sons and daughters aged 3 to 14 (El-Feki, et al 2017). In a study conducted with caregivers of pre-schoolers in Gaza, two thirds (65%) of the participants stated that they had never participated in any sessions about child development (69%), child rights (68%), and child learning (67%) (Abu Hamad and Melehat, 2014). This shows that caregivers' awareness about positive parenting is limited and more sensitization sessions should be implemented. Over one half (52.3%) of caregivers reported reading to their children once a week. Purchasing toys once a month was reported by around 33.7% of respondents (ibid). Only 31.2% of the respondents reported taking their child for recreational activities once a week. On the other hand, 82.5% of caregivers reported providing incentives once a week to discipline their children. The percentage of caregivers who practiced at least two positive parenting techniques was 93.5%. Around 82% performed at least three techniques and 59% performed at least four positive parenting techniques (ibid). The PCBS MICS study (2020) shows that the child development index has reached around 84% (in 2014 it was 72%) for children aged 3-4 years who follow the correct development path in at least three of the following four areas: literacy and numeracy (38%); physical development (99%); social-emotional development (82%); and learning (93%). In Palestine, El Feki and colleagues (2017) indicated that fathers were least likely to report bathing a child (14%), and changing the child's diapers or clothes (12%). Moreover, fathers reported some level of involvement in helping the child with homework (42%), dropping off or picking up the child at school (44%), staying at home with the child when the child was sick (44%), and daily routine care of the child (39%). About 81% of the men play with the child or perform various leisure activities together and 96% of the women do the same (ibid).

3. Methods and design

Informed by consultative meetings conducted with stakeholders during the inception phase, this study used a mixed-methods approach involving a literature review, empirical quantitative KAP survey collected in March/April 2021, and qualitative data collection during the same period. The quantitative component aimed at obtaining more generalizable findings across the target populations, around men and youth KAP related to SRHR and child-rearing. The qualitative data sought to explore, in greater depth, men's involvement in SRHR, what drives and what constrains men's involvement in SRH and child-rearing and how men's involvement could be promoted. The data collected were triangulated to produce a layered analysis, enabling us to more fully explore KAP around men's involvement in SRHR and child-rearing and how to maximize their engagement.

3.1 Literature review

The study team carried out a literature review and analysis, drawing on existing documents made available by UNFPA Palestine, as well as an independent investigation by the study team and also reviewing the available referred and grey, local, regional and international literature. The literature review process followed the study framework developed in the inception phase, with a focus on identifying knowledge gaps and preliminary indications of male participation in SRH and barriers to their participation, in order to inform the study design, scoping and development of the study quantitative and qualitative tools.

3.2 Quantitative component

3.2.1 Sample

The quantitative findings presented in this report were drawn from a clustered random HH survey of 50 clusters with 476 HHs-based on a PCBS sampling frame (2020), proportionately distributed across the five governorates of the Gaza Strip, 10 HHs were systematically selected from each cluster (every tenth HHs). From each HH, we interviewed an adult male, an adult female, and an adolescent aged 15-19 years (270 males and 206 females). The sampling parameters included a 97% confidence level and a 5% confidence interval (Annex 2) presents the output of the calculated sample). The sample parameters were congruent with the Gaza Strip population, for example, 67% were refugees and 84% were living in nuclear families. We deliberately oversampled some groups of particularly marginalized populations, including those with disabilities (13.3% of the sample) and early married girls. Table 2 shows the characteristics of the quantitative sample.

Table 2: Distribution of study participants by characteristic variables

Variable	Number	%
Gender		
Male adults	476	50
Female adults	476	50

Total adults	**952**	**100**
Male adolescents	270	56.7
Female adolescents	206	43.3
Total adolescent	**476**	**100**
Age (male adults)		
20–30 years	72	15.1
31–40 years	147	30.9
41–50 years	164	34.5
51 years and over	93	19.5
Mean age 41 years; median 42 years, range from 22–70 years		
Age (female adults)		
20–30 years	109	22.9
31–40 years	165	34.7
41–50 years	161	33.8
51 years and over	41	8.6
Mean age 38.5 years; median 39, range from 20–60 years		
Age (male adolescents)		
15 years	41	15.2
16 years	62	23.0
17 years	78	28.9
18 years	55	20.4
19 years	34	12.6
Age (female adolescents)		
15 years	30	14.6
16 years	53	25.7
17 years	49	23.8
18 years	50	24.3
19 years	24	11.7
Family type		
Nuclear	402	84.4
Extended	74	15.6
Refugee status		
Refugee	322	67.8
Non-refugee	153	32.2
Governorates		
Rafah	59	12.4
Khanyounis	92	19.3
Deir Al-Balah	74	15.5
Gaza	173	36.3
North Gaza	78	16.4
Place of living		
Camp	162	34
Non-camp	313	66
Family size		
Up to 6	115	24.2
6–10	275	57.8
More than 10	86	18.1
	Mean	7.33
Education attainment for adult male		
University education	136	28.4
Secondary	139	29.2

Preparatory	110	23.1
Elementary	68	14.2
Can read and write	20	4.2
Illiterate	3	0.6
Education attainment for adult female		
University education	94	19.8
Secondary	131	27.5
Preparatory	181	38
Elementary	54	11.4
Can read and write	12	2.5
Illiterate	4	0.8
Monthly income		
500 Israeli Shekel (ILS) and less	138	29.2
501 ILS to 1,000 ILS	161	34
1,001 ILS to 2,000 ILS	123	26
More than 2,000 ILS	51	10.8
	Mean 1091	**Median** 800
HH includes a person with a disability		
Yes	63	13.3
No	409	86.7

3.2.2 Data collection

Quantitative data collection took place between March/May 2021. The research team developed the instruments for the quantitative component of this study in congruence with the study objectives and also benefiting from consultative meetings at the inception phase. The quantitative instrument included questions from HH questionnaires that have been previously used by members of the team for other studies, from internationally known instruments, like the GEM Scale and PCBS relevant surveys. The developed tool was shared with the UNFPA, members of the steering committee, and international experts who provided valuable feedback. The questionnaire included several modules, including knowledge about SRH, participation in SRH, norms around SRH, decision making around SRH, and scenarios of possible interventions to promote male participation in SRH (for further details see the questionnaire in Annex 3). The draft tool was translated into Arabic and then reverse translated into English to ensure credibility. The Arabic version was used during the HH interviews. Twelve female enumerators living in the targeted governorates and the field supervisors attended a 4-day training course to orient them on the quantitative data collection processes and tools. During the training, each question in the questionnaire was also discussed and explained to the enumerators. Then field piloting was conducted with 30 HHs and resulted in further modifications to the tool. The response rate was high 87.5%. Field supervisors also conducted validation visits and call-backs (100 calls).

3.3 Qualitative component

In parallel with the quantitative component, the qualitative component was conducted between March/April 2021, where we aimed to explore how community members particularly men and male youth, community leaders, and key informants perceive male participation in SRH and the possibilities they foresee for future male participation. This

included 41 FGDs with adults and young males and females, diverse in socioeconomic backgrounds as well as 18 KIIs with a purposive sample of service providers, international experts, donors, media influencers, NGOs, other UN agencies, and government officials.

The qualitative component included talking to 335 participants, of them, there were 18 key informants (9 males and 9 females), 31 service providers and 20 religious, tribal, male and female community leaders who participated in 7 FGD, and 266 community members (112 F, 154 M) who participated in 34 FGDs with purposively selected community members from all areas in the Gaza Strip. A purposive sampling technique was used to ensure a mix of participants for the FGDs from different socioeconomic backgrounds, including youth and adults, adolescent mothers, child brides, divorced/separated, unmarried women and people with disabilities. For example, community members included refugees (68.6%), and non-refugees (31.4%), from different localities in Gaza, including people from camps (21%), non-camp and ARA (16.5%). We oversampled particularly vulnerable groups, including people with disabilities, unemployed, economically disadvantaged, early married and divorced.

Similar to the quantitative component, the instruments for the qualitative component were developed by the research team, informed by the study objectives, literature review and consultative meetings. The developed tools have been shared with the UNFPA and the members of the steering committee, and international experts who provided valuable feedback. For further details about the content of the tool (see Annex 4). The draft tool was translated into Arabic and then reversed to ensure credibility. To ensure the scientific rigor of the study, a two-day training session was provided to the 7 qualitative researchers assigned to collect the qualitative data followed by piloting and refinement of the tools. Other measures used to support the credibility of data included following a standardized approach for data collection and processing, ongoing daily checking, and members and peer check. Qualitative meetings were conducted at CBOs, in a convenient non-threatening environment. The average duration of FGDs was 110 minutes and the average number of participants per group was 8 members. FGDs were conducted face to face with adequate considerations to meet Covid-19 standard protective measures including using masks, disinfectants, appropriate distance and measuring temperature. With regard to KIIs, the average duration was 52 minutes. Almost half of KIIs were conducted through face-to-face interactions while the rest were done using telecommunication means. The team kept an eye open for a maximum prolonged engagement. More demographic characteristics of the FGD participants are available in (Table 3)

Table 3: Distribution of FGD participants (community members)

Variables	Number	%
Age		
Less than 20 years	59	22.6
20–39	157	60.2
40 and over	45	17.2
	Mean 30	Median 28
Gender		
Female	112	42.9
Male	149	57.1
Marital status		
Married	150	57.5
Single	98	37.5

Other (divorced/separated/widowed)	13	5
Refugee status		
Refugee	179	68.6
Non-refugee	82	31.4
Place of residency		
South of Gaza	84	32.2
Central	83	31.8
North of Gaza	94	36
Location		
Camp	57	21.9
Access-restricted area	43	16.5
City	143	54.8
Village/town	18	6.9
Current enrolment in education		
Enrolled	51	19.5
Not enrolled	209	80.5
Educational attainment		
Less than secondary	65	25.3
Secondary	132	50.6
University	63	24.1
Current working status		
Working	52	19.9
Not working	209	80.1
Head of the family		
Female-headed HH	37	14.2
Male-headed HH	224	85.8
Type of family		
Nuclear	181	69.3
Extended	80	30.7
Family income	Mean 855	Median 600
Family size	Mean 7.25	Median 7
HH includes a person with a disability		
Yes	67	25.7
No	194	74.3

3.4 Ethical considerations

The research team adhered to stringent ethical measures to protect participants as per the international ethical principles. We followed the Modified International Code of Ethics Principles (1975) known as the Declaration of Helsinki. Permission was sought, and given, from Gaza's Helsinki Committee (PHRC/HC/792/20) as shown in Annex 5. To protect the rights of the participants, each of them received a complete, standardized explanation of the purpose and parameters of the research, and informed consent for adults and assent for young people 17 years and under was sought.

3.5 Analysis

The quantitative data were entered, cleaned and analysed using SPSS 26. Frequency analysis and central tendency measurements were conducted first, followed by inferential analysis to examine the statistical differences among the variables. P-value was regarded as statistically significant when it falls below 0.05.

Qualitative interviews were double-recorded, listened to and then detailed minutes were taken, reviewed, carefully read several times (immersion), and then thematically coded. To facilitate the coding process, a one-day in-depth debriefing meeting was held to discuss emerging findings and key themes. Subsequently, qualitative stuff and materials were coded using a thematic coding structure, informed by the study frame, and findings were first aggregated by instrument and then collectively across all instruments.

3.6 Study limitations

- A lack of clear baseline data to ascertain the change in men's KAP related to SRH by time making it difficult to identify trends in KAP.
- The limitations of this study are those common in cross-sectional surveys. Cross-sectional studies (snap-shot) assess the situation at a particular time, while perspectives and behaviours could be influenced by time, circumstances, and so on. Using research designs with longitudinal methods of data collection might also elicit more credible information.
- Additionally, the collected quantitative data was solely reliant on self-reported responses. Self-reported surveys may be inaccurate because participants are sometimes unwilling to describe accurately their experiences, attitudes, or feelings especially around culturally sensitive issues like SRH.
- Covid-19 pandemic constituted a major barrier, to engage more with beneficiaries and use more participatory interactive qualitative methods. In April 2021, the research team suspended the fieldwork for several weeks because of the lockdown measures.
- May 2021 has witnessed another Israeli aggression on Gaza. The area was heavily bombed by Israel for 11 consecutive days which resulted in the death and injury of thousands of people, destruction of thousands of houses and institutions, and also damaged the infrastructure, including the electricity and internet networks. During this period research activities were also suspended.
- Measuring attitudes during this study was one of the most challenging parts; despite the availability of validated scales, the assumed linearity, the relatively sharp cut responses, and the snapshot effect were limiting the research team's ability to accurately ascertain attitudes about SRH.
- Because participants completed the survey at the level of the HH, it is possible that their responses were influenced by the setting. This might be more noticeable with adolescents who might give be more expressive in their responses if they completed the survey online or at other settings other than their HHs.

4. Findings

To start with, similar to understanding masculinities, looking at the KAP about SRHR and child-rearing aspects among men, requires attention to male realities and inherited vulnerabilities in the context of the Gaza Strip. In the Gaza Strip, men continue to assume the breadwinner role and hold a relatively absolute responsibility for sustaining the family. With almost all of their castles and fortresses destroyed by the siege, blockade, and economic depletion policy, men are left barehanded. For men in the Middle East and North Africa (MENA) region including Palestine, under such circumstances of unemployment and dearth of viable business models, it is not easy to tolerate the social pressure to realize the "provider" model of manhood (El-Feki et al, 2017). This pressure is even harder for young men who are overwhelmed by the pursuit of an employment opportunity, which is often a prerequisite for marriage, and therefore, they feel emasculated. For women, the circumstances disable, if it doesn't push back mobility, employment, and independence whereby the studies have found widespread frustration, marginalization, and alienation from social and political institutions, with profound implications for young men and young women alike (ibid). Let only losing the power of hope as a current reality added to the heavy inheritance of chronic exposure to violence, military threats, political and social repression, and the protracted no-win of non-violent "solutions" be the picture, would explain how the shadow would look like. The largest section of this report below shows the key findings that emerged from the quantitative and qualitative analysis. The reader is advised to contextualize the findings in order to draw a more comprehensive conclusion.

Findings in this chapter are organized to give insights about the general knowledge, sources of information, and the level of awareness about SRHR and child-rearing aspects and concepts prior to describing the knowledge and access to information/support throughout the puberty stage. The second part of this section provides an overview of the attitudes, cultural norms, mindset and way of decision-making pertaining to SRHR and child-rearing aspects. The third part reflects on how both knowledge and attitudes translate into actions and highlights both motives and barriers towards male participation to conclude with some ideas for greater male involvement.

4.1 Perception, knowledge, and awareness about SRHR

4.1.1 Knowledge about SRHR in general

When asked about what SRH means, two-thirds of men (66%) and nearly 80% of women indicated that they are familiar with SRH; still, a considerable proportion reported not knowing what the term means. The differences between men and women were statistically significant and stark as women are 21% more aware of SRH meaning than men. With nearly 45% difference between males and females, familiarity with SRHR among adolescents is even lower than their adults' counterparts as only 46% of boys reported knowing the term and 67% of girls reported the same with statistically significant differences in favour of girls.

Among males who reported familiarity with SRHR term, ANC (62% reported by men and 58% by boys), FP (49% by men and 37% by boys) and NC (41% by men and 45% by boys) were more frequently cited than other services which were rarely reported by male respondents, like early detection of breast cancer (2% reported by men and by none of the boys), STIs (2% reported by men and boys) and abortion (1% by men and 2% by boys). Care during the menopausal period (12% reported by men, 14% by women and 10% by adolescents), providing information, advice and services on sexual health and wellness (8% reported by men and 6% by women, 3% by boys and 1% by girls) and adolescent health (6% by men, 4% by women, and 10% by adolescents) were also reported by few respondents.

Exploring the extent of understanding in the community about the changes in the mood and the psychological status among girls as well as women due to hormonal fluctuation, our findings reveal that 71% of men and 90% of women (nearly 30% difference) were aware about these psychological changes. Nevertheless, when asked to mention examples of these conditions, when women suffer from changes in mood due to hormonal changes, 88% of men who reported being aware about these changes, mentioned during the bleeding phase of the menstrual period, only 33% recognized the pre-menstrual tension related systems and 40% mentioned during pregnancy. A low proportion of men mentioned during the postpartum period (17%) although it frequently occurs, and very few mentioned menopause (2.3%). There is little understanding about the effects of hormonal changes on women/girls' psychological status especially among men (Table 4).

Table 4: Participants' knowledge about SRHR

Variable	Male		Female		P-value
	Number	%	Number	%	
Adults					
Knowing what is meant by 'SRHR'	313	65.7	377	79.2	0.001
Components of SRHR as reported by those who reported knowing the term 'SRHR'					
Antenatal care	194	61.9	207	54.9	
Family planning	153	48.8	228	60.4	
Natal care	129	41.2	186	49.3	
Postnatal care	90	28.7	173	45.8	
Preconception care	81	25.8	123	32.6	
Menopause care	38	12.1	53	14	
Information, advice and services on SRH	24	7.6	24	6.3	
Adolescent/youth health	18	5.7	15	3.9	
Fertility services	14	4.4	9	2.3	
Pre-marital medical examination	10	3.2	2	0.5	
Early detection of cancers among women	7	2.2	12	3.2	
STIs	5	1.6	4	0.1	
Gender-based violence	4	1.2	4	0.1	
Care post-abortion	2	0.6	5	1.3	
Knowing male-specific SRHR	185	38.9	171	35.9	0.335
Components of SRHR specific for men as reported by those who reported knowing SRHR for men					
Infertility	83	44.8	80	46.7	
Sexual dysfunction	73	39.4	95	55.5	
Need for contraception	70	37.8	52	30.4	
Information and counselling	46	24.8	38	22.2	
Prevention and treatment of STIs	21	11.3	9	5.2	
Male reproductive health-related cancers	8	4.3	4	2.3	

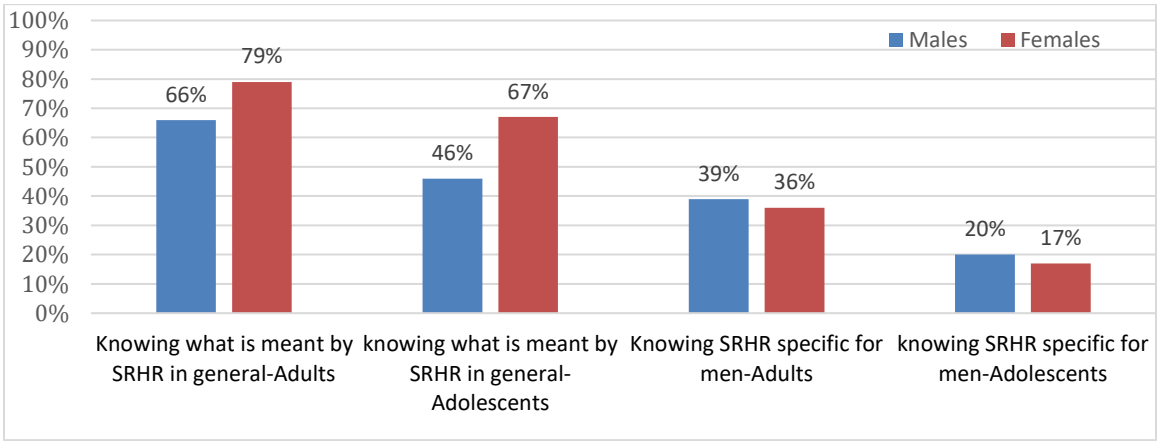
Knowing when women/girls suffer from a change in mood and psychosocial issues due to a change in hormones	337	70.8	428	89.9	0.001
Knowing situations at which women/girls experience mood and psychosocial challenges among (N=337 among males and 428 among females)					
During the menstrual period – bleeding stage	296	87.8	358	83.6	
A few days before monthly menstrual cycle	111	32.9	160	37.4	
When she is pregnant	136	40.3	186	43.5	
Postpartum phase	57	16.9	93	21.7	
During hormonal treatment	3	0.9	4	0.9	
At the menopause	8	2.3	23	5.3	
Adolescents					
knowing what is meant by 'SRHR' in general	123	45.6	137	66.5	0.001
Components of SRHR as reported by respondent who knows the term 'SRHR'					
Antenatal care	71	57.7	80	58.4	
Natal care	55	44.7	73	53.3	
Family planning	45	36.6	58	42.3	
Preconception care	36	29.2	53	38.7	
Postnatal care and child care	34	27.6	58	42.3	
Adolescent/youth health	13	10.6	14	10.2	
Care during menopause	12	9.7	14	10.2	
Fertility services	6	4.8	3	2.2	
Relationships between a man and a woman and the ability to have children	6	4.8	3	2.1	
Pre-marital medical examination	5	4.0	4	2.9	
Child care	5	4.0	1	0.7	
Fertility management	4	3.2	1	0.7	
Women's health	4	3.2	2	1.4	
Prevention and management of STIs	2	1.6	4	2.9	
Care after abortion	2	1.6	7	5.1	
Gender-based violence	2	1.6	7	5.1	
Early detection of cancer among women (breast cancer)	0	0	7	5.1	
Knowing male-specific SRHR	54	20.0	35	17.0	0.404
Knowing what is included in male-specific SRHR, among those who reported knowing in the previous question					
Sexual dysfunction	27	50.0	16	45.7	
Infertility	22	40.7	21	60.0	
Need for contraception	16	29.6	12	34.3	
Information and counselling	13	24.0	12	34.3	
Man's ability to have children	9	16.6	2	5.7	
Relationships between a man and a woman	4	7.4	1	2.8	
STIs	2	3.7	1	2.8	
Male reproductive-related cancer	1	1.8	0	0.0	
Child care	0	0.0	1	2.8	

4.1.2 Familiarity with SRHR specific to men

The nuance between qualitative and quantitative findings has clearly manifested when it came to the SRHR awareness, where, because the SRH concepts are highly materialized, the familiarity with men-specific SRHR has almost halved the respondents who reported knowing the meaning of SRHR in general. Thus, when asked about SRHR specific for men, only around one third of adult participants and less than a quarter of adolescents reported knowing what the term entails (39% of men, 20% of boys, 36% of women and 17% of girls),

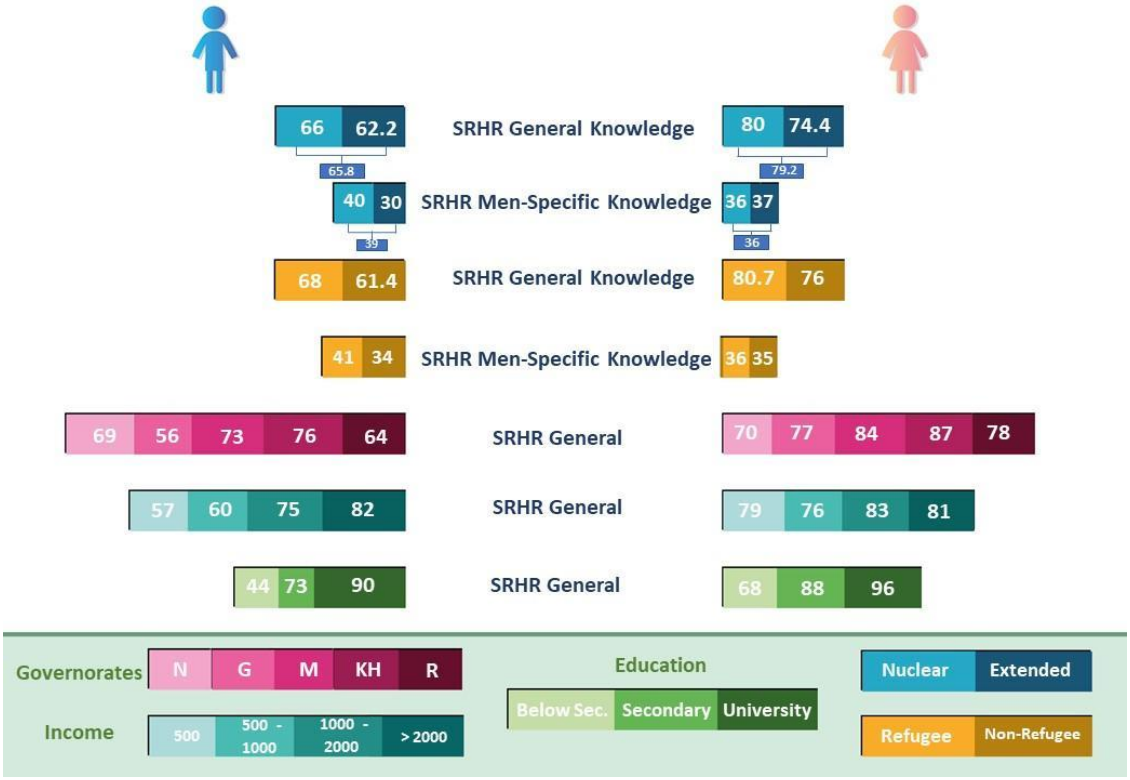
gender differences were not significant. Among those who reported knowing SRH specific to men, infertility (45% reported by men, 47% by women, 41% of boys, and 60% of girls), sexual dysfunction (39% by men, 56% by women, 50% of boys and 46% of girls), and the need for contraception (38% of men, 30% of women, 30% of boys and 34% of girls) were the most frequently reported aspects. Despite its particular importance, prevention of STIs was less frequently cited (only by 11% of men, 5% of women, 4% of boys and 3% of girls). Our findings confirm that familiarity with SRHR in general and, specifically for men, is limited in Gaza, particularly among young people. The maternity-related aspects such as ANC and NC and less likely PNC are more known than GBV, STIs and counselling, which implies that these should be prioritized.

Figure 3: Knowing what is meant by 'SRHR'



Generally, our survey concluded that, higher knowledge level was reported by females, those with a higher level of education, are refugees, financially better off, and who belong to a smaller size, and/or nuclear family. It is noticeable that living in Khanyounis or Dier Albalah/Middle governorates were among the characteristics to report a higher level of knowledge. In most of our knowledge questions (such as naming danger signs for pregnancy, hearing of STIs, naming FP means, needs during menstruation, and the general meaning of SRH), the level of education followed by family income were the main sources for high statistically significant intra-group differences. Compared to younger and older same-gender respondents, women aged between 31 and 40 years old and men aged 41 to 50 years old were also significantly more knowledgeable in most general knowledge questions.

Figure 4: Cross-tabulation of SRHR general and men specific knowledge based on selected demographic characteristics



During FGDs with men who are married and have at least one child, a considerable number of them, especially those living in ARA, it was the first time for them to be in a session that tackles this topic openly and had not yet conceptualize what the SRHR term entails. Despite that many other men reported being familiar with the term, their perceptions of SRH pivoted around women's health in terms of childbearing, delivery, and having healthy children while a few of them had also mentioned marriage relationships and FP. Echoing participants in Qa'a Qreen area in Khanyounis, when they first heard about SRHR, the things that came to their mind were about '*The health of mother and children*' while others referred to '*Having a sexual relationship with the wife, not against her will, that also depends on his mood, it could be frequent or not*'. Interestingly, one of the participants, 25 years old, from Qa'a Qreen said that the first thing that comes to mind when hearing SRH is that '*We have no relevant services*'. In Jabalia, the participants, despite sharing interesting examples about their participation later during the discussion, the participants literally said that '*SRHR, I don't really understand what does it mean*' while others were guessing saying '*If you mean having spaces between children, or maybe having children at the first place, anyways, if you mean it, then I would say I like having many children*'. Following probing, sometimes intensive probes were needed, men referred to PNC, fertility care, informing adolescents about puberty, and FP which was the first and most reported during the first parts of FGDs. Interestingly, STIs have not been spontaneously mentioned by any of our male participants including community leaders. Immediately when zoomed, inputs about SRH specific for men evolved around issues related to impotency, dysfunction, problems with erection, rapid ejaculation and these were noticeably mentioned as drivers to seek services, yet, they were seldom mentioned under the SRHR perception/definition

when broadly explored during the discussion. This observation confirms how feminized the SRH concept is among community members, leaders, and largely among some providers. As an additional evidence of the impact of personal experiences in shaping our perceptions, the individual participants who have children with disabilities or are married to persons with disability (PWD) pointed that SRH, according to them, includes '*Woman health, care during pregnancy, and ways to ensure having a healthy baby without disability if possible*'.

As an aforementioned, male community leader, who seemed the least progressive about SRHR, hold perceptions which favour a much bigger role for women where the components to them revolved around preparing girls and boys for marriage, having healthy relationships and offspring, care of pregnancy before and during, safe delivery, In-vitro Fertilization (IVF) services, and health education. A few of them with medical backgrounds mentioned puberty and sexual education and FP. On the other hand, consistent with our survey findings, females in general, especially female community leaders have more knowledge of SRHR components.

4.1.3 Adolescents are confused

Our qualitative discussions with adolescents revealed blurred perceptions around the SRHR. For many boys, reproductive health (RH) relates to women only and how to have a healthy child, in a suitable place and service for childbirth while sexual health (SH) concerns both men and women. SH also includes personal hygiene, taking care of reproductive organs, and maintain the Tahara [washing the body in a certain manner to keep it clean and suitable for the prayers following intercourse or masturbation or menstruation, Tahara is a must prior to performing prayer]. The male participants used marriage and how to get married to refer to intimate male-female relationships, and then, following probes, they added childbearing and giving birth, and having healthy babies.
It is interesting but underpinning that when we asked about SH in particular, the first reaction for more than one of the boys in east Gaza was saying '*SHAME* عيب'. A few boys in east Gaza expressed misconceptions such as referring to SH as when a woman sleeps with several men and that leads to mixing of genealogy among families (ansab) and chronic diseases. A 16 years old boy from Daraj area in Gaza stated *'Sexual health refers to a situation when a woman gets with and sleeps with more than one person. This leads to mixing sex and chronic diseases'.* Also, some boys in the south of the Gaza Strip mixing up SRHR with healthy life activities, such as doing sports. Generally, boys did not name any clear component of SRHR but they responded when asked about STIs in Al Daraj area by saying *'Yes, such as AIDS'.* Another boy added *'Which is transmitted through sperm'*.

Other boys talked about marriage, the process of having children in reference to sexual relations after marriage (Halal) and having healthy babies while some boys presented interesting ideas such as sexual relations free from violence and ending child marriage. Boys, especially refugees from moderate to high-income nuclear family introduced interesting ideas about SRHR referring to the right for both men and women in particular to choose their partner, who and when to marry, when to have children and to decide with husbands about that. A 17 young refugee boy from middle-income nuclear family in Rafah City said *'SRHR is the right for a girl to select her partner, and when to have children, meaning that the husband should not dominate the decision solely, they have to decide together in*

order to get healthy children in harmony'. 'Also, it is the right of security in relations, that the relationship is not hostile or violent, the right to security and settlement'.

Girls below 18 years old in South Gaza know little (or express little) about what they know. For them, SRH relates to how mothers raise healthy children, mother care and FP. Girls defined FP as spacing between pregnancies. A few of them referred to having a relationship with others (they avoided saying men or males at first and used others to indicate males). Girls think SRH –aspects other than puberty- is the business of people older than 18 years, and were not aware of services are provided to them or to the males at their age. Some girls mentioned combating violence under SRH. When cards that explain some SRHR components were demonstrated, girls said, there are some services for adults and there are components they never heard about such as STIs and pre-marriage counselling. For the majority of girl participants in one of the most conservative neighbourhoods in Gaza City (most are 15 or 16 years enrolled at schools, mostly non-refugee), the SRH concepts were not clear; they named only marriage and childbearing but then when exposed to the components by the facilitator, they engaged better in the discussion and said that all is important especially pre-marriage counselling and preconception counselling.

4.1.4 Youth have narrow ideas around SRHR

Male youth (aged 19-24 years) have ideas that evolved largely around sexual relations, personal hygiene, and male ability to have sex and bring children or more precisely make women conceive, and sexual power. This perception was consistent to how youth leaders and youth NGOs reaching out to youth, in order to raise their awareness about SRHR conceptualized initial thoughts of youth about SRHR. For instance, the programme coordinators said that '*During the opening sessions or information sessions about the programme, most of the attendees think that SRHR revolve solely around sexual relationships, potency, and reproductive capacity until we clarify the concept to them, some participants had difficulty understanding the terms used and scientific information about the anatomy of reproductive organs and their functions, we simplify and think that it works for many youth*'. In this study, youth participants coming from an underserved area in the middle of the Gaza Strip were almost unable to widen their views about SRHR apart from sexual relationships, even when they refer to FP service, the inputs were bounded by potency/ protecting one's power as a 56 years old male said '*A man is like the tromba* الطرمبة *[a pump], it does not end, the key is the woman, she is the one who feels exhausted, so the man has to control his sexual desire [frequency] for his health and hers as well*'. Our observations envision that youth participants with a diploma or university had more information and mentioned healthy relationships, puberty education about the change in body and seeking answers around puberty or relationship concerns from health professionals or NGOs.

Our qualitative findings revealed that there were huge differences between youth who were engaged in special raising awareness programmes such as Y-peers[1] and their

[1] UNFPA established the Y-Peer network in Palestine in 2013, to promote a healthy life style among Palestinian youth through peer-to-peer approach using alternative methods of education (such as theatre-based techniques, role games, simulations, social media campaigns, etc.). In Gaza, the Y-Peer network has

counterparts. Y- Peers were able to name many of the SRHR components, they provided examples about how the programme influences their ways of thinking and shared possible future behaviours such as deciding together on FP issues, support during menstruation or pregnancy, etc.

Alarmingly, and more importantly, our findings of perceptions and knowledge revolving around SRHR among youth and adolescents concluded that both the youth NGOs and school teachers and some healthcare providers possess a close to "real image" about the SRHR perceptions among adolescents and youth while parents and a significant number of healthcare teams fallaciously assume that youth and adolescents of this generation are sufficiently informed on their own, as a father from Biet Hanoun said '*They know and understand everything*' and another participant from Jabalia said that '*This generation has more information than teachers themselves*' and added '*A girl at the age of 15 knows almost everything that they need to know, in order to get married*'. During FGD with service providers, a teacher of biology described how confused boys were about SRHR basic information and referred to a time when he was shocked by the answers of his students (16 or 17 years old) about the possible consequences of cutting off the ducts of the male reproductive organ saying that '*The students shockingly said that the sperms will blow and explode inside the ducts! Imagine at the age of 17 years, boys don't have even such simple information*'. One of the healthcare managers said during a KII that '*Practice is wrong because the information is wrong, for youth, marriage or relationship between a wife and a husband is all about sexual acts only*'.

Also, there were differences between male and female adolescents; whereat a young age, girls seemed to possess more information about puberty, anatomy of female reproductive organs, some knowledge about GBV, and FP general concept while their information about STIs, male reproductive organs and puberty experience of males, intimate relationship, pre-marriage counselling, and about the services that can be provided to them was limited. Boys on the other hand, possess limited information about puberty for both males and females, very few information about STIs and FP while they have some information about intimate relationships, their own puberty experience, in addition to a modest knowledge of GBV. They were unclear about their position or role in the SRHR -especially RH-. Girls were not keen to learn details about puberty of males while boys, on the contrary, were more open to learning about that, with some of them against getting deep information about menstruation.

Congruent with our survey findings, our qualitative discussions suggest that age seems to have an influence on perceptions about SRHR. For instance, we have noticed that the group of youth in Biet Hanoun has clearer conceptions of SRHR, more progressive and/or less conservative attitudes than younger boys in the same area when the two groups talked to the same facilitator. Also, the majority of wider ideas about SRHR that included puberty education, male roles in FP, and supportive treatment to wives came from men who roughly aged around 32 to 45 years old while older participants were less sensitive about the male role, GBV, STIs and almost equally sensitized about FP, fertility care and classical care around pregnancy and childbirth. Additionally, we have also noticed that the most interesting ideas around what the SRHR term entails came from boys who

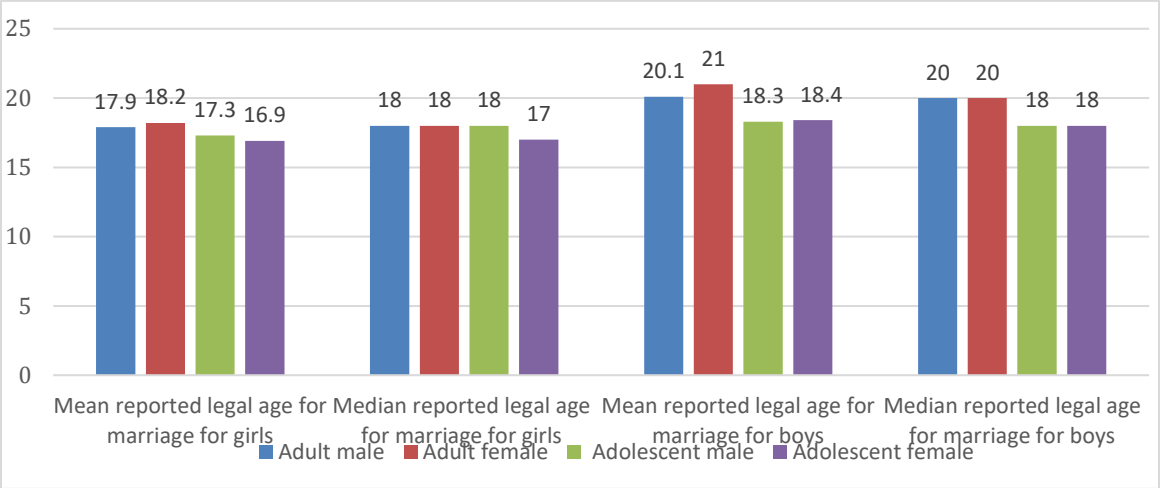
around 100 active peer educators in many areas surrounding SRHR, life-skills, Gender-Based Violence, and HIV prevention.

belong to nuclear families, middle or relatively "high" income, enrolled in education, and who had supportive counsellors/teachers at their schools and those who have more space to express their opinions in their homes. Religious aspects, although not observed independently, seemed to influence the overall perceptions about SRHR practices but did not seem to be a source of major differences when it comes to the perceptions of SRHR among adolescents. Almost all participants mentioned the necessity of respecting religious boundaries during SRHR educational services and/or align the key educational messages with religious instructions. The qualitative team has not felt huge geographical differences, however, adolescent males from North Gaza and Gaza were less informed than those from its south while adult males from east Gaza and Rafah (non-refugees are less informed than refugees) reflected a modest knowledge around SRHR aspects.

4.1.5 Perspective about the legal age of marriage

Our survey included asking participants about the minimal legal age below which girls are not allowed to get married. Adults' responses from both genders consistently indicated that the mean age is 18 years. It could be claimed that the provided age is based more on their expectations rather than knowing the real legal age which till now stands at 15 years for girls and 16 years for boys and judges can issue marriage certificates at a younger age in exceptional cases (UNFPA, 2016). Our findings confirm that only 8.5% of the adult participants in this study knew the real legal age for marriage for girls and 12% knew the legal minimum age for marriage for boys. Again, this reflects inadequate knowledge about issues around SRHR. Interestingly adolescent respondents reported that the mean legal age for girls is 17.3 years as reported by boys and 16.9 as reported by girls, which is closer to the actual legal age of marriage in the Gaza Strip. When asked about the minimum legal age of marriage for girls according to their preference, boys and girls suggested 19 years and above for the girls (boys mean suggested age 22.2 years and girls 19.9). For boys, girls suggested the age of 22.7 years and boys suggested 22.4 years. Moreover, when asked about the age at which they may consider marrying, boys reported 24.5 years and girls reported 21.4 years. Similarly, girls and boys who participated in the FGD considered somewhere around 21 and 24 years to be a suitable age for girl marriage while 23 to 27 was the interval for suitable (not necessarily desired) age for males to marry as one participant said *'Not before 24 or 25, it would not be even possible'*. Generally, while the preferences of female and male participants about the suitable age of marriage were close, female participants referred to younger suitable age of marriage for both male and female youth.

Figure 5: Reported mean and median minimum legal age for marriage



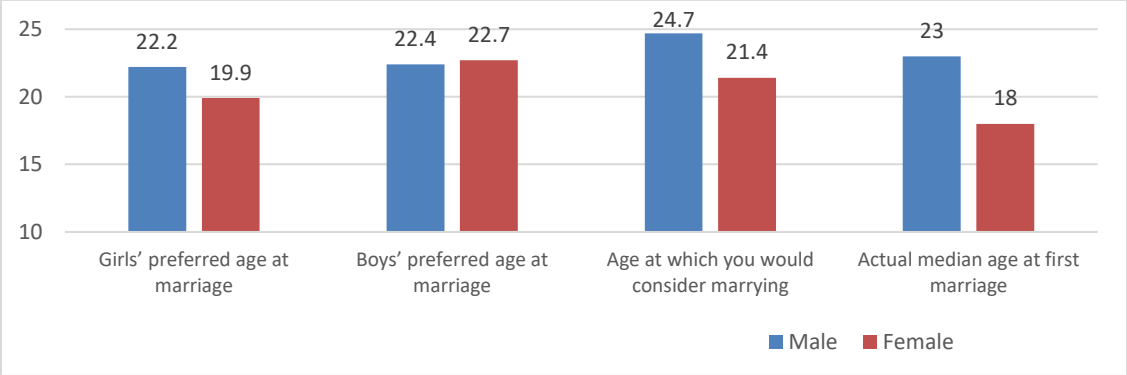
Compared to the actual age of marriage of our survey respondents, among whom, 50% of females got married before or at the age of 18 years (mean age for females is 18.8, median 18 years), the current preferences are relatively assuring (see figure 5). Child marriage in the Gaza Strip is slowly decreasing, it persists however among some communities, driven mainly by cultural customs and beliefs. During our discussions with men who were married to child females, despite that many of them reflected on unpleasant experiences related to lack of information for them and/or their wives, some of them still see the rational logic behind marriage with a younger female where they believe that younger girls are "innocent" and have no relationships with other males. One of the participants in Khanyounis said '*In this area, it is rare to marry early but my friend did and I did like him too. She is 16 years old, and she doesn't know anything and doesn't talk to male youth*'. Our key informants reflected on cultural convictions especially among the parents-in-law, at the older generations, 30 and 20 years ago who believed that young women are more controllable. The key informant said '*It is easier to handle a younger wife, you raise her up your way*' while another ECD specialist said '*Early marriage is a protection for girls'*. One of the key informants has reflected also on an economic driver behind child marriage where the social protection "Welfare system/social protection" either adds or deducts food parcel and/or money allowances based on marital status and age of HH members, so, some families marry males and female at a young age to neutralize or to take the benefit of that system on their income. This is possibly part of the explanation of why early marriage occurs among poorer communities the most. It is worth mentioning that the Palestinian government has committed to eliminating child marriage by 2030, but to do so it must design and implement multi-sectoral strategic interventions on prevention, identification, and support.

4.1.6 Age at first marriage

The mean age at first marriage among adult female respondents was 18.8 years and the median was 18 years (Figure 6). This means that half of the women in this study got married when they were children below 18 years old. Among male adult respondents, the average age at marriage was 23 years old. In Gaza, child marriage is slowly decreasing

but persists among some communities, driven mainly by cultural customs and beliefs. The Palestinian government has committed to eliminating child marriage by 2030, but to do so it must design and implement multi-sectoral strategic interventions on prevention, identification, and support.

Figure 6: Adolescents' preferences around the age at marriage



4.1.7 The use of Information and Communication Technology sources by adults

Findings confirm the substantial use of information technology to access information about SRHR where this has been reported by 42% of men and 52% of women and the differences are statistically significant (Table 5).

Table 5: Adult respondents' use of technology to obtain information around SRH

Variable	Male		Female		P value
	Number	%	Number	%	
Using technology to obtain knowledge about SRHR					
Yes	200	42.1	248	52.1	0.002
No	275	57.9	228	47.9	
The application used by those who reported using technology to obtain information about SRH					
Google	124	62	159	55.9	
YouTube	99	49.5	113	39.7	
Social media pages on Facebook	59	29.5	65	22.8	
Blogs and official webpages sites	23	11.5	20	7	
Social media Twitter	5	2.5	2	0.7	
Vlogs and films	3	1.5	4	1.4	
Social media, WhatsApp	3	1.5	2	0.7	
NGO Youth platform	3	1.5	3	1	
Social media on Instagram	2	1	6	2.1	
Social media Tik Tok	1	0.5	0	0	
Broadcast	1	0.5	2	0.7	
Social media, Flicker	0	0	0	0	
Access to technology for adults					
Having personal account at social media	345	72.4	330	69.3	0.293
Having personal computer	85	17.8	65	13.6	0.088
Having smart phone or tablets	363	76.4	353	74.1	0.499
Having Internet	421	88.4	418	87.8	0.677

Despite that, men are having better access to information technology, women are more active in using this source to access information related to SRHR possibly because men have other sources as they face lesser social restrictions while women have fewer sources, as their exposure to experiences outside HHs remain limited. Differences among male and female counterparts, in accessing technology were minimal, although males generally had better access to a computer, smartphone, or having personal social media accounts. With regard to the application used, among those who reported using technology to obtain information related to SRHR, around two-thirds of males and more than half of females reported using Google to obtain information about SRHR followed by YouTube (used by 50% among men and 40% among women) and social media (30% among men and 23% among women). This opens a new horizon for conveying SRHR awareness messages through these information technology outlets. It is worth mentioning, that the Palestinian Medical Relief Society (PMRS) has created a smartphone application that secures responses to visitors older than 18 years as indicated by a key informant from PMRS. Despite the limited number of users, given the recent creation of the app, the most frequent question was "how to talk to my offspring about SRHR topic?" which indicates both the lack of information/communication methods around SRHR and the sensitivity/need to privacy getting such information. As for the community outreach raising awareness activities, as a source of information, our key informants pointed out that targeting males in raising awareness efforts is below the needed. Almost all of the first-line service providers underlined a scarcity of men engaging plans or men-friendly activities.

Equally important, men's sensitization towards SRHR and child-rearing educational activities is a challenge because, according to key informants, the community still sees SRH and child-rearing belong to women's typical roles. The key informant described her experience with outreach activities in the North Gaza saying '*For them [men], reproductive roles are women specific'* and she added '*With the absence of incentives, men are less likely to attend raising awareness sessions*' or '*They attend in some conservative communities to double-check what their wives might be told when they participate, such as in Om Nasser village in the North'*. Therefore, CBOs and NGOs have to create a motivating atmosphere and consider other needs of the community. Two of the field teams in NGOs said '*It is necessary to motivate men by incentives and possess a good reputation/network especially in the remote and underserved communities*'. Men themselves, especially those aged above 35 years referred to friends followed by schools as major sources of information about SRHR. It was frustrating that healthcare facilities, whether governmental, UNRWA, or NGO operated were barely mentioned by male participants as sources of information but were mentioned by married and separated women (especially UNRWA and non-profit women health) centres. Again, the first line healthcare providers, as well as managers, diagnose the system pitfalls of not being a source of information, especially for men. They also uncovered the consequences of lack of information especially about the rights of SRH care clients where one of them said '*It is strongly possible that the extended denial of rights for a long time makes us accepting what I call the bad values. For instance, it is the right of a man to attend the childbirth, and the right of the wife to have her husband present with her. However, since this right has never been respected, then women accept not to exercise it, maybe they don't even recognize it as a right*'. Interestingly, some of the key informants referred to the role of Imams as information providers where they are relatively more consulted in issues such as hygiene, taharah, masturbation, and why not intimate relationships. For many people including youth, '*It feels less embarrassing to talk to Imam*

than talking to counsellors, and it is more confidential' said a boy in Rafah. Key informants explained why Imams are consulted by being '*Stigma free places, anyone can have any conversation with Imams without being watched*' and '*This gives high privacy*' and some sort of assurance that '*The advice will be consistent in line with religious values*'. Unlike parents and school personnel, Imams don't have official authority over adolescents.

4.1.8 Puberty experiences

Linked to the general perceptions about SRHR, the study team explored the type of experiences that adolescents and young adults go through during the puberty stages. Our participants reflected on the physical, psychological, and social changes they experienced. At puberty, besides the physical changes, there are changes in the level of freedom, observation from parents, and communication and decision-making context. Generally, the process of reaching puberty and transition to adulthood seems to be not directed or guided as it follows the natural paths without timely information backing or vigilant support when it comes to confusing thoughts or concerns among adolescents. Our findings suggest that access to information, regardless of the source, timeliness, and quality, although not yet sufficient, has been improved, while the level of support and openness around the topic remain immature; at the attitude level, most of the participants (adults, service providers, and youth) are positive around talking/informing adolescents about puberty, yet at the practical level, such conversations remain suboptimal.

4.1.9 Puberty: is it an easy conversation?

When faced with difficulties related to puberty, few percentages of boys (39%) reported that it is easy or very easy to approach mothers. Fewer percentage reported ease at approaching fathers (38%), health centre (34%) or school counsellor (23%), and a friend (23%). Regarding girls, opening a conversation within HHs seemed easier as 79% of girls feel easy to approach their mothers, much more than seeking help from outside the HHs. A quarter of girls will approach health centres, 19% will approach school counsellors and only 14% will approach a friend. These findings confirm that family is the main sort of support for adolescents in issues related to puberty especially mothers and the contributions of professional/formal services are limited (Table 6).

Table 6: Distribution of adolescent responses with regard to seeking support when they get confused about certain issues related to puberty

Items		Very difficult		Difficult		Possible		Easy		Very easy		P value
		N	%	N	%	N	%	N	%	N	%	
Mother	M	55	20.4	61	22.6	48	17.8	71	26.3	35	12.9	0.001
	F	3	1.4	9	4.4	32	15.5	68	33.0	94	45.6	
Father	M	62	22.9	58	21.5	45	16.7	69	25.6	32	11.9	0.001
	F	117	57.6	51	25.1	20	9.8	12	5.8	3	1.5	
Health centre	M	71	26.3	42	15.6	65	24.1	77	28.5	15	5.6	0.043
	F	46	22.3	47	22.8	60	29.1	39	18.9	14	6.8	
School counsellor	M	92	34.1	73	27.0	44	16.3	50	18.5	11	4.0	0.441
	F	64	31.0	58	28.2	44	21.3	36	17.5	4	1.9	
Friends	M	0	0.0	2	0.7	15	5.6	36	13.3	61	22.6	0.057
	F	1	0.5	2	0.9	2	0.9	6	2.9	24	11.6	

Health services should be tailored better to serve adolescents by strengthening preventive services particularly counselling, which almost doesn't exist. During our discussions, mothers were reported by adolescents and key informants to provide more support than fathers at this stage, where our key informants and mother participants explained how the mother opens the topic with her sons or daughters. One of the key informants said '*When the mothers notice the signs, maybe some stains in the clothes of boys. It is mostly at that stage, mothers may start the conversation about puberty, mostly focusing on hygiene issues*'.

4.1.10 Information and support

Our findings indicate that there are great variations in the sources of information about puberty, across the different generations. For male adults themselves, the main sources for their information about puberty-at a younger age- were friends (33%) followed by schools (29%), previous experiences (23%), online sources (21%), and health workers (14%). Less frequently cited sources by male adults include fathers (10%), books (9%), and other family members (mother 7%; brothers 5%). For women, the most cited sources are mothers (40%), online sources (28%), schools (27%), and personal experiences (22%). It seems that sources for males are mainly non-family related sources while for females, sources are nested within the families due to social taboos around puberty and sexuality. Females were informed mostly by their mothers, while fathers played a limited role in informing their sons about puberty.

With time, sources of information about puberty have changed, according to responses reported by adult participants. Three-quarters of men and women reported that mothers are the main source of information for their daughters (76%), followed by schools (reported by 67% of men and 75% of women); and online sources (18% by men and 22% by women). Regarding boys, school teachers were more mentioned than any other sources (68% by men and 72% by women), followed by fathers who played less role in informing the boys than the role of mothers in informing the girls (reported by 40% of fathers and 21% of mothers). Again, consistent with qualitative inputs, it was striking to see a dramatic decline in the role of health providers in informing young generations about puberty, although providing information and counselling doesn't require a lot of financial resources and also the limited role of NGOs in communicating messages about puberty despite that these NGOs claim to play an important role in this regard. Also, puberty among females and its related issues are less of an open topic of discussion among friends than boys' related issues.

Adolescents' responses indicate that girls (95%) attended sessions about puberty more than boys (85%) and the differences (about 12%) are statistically significant. The main source of information about puberty for boys were schools/counsellors (80%), followed by friends (29%), parents (fathers 18%, mothers 16%) and internet sources (13%). With regard to girls, schools (87%), mothers (79%), friends (14%), and books (11%) are the main sources for information about puberty-all as reported by adolescent participants (Table 7).

Table 7: Sources of knowledge and awareness about puberty

Variable	Male		Female		P-value
	No	%	No	%	
Adults					
Sources of information about puberty for adult participants					
Friends	159	33.4	61	12.8	0.001
Schools/teachers	136	28.5	127	26.6	0.193
Previous experience	108	22.7	106	22.2	0.286
Online sources	99	20.8	132	27.7	0.001
Health workers	66	13.8	64	13.4	0.706
Father	49	10.3	3	0.6	0.001
Books, magazines	42	8.8	33	6.9	0.030
Mothers	34	7.1	190	39.9	0.001
Brother(s)	23	4.8	0	0.0	0.001
Radio/TV/Films/Videos	13	2.7	26	5.4	
Information sessions/NGOs	7	1.4	5	1.0	
Sister(s)	2	0.4	73	15.3	
Sources of information for girls as reported by adults					
Mothers	253	76.4	268	76.8	0.064
Schools/teachers	222	67.0	262	75.0	0.308
Online sources	59	17.8	77	22.0	0.001
Friends	53	16.0	64	18.3	0.030
Sister(s)	19	5.7	26	7.4	0.032
Fathers	13	3.9	2	0.5	
Radio/TV/Films/Videos	12	3.6	11	3.1	
Books, magazines	8	2.4	9	2.5	
Health workers	1	0.3	0	0.0	
Information sessions/NGOs	1	0.3	0	0.0	
Brother(s)	0	0.0	0	0.0	
Others	2	0.6	8	2.3	
Sources of information for boys-as reported by adults					
Schools/teachers	231	68.3	258	72.0	0.157
Father	135	39.9	76	21.2	0.001
Friends	117	34.6	140	39.1	0.001
Online sources	80	23.6	99	27.6	0.003
Mother	58	17.1	81	22.6	0.001
Brother(s)	14	4.1	15	4.2	0.706
Books, magazines	9	2.6	8	2.2	
Radio/TV/Films/Videos	7	2.0	7	1.9	
Sister(s)	1	0.3	1	0.3	
Information sessions/NGOs	1	0.3	2	0.6	
Health workers	0	0.0	1	0.3	
Others	0	0.0	5	1.4	
Adolescents					
Ever attended sessions or received information at schools/clinics or NGOs about puberty					
Yes	227	84.7	195	94.6	0.002
No	39	14.6	11	5.4	
DK	2	0.7	0	0.0	
Primary sources of information about puberty					
Schools/counsellors	217	80.3	179	86.9	0.001

Friends	79	29.2	29	14.0	0.001
Father	50	18.5	1	0.5	0.001
Mother	43	15.9	162	78.6	0.003
Internet	35	12.9	14	6.8	0.001
Books, magazines	20	7.4	22	10.7	0.013
Brother(s)	14	5.1	2	0.9	
Mosque	14	5.2	0	0.0	
Health workers	10	3.7	12	5.8	
Sessions at youth programme	9	3.3	5	2.4	
Other family members	6	2.2	10	4.8	
Radio/TV/Films/Videos	4	1.5	1	0.5	
Social media	2	0.7	2	0.9	
Other relatives	2	0.7	3	1.4	
Sister(s)	0	0.0	40	19.4	

Girls' responses to the survey questions have been almost identical to their inputs during the FGDs. Girls shared being comfortable approaching mothers for puberty-related questions where mothers, followed by sisters and schools are the main sources of information. At schools, girls said '*At grade 7, we get lessons about puberty for girls, well explained, while information about boys is not explained at all. All that we know are definitions such as semen and wet dreams that we learn by heart for the exam purpose only*'.

For boys, however, our qualitative findings don't support that schools, at least in terms of quality and comprehensiveness, are a major source of information about puberty as the teachers '*Provide superficial information*' said a 21 years old male from the middle area. The information provided stands only at '*Less than 30% of what is inside the book and 10% of what should be explained in general*' according to key informants and youth from North Gaza. During the discussions, only a few boys, especially in Gaza City, referred to schools are primary information sources compared to friends/own experiences and online sources. At schools, during religion classes, boys, almost in all groups, reported being informed about taharah and hygiene following intercourse. It is worth mentioning that those who enrolled in secondary school during COVID-19 (aged 17 to 18 years currently) didn't have the chance to learn about puberty/SRH at schools. A 17 years old boy from Gaza said '*I got only 3 awareness lectures in the 10th grade at school, it was done by an external party and I don't remember its name*' another participant added '*In the online courses this year, this chapter is not covered, there is no time for that as the teachers say*'. This means that issues related to SRHR are regarded as a luxury and easily dropped; other topics and academic contents are regarded as more important and covered during crises like during the pandemic.

The other two main sources for information are '*Streets and friends*' as the boys in South and North Gaza, mentioned it as a source of information, especially from the ones who are a few years older. Both friends and online sources seemed to be the largest sources for boys aged roughly between 16 and 20 years. Friends are more frequently mentioned in Gaza and Northern Gaza while the groups in Southern Gaza focused on online sources but they referred to these sources as '*Bad sources*' said a boy in the centre of Rafah City. Other participants considered that streets (especially older friends who are probably married and some online sites) are bad sources – despite being widely approached by

some adolescents - as talks revolve around sexual issues rather than useful information that can fade out the ambiguity of puberty stage according to FGD participants.

4.1.11 Online sources and use of social media at puberty stage

There were a lot of differences between girls and boys regarding the use of social media in terms of frequency, topics, and freedom of access to internet sources. Also, we have noticed some geographical differences among girls as young girls in the South of Gaza consult social media about too few relevant topics but they reported following funny people, makeup or skincare bloggers, and social/romantic series. It was stark that girls in east Gaza don't learn about the existence of social media influencers or what the term means. They only google a few topics such as STIs, menstruation symptoms, danger signs of pregnancy, and relationships during the marriage (only one participant has mentioned that openly) and watch random YouTube channels quite rarely. Girls, who follow social media outlets, trust the social media and the influencers they follow especially when the number of followers is high and the content is funny. Consulting social media is relatively more difficult and more observed for girls as reported by girls themselves, boys, and mothers participating in our discussions. One of the mothers said '*We allow that, I would ask my daughter to keep the voice loud while watching social media so I learn what she is seeing'*. Interestingly, girls think that boys consult social media for SRH more frequently due to poor communication with parents. One of the girls in Rafah said '*Because they are not close enough to fathers and also, they are not observed but girls are*' while another in Gaza said '*Maybe they feel shy to ask their fathers*'. A 16 years old girl from Daraj area also said about puberty-relevant information '*Why would we consult online sources while my mom is there*'.

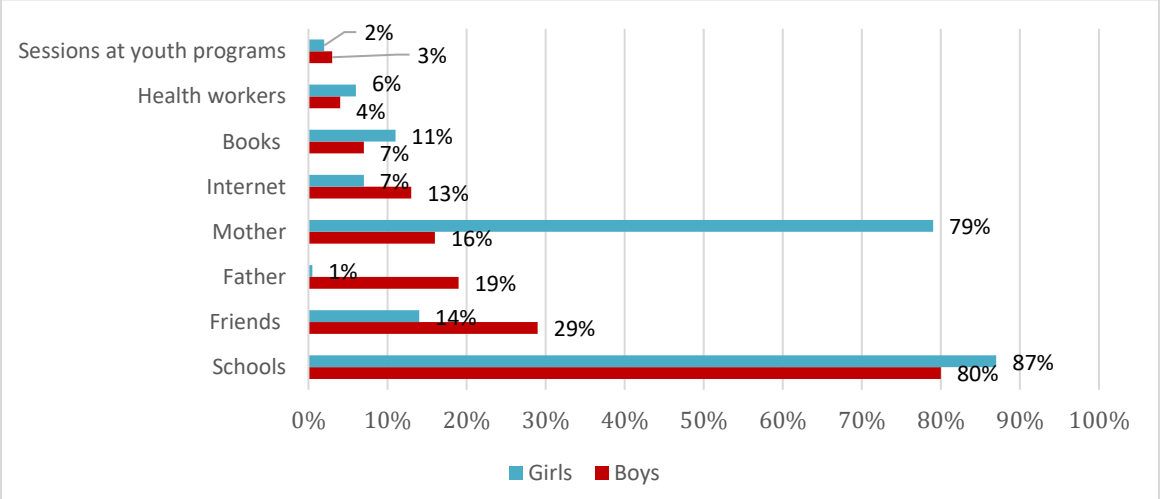
On the other hand, boys had reported more frequent use of online sources, both typical google searches and the trendier social media sites. Some participants from Rafah referred to watching some doctors on YouTube channels for topics such as describing reproductive organs, their functions, and also about relationships. Other boys shared using Facebook or Google for general information about puberty but sometimes they don't trust the information they find. A 17-year refugee boy in Southern Gaza said '*Possibly social media, but it is not always trusted, it is better to obtain information from trusted sources'*. In Gaza and Northern Gaza, the participants reported that sites are consulted more often for a relationship, how marriage happens (the first intercourse), and videos with sexual behaviours content that sometimes mix funny content with it. Tik Tok is the site where similar content appears, watched by many, while other apps such as Instagram (widely used) and typical Google search are used for topics around relationships, STIs "rarely", what youth call it as wrong things such as secret habit [masturbation]. Also, some adolescents and young adults search religious sites in order to learn how to perform taharah correctly, quit masturbation, and about the dangerous relationships or behaviours related to sexual life. Boys think that girls don't search the same topics as girls use YouTube for romantic series and films. They also think the information obtained from the internet is not always trustworthy, yet the information they get from the influencers is highly trusted, however, they did not remember to name those who post SRHR content. A participant aged about 18 years talked about trusting some influencers saying '*If I have 2,000,000 plus followers, I won't need to post inaccurate or false information, those are trustworthy*'. Generally, youth and adolescents enjoy following influencers especially

funny ones regardless of the provided content. A boy named two YouTubers who present funny content or serious content in a funny way saying '*Such as the Jordanian YouTuber [name] who presents critique, fictive things and funny stuff, and also another [name] who does funny pranks and things like that*'. Another participant said '*The family of [name] is the best who presents social life*'. When we checked the content of listed names, they have between 0.5 and 13 million subscribers or followers and present social content in a funny way.

When surveyed, adolescents reported what seems less frequent use of social media than expected and less than what they reported during the FGD (See table 7). A possible explanation is that they did not have a broad conceptualization of SRHR relevant issues so they thought about direct scientific rather than social or everyday life content. It is also possible that interviewed face-to-face individual questionnaire was less encouraging than group discussion, despite its small number, where the group support effect obviously helped to speak out own ideas. Also, the "generalization or a third-party voice" seemed to be assuring and avoid stigmatization or breaching the private personal space of respondents. For instance, while a considerable number of adolescents and young adults participating in the FGD reported consulting social media and watching what they named as '*Bad or non-sense videos*', they referred to that in a less personalized voice such as saying '*The info that everybody knows*' or '*Those [boys] who want to see inappropriate content or indecent blogger would go for Tik Tok, where plenty of such content is available*' and they were able to provide some details about that content.

Consistent with the survey data, both boys and girls, similar to service providers referred to the fact that girls are more informed about puberty (for girls but not for boys) while boys are left behind from being adequately informed. However, parents such as male groups in Tal Sultan mentioned incidents of shocks among girls at menarche and fear when the child wakes up to find himself wet (wet dreams at the onset of puberty). Somewhat assuring, the majority of participants mentioned not being oriented about marriage at this age (15-18 years), an input that confirms that child marriage is declining.

Figure 7: Main sources of information about puberty (as reported by adolescent boys and girls)



Generally, our finding confirms that access of young people to timely age and gender appropriate information about puberty and its associated bio-psychosocial dramatic changes is limited which urges adolescents and young people to explore other channels to know about the worrying puberty phase, which they are going through. The current sources of information for adolescents don't necessarily guarantee adolescents access to information through these channels, which are not necessarily safe or provide appropriate information, therefore health services should be more involved in designing and implementing age and gender appropriate information in coordination with other actors particularly schools, media, families and community organizations. It is also important to ensure the delivery of age-and-gender appropriate information through different channels including using adolescents' friendly channels like ICT and social media.

4.1.12 The social model of puberty

When we talked to boys about the changes, they/their friends experienced prior to and at the onset of puberty, they named the puberty physical signs they experienced. They know a little about puberty in girls, named change in body and voice, of their own/their friends. The social changes associated with reaching the onset of puberty evolved around more freedoms. One of the boys in North Gaza said '*Allowing us to go late outside till late*' while at the same time, although less than feeling free, boys felt they are more controlled and that their social behaviours are mostly monitored. For example, many boys in North and South Gaza said that '*We are no longer allowed to visit relatives, who have Horma [girls or women] inside the HH*' and that fathers are concerned that the son might misbehave, therefore, boys are warned not to cause social problems with neighbours or look at girls in the neighbourhood. Treating boys at the puberty stages as a source of danger is interpreted differently by boys themselves where some of them understand that as they grow to be physically mature, it is normal that they are no longer welcomed to places or houses where young females live, while other boys feel bad about not being accepted or isolated. A 24-year young man from Rafah reflected on how he felt at this stage saying '*ينقهر قهر feels deeply oppressed*' and another same age participant said '*If you used to go to uncle's house to meet your cousins, once you are mature, if you overstay there by one minute, after 10 o'clock, then people get curious, so you stop going… some youth feel upset and may get depressed because they are being refused and some others think it is normal as they are now mature, so, their treatment differs than before, it all depends on the surrounding community'*. It is also interesting that decision-making dynamics mirror this on-off mode as boys and their parents, particularly fathers, consider them as older and wiser, yet, they remain obsessed with the containment of the extra power or puberty vigour in order not to misbehave. Hence, a father tends to be aggressive with boys. One of the youth participants in the middle area who has already passed into adulthood said about his father '*Controlling his children at young age otherwise he loses the control over them*'. Also, boys described how fathers think and behave as one of the participants said '*They try to instruct us, they don't beat us as much as they used to do when we were young, but they keep watching us during these three years, in order not to cause problems with other people*'. Boys reported that they behave better if they are eldest sons, act as supporters to mothers and fathers in taking up the home responsibility such as shopping. In Rafah, one of the boys said '*Indeed, when he is outside, we replace him {referring to his father}*'. On

contrary, some boys refused to be instructed so they overrule the parents' wish. One of the young adults in North Gaza said '*At that stage, we tend not to be submissive, we go against what he [father] tells us, if he said to go right, I go left*'.

Boys reflected on stressful times at the onset of puberty. '*Unexplained mood changes, we feel okay while all of a sudden, we feel bad, without a reason*' said a 19 years old boy from Gaza. They also referred to easy excitability which is associated with an uncomfortable feeling in public places or sometimes at home. Missing childhood and holding more responsibility as they also start to think about how they will earn money to satisfy the provider role, to be ready for marriage as a 17 years old boy in Daraj said about boys in his age '*When he reaches the puberty stage, thoughts keep him busy, he has concerns and thinks about the future*'. Uncertainty about reproductive rather than sexual ability was not the least a source of stressful moments for adolescents. Youth reflected on their puberty concerns and thinking heavily about their sexual desire and sexual capacity as a 22-year-old participant in Rafah said in a generalizing tone about youth '*He [a youth] says he does not want to marry for the sake of making family and children, he says he wants to marry for this thing [both sexual desire and capacity]*'. Another participant immediately commented saying '*He feels mentally relieved*'. In general, however, boys feel positive about being treated as responsible persons and about enjoying some moments with friends including talking about marriage, sexual relations, and taking part in conversations that they used to be dismissed from when they were younger. They also seem to enjoy or feel proud of, despite feeling somehow guilty thinking about sexual relations or due to masturbation, their vigour and signs of "maturity" as they say '*It is nice to be treated in a better manner, you also feel confident, maybe and want to show off, youth take care of their appearance, that is good if his father or he himself affords it*'.

Boys, girls, youth, parents, and services providers, all agree that girls are subjected to much more restrictions when they reach puberty. Girls on the other hand were reluctant to talk about these topics as several probes were practiced to encourage their inputs. The first reaction to girls talking about puberty was about menstruation and they link it to becoming adults and have to wear the hijab. Girls said that they turned wiser and more aware – as observers - of what is going on in the family and around it but they are not involved in discussions around that. For example, a girl in Gaza said '*We become aware, we understand what is going on, we observe things*' while another girl from Rafah aged about 16 years described how she may or may not participate in SRH awareness activities saying '*No, they [girls] won't come, they are blamed even for knowing about this topic, the family will say, how did you know, this stuff is not for your age, not your business now*'. Congruent to other group inputs, girls felt more observed; they are being blamed if they play even inside the house and get to hear instructions all the time and get blamed for behaving like little girls. One of the girls said that her mom used to say '*Like playing or doing funny things is not appropriate for girls at your age*". Mothers ask girls to stop sleeping for long hours and be active in the house. Some girls refer to violence from brothers who try to show off and yielding to girls when they (boys) reach puberty. Girls have a little say in general in their HH, but they said that regarding their future marital life, they will resist pressure and take part in decisions in their HH as wives. It seems that decisions taken by parents pass smoothly rather than being questioned. At the onset of puberty, girls take a greater share of housework and their mother's "responsibilities". Also, they are asked to wear hijab regardless of whether they want it or not, they are told to stop playing especially outside the house, stop visiting neighbours or relatives alone, wear

looser clothes, and talk wisely. Physical violence from fathers is more common against boys as compared to girls. One of the explanations provided by girls is that they behave correctly. She said '*Behave nicely so there is no need, while boys cause problems and headaches to parents, or maybe they are too spoiled, so sometimes their fathers beat them*'. Generally, girls reflected on less confrontation with parents as they abide by the instructions and easily comply with the social expectations from them, despite feeling that '*Childhood is better*' said 16 years old from Rafah. It is worth highlighting that girls frequently (as well as mothers) in Rafah referred to fear from harassment and rape when they were talking about the reduced level of freedom and increased restrictions on mobility. The research team observed though that none of these groups mentioned raising awareness or self-protection among the needed topics or services. This might be linked to girls' responsibility to self-protection through conformity to norms related to dressing and accompaniment rather than a collective social responsibility or possibly that the stories about harassment are given greater space than they really deserve. It is also possible that creating demand for certain services requires more effort from the service providers.

4.1.13 Perspectives and experiences around menstruation

In the Gaza Strip, menstruation is not openly discussed; therefore, most girls only approach their mothers or older sisters when they got their menses for the first time (Abu Hamad, et al 2017). Also, there is a dearth of research around menstruation in the Palestinian context especially around men and boys' role during menses. When asked to nominate the needs of women and girls during menstruation, generally, women's responses imply more understanding of the needs during menstruation than men. The most prominently reported need was hygiene supplies and sanitary pads at more than 90% by both men and women. Understanding other physiological and psychological issues like sleep, change in psychological status, and the need for pain killers was reported by 30% only of the men participants. Less than 2 of ten men reported the need for having good nutrition and fluid (16%) and having more privacy (5%).

Despite that 90% of male adults have indicated that men should support women during menstruation, their practices on the ground were different. The most frequently reported supportive practices by men were providing pads and sanitary supplies (91%), respecting privacy (88%), acknowledging psychosocial needs (87%), allowing her to sleep or rest as she needs (87%), and giving priority in using toilets/Bathrooms (86%) to menstruating women/girls. In contrary to what adult males have reported, adult females reported much less support provided by male adults in their HH, less than 60% of women reported that men perform these practices (see table 8). While 91% of men reported supporting their wives during menstruation, only 73% of women agreed that men do support them during that stressful period; indeed, 15% reported that their husbands are not supportive.

Table 8: Distribution of participants' perspectives and experiences around menstruation and its management

Variables	Men		Women		P value
	No	%	No	%	
Adults					
Familiarity with girls/women needs during menstruation					
Hygiene supply and sanitary pads	448	94.1	453	95.1	0.150
Understanding of psychological situation	163	34.2	188	39.5	0.001
More sleep and physical rest	157	32.9	209	43.9	0.001
Pain killers	146	30.6	184	38.6	0.001
Good nutrition and drinks	74	15.5	101	21.2	0.001
Less burden in HH chores	67	14.0	101	21.2	0.001
Herbal remedies	36	7.5	80	16.8	
More privacy	24	5.0	24	5.0	
Others	17	3.5	19	4.0	
Don't know	6	1.2	0	0.0	
Refused to answer	4	0.8	1	0.2	
Role of caregivers/parents during menstruation of a female member in the HH					
Provide pads and sanitary supplies	435	91.4	282	59.2	0.171
Respect privacy	420	88.2	280	58.8	0.044
Acknowledge psychosocial needs	415	87.2	276	58	0.116
Allow her to sleep or rest as she needs	413	86.7	279	58.6	0.006
Give priority in using toilets/Bathrooms	407	85.5	275	57.8	0.016
Ensure other members don't annoy her	392	82.3	269	56.5	0.018
Provide support	367	77.1	242	50.8	0.686
Reduce HH chores	365	76.7	277	58.2	0.001
Pain killer	362	76	211	44.3	0.013
Herbal treatment	338	71	245	51.5	0.002
Does not apply (no female in adulthood)	28	5.9	189	39.7	0.001
Do nothing	7	1.4	0	0.0	0.033
Blame or played a constraining role	7	1.4	0	0.0	0.033
Agreeing that it is important that male members of the family show support to females during their menstruation days					
Agree	392	82.5	337	70.8	0.001
Somehow Agree	39	8.2	51	10.7	
Don't Agree	44	9.3	88	18.5	
Husband supports wife during the menstruation days					
Yes	433	91.0	345	72.8	0.001
Sometimes	32	6.7	59	12.4	
No	11	2.3	70	14.8	
Type of supplies used during menstruation					
Disposable pads			475	100	
Ever heard of reusable menstrual hygiene products			20	4.2	
Willingness to use reusable pads			27	5.7	
Willingness to use menstrual cups			17	3.6	
Men know when a female member at the HH is on menstruation days					
Yes	437	92			
No	30	8			
Adolescents					

Type of supplies you use during your period- Disposable pads			205	100.0	
Heard of reusable menstrual hygiene products					
Yes			13	6.3	
No			193	93.7	
Willing to use reusable pads					
Yes			11	5.3	
No			188	91.3	
Maybe, with more information			7	3.4	
Willing to use menstrual cups					
Yes			2	0.9	
No			199	96.6	
Maybe, with more information			5	2.4	
Experienced any sort of anxiety at menarche due to insufficient information					
Yes			126	61.5	
No			79	38.5	
Boys should receive information about menstruation and puberty about girls and how it affects girls	160	59.3	119	57.7	0.285
It is important that girls have some knowledge about puberty relevant changes for boys	144	53.3	129	62.6	0.070
On the menstruation days, a female is having what she needs of the following					
Sanitary pads and personal hygiene supplies			204	99.0	
Your privacy is respected			199	96.6	
You feel your emotional needs are respected			196	95.1	
You do fewer HH chores or rest if needed			185	89.8	
Emotional support			184	89.3	
Natural remedies			121	58.7	
Pain killer			117	56.8	
Others			1	0.5	
It is important that male members of the family show support to females during their menstruation days					
Agree	208	77.3	153	74.2	0.252
Somehow agree	24	8.9	14	6.8	
Don't agree	37	13.8	39	18.9	

Men's overestimation of their support was clear among fathers who participated in FGDs where they indicated a relatively higher level of support than what girls and women reported. More importantly, the nature of support evolved almost solely around providing sanitary pads, pain killers, besides allowing more rest to them, usually to demand support from other sisters. A man in Gaza said '*If the father knows a girl is in her period, he won't ask her to do him something so she can rest, or maybe he asks her sister to do things instead of her*'. Congruent with the survey results, the absolute majority of girls reported that they have their basic needs available. The majority ask their mothers to tell fathers that they need pads, nothing relates to the use of bathroom changes since none except mothers know about menses days. The majority of girls said they take rest, pain killers, hot drinks usually made by other sisters and if their fathers get to know about menses, they don't ask them to do things (house chores) and to get rest. The process of satisfying the needs during menses is mediated by mothers as one of the participants said '*We tell mom, she asks my father or brother to go pick for us the needed stuff*'. Girls do not dare to tell their fathers about menstruation, which doesn't necessarily mean that fathers are not

supportive rather than a feeling of shyness associated with menstruation among adolescents and expecting support from other females. Some girls don't tell the mother herself in order to avoid anyone getting to know about her menstruation as one of the widowed mothers said '*I have five sons and one daughter, I found a spot of blood on the chair, I thought someone was injured, I asked all of them and no one said yes, I went to her in the room and then she laughed and said yes, she was only 11 so I did not expect that yet and she did not tell me*'. It is very rare that a male brother learns about menses and they seldom help instead of their sisters these days so they ask girls to do somethings such as preparing food or drink. A 15-years old participant from east Gaza said '*If my brother happens to learn about that -menstruation days- I would hide and would never let him see my face*'. In few cases, a girl may ask her father to take her out of home when she gets into a bad mood. Girls said that brothers learn about their menstruation, they would help and offer support or at least don't demand things. Also, rarely, mothers don't support their daughters. One of the participants described how a few mothers keep urging their daughters to remain active even if they feel tired at the menstruation days, she said '*Mothers say stop sleeping all day long, you are not the only one who has a period, so don't be lazy*'.

During the discussions with boys and male youth, they were shy to talk about the menstrual period and were looking at each other as they consider it girls' business. One of the participants was wondering why such a question is being raised saying '*It is not of our business or interest'* said a 20 years old male from Biet Hanoun. While the Y-peer groups indicated that when they learn about the menstruation days or otherwise, they will help. A male participant, 19 years old in Gaza City said, *'I don't mind helping and taking my sister for a short walk during menses, in order for her to feel better.'* Our team concluded that the impression of parents about girls is that they act normally during the menstruation days.

Menstruation management

Almost all women and girls reported using disposable pads to manage their menstruation. Very few reported ever hearing about reusable menstrual products (4% of women and 6% of girls), and also very low proportions are willing to use reusable pads (6% of women and 5% of girls) or menstrual cups (4% of women and girls) even with having more information about these methods). The vast majority of men (92%) indicated that they know when a female member in the HH is having menstruation (table 8).

The mean age at menarche for the girls surveyed was 13.5, median 14 years, nevertheless, 61% experienced a sort of anxiety at menarche, possibly because they were not prepared or adequately informed. A previous study that targeted females 15-29 years old found that nearly 54% of respondents have not received appropriate information about menstruation before menarche (Alshawish,, 2019). More than half of boys (59%) and girls (58%) reported that it is important that boys should receive information about menstruation and puberty about girls and how it affects girls and the same is true regarding the importance that girls should have some knowledge about puberty related changes for boys which were reported by 53% of boys and 63% of girls. Regarding having access to their needs during menstruation, sanitary pads and personal hygiene supplies were the most prominently mentioned need (99%) followed by privacy (97%) and emotional support (95). Doing fewer HH chores or having rest as needed (90%) and receiving emotional support

(89%) were less accessible. The least accessible needs during menses as reported by girls were pain killers (57%) and natural remedies (59%). Around three-quarters of boys (77%) and girls (74%) agreed that it is important that male members of the family show support to females during their menstruation days. Our qualitative findings refer to particular hardships for girls living in camps and belonging to large families where this group of girls reported more frequent mood changes and pressure. One of them said about this stage '*It is full of awful days and bad mood during the menses*".

4.1.14 A proxy indicator for measuring overall knowledge about SRHR and child-rearing

To assess the overall level of knowledge about SRHR and child-rearing, a proxy indicator was computed based on 14 knowledge-related questions (see Table X). The mean percentage of overall knowledge elicited by men stands at 47.6%, while women elicited a higher score (53.9%) and the differences between men's and women's knowledge are statistically significant. Men are 13% less knowledgeable about SRHR and child-rearing than women.

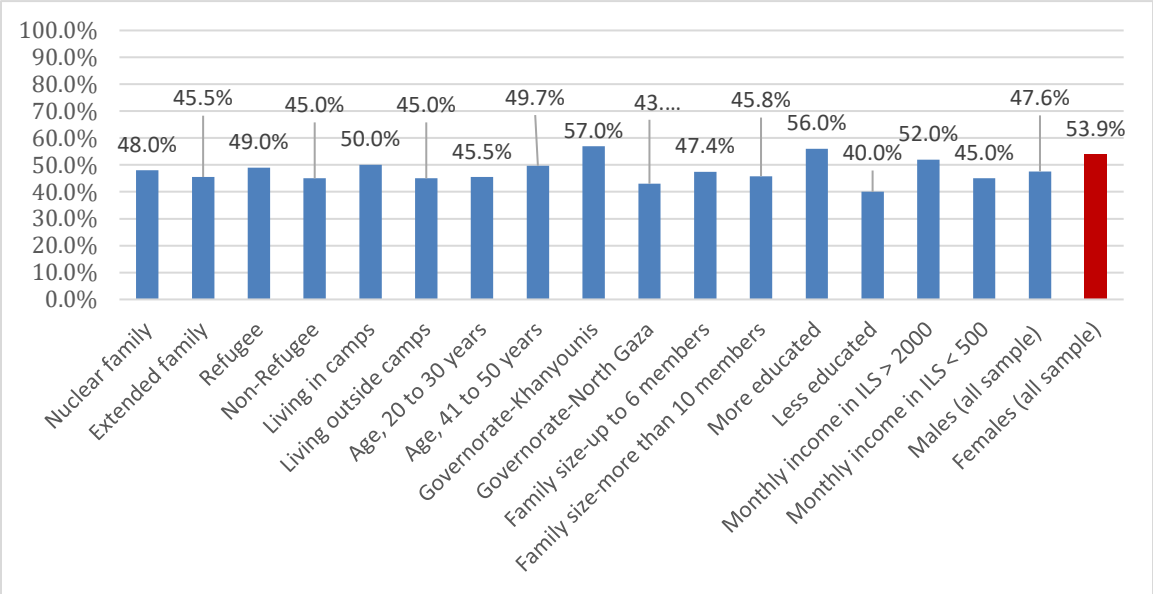
Table 9: Proxy indicator measuring overall knowledge about SRHR and child-rearing

Variable	Male		Female		P-value
	Number	%	Number	%	
Knowing what SRHR means in general	313	65.7	377	79.2	0.000
Knowing that SRHR includes postnatal care and child care	90	28.7	173	45.8	
Knowing that SRHR includes family planning	153	48.8	228	60.4	
Knowing that SRHR includes adolescents/youth health	18	5.7	15	3.9	
Knowing what SRHR means for men in particular	185	38.9	171	35.9	0.335
Knowing that SRHR for men includes need for contraception	70	37.8	52	30.4	
Knowing the minimum legal age of marriage for girls	140	29.4	126	27.2	
Knowing that women during menstruation have psychosocial needs	163	34.2	188	39.5	0.001
Knowing that absence of bleeding/menstruation is an early sign of pregnancy	244	51.2	309	64.9	0.001
Knowing that bleeding is a danger sign during pregnancy	243	51.1	268	56.3	
knowing how to get his/her child to smile	444	94.1	455	95.6	0.297
Knowing any methods to delay, space, or avoid getting pregnant	455	95.6	475	99.8	0.001
Knowing that male condom is a male method for contraception	304	66.8	408	85.9	0.001
Familiar with STIs	351	73.7	350	73.5	
Total mean and mean percentage for knowledge	**6.66**	**47.6**	**7.55**	**53.9**	**0.001**

Among men, findings showed that some men have greater levels of knowledge – for instance, refugees compared to non-refugees (49% vs 45%), residents of Khanyounis governorate compared to other governorates (57% for Khanyounis, 49% for Rafah and Dier

Al-Balah, 44% for Gaza, and 43% for North Gaza), more educated men (56%) compared to less-educated men (40%), and men who earn a higher monthly income (52% of men with income above ILS 2,000; 45% of men with monthly income less than ILS 500) (see Figure 8).

Figure 8: Differences in men's mean percentage of overall knowledge scores on SRHR and child-rearing, by characteristics variables



NB: Column in red pertains to adult females; other than that, all figures are for adult men.

Differences in levels of knowledge about SRHR and child-rearing are most likely attributed to socio-cultural and economic variations among respondents. For example, educated and better-off participants enjoy better access to SRHR information, resources, and services, so have greater opportunities than their less educated and poorer counterparts. Also, variations across governorates could be attributed to the demographic structure of different areas, whereby governorates with higher concentrations of refugees (especially in the southern areas) and refugees, in general, have higher levels of knowledge about SRHR and child-rearing (this is possibly the legacy of UNRWA standardized PHC services that were launched three decades earlier than governmental services). UNRWA services are, to a greater extent, more accessible, and also more gender- and age-sensitive than governmental services. Also, the presence of NGOs focusing on gender and women's health in the south and Deir Al-Balah governorate could contribute to men's greater knowledge about SRHR and child-rearing in these areas. Demographic characteristics of refugees include a greater tendency to join university education (especially for girls), better utilization of FP, and smaller size families (PCBS, 2020; Jones and Abu Hamad, 2016). On the other hand, non-refugee families tend to wed their daughters early and to have larger families (Abu Hamad et al., 2021). For farmers (who are mostly non-refugees), having a large family is a necessity.

To sum up, our findings confirm that familiarity with SRHR in general, and specifically in relation to men, is limited among males in Gaza, and particularly among young adults. Indeed, among men and women, both our qualitative and quantitative analysis conclude

a knowledge difference by age group; women in their 30s and men in their 40s are most informed about SRHR-related issues, and especially male-specific issues.

4.2 Attitudes and perspectives around SRHR and child-rearing

As aforementioned, measuring attitudes during this study were one of the most challenging parts. In this section, we present an overview depicting the positions of men, women, youth, and adolescents from SRHR and child-rearing selected issues based on their responses on gendered equitable men (selected items of the GEM scale) and the prevalent thoughts around manhood and masculinities they shared during the discussions. At the end of this section, a few aspects related to the attitude of healthcare providers, school teachers, community leaders, and some key actors are presented. This section feeds and links to an unpolished description of decision-making dynamics, cultural norms, and individuals' use of their time.

4.2.1 Gender Equitable Men-GEM

Our survey included a module "the GEM Scale to measure participants' attitudes and perspectives related to supporting equitable versus inequitable gender norms. It is widely used with men to ascertain baseline and subsequently evaluate the impact of interventions that target gender-related attitudes (see Table 10)

Table 10: Adults and adolescents' responses on the GEM Scale

Items		Strongly Agree		Somehow Agree		Don't Agree		P
		N	%	N	%	N	%	
Adults								
Woman's most important role is to take care of her home and cook	M	263	55.2	52	10.9	161	33.8	0.004
	F	215	45.2	76	15.9	185	38.8	
There are times when a woman deserves to be beaten	M	66	13.8	114	23.9	296	62.2	0.000
	F	22	4.6	61	12.8	393	82.6	
Changing diapers, giving kids a bath & feeding kids are mother's responsibility.	M	351	73.7	83	17.4	42	8.8	0.544
	F	356	74.8	72	15.1	48	10.1	
It is a woman's responsibility to avoid getting pregnant	M	122	25.6	66	13.9	288	60.5	0.030
	F	155	32.6	72	15.1	249	52.3	
A man should have the final word about decisions in his home	M	293	61.5	78	16.4	105	22.1	0.000
	F	208	43.7	83	17.4	185	38.9	
A woman should tolerate violence in order to keep her family together	M	298	62.6	64	13.4	114	24.0	0.093
	F	269	56.5	64	13.5	143	30.0	
A man and a woman should decide together what type of contraceptive to use	M	446	93.7	13	2.7	17	3.6	0.165
	F	453	95.3	5	1.1	17	3.6	
To be a man, you need to be tough	M	36	7.6	49	10.3	391	82.1	0.000
	F	11	2.3	24	5.0	441	92.7	
The participation of the father is important in raising children	M	465	97.7	8	1.7	3	0.6	0.406
	F	463	97.3	12	2.5	1	0.2	
	M	130	27.3	59	12.4	287	60.3	0.123

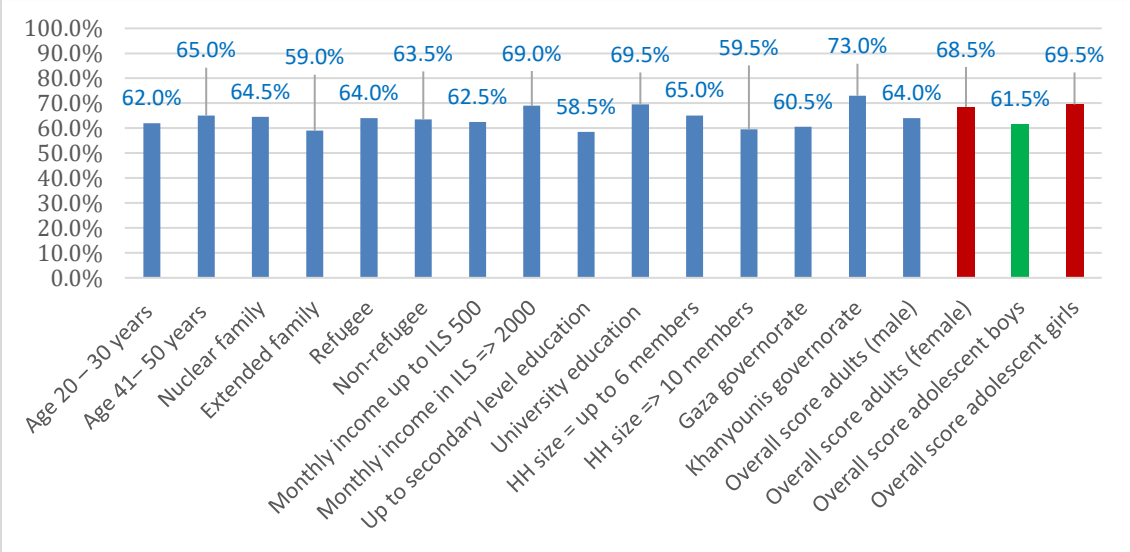
It's important for men to have friends to talk about their problems	F	115	24.2	45	9.4	316	66.4	
Couple should decide together if they want to have children	M	464	97.5	4	0.8	8	1.7	0.007
	F	474	99.8	1	0.2	0	0.0	
Total Mean score adults (out of 2)		**Mean**			**Median**			0.217
	M	1.2811			1.2727			
	F	1.3784			1.3636			
Adolescents								
Woman's most important role is to take care of her home and cook	M	150	55.7	48	17.8	71	26.4	0.001
	F	84	40.8	34	16.5	88	42.7	
There are times when a woman deserves to be beaten	M	22	8.1	39	14.5	209	77.4	0.155
	F	11	5.3	21	10.2	174	84.5	
Changing diapers, giving kids a bath & feeding kids are mother's responsibility.	M	194	71.8	51	18.9	25	9.3	0.773
	F	142	68.9	42	20.4	22	10.7	
It is a woman's responsibility to avoid getting pregnant	M	117	43.3	36	13.4	117	43.3	0.601
	F	80	38.8	31	15.1	95	46.1	
A man should have the final word about decisions in his home	M	185	68.5	23	8.5	62	2.3	0.001
	F	93	45.1	35	17.0	78	37.9	
A woman should tolerate violence in order to keep her family together	M	173	64.1	24	8.9	73	27.0	0.001
	F	89	43.2	21	10.2	96	46.6	
A man and a woman should decide together what type of contraceptive to use	M	254	94.1	5	1.8	11	4.1	0.246
	F	199	96.6	4	1.9	3	1.5	
To be a man, you need to be tough	M	28	10.4	16	5.9	226	83.7	0.001
	F	3	1.5	8	3.9	195	64.6	
The participation of the father is important in raising children	M	261	96.7	9	3.3	0	0.0	0.196
	F	203	98.5	3	1.5	0	0.0	
It's important for men to have friends to talk about their problems	M	116	42.9	24	8.9	130	48.2	0.319
	F	75	36.4	18	8.7	113	54.9	
Couple should decide together if they want to have children	M	267	99.0	1	0.3	2	0.7	0.205
	F	203	98.5	3	1.5	0	0.0	
Total score out of 2		**Mean**			**Median**			0.118
	M	1.2346			1.2273			
	F	1.3910			1.3636			

More than half (55%) of men and boys (56%) reported that a woman's most important role is to take care of her home and cook; 45% of women and 41% of girls agreed with that and the differences are statistically significant. Shockingly high, 38% of men, 23% of boys agreed or somewhat agreed that there are times when a woman deserves to be beaten, 17% of women and 16% of girls agreed with that statement. Three-quarters of men (74%), 75% of women, 72% of boys and 69% of girls strongly agreed that changing diapers, giving kids a bath & feeding kids are the mother's responsibilities. Nearly 40% of men, 48% of women, 57% of boys, 54% of girls agreed (strongly or somewhat) that it is a woman's responsibility to avoid getting pregnant. Of men, 78% of respondents, 61% of women, 77% of boys, and 62% of girls reported that a man should have the final word about decisions in his home. Similarly, 76% of men, 70% of women, 73% of boys and 53% of girls strongly agreed and somewhat agreed that a woman should tolerate violence in the HH in order to keep her family together. The percentage of agreement with the statement “to be a man, you need to be tough” was as follows, 18% by men, 7% by women, 16% by boys and 5% by

girls agreed or strongly agreed that. On the positive fronts, the vast majority of participants of all categories (more than 96%) strongly agreed or somewhat agreed that a man and a woman should decide together about the type of contraceptive to be used, that father's participation is important in raising children and that couples should decide together if they want to have children or not.

Figure 9 shows that in total, on the GEM Scale, men scored 1.28 (64%), which is close to 8% less than women, who scored 1.38 out of 2 (69%). Similarly, girls elicited higher scores than boys and the differences between the two categories are statistically significant. Also, adult males elicited higher scores than adolescent males! The lower score among adolescents could be attributed to the effects of cultural norms, which they learn while growing up. It could also be linked to false and untrusted information they receive at the onset of puberty. An important driver of adolescents' overall perceptions and attitudes about SRHR and child-rearing could be their insecurity and uncertainty about the extent of control they have over their lives, their ability to respond to their assumed roles and, ultimately, to satisfy their sexual and reproductive health needs. Key informants pointed out that community members, especially groups who have lived most of their lives under the siege and blockade, tend to hold more conservative attitudes as their protection needs are considerable. Findings confirm that as some of these insecurities become less salient, and as the influence of norms partially fades (as indicated by the difference between people who live in extended families versus those in nuclear families), more gender-equitable attitudes are evident. For instance, for married adults, it seems the experiences they went through have somewhat promoted more gender-equitable attitudes. Being a refugee, living in a nuclear family, being educated, being better off, and belonging to a small size family were associated with higher scores, indicating more gender-equitable attitudes than their counterparts from other groups. Observed differences in attitudes are also consistent with differences in knowledge about SRHR, and the reasons for the difference in attitudes are similar to those reported for differences in knowledge.

Figure 9: Mean percentage of GEM Scale scores for men (adults) by characteristics variables



NB: Blue bars pertain to men, red to female adults/girls, and green to boys.

4.2.2 Position of adolescent respondents from selected aspects around SRHR and CSE

While the vast majority of boys (94%) and girls (96%) respondents indicated men and women should have equal opportunities to study and to attain any education level they want, a lesser proportion of boys (69%) and girls (89%) respondents indicated that men and women should have equal opportunities to work for pay, inside or outside the house with significant differences among the two groups indicating that cultural norms around studying is more gender streamed than around work. Similarly, 62% of males and 69% of females agreed that men and women should share the domestic chores and the differences among the two genders are statistically significant. Almost two-thirds (63%) agreed that SRHR education is essential for boys and girls from a young age, much higher than what adults reported (see table 11).

Table 11: Attitudes and perspectives of adolescents on other selected gender-related aspects

Variables		Agree		To some extent		Don't agree		P
		N	%	N	%	N	%	
Men and women should have equal opportunities to study and to attain any education level they want?	M	250	94.0	4	1.5	12	4.5	0.139
	F	197	96.1	5	2.4	3	1.5	
Men and women should have equal opportunities to work for pay inside or outside the house?	M	186	68.9	25	9.2	59	21.9	0.001
	F	184	89.3	12	5.8	10	4.9	
Men and women should share the domestic chores?	M	167	61.8	33	12.3	70	25.9	0.047
	F	142	68.9	30	14.6	34	16.5	
It is no way children stop misbehaving without physical punishment	M	67	24.8	47	17.4	156	57.8	0.025
	F	34	16.5	28	13.6	143	69.4	
I think SRHR education is essential for boys and girls from a young age	M	169	62.6	32	11.9	69	25.5	0.150
	F	129	63.2	14	6.8	61	30.0	
I believe that parents should not allow girls to receive CSE at a young age to protect them	M	128	47.4	32	11.9	110	40.7	0.263
	F	82	40.0	26	12.7	97	47.3	
I believe that parents should not allow boys to receive CSE at a young age to protect them	M	121	44.8	36	13.4	113	41.8	0.138
	F	83	40.5	26	12.7	96	46.8	
I think people should consider a conflict between a married couple as a private matter and don't intervene even if violence happens	M	168	62.3	29	10.7	73	27.0	0.102
	F	110	53.4	33	16.0	63	30.6	
I believe that when couples give birth to a baby girl, it is normal that mothers are the ones to be blamed	M	13	4.8	9	3.3	247	91.9	0.234
	F	6	2.9	3	1.5	197	95.6	
Personally, I would like to receive pre-marriage counselling when I got married	M	195	72.2	21	7.8	54	20.0	0.257
	F	130	79.2	9	5.5	25	15.3	
Personally, I would like to participate (my husband/future husband) in preconception care	M	235	87.4	19	7.0	15	5.6	0.031
	F	190	93.6	4	2.0	9	4.4	

Personally, I would like to participate (my husband/future husband) in antenatal care session	M	240	88.9	17	6.3	13	4.8	0.001
	F	201	98.5	3	1.5	0	0.0	
Personally, I would like to participate (my husband/future husband) in postnatal care sessions	M	242	89.6	16	5.9	12	4.5	0.001
	F	203	99.0	1	0.5	1	0.5	
Personally, I would like (my husband/future husband) to play a supportive role in breastfeeding	M	244	90.4	15	5.5	11	4.1	0.003
	F	201	98.0	2	1.0	2	1.0	
Personally, I would like (my husband/future husband) to be involved in FP	M	248	91.8	11	4.1	11	4.1	0.001
	F	203	99.0	2	1.0	0	0.0	
Personally, I would like (my husband/future husband) to attend or be involved in natal care/delivery	M	247	91.5	11	4.1	12	4.5	0.005
	F	200	97.5	5	2.5	0	0.0	
Personally, I would like to participate in childcare	M	249	92.2	16	5.9	5	1.9	0.006
	F	202	98.5	3	1.5	0	0.0	

The prevailing inappropriate information and the social taboos around SRH make it no surprise, to learn that nearly half (47%) of boys believed that parents should not allow girls to receive CSE at a young age to protect them and 40% of girls agreed on that. Similarly, 45% of boys and 41% of girls believed that parents should not allow boys to receive CSE at a young age in order to protect them. It is worth pointing that females reported agreeing more on providing CSE at a young age than males and there is more agreement to provide CSE to boys more than girls.

Less than 10% of adolescent respondents agreed that when couples give birth to a baby girl, it is normal that mothers are the ones to be blamed, although males (92%) disagreed with that less than females (96%). Significantly high, 80% of boys and 85% of girls reported that they like to receive pre-marriage counselling when they get married. With regard to preconception care, 87% of boys and 94% of girls (their husbands/future husbands) expressed their willingness to participate in preconception care.

Intentions to participate in the different SRH services was reported by a higher proportion of boys as 89% reported they would like to participate in ANC, 90% in PNC, 90% in breastfeeding (BF), 92 in FP, 92% in natal care and 92% in childcare. These positive attitudes about SRH are encouraging for the active involvement of future generations in SRH. Still, high proportions of girls (differences were statistically significant almost in all domains of SRH services) reported that they would like their husbands/future husbands to be involved in SRH (ANC 99%, PNC 99%, BF 98%, FP 99%, NC 98% and child care 99%).

A strong observation derived from the FGDs is the changing attitudes pattern with age. While it is no surprise that older generations (around 55 or 60 years) hold conservative attitudes and maintain some of the stereotyped roles and decision-making preferences and domination, it was an overwhelming, but explainable, surprise that adolescents and youth both males and females possess or deliriously attached to strict attitudes towards SRHR but more progressive attitudes towards male contribution to child-rearing at least at the level of positive disciplining practices, relatively greater voice and agency, and assertive communication with parents. The good news though is that as the age increases, attitudes towards SRHR tend to take and/or be expressed in a more

progressive manner. As concluded from inter and intragroup comparisons, age followed by refugee status, higher level of education, and better economic reality seemed to be associated with more positive or at least, less conservative attitudes in general. Women, in general, had the most supportive attitudes and were pro more engagement of men in the entire package of SRHR and child-rearing aspects while they were fairly supportive to CSE and puberty education at schools and health centres. Women were somehow confused about other SRH services to unmarried girls where they supported services to those who intend to get married but not to those who decided not to have children.

Almost all groups were supportive of the medical examination[2] that takes place in schools as some health problems were discovered and treated quickly. Likewise, the absolute majority of participants were against child marriage, especially among women who had experienced it themselves. On the contrary, views of multiple marriages varied as some boys linked it to the preferences and financial ability of men. Two boys from the North Gaza and Daraj area in Gaza City explicit their views of multiple marriages saying '*Normal*' and *'No problem*' and denoted if the man likes it and has the ability to control many women and sustain them or have financial resources. Other adolescents and youth linked a second marriage with their first marriage experience as said by a 19-years old first-year university student '*In principle, I don't support it as long as I have a good wife that satisfies my needs and takes care of the house. Then why would I marry another one?'*. In the middle area, namely at Moghraqa where many grandparents and parents had more than one wife, the views of youth were clearly against that as one of them said '*I was thinking it is okay but after experiencing many problems especially by my siblings [due to having stepmothers at the same house], I don't support it at all*'. On the positive side also, a few numbers of boys in Rafah categorized multiple marriages under GBV. Except for a few numbers of boys, the majority of adolescents and young adults expect that women hold on with infertile husbands while husbands are excused to go for divorce or a second marriage. The majority of boys and youth are against violence, yet, being common around them, one of them in the middle area said as if it is normal '*All men beat their wives*' then describing that with a forgiving tone as wrong behaviour. The majority of male youth support speaking more openly about SRH and introducing this theme at schools (except youth who have almost all thoughts about SRH evolve around sexual relationships). Pertaining to male-specific services, youth, men, and service providers think that men care the most when the issues touch their sexual capacities, such as issues of sexual dysfunction, rapid ejaculation, or infertility which means that their attitudes around the relevant services are linked to the direct impact on their potency and reproductive capacity. It is worth mentioning that boys refer to bad friends as a source for bad behaviours such as smoking and having friendships (referring to sexual or intimate relations) with girls so they see relations at this age as bad behaviour. Boys think that it is rare to force wives to have a sexual relationship (intercourse) against their will and considered that as violence. Men were against that despite their knowledge about several cases conducting such a forceful practice and possibly even taking part in one. Our discussions with males from different age groups conclude that men (aged about 35-45 years) hold the most positive attitudes compared to younger and older groups. This has also been confirmed by health services providers and other key informants who said '*Younger couples are thinking differently, we can see the change among them'*. Also, the majority of men were supportive of more

[2] Medical examination as described by our participants includes performing only physical examination for testis, sometimes checking other physical health aspects, measuring visual acuity. For girls, almost no examination occurs except for hygiene check (lice).

education about SRH to their offspring despite that some of them listed a few concerns as detailed later in this report. Also, men reported being willing to participate in STIs management and treatment, attending delivery, balanced say for women in FP, and selection of the contraceptive tools. Interestingly, while the majority of parents, service providers and key informants were concerned about online sources accessible to adolescents, some men from Khanyounis Governorate were supportive of internet use by their offspring (it is more acceptable for boys) as long as there is no content that is classified as bad or inappropriate. One of the men in Qa'a AlQreen said happily about his son who knows a lot of things '*Yes, he uses the internet. He knows a lot. I tested that. It is good as long as there is no dirty content, otherwise, he will be punished'*. However, a greater number of men preferred to be the source of knowledge for their sons as a 40 years old man from Gaza said '*We should talk openly to our sons about puberty. It is better than leaving them knowing about that from the outside environment*'.

4.2.3 Men and adolescents' position from child-rearing

The absolute majority of men and youth confirmed the importance of increasing the roles of fathers in child-rearing aspects. Still, they limit baby care tasks such as changing diapers, feeding, and hygiene to their mothers or sisters. For many of them, it is not shameful to contribute to these tasks but they are not used to taking part in them. There was a consensus among men that it is optional to participate in such activities. For them, a good man, besides being able to sustain the family and secure the required financial resources, is helping his wife and caring for his children. However, the responsibility of raising the children, and so as the blame for their misbehaving, remains a mother's role. Men seem resistant to the idea of taking part in house chores as an obligation or responsibility. Some of them, especially the older generation around or above 60 years considered the wife who does not ask/accept her husband to contribute in house chores and baby care as '*Polite*' or '*Well raised*' and belong to '*Family with principles, Banit Osol* بنت اصول *[reputable family]*', said the male community leaders. Many other men, like participants from Jabalia and Khanyounis balanced a little between wife's role inside and outside the house but still regarding house duties more important and connected to women. One of the community leaders said the good wife is '*the one who can make a balance between her work, if she works, and her house duties and raising children*'. Both men and women including service providers and community leaders see a greater role for men in guiding children, especially at the onset of puberty as more control and observation are usually needed, according to the participants. Mothers also hold similar perspectives and convey the message to children that in case they misbehave, their fathers will take care of not letting them repeat the mistake. A widowed woman from Gaza City, when faced with an issue with the neighbours regarding her son, approached the uncle as a first reaction since she believes, as a man, his ability to discipline the son and talk to neighbours is more effective than hers.

Our qualitative discussions concluded that the concept of positive parenting is immature among parents, older groups in particular. Younger fathers, who have their children still at a young age, seemed more positive about spending time with children, taking them outside and playing with them. Also, the inputs from mothers, key informants, and adolescents underlined the tendency of men to behave violently with boys while they

consider girls as weaker/sensitive, and more obedient, so they deserve to be treated less violently. Linked to SRH and child-rearing, a remarkable majority of men were willing to talk to their children about puberty and were keen to learn how to initiate such conversations. Fathers believe that mothers are in a better place to raise the awareness of girls as they consider conversations about SRH between a daughter and a father as sensitive and will be embarrassing to girls as well as to the fathers. A father said '*They [girls] themselves don't take it easy. My daughter self-imprisoned herself in her room because she felt embarrassed when I told her that her mom and I brought her some underwear, she escaped to her room, imagine if I talk to her about other issues*'.

For boys and girls, it is necessary to be closer to their kids in the future, be less violent, and be more encouraging than the current generation. Boys also expressed their will to contribute to taking care of babies and "helping" their wives, especially if both are working. Girls also loved to see more involvement of their fathers inside the houses, however, they hold some concerns about fathers' intolerance to increased responsibility that probably turns into violent situations. One of the girls said '*They work outside, I am afraid, it will be too much for them to do work inside the house, they would be stressed, and will possibly show outrage against us*'.

4.2.4 Community leader and service provider attitudes: the sombreness of the headlights

The conversations with male community leaders revealed that the majority of them (included religious men, Islah {moderators} committee members, other figures with health and education backgrounds, and heads of big families/mukhtars) hold classical attitudes about SRH and child-rearing, in general, as they share other men -some were even stricter- a perception that entails greater if not absolute role for women in SRH services and child-rearing activities while maintaining decisions solely controlled by men. Community leaders diplomatically expressed that it is no problem to target men in SRH education especially younger generations and to invite them to utilize the services and to support their wives. They were encouraging the establishment and introduction of fertility care services. One of them said '*It is understandable and good to urge men to use FP and to call for that under certain projects, it is also necessary to introduce other services they need such as visiting a fertility care unit to treat those who want to have children*'. For them, SRH education and services are acceptable if they conform with cultural norms. According to leaders, if boys are not aware, they do harmful practices, and there is an abuse of masturbation and the internet because they don't find other sources for good information.

That is why the community leaders support that the fathers should work with their kids on these issues. Likewise, it will be acceptable that schools talk about it in an acceptable way (complaint with culture and religion, nice words, non-violent, age-appropriate, not at a very young age so 7th or 8th grade is too early as they think of smooth gradual increase of information to present its main bulk to students aged 17 or 18 years). While the leaders did not seem at all progressive about SRH education or SRH aspects in general, there is a sense of approval or more precisely no objection to passing some SRH concepts through projects, education/health facilities, and religious figures as one of them said '*It is a good idea to engage religious people and mosques who have a greater influence*'. [commenting on the possibility that religious people accept to take part] he added '*If this serves a good*

end, they will be ready to do it, for instance, if they learn and convince people that male participation and education will decrease or prevent divorce, then they will do'. The community leaders have strict views when it comes to the male role in child-rearing as a caregiver rather than a breadwinner and disciplinary agent. Leaders do not mind that men get more roles in house chores and baby care as long as this is not compulsory. This is also true for women who work outside the house. As for the views about child marriage, community leaders were fully against that where they consider it inappropriate to think about marriage before the age of 18 for females and 20 for males conditioned by being ready (mature) to hold the responsibility of a family. Also, they do not support violence against women (see issues under the spotlight section) and try to stop it through tribal Islah procedures but they admit that in many cases, women don't get their full rights because their fathers decide to be tolerant to the mistakes of their sons' in-law, to maintain the marriage of their daughters. Community leaders referred that they are seeing more and more parents who insist on preserving the rights of their daughters and mentioned an improvement in this regard. It is important to note that women leaders, who have much less power in the community than male leaders, hold more progressive attitudes and call for greater voice and agency for women and greater awareness-raising programmes for partners, about their roles in SRH and child-rearing activities. They also think that some mukhtars and some female preachers contribute to stabilizing negative and/or conservative attitudes among men and women as one of the participants said '*I attended [session] for a female preacher, there are preachers who damage the ammar* بخربوا العمار *[good build]*'.

At the service provision front, great variations in the attitudes of providers were observed as they themselves have reflected on the contradictions and ambiguity around male engagement in SRH at their practices. A senior nursing staff who holds progressive attitudes said '*We have to face our contradictions in the first place, the system, and the providers themselves are not open to that, it seems no one is willing to open the topic and speak up about our roles and how we can improve our own attitudes before the community members*'. Despite their varied views, in general, service providers in a healthcare facility are not that progressive. Also, the concept of shyness about what is appropriate versus not acceptable remains dominant. For instance, service providers mentioned that '*It is not easy and it is embarrassing for a female provider to talk about SRH to men*' said a nurse in her 30s. In some of our conversations with first-line providers, we observed, without any generalization, that there is a tendency of agreeing with what the context dedicates when it comes to GBV issues, as some providers said that referral policy exists and is practiced/respected while others said it exists but it is not applied which gives an impression that personal preferences or individual decisions disable/delay the strengthening of the organization culture against GBV. It is wise to read these inputs also in the context of larger frustration of service providers rather than holding negative attitudes where sometimes the inaction aims at self-protection from the clients and/or the institution. A female doctor at a governmental clinic responded to a question about her reaction when serving a victim of violence saying '*I feel sympathy with her, sometimes I would cry for her and wish the hand of the husband was cut before beating her -talking about her client who is exposed to domestic violence*'.

Regarding adolescent health, while some providers were relatively sensitive to their needs as one of the UNRWA clinics managers said '*Three years ago, I had a problem in the clinic, we did review for the repeated visits to surprisingly find out that top 30 were adolescents 14*

to 19 years old, we called them rambling ones, they come with no clear complains, most of the prescriptions were for pain killers due to discomfort or back pain. I realized they needed PSS or wanted someone to listen to them', we still see other providers judging the adolescents who attend clinics as seeking dating at clinics! which resonates or probably tells something pertaining to the impressions about the inability or unwillingness of service providers to offer gender-and-age sensitive services (Sayej, 2018). During our discussions, one of the private doctors at gynaecology services who used to work for NGOs and government clinics commented on the repeated visits of adolescents to clinics without having a medical motive/complaint negatively saying that it is for '*Rendezvous, they attend there to see or meet with girls, the clinic could be the place of a date*'. The impression obtained by our qualitative findings does not differ largely from a previous study around PSS services to adolescent girls during conflicts where some of the clinic-based PSS counsellors explicitly indicated an unwillingness to show any empathy or support to girls who seek the services while their concerns relate to love and relationships during the war (Abu Hamad et al, 2015). Although this attitude is not generalizable, it gives an impression that healthcare providers stabilize if not contribute to lowered participation and stigma associated with seeking SRH services by unmarried adolescents. The research team watched the group's dynamics and has observed that this and similar comments passed with no objection and/or disclamation signs by other participants. We have also observed that nurses are more progressive than doctors, younger staff in general, and those who work for UNRWA and some NGO clinics are either more progressive (hold more equitable positions), enthusiastic, or have the least complaints when it came to improved adolescent health and engaging men in service utilization. As for school teams, our findings argue that MOE staff participating at school health teams are slightly more supportive of the education of young people about SRH than MoH teams who focus on medical services and physical health. This is also true for the difference between counsellors, who are willing to handle male behaviours at puberty stages with less disciplinary measures than how teachers and headmasters think/do. The school health teams mentioned several discouraging conducts by teachers who may beat, punish, or expel the students for asking even naïve/simple questions around SRHR. Our key informants from NGOs also were concerned about the attitudes and the unwillingness of teachers and school administration to cooperate and transform their teaching methods towards a more interactive open learning atmosphere around SRHR. Counsellors also reflected on their observation that female colleagues and female teachers are more open to talking to girls about girls' related issues but they obliterate the subjects related to male issues, even at the technical meetings that both male and female counsellors attend. This argument partially explains the conservative attitudes of girls aged 18 years and less who receive most of their information from mothers, teachers, and counsellors. Thus, it is no wonder that girls both in Gaza and South Gaza don't think they need to learn about puberty aspects of boys and consider it as '*The business of people over 18 years or engaged girls, we don't need to learn about it now*' said a 17-year-old girl in Daraj area. Our findings call for a vigorous mainstreaming of supportive attitudes among service providers on the route towards gender transformative involvement of men and also women in SRHR and child-rearing aspects.

4.2.5 A good man and a good woman

Echoing one of the most progressive and experienced managers who said '*I do confirm that more than 70% of youth are completely ignorant about the comprehensive SRHR meaning, as they link it solely to the sexual relation. Parents do not provide answers and this creates a lot of problems in their sexual relations and family relations. This also reinforces the concept of shame, this also affects how boys and girls look at themselves*'. Indeed, the image of a good man and a good woman drawn by adolescents was only a little different than the typical thought held by older generations. It is interesting to learn that, when asked about the views of the opposite sex regarding the same topic, the majority of girls and boys were able to read the opposite sex ideas about a good woman and to a slightly less extent about a good man.

Girls in the south of Gaza, despite being willing to have greater say in their future marital life than what their mothers currently do, still relatively hold the perceptions of the older generations about a good man and a good woman. They also seem confused about other issues, such as the importance of SE but still unwilling to learn about puberty of boys as they think it is shameful to do that (they labelled the 'Shame' concern as not needed now). It is totally understood that girls at this age (below 18 years) live with some contradictions because the community expects them (and they comply) to be nice and wise. For example, they said the kind of support a man can offer is to bring the girl some chocolates, talk to her nicely and say supportive or loving words, yet, at their description to the ideal man they somehow reflected the same views of their mothers as a good man is the one who takes care of the expenses of his family members, has a good reputation and good behaviours. Almost no difference was observed among girls in Gaza and Northern Gaza, except adding more description of seriousness. They see the ideal man as the one who takes care of the family in terms of financial aspects, is university educated, loving to people, respects his parents, not frivolous, does not waste time on the internet or playing, does not stay out late, and does not smoke, able to protect and guide his children in the right directions, is not angry while treating his children and preserve his family. They think that mothers expect a good man to respect his parents, obey their wishes, and deal with his wife non-violently. Boys on the other hand think that girls' image of a good man revolves around his financial capacity, strength, and not causing social problems. Some of them also mentioned, in addition to money and strength, girls expect a man who makes them happy, brings her chocolates and takes her out, and the one who protects her. Only a few boys referred to respectful treatment as 17 years old boys said '*Who treats her nicely and respects her*' he also added and a good woman is '*A strong woman who can also preserve her marriage and home*'. For boys themselves a good man is a strong man, who prays, doesn't hurt others '*Fe halo* في حاله *[has no issues with neighbours and surrounding community]*', and who controls the house and affords the responsibility. Some others added; good men do not smoke and don't practice masturbation/the secret habit. They think that the community at large, including girls who are about to marry, puts more value on money and financial capacity than on religion but money comes first and people can give up other conditions. Older groups have indeed mentioned financial capacity as a feature of bearing the responsibility of a family but also kept other morals and characteristics such as education (least stressed on) and commitment [social and religious].

The good woman, almost for all participants including young females, is the one who preserves herself, her 'sexual purity', and her family 'family honour'. She takes care of her husband, does not cause problems, does her duties at the house, appreciates her husband

and his family, balances her work and responsibility at her house, raises the children righteously. Females think that the male view of a good woman revolves around being beautiful, not sulky, does not talk to strangers, and does not go outside a lot. Adolescents think that the older generation has some similar views but hold more conservative positions about women's mobility as, for older generations, a good woman stays at home, is good in the kitchen, goes with her husband wherever he likes to and focuses on her children. The male participants phrased their image of a good woman as the one who '*Tsoon jozha* تصون جوزها *[preserve/respect her husband]*', preserves the male honour and values the relationship with him, takes care of her house and makes him happy. Youth, from the underserved area, whose level of knowledge was extremely disappointing, added, besides the ability to preserve her marriage, a good woman is pretty and obedient in most cases.

The majority of key informants and participants think that although the community at large remains stereotyping a feminine caregiver role and a masculine breadwinner role; there are increasing supportive voices and practices of women working outside the house, who enjoy a greater "autonomy" for themselves, especially at an older age. The drivers of this positive change were linked partially to financial hardships as more of her contribution is needed, but the change is largely attributed to an increased level of awareness according to our participants.

4.2.6 The light at the end of the tunnel: changing community attitude over time

Since there has been little research was done to understand the modalities of thinking about men's role or involvement in SRHR (Shalash et al 2019), there is no sufficient or baseline information about the attitudes of the Palestinian community in Gaza Strip around SRHR and child-rearing aspects. Key informants, as well as participants of FGDs, referred to significant changes in men attitudes and decision making favouring more flexible positions in utilizing FP services and methods, slightly better positions about wife's share in these decisions, improved attitudes-despite holding some concerns-towards CSE, rejecting child marriage and willing to take part in SRH in addition to showing more resilience and resistance towards social pressure, that prevent greater roles of men in child-rearing practices.

With the majority of participants, even among the youngest female participants who hold strict attitudes about SRH education due to shyness or maybe fear of exposure to the unknown, our discussions pointed out that the younger generation is less tolerant to forced and exchange/Badal زواج البدل marriage[3], GBV, and violence with children. Girls from Rafah, again, who were drawing an image of a good man similar to the image they think their mothers hold, have said they would love to have a say in their future marital life and FP and will resist the decisions they don't agree with. Also, the service providers reflected on the fact that, unlike before, some of the young and newly married or engaged couples tend to be eager to attend the services together. One of the nurses working at a clinic

[3] The exchange marriage is usually organized according to certain agreement between the fathers where a male and a female sibling marry to a female and male sibling from another family or a relative family. This formula usually connects the destiny of the two couples together so one life event for couple A will have similar impact on the couple B. In many exchange marriages, bride and sometimes groom opinion is camouflaged by the fathers' decisions. Exchange marriage has economic and cultural drivers and tend to be decreasing among Palestinians.

inside a refugee camp in the middle area said '*We start to see engaged couples coming together, he catches the hands of his fiancée in the front of all, this was not the norm and is a little surprising, I think that younger people are more open, we see some change*'. Regardless, of the attitude setters - as economic hardship seen among the drivers of attitudinal change-, we noticed that adult youth described those who plan for the number and timing of having children as organized and as good fathers and some of the young youth, both males and females referred to their unwillingness to repeat their parent's mistake of having too many children. Also, less frequently, some service providers mentioned a "*Change in the way of thinking and acceptance from the community that man can have daughters only without thinking about getting married again to have a boy" said a nurse from Jabalia.* However, men who accept or ask for the use of FP if they have one or two daughters remain a minority. During the discussions with community leaders, a religious figure reflected on his personal experience indicating that he accepted to use FP after having two daughters and did not think of a second marriage or tried to push his wife to bring more children. A mukhtar participating in the same group commented on that experience saying '*This is very exceptional; it doesn't happen frequently*'.

When it seems undoable to quantify the attitudinal changes among the community members in the Gaza Strip, our key informants, especially the most progressive participants who appeared impatient to see tangible changes, considered this progress as a slow-paced process that requires a long time to see tangible outcomes. The dominant culture which does not favour equitable attitudes and practices is further deepened by the political instability and lack of security. Besides the after-wave uncertainty (due to military invasions), pressure, and threats of one's control over his/her destiny, all are factors which block, if not causing relapse and reverse the positive change. We concluded that the context is too constraining to the positive change in norms and therefore, making a cultural breakthrough should remain a priority area for planners and executers at the legislative, social, and service provision levels.

Besides the various attitude setters such as access to and quality of information, availability of services, service quality, culture, and socioeconomic realities, we observed a considerable weight for personal experiences. For instance, sub-fertile men were keen on the greater role of fathers in child-rearing. Also, they referred to attending SRH education sessions more often than other men. The driver for their attendance as expressed by a man from Biet Lahia, North Gaza who said about their participation '*When we hear about similar sessions, we go to attend, we hope to have children and put up with some expectation that organizations will help us, we pray to Allah to have children*'. Other examples were demonstrated by PWD where women married to PWD, have more assertive attitudes about their decision-making space pertaining to FP and this is accepted by their partners who delegate a significant much of responsibilities to their wives. Likewise, females who are aged 30 years or more and not yet married, who usually have fewer chances of "good" marriage opportunities, appeared somewhat more tolerant to living at extended families of husbands than younger females, although this part was not thoroughly explored. Divorced women, especially those who were married at a young age or as children were fully against child marriage, despite that some of them were forced to accept that for their daughters. Youth at Mughraqa area were not supportive of introducing CSE at schools at a young age, during the discussion, some of them referred to an incident of a despicable teacher who '*Was putting his hand on the neck of students in an improper way [reference to harassment]*' which probably awakens a concern among

the participants about the possibility of harassment or behaving badly among boys. A youth said about the situation when CSE is introduced to little boys that '*It is a risk that children might behave like him and try inappropriate things if they are exposed to that early by a teacher with bad behaviour* شمال'. In Rafah governorate, our qualitative team observed that sexual harassment was mentioned, sometimes more than once, at each discussion carried out in that area. Therefore, it is possible that holding some more conservative attitudes in certain areas is driven by fear or need for protection. This calls for greater efforts to ameliorate the personal experiences of younger generations especially at schools, healthcare facilities, and CBOs in order to keep pushing the change of attitudes in the positive direction.

The combination of attitude survey questions and the inputs from FGDs and KIIs highlights some shared attitude patterns like increased positivity with age among adult youth from both sexes, less conservative attitudes especially about male engagement in child-rearing among nuclear families, refugees whether living in cities or camps, relatively economically-advantaged, and residents of Khanyounis and middle governorates who also reported a higher level of knowledge. One of the interesting observations links the positive change to the marriage experience as it seemed that marriage in a few years forms a turning point of a tangible move toward more progressive attitudes. It is possible that according to one of the key informants, female community leaders, and some service providers that women's secondary and university education mediates such change. Another possible reason is receiving SRH education at schools as the majority of progressive individuals –based on both quantitative and qualitative findings – belong to the generation of late 70s and 80s who were at schools during the 90s and millennium school graduates. This period, as reported by service providers and many individuals, belongs to the time when SRH education was more prevalent at schools, and also when "security/fewer hostilities", economic life, and mobility were much better than the most recent 20 years per se.

4.2.7 Decision making around SRHR and child-rearing

To understand cultural norms and the impact of the environmental factors around SRH decision-making dynamics, participants were asked about who decides about the number of children in their families, the majority of respondents reported that both couples decide together (73% by men and 66% by women). Still, 19% of respondents (men and women) indicated that within their families' husbands alone decide the number of children, while 5% of men and 8% of women indicated that women are the ones who decide in this regard. Figures reported earlier are close to what the participants themselves prefer (see table 12).

Table 12: Distribution of responses related to cultural norms and decision making

Variable	Male		Female		P value
	No	%	No	%	
Who decides about the number of children					
In your family					
Husband	89	18.7	92	19.3	0.005
Wife	24	5.0	38	7.9	
Both	347	73	315	66.1	
Parents-in law	8	1.6	24	5	

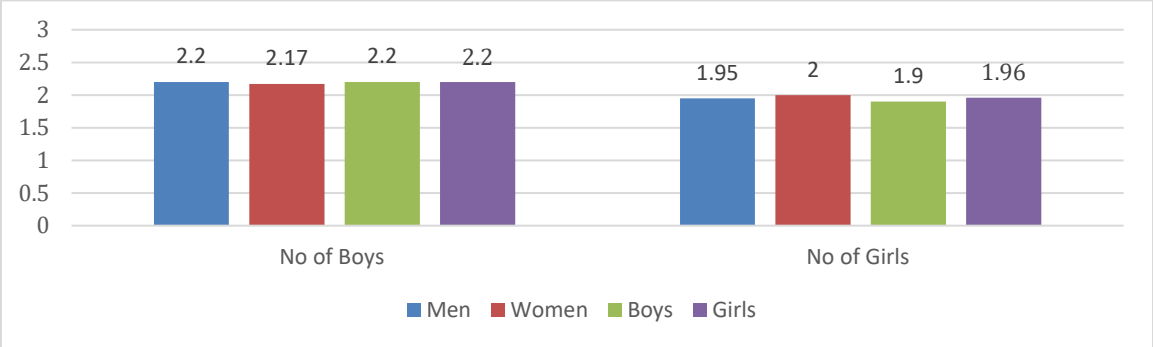
Every one mentioned	0		3	0.6	
Others	7	1.4	4	0.8	
In your community					
Husband	211	44.4	189	39.7	0.019
Wife	39	8.2	41	8.6	
Both	204	42.9	201	42.2	
Parents-in law	16	3.3	42	8.8	
Every one mentioned	2	0.4	1	0.2	
Others	3	0.6	2	0.4	
Your personal preference					
Husband	119	25	43	9	0.001
Wife	16	3.3	78	16	
Both	338	71.1	353	74.1	
Parents-in law	1	0.2	2	0.4	
Every one mentioned	0		0	0	
Others	1	0.2	0	0	
Preferrable number of boys and girls					
Number of girls					
0	7	1.4	3	0.6	0.001
1	124	26.1	70	14.7	
2	259	54.6	317	66.7	
3	62	13	76	16	
4	9	1.9	9	1.9	
5	12	2.5	0	0	
6	1	0.2	0	0	
Mean number of girls	1.95		2		0.134
Number of boys					
0	4	0.8	2	0.4	0.001
1	89	18.7	51	10.7	
2	241	50.8	306	64.4	
3	104	21.9	99	20.8	
4	17	3.5	14	2.9	
5	12	2.5	1	0.2	
6	4	0.8	2	0.4	
7	2	0.4	0	0	
9	1	0.2	0	0	
Mean number of boys	2.22		2.17		0.329
	Boys		Girls		
Differences in the means between boys and girls for the entire samples (men and women)	2.1987		1.9958		0.001
Differences in the means between girls and boys for the women respondents only	2.17		2.03		0.001
Differences in the means between girls and boys for the men respondents only	2.22		1.95		0.001
Decide about work (to work or not) on your own					
Yes	451	95	233	49	0.001
No	24	5	242	51	
Decide about work (nature of work) on your own					
Yes	449	94.6	231	48.6	0.001
No	26	5.4	244	51.4	
Men and women should have equal chances to access work opportunities					
Agree	307	64.6	400	84	0.001
Somehow agree	48	10.1	43	9	
Don't agree	120	25.3	33	7	
Has an intermediary person arranged your marriage					
Yes, a parent	282	59.2	212	44.5	0.001
Yes, relative	74	15.5	126	26.5	

Yes, Khatba	12	2.5	28	13.3	
No	108	22.7	110	23.1	
Were you ready to marry or would you have rather waited					
Ready	419	88.1	301	63.2	0.001
Rather wait	54	11.3	174	36.6	
DK	3	0.6	1	0.2	
Regarding your marriage, have you been pressured by your family, friends, or relatives to take this decision					
Yes	53	11.2	62	13	0.377
No	422	88.8	414	87	
A woman should decide free of pressure or influence when to marry					
Agree	296	62.2	320	67.2	0.139
Somehow agree	41	8.6	44	9.3	
Don't agree	139	29.2	112	23.5	
A man should be free to decide whether he wants to marry or to remain unmarried					
Agree	319	67	337	70.9	0.418
Somehow agree	40	8.4	34	7.1	
Don't agree	117	24.6	104	22	
When the family faces certain difficulties managing the household expenses, who decides/prioritize facets of expenditure					
Husband	254	53.3	204	42.9	0.001
Wife	67	14.1	80	16.8	
Both	147	30.9	163	34.3	
Other adult members	8	1.7	28	5.9	
Adolescents					
When the family faces certain difficulties managing the household expenses, who decides/prioritize facets of expenditure					
Father	139	51.5	80	38.8	0.001
Mother	38	14	25	12.2	
Both	85	31.5	70	34	
Others	8	3	31	15	
Families and relatives should not put any pressure or influences on boys regarding when or whom to marry					
Agree	238	88.2	183	88.8	0.753
To some extent	7	2.6	7	3.4	
Don't agree	25	9.2	16	7.8	
Families and relatives should not put any pressure or influences on girls regarding when or whom to marry					
Agree	234	86.7	182	88.3	0.808
To some extent	9	3.3	7	3.4	
Don't agree	27	10.0	17	8.3	
Males who decide to remain unmarried should not suffer any social blame, stigma, or mocking					
Agree	232	85.9	188	91.3	0.192
To some extent	10	3.7	4	1.9	
Don't agree	28	10.4	14	6.8	
Females who decide to remain unmarried should not suffer any social blame, stigma, or mocking					
Agree	236	87.4	190	92.2	0.234
To some extent	9	3.3	4	1.9	
Don't agree	25	9.3	12	5.9	

However, away from their families and their own preference, in their community, men reported that the husbands are the ones who decide as reported by 44% of men respondents and 40% of women respondents. Only 8% of men and women respondents reported that the wife decides the number of children in their community.

The preferable mean number of girls reported by male respondents was 1.95, and by female respondents, it was 2. The differences were not statistically significant. Regarding boys, both males and females reported a preference for more boys than girls (2.2 by men and 2.17 by women) with males. For the entire sample, the preferred number of boys is higher than that of girls as reported by both male and females' respondents and the differences are statistically significant. Similarly, male and female adolescent respondents showed a similar slight preference for males over females (2.1 for boys and 1.9 for females) and the differences are statistically significant.

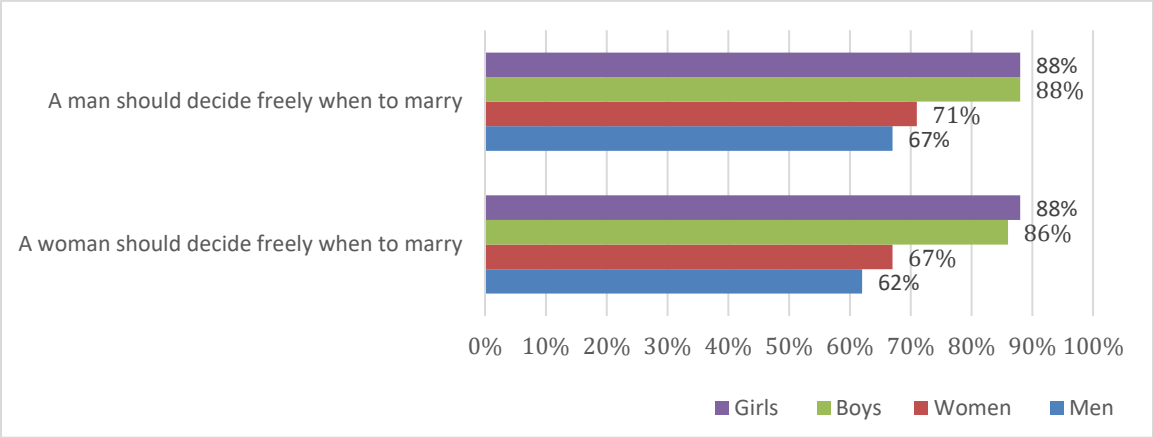
Figure 10: Participants' preferred number of children



While almost all men respondents reported that they decide whether to work or not, almost half (49%) of female respondents reported their ability to decide themselves in this regard. The same applies to the type of work where only half of the women were able to decide in this regard. While two-thirds of male respondents (65%) agreed that men and women should have equal chances to access work opportunities, 84% of female respondents agreed on that.

When asked about whether their marriages are arranged, only 23% said no, for the majority it was arranged marriages mostly by parents and relatives. While 12% of men preferred to wait as they felt that they were not ready for marriage; 37% of women were not ready and would prefer waiting. Although 37% were not ready for marriage, only 11% of men and 13% of women reported that they have been pressurized to marry. Influenced by cultural norms, 29% of male respondents and 24% of women respondents don't agree that a woman should decide free of pressure or influences when to marry. Among adolescents, the majority of boys and girls (over 85%), agreed that families should not put any pressure on boys and girls regarding when or whom to marry (see table 12). Also, less than 10% of boys and girls didn't agree that males and females who remain unmarried should not suffer any social blame or stigma; the vast majority agreed on that. Among male respondents, 25% reported that a man should be free to decide whether he wants to marry or to remain unmarried. Finally, when the family faces certain difficulties managing the HH expenses, husbands alone usually decide/prioritize facets of expenditure as reported by 53% of male respondents and 43% of female respondents. Young people's perspectives are not that different, 51% of boys and 39% of girls mentioned that their fathers usually decide HH expenditure. Nearly one third reported that fathers and mothers jointly decide (32% by boys and 34% by girls).

Figure 11: Perceptions about men's and women's freedom to decide when to marry



During the discussions with married participants, key informants, and community leaders, diverse inputs around SRHR and child-rearing decision-making were presented. The majority of participants confirm almost absolute dominance of men over SRHR decisions pertaining to the timing and frequency of FP, and the largest share of decisions about SRH service utilization including regular ANC and post-natal care. Only a few participants including mukhtars believe that wives have their own calculations to shape the decisions (indirect influence on decision making) as one of the Mukhtars said '*In many cases, women themselves want to have more children to make sure that her husband doesn't leave her and for other reasons related to the cultural values the woman holds and her psychological composition'*. When women attempt to influence the FP decisions, they must pay extra effort than simply commencing a mature/mutual discussion with their husbands. Some women in the south areas referred to '*playing around decision making dynamics'* as a female teacher said '*At the middle of the tension my husband feels between me and his parents, I know how to resist their effect and bring him closer to my point of view'* while another one living in an extended family in the eastern villages of Khanyounis said '*I am supported by my father-in-law, he loves me, so he helps me to convince my husband about FP, as we live in a small area and he still wants more children but I don't*'. Our team noticed that men, generally, are easier to give up their assumed authority or to pass a wife's decision when she wants to have more children but they tend to be strict when the decision is needed to seek spacing or stopping pregnancy for a while. Several key informants and community members highlighted those decisions, in many cases when women go against their husbands, turn into violent situations. This is true for everyday life decisions such as when and how to engage in an intimate relationship to the more strategic decisions such as FP and second/multiple marriage decisions. Similar to the majority of SRHR components, the study participants referred to a slow positive change as working women, more educated couples, nuclear families, and younger couples tend to have "balanced voices" for both partners.

Our activities sought to understand, besides the level of knowledge and the current attitudes with their setters, the other factors implicated in the decision-making process, and how those seat men and women in certain positions from the mutual decision-making process. As detailed below, part of these factors pivots around a tangled jungle of social

norms and, according to the participants, selective or misinterpretation of religious standards, besides the impact of the grievous Israel hostilities and political uncertainty.

4.2.8 The effect of occupation and political turbulence

When they are suppressed day and night, would it not be expected from them to dismiss non-aggressive reactions?!' That was one of the explanations about the dominance of decision-making presented by one of the key informants who have a long experience working in Gaza with social and political actors. Without isolating the cultural context of male power dominance in the Arab countries (El-Fekri, et al 2017), the impact of living under continuous violence imposed by being under occupation, added to the limited freedoms due to the siege and the internal political conflict, leave people with a status of helpless and anger. That would normally manifest in domination and possibly oppression as clear forms of violence. Linked to how people are raised, and how men assume possessing power and strength, one of the ECD specialists reiterated the need for preserving what remains of power/capacity to have control which would mix up with feeling a responsibility of protecting the family members to translate into more control and domination. She said '*Poverty, oppression, and fear pushed people to reject things they used to accept before. I am talking about a lot of social and family progressive ideas that could not live longer under these conditions*'. She added *'Ignorance and poverty are recycled, this leads to violence, and that brings people down in terms of ethics in general*'. What we understand is that the difficult environment and difficult realities imply/dictate difficult attitudes and practices; it partially awakens people's insecurities and that urges the need for protection and sometimes overprotection. Combined with their cultural inheritance, their version of religious values, the legal environment, poor targeting of men and youth, their unmet needs, all draw a heavy picture about what a balanced decision-making process looks like. The context ignites deeply rooted conservative cultural norms and result in non-linear development where, unlike other stable contexts, change goes in the wrong/reverse direction.

4.2.9 More sons mitigate the limpness of the welfare system and hold the family name

Generally, Palestinian families encourage having many children and this is part of the culture. Both key informants and community members attributed that to the tribal culture, working in farms at previous periods, and feeling more appreciated socially. In Biet Hanoun, men said having children is '*Ezwa* [4]*عزوة', a* big family which brings prestige and power to the family in such tribal context. Some women, especially the older generation and housewives, tend to look at children in general as bonds that will enforce their relationship with husbands. Also, being aware that men like to have many children and are allowed socially, legally, and by religion to marry another woman, the wives believe that more children will satisfy men's desire and will impose some additional financial burden. That is how men withdraw the idea of a second marriage. For both men and women, as aforementioned, sons are sources of security as a man from Qa'a Qreen in Khanyounis

[4] Ezwa means عزوة having large family with many men provides protection and backing for the family against other families. Provided that some disputes are solved through tribal mechanisms, those who have a bigger Ezwa also enjoy a stronger position even when it comes to peaceful solutions among families.

said '*Poorer love to have more children, because a son is about securing aback, they support, they help/benefit me when I become old in age*'. Another favourite cultural standard is having many children, particularly sons, for the continuity of a family name as one of the men in Biet Lahia FGD said '*If I had not had many sons, we [our family] would have been erased, I am a sole son to my father*'. Another man, 44 years old, from Rafah reflected on the power of prevailed culture even among those who hold different beliefs saying '*SRHR entails the right of women to refuse to have intercourse if she feels sick or bad and that is also true for pregnancy. However, we belong to a tribal society, demanding more children irrespective of women's health. If she is sick, men look at a second marriage, also if she gives birth to several girls, despite this coming from Allah [out of a woman's control], and is entirely a male rather than a female factor, women may get divorced*'.

The community leaders and some old men believe that some women, who live in extended families, feel jealous when a sister-in-law has more kids than her. For women themselves, having sons assure the insecurity of being left or share the husband with another woman. More importantly, as males are the typical breadwinners, having sons is likely to help to sustain the family when the parent gets old or in case of sickness or death of the primary breadwinner. Sons, when they are old enough, may support their mothers in case of social problems or disputes with the father or other family members. One of the key informants who have deep knowledge of the Palestinian culture said '*FP is an easier decision for working women as they are secured so they do not need to assure themselves by having many sons*'.

One of the difficult to explain phenomenon is that poorer families use fewer FP services and when they do, it is usually at a later stage after having many children compared to financially better-off ones. Several arguments were presented attempting to link the culture and religious beliefs to that. Some of the interesting explanations by a social worker who used to work with farmers said '*Poorer families, who were not poor in the first place, formed large families when they were working in the farms or the Israeli labour market. At that time and now as well, they remain neglected and not sensitized about the consequences of that, sometimes, people even those educated are not aware enough about their needs*'. Other participants linked that people, in general, do not decide about FP as they '*Trust in God, and accept it is as his wish*', they don't plan '*Albarakah* على البركة ', and believe that '*A child comes, and God sends his rezq* رزقه *[livelihood/food] with him*' and as a reminder, this was number one why seeking FP services is limited when people were surveyed (Table 24). A few participants said that they were linking having children with receiving more food aid but they reconsider how mistaken that was as they said '*People used to say, ten kids, ten flour parcels, now there is no money and no flour, it backfires all over our heads now*'. Also, the participants think that the educated ones and who have better income usually have higher expectations and living standards so they take the decision about FP into consideration to ensure that they afford good education and the requirements of a smaller number of children. The literature suggests that having many children in the Gazan context provides a type of social security and protection for the family and the tribe against others (UNFPA, 2016). Having many children is also an outcome of the political situation dominating the area. Many families have lost members in ongoing political violence and most Palestinians are aware of the demographic dimension of the Arab-Israeli conflict and are committed to the principle of having many children. Some especially men, perceive high fertility and having many children as prestigious (e'zwa) and one of the very few available opportunities to gain status and

recognition, particularly for males whose ego might struggle with the prevailing lack of employment and other opportunities (ibid).

The service providers understand how poverty and insecurity dissuade people from thinking about planning as poverty is overwhelming. One of the PMRS field staff said '*Financial status plays a big role in people's acceptance of awareness about SRH issues. When you talk to people from a region with difficult access to water, their answer will be: Have all our problems been solved and our needs met so that we can address this issue? Did not you find another topic for discussion other than this?*' Therefore, in addition to continuing to empower women and men at the financial and social levels, a sound social welfare system is indispensable for better utilization of SRHR, mainly FP services. Only speaking about the insecurities of men and women may result in a tangible change in their attitudes and practices, as a consequence.

4.2.10 The jungle of social norms, religious values, and outdated legislative frame

Despite the fact that the religious values are embedded within the Palestinian culture that finding the separation line seems unfeasible (Jones and Abu Hamad, 2016), some worthy inputs suggest that cultural preferences more than religious values seem to be stronger determinants of community perspectives and decisions pertaining to SRHR and more evidently about child-rearing aspects. For instance, the participants' inputs confirmed that the concept of shame encourages or blocks certain practices that religion prohibits or allows. '*Despite that in religion, nothing is shameful when it comes to seeking information, however, since this topic is culturally shameful, we escape from speaking about it*' said a parent in Tal Sultan, Rafah refugee town. This and similar other inputs suggest that the religious approach towards sensitizing the community about more equitable or balanced roles of men and women in SRHR and child-rearing activities could be helpful to dislodge some of the restricting cultural norms. Therefore, actors could build on the encouraging religious values mentioned in the Quran which describe the purpose of marriage as a mutual soother and source of serenity. For example, the meaning of verse 21 in Surah Ar-Rum, is, *'And of His signs is that He created for you from yourselves mates that you may find tranquillity in them, and He placed between your affection and mercy. Indeed, in that are signs for a people who give thought"*.

Being sexually impotent or infertile is no different than being useless!

Without diving back into the history - which may tell a little about the Arab tribal settlement, male head of tribes, and the logical assumption that family composition copied a diluted version of this structure, as aforementioned, the participants' version of manhood and muscularity enforce typical roles of men as they are seen more powerful and responsible. Thus, according to our analysis, as breadwinners and protectors, men retain full control over the decisions that "enable them" to practice their roles of sustaining the family and protecting its members. Culturally, one of the stabilizers of this image is the misconception of the local community which does not look resilient to the idea that a man can give up his control over the entire family unless he is a flunkey or has a problem or certain imperfection.

Delegating decisions to wives, especially those who are still young as they are assumed to still need protection, or taking parts of wives' traditional responsibility are widely perceived not only as a loss of control but also as being a helpless follower. Being a '*Follower of his wife*' or a '*Controlled man*' was frequently indicated by our FGD male participants in North Gaza and Gaza City. Some participants had even more stigmatized images as a man in Biet Hanoun described men who participate more with their wives or take part in wives' traditional role as '*Vassal* ذليل' while in Jabalia, an elderly said '*Like a medallion/medal [a keyring to hang the keys]*'. Also, among service providers who reflected on the community culture about men participation along with their wives saying that those men are widely seen as '*Rattle* شخشيخة ' and one of the school health team talked about his personal role where he does the exact same role as his wife saying '*I do everything she does, changing diapers, hygiene, taking the child to get his/her vaccine, everything*', he jokingly added when the rest of the group laughed '*I am controlled, I swear I don't know [kind of saying, Alas]*'. Part of the community classifies sexual dysfunction or impotency as major sources for feeling imperfect or inferior! Being a day for the biggest manhood test, it is no wonder why a considerable number of young adults are stressed about the first day of marriage. A health educator among female leaders group said '*For the young man, it is not the night he should enjoy and set the first stone for an everlasting, nice relationship, for him, it is an exam, a test where he either succeeds/pass or fails as a man, it is very stressful*'.

The inputs from male community leaders at FGD, according to our analysis and without generalization, connote some sort of reinforcement of this link between power and sexual performance as they said '*Most important thing to every man is his sexual satisfaction/desire and he usually does not search [regard as important] other things*'. One of the physicians who reported that there are men who feel confused and fail their intercourse, also described that there are men who are confused during their first days of marriage and feel sensitive about the process so he shared a situation when he consulted by a newly married young man regarding whether or not this man should control the frequency of intercourse since he was concerned about the bleeding resulted from hymen membrane rupture saying '*He came to me to ask, he thought it is a bleeding and that he must give his wife a rest, I told him no, you and your power [meaning it is okay to do the maximum number of intercourse you can]*'. Despite a significant decline of showing obsession about men successfully performing the first intercourse, some families remain concerned about that to the extent that some mothers' in-laws monitor and wait for the couple to successfully have their first intimate relationship, according to some participants from Biet Lahia and Rafah. Our understanding is that, because being impotent or infertile is no different than being worthless, men want to have children, among other motives, to prove their sexual potency. Our participants in FGD frequently shared that if they attend SRH healthcare, people will doubt their strength as a teacher in Gaza said '*They will look and wonder what is wrong with him*' and another added '*Kharban [sexually impotent]* خربان'. Of men themselves, a young male from Tal Sultan in Rafah described how his mother-in-law reacted to his decision of postponing having children since he was considering a long trip abroad saying '*I did not wish to have children, I wanted to travel abroad, I am radiologist, my mother-in-law kept pushing, come on, we want you to get married, or you are sexually impotent or inutile* لتكون خربان ولا مش نافع '. Linked to the concept of sexual strength, some men, especially the older generation, considered multiple marriages as a strength showcase. One of the youth participants, 22 years old, from an underserved locality in the middle of the Gaza Strip said that his grandfather who is about

50 years old told him that he should marry at least two, he said '*My grandpapa told me only hamel/ هامل [weak] man marries one woman only. I don't support that though*'. While these norms are slowly shrinking according to the majority of key informants and other participants, they had and still contributing to shaping the cultural beliefs around SRHR.

Women need protection

Also, connected to the male role, the perception that women are weak and need protection impacts their space of taking decisions and going outside the house to seek services since younger women have more lure, they are usually accompanied and more restricted. This is also tied to the ways of child disciplining in a positive direction as men think that girls do not force fathers to use violent discipline and that girls are sensitive, they also do not think that girls need to be tough, in contrary, they maintain that girls are shy and soft. Youth who participated in FGDs in the middle area linked the better treatment girls receive from parents due to their weakness. An adolescent in Gaza said '*Because they are weak, they are sensitive, with weak wings*'. One of the interesting inputs came from a psychologist who participated in our FGDs who described the role of media and series in informing the men and women image saying '*Having films and movies with a certain example of rosy life or a full misery is negative because it either raises the expectations or normalizes bad behaviours and therefore, adolescents should learn that both models are not realistic or possible to avoid frustration or submissiveness*'. One of the most overwhelming observations of the study team relates to the notion of the need to protect and that protection is best guaranteed for married females. Also, unmarried females are regarded as useless by a significant proportion of the community members!

Our conversations with the families of and with females older than 30 years and not yet married confirmed a lowered status of those girls. One of the brothers of unmarried females in Jabalia said '*The community is iniquitous towards them*'. Despite that fathers and brothers of those females mentioned taking good care of them, females themselves felt hugely underestimated and maltreated especially by their family members and sisters-in-law. As a consequence, their self-esteem and autonomy are harmfully brought down. One of the participants in Rafah said '*I feel broken because of that, they mock us, because of that I no longer care about myself, they don't stop talking badly, my father too is difficult* '. Likewise, one of the participants in Jabalia, North Gaza said '*They regard us as servants, we are not allowed to go anywhere, they even wonder why would we take care of ourselves at homes for ourselves such as when we loosen our hair or apply some lipstick, everything is difficult*'. The discussions with these groups were among the heaviest, tear-jerking conversations during the study. Moreover, the position from unmarried adult females, links to the perception about their SRHR needs and access to service, and the materialization of SRH in general. Many participants overlooked the existence of such needs. A 28 years old teacher mother from Khanyounis commented on the service available for unmarried adult women saying '*They decided not to marry, this is their decision no doubt, what is the need for them then to seek SRH service? It is as if they are saying we don't need these services*'.

Offspring are in God's hand

Many of our key informants and community members reflected on the impact of religious values on SRH perception, practice, and position the majority of people hold from certain

SRH and child-rearing roles. Since some people selectively privilege certain religious standards over the others, for example, there is a perception among a few men that people are not entitled to control the number of children as this is God's business. One of the older generation participants in Biet Hanoun said '*Offspring in the God's hand, no one controls offspring*'. It is noticed that this perception remains relatively common among old people as the community leaders and Mukhtars said '*The majority of men understand FP as termination or control of a number of children and that it is against religious values*'. Almost all participants reflected that the appropriate FP concept that does not contradict religious values is increasing among men and women alike. Many other participants provided an example of people admitting religion as the boundary but are not applying what religion dictates as some men, even though not many, perform prohibited sexual practices. Key informants mentioned that some women accept maltreatment or don't object to having sexual relations with husbands because of fear to contradict religious values. A lawyer and human rights activist described why some women accept that copying the misconception, according to him, that women hold saying '*Otherwise, the angels will curse/damn them if he [the husband] slept while angry*'. Religious people remain approached by a considerable number of people seeking advice or information because there is a high level of privacy involved in talking to them and that their prices of advice are believed to be consistent with religious values. Key informants and female community leaders regarded that the impact of some religious persons, those who possibly provide incorrect information, as negative. One of the female community leaders who is also a health educator said '*I attended some female preacher's sessions, some of them destroy/damage the good structure, they do harm*'.

Autonomy is not a member of the extended family

The influence of the extended family, mainly father and mother or in-laws, is manifested mostly in marriage and FP decisions. According to the participants, this impact splits in two directions; some in-laws push for many and early child-births while others impose or try to impose FP solutions especially when the couple lives with them inside narrow houses or under financial hardship. Participants in this research provided several examples about the intervention of extended family members. This influence started to decrease over time and with the tendency of people to live in nuclear families, however, it remains one of the cultural norms to respect the wish of in-laws or the couple obeys them, if they have financial power. A man in Tal Sultan, Rafah said 'The grandfather was the one to determine the number of children to everyone [couple]'. Also, the service providers reflected on the roles of mothers-in-law in accompaniment of women to ensure that the desire/decision of the husband is adhered to. One of the providers said '*Mothers-in-law are key in FP, they come with women and talk on their behalf, I realized that once and when the mother-in-law asked me to insert an IUD for her daughter-in-law. I asked her to leave the room during the procedure. The lady told me then she doesn't want it and I had to lie saying that there is a problem that the IUD insertion is not possible, so I sent them back at that time*'. Another service provider added '*True, especially with child marriage, also young wives are poor, sometimes they want the mother-in-law to be there because they know nothing on their own, we started to stop any accompaniment except husbands*'.

Marriage is the right of a man to enjoy the woman

Our key informants have reflected on the legal pitfalls which impact some of the practices and certainly the attitudes towards SRHR. The report doesn't detail these pitfalls from a legal point of view, it, however, highlights that, according to key informant inputs, the laws are not unified in the West Bank and Gaza and not advanced as some articles are dated back to the Turkish era[5]. Also, the law includes plenty of depowering and/or fluid articles that may or may not connect the unpronounced issues to Fiqh[6] rather than to the Quran. The existing legal reality contributes to stabilizing some concepts such as a marriage contract (Nikah Contract[7]) signifies permission for the man to enjoy the woman but did not denote at least a mutual relationship – despite the fact that certain verses referred to the right of both partners of enjoyment. Indeed, according to Quran, the primary purpose of marriage goes much beyond sexual relations, as the coming versus explicitly implies: '*And of His signs is that He created for you from yourselves mates that you may find tranquillity in them, and He placed between your affection and mercy. Indeed, in that are signs for a people who give thought"*[8]. Associated with these perceptions, which are more underpinned by cultural rather than religious norms, the space for women in SRH decisions is limited. Also, their expression about their sexual needs involves multi-layered risks; speaking about the sexual performance of men may lead either to husbands accusing them of being impolite or turn into violent situations, and mostly none of the community members would support their complaints. Being too sensitive, talking about a wife expressing her unmet needs, one of the FGD participants in Biet Hanoun described the consequences of that with some vague words saying '*In marital relation, it is obvious, especially her husband, because he will accuse her with other things, and other matters*'. Culturally, this perception along with other factors puts pressure on widowed and divorced women, it is far associated with the community's intolerance to their second chances of marriage. One of the female mukhtars narrated how a widowed woman aged above 45 years and has youth sons expressed her desire for a second marriage and how that provoked her sons saying '*When I talked to her and she said that [she wants to marry again], I myself was surprised, although at the end this is her right, the sons were against that, they did everything for her including helping her to drive a car and brought her a Jeep even, but she said she wants to marry and they were against that*'. Also, culturally couples are not allowed to talk about their intimate relationships as these are internal issues that should not be disclosed outside the HHs, especially by women.

4.2.11 Decisions about using time: domestic and child-rearing roles of men and women

Our findings confirm that the use of time is also gendered. On a typical day, men reported spending 1.3 hours doing domestic work, while women reported spending around 4 hours daily doing the same (boys reported 1.4 and girls 1.9). Men (2 hours) spent more time surfing social media and communicating with others and watching TV (1.9) than women

[5] The Turkish control of Palestine ended in 1917, with the end of the first world war (1914-1918)

[6] Fiqh is often described as the human understanding and practices of the Islamic Sharia, that is human understanding of the divine Islamic laws as revealed in the Quran and the Sunnah

[7] A contract that allows sexual intercourse between a male and a female to take place

[8] In Surah Ar-Rum, versus 21

(1.4). Similarly, girls spent more time in domestic chores (1.9 hours) than males (1.2) and in child care (males 0.7 for males and 1.1 for females). Boys spent more time surfing social media (3 hours) than girls (1.9) (see table 13).

Table 13: Time use and participation in positive parenting practices

Variable	Male		Female		P value
	Mean	Median	Mean	Median	
Adults					
Daily time spent on activities by hours					
Domestic chores and housekeeping including cooking for the family and shopping for the household	1.3	1.0	3.8	4	.001
Watching TV, reading books or other entertainment time.	1.9	2.0	1.4	1	.001
Surfing social media outlets or telecommunication with others	2.0	1.5	1.4	1	.001
Childcare including feeding, hygiene, dressing them up, helping homework, seeking healthcare, and playing with them	.04	.017	.02	.017	.001
Taking care of other family members such as PwDs or old age	.07	.08	.07	.05	.002
Adolescents time use					
Domestic chores and housekeeping including cooking for the family and shopping for the household (Unpaid work)	1.2	1	1.9	2	0.047
Watching TV, reading books or other entertainment time.	1.9	2	1.9	2	0.028
Surfing social media outlets or telecommunication with others	3	2	1.9	1	0.001
Childcare including feeding, hygiene, dressing them up, helping homework, seeking healthcare, and playing with them (Unpaid work)	0.7	0.5	1.1	1	0.001
Taking care of other family members such as PwD or old age (Unpaid work)	0.3	0.0	0.3	0	0.311

Congruent with quantitative data, both men and women provided qualitative inputs that estimate the men contribution to a maximum of 20 to 30% of what women do inside the house, and that generally, men who do greater domestic roles and take a good share of child-rearing activities inside the house stand at 10 to 20% most of them are younger couples who live in nuclear families. Also, men married to working women do take a greater part in domestic and child-rearing activities. One of the women in FGD in Gaza City said while laughing '*When I really felt that my husband helps me, that was when I worked on a temporary job for six months, at that time, he was helping. I return on Monday, he is at home on Mondays, I found that he did everything for my son, everything. I do not talk about house chores, that is what I did after I return, I was talking about our son, he did everything for him, regarding his food, hygiene, all. But now, it is over, nothing at all. Sometimes I ask him to get closer and pay attention to the baby, all that he does is kissing the boy and that's it*'.

4.3 Participation in sexual and reproductive health and child-rearing

This part of the report presents the survey results about men's and women's participation in SRHR and child-rearing activities. The findings present the views of our respondents about the participation of men and boys in SRHR in general as they evaluate the level of participation among the Gazan community at large. Then, the respondents reflect on their own experiences and actual practices as they rate/quantify their level of participation in certain SRHR aspects and child-rearing activities. The report also narrates the participants' qualitative inputs which partially explain the discrepancies between their attitudes and practices. Our participants and key informants highlighted the major barriers of male engagement and active participation in SRHR and child-rearing activities as presented at the end of this section.

4.3.1 Male general participation in SRHR and child-rearing at the community, at large

Unsurprisingly, the vast majority of participants totally agreed that male participation in SRH is limited (68% of men and 72% of women), only 12% of men and 10% of women didn't agree on that. Recognizing that men's participation in SRHR is limited is important for addressing this issue in the future. Men, women, boys, and girls hold similar perceptions about the possible reasons which prevent men from participating in SRHR. The key reasons given were feeling shy and embarrassed (reported by 59% of men, 51% of women, 55% of boys, and 54% of girls), followed by the perception that SRH is more a women business (reported by 68% of women, 51% of men, 36% of boys and 48% of girls). Lack of awareness about the importance of men's participation was also cited by 42% of both men and women, 40% of boys, and 46% of girls. Inappropriate perceptions about masculinity were reported by 27% of men and by 36% of women participants, 22% of boys, and 25% of girls. Moreover, around 13% of men and women reported fear of being stigmatized by the community, which was also reported by 10% of boys and 6% of girls. Men (20%) and boys (19%) slightly more than women (16%) and girls (17%) think that men don't participate because they are busy at work. Other structural factors at the supply side also constrain men's participation, as 9% of men and 4% of boys reported that service providers don't engage them, gender of service providers (8% of men), and the provided services either don't target or even exclude them (reported by 6% of men and 3% of boys), 4% of men and 2% of boys reported that they don't know about the existence of SRHR services and 3% of men reported that service providers are not trained to serve them. The provided reasons which hinder men's and young male participation in SRHR constitute a good base for future interventions to address these causes to increase male participation in the future. To address these reasons there should be multi-sectoral interventions at the demand side in order to increase male utilization of services as well as at the supply side to incorporate men in SRHR (see table 14 for detailed responses).

Table 14: Perceived participation of men in SRH in the community at large

Variable	Male		Female		P-value
	No	%	No	%	
Adults					
Agreeing that men participation in SRHR is limited in Gaza					
Agree	323	67.9	344	72.3	0.284
Somehow agree	96	20.2	87	18.2	
Don't agree	57	11.9	45	9.5	
Reasons that may make men reluctant to participate in SRHR services (agreed and somewhat agreed)					
Shyness, shame, and embarrassment	248	59.1	221	51.2	
The perception that SRH is more a women business	215	51.3	295	68.4	
Lack of awareness about the importance of men involvement	176	42	180	41.7	
Due to their own perceptions about masculinity	116	27.7	156	36.2	
Busy at work/doesn't have time	83	19.8	69	16.4	
Fear of being stigmatized by the community	53	13	54	12.5	
Health providers don't engage them	37	8.8	21	4.8	
Most SRH providers are women (gender of provider)	34	8.1	38	8.8	
Personal characteristics like limited education	34	8.1	22	5.1	
Fear of being stigmatized by parents/in-laws	30	7.1	29	6.7	
SRH Services don't target them/exclude them	27	6.4	17	3.9	
Don't know about the existence of SRH services for men	18	4.3	7	1.6	
Custom and traditions	13	3.1	6	1,4	
Health providers are not trained to serve men	11	2.6	8	1.8	
Physical space at a health facility is not appropriate	5	1.2	3	0.7	
Others	21	5.0	15	3.6	
Adolescents					
Reasons that may make men reluctant to participate in SRHR services					
Shyness, shame and embarrassment	149	55.2	111	53.9	0.584
Lack of awareness about the importance of men involvement	107	39.6	95	46.1	0.014
The perception that SRH is more a women business	98	36.3	99	48.0	0.001
Due to their own perceptions about masculinity	59	21.8	51	24.7	0.140
Busy at work	52	19.2	36	17.4	0.320
Fear of being stigmatized by the community	28	10.4	12	5.8	
Personal characteristics like limited education	17	6.3	11	5.3	
Fear of being stigmatized by parents/in laws	12	4.5	8	3.9	
Health providers don't engage them	11	4.1	9	4.4	
SRH Services don't target them/exclude them	8	2.9	9	4.4	
Hard Economic situation	8	2.9	3	1.4	
Don't know about the existence of SRH services for men	6	2.2	3	1.5	
Health providers are not trained to serve men	6	2.2	2	0.9	
Negligence	6	2.2	4	1.9	
Physical space at a health facility is not appropriate	5	1.8	10	4.9	
Customs and traditions and fear	2	0.7	4	1.9	
DK	1	0.3	2	0.9	

4.3.2 Participation in child care in the community at large

Concerning the participation in child care, almost two thirds of men (64%), and 71% of women agreed or somewhat agreed that men are not active in participation; more men (36%) didn't agree with this assumption than their counterparts (29%). Young people's perceptions were similar, 32% of boys stated that men largely participate, 56% stated that

they somewhat participate, only 12% stated that they don't participate. Similar to the reasons given for non-participation in SRH, women, and men were consistent in their opinions about what prevents men from active participation. Reasons given are gendered-oriented, for example, more than 70% of both males and females reported that men are busy working outside HHs. Adolescents also cited this reason as the main reason which prevents men from participation (82% among boys and 76% among girls). Similarly, 72% of women, 64% of men, 62% of girls and boys reported that child-rearing is more perceived as a women's business. Being tired was also reported by 34% of men and 28% of boys and not having adequate patience was also considerably reported (33% among males and 35% among boys). Perceptions related to inappropriate masculinity were reported as a reason for limited participation in child-rearing by 25% of men, 19% of women, 15% of boys, and 21% of girls. Men and boys reported other reasons included lack of awareness about the importance of participation in child-rearing (20%), never trained on that (12%, 9% respectively), and lack of experience (10%). Reasons revealed by this study provide a framework for future interventions to promote men and young males' involvement in child-rearing practices (table 15).

Table 15: Distribution of responses related to men general participation in child-rearing

Variables	Men		Women		P value
	No	%	No	%	
Adults					
Men are not active in participation in child-rearing activities					
Agree	144	30.2	156	32.8	0.051
Somehow agree	159	33.4	182	38.2	
Don't agree	173	36.4	138	29	
Why men don't actively participate in child-rearing activities among those who agreed					
Busy in work outside the HH	231	76.2	239	70.7	
It is mothers' business	195	64.3	242	71.6	
Tired	102	33.6	108	31.9	
Impatient like mothers	99	32.6	136	40.2	
Their perception about masculinity	75	24.7	65	19.2	
Lack of awareness about the importance of participation	63	20.8	65	19.2	
Never trained on that	37	12.2	40	11.8	
Not experienced to take a part	31	10.2	47	13.9	
Shyness and embarrassment	22	7.2	20	5.9	
Fear of being stigmatized by parents or in-laws	16	5.2	9	2.6	
Fear of being stigmatized by the community	9	2.9	18	5.3	
Personal characteristics like limited education	7	2.3	13	3.8	
Influence of extended family	6	1.9	13	3.8	
Fear for their image in front of children	6	1.9	6	1.7	
Having many children	5	1.6	4	1.2	
There are other females in the HH to do that	4	1.3	3	0.8	
Mothers prevent them from doing that	2	0.6	5	1.4	
Others	10	3.3	9	2.6	
Adolescents					
How much men in your community men participate in childrearing practices					
Largely participate	85	31.5	36	17.5	0.002
Somewhat participate	152	56.3	145	70.4	
Don't participate	33	12.2	25	12.1	
Why men don't actively participate in child-rearing activities					
Busy in work outside the HH	151	81.6	129	75.9	
It is mothers' business	115	62.1	106	62.3	
Impatient like mothers	64	34.6	69	40.6	

Tired	52	28.1	32	18.8	
Lack of awareness about the importance of participation	37	20.0	30	17.6	
Their perception about masculinity	27	14.6	35	20.6	
Not experienced to take a part	18	9.7	27	15.9	
Shyness and embarrassment	16	8.6	11	6.5	
Never trained on that	16	8.6	13	7.6	
Fear of being stigmatized by the community	7	3.7	6	3.5	
Fear of being stigmatized by parents or in-laws	6	3.2	6	3.5	
Influence of extended family	4	2.1	2	1.2	
Personal characteristics like limited education	3	1.6	6	3.5	
Having many children	2	1.1	1	0.6	
Fear for their image in front of children	2	1.1	4	2.3	
Mothers prevent them from doing that	1	0.5	3	1.7	
There are other females in the HH to do that	0	0.0	3	1.7	
Others	4	2.1	3	1.7	

4.3.3 Aspects of men participation in SRHR and child care components

Our survey indicates that in general, the proportions of men who reported being engaged or supportive to SRHR components were more than what has been perceived by women regarding male participation. It seems that men overestimate their engagement or women don't feel that men are really engaged or that supportive of SRHR. Mostly, men respondents are supportive during the delivery care (75%), possibly accompanying their wives to the facility, but not actually being engaged in the care processes or the delivery process itself. Men reported being highly engaged (73%) in SRHR when they face sexual dysfunction-related issues or facing difficulty in conception as reported by a high proportion of males and female respondents; 72% reported engagement in infertility care.

Men also reported high engagement in child health (68%), while only 59% of women reported that men are engaged in child health. Despite its importance, only around half (56%) of men engaged in FP. GBV, ANC, abortion, and PCC were the least areas men engaged at as reported by both men and women. Adolescents' perceptions about male involvement align with those of adults where boys and girls reported that men are usually more involved in Natal care (reported by 75 of boys and 82% by girls) and child health (around 70%). Also, young respondents indicate that men are more engaged in cases with sexual dysfunction and infertility. According to boys, involvement in PNC and STIs stands at 58% and 56% respectively. Similarly, boys' responses show that involvement in ANC and FP stands at 50%. Moreover, boys reported less involvement in GBV and PCC-related interventions. These findings as detailed in (table 16) are very useful to prioritize areas that require further attention in efforts to aiming for increased male involvement in SRHR.

Table 16: Distribution of participants responses related to the aspects of SRHR at which men are more engaged or more supportive in the community

Variables	Men		Women		P value
	No	%	No	%	
Adults					
NC	360	75.6	348	73.1	
Sexual dysfunction	348	73.1	306	64.3	
Fertility care Infertility care	344	72.2	292	61.3	
Child health	325	68.2	281	59	
STIs	280	58.8	252	52.9	

PNC	268	56.3	260	54.6	
FP	259	54.4	226	47.4	
Adolescents' health needs	228	47.9	216	45.3	
Counselling service in general	222	46.6	206	43.2	
GBV	210	44.1	186	39	
ANC	205	43	191	40.1	
Abortion	203	42.6	223	46.8	
PCC	144	30.2	152	31.9	
Adolescents					
NC	202	74.8	168	81.5	
Child health	193	71.5	151	73.3	
Sexual dysfunction	191	70.7	119	57.7	
Fertility care Infertility care	169	62.6	121	58.7	
PNC	156	57.8	123	59.7	
STIs	152	56.3	103	50.0	
FP	135	50.0	88	42.7	
ANC	134	49.6	103	50.0	
Abortion	129	47.8	80	38.8	
Counselling service in general	128	47.4	79	38.3	
Adolescents' health needs	123	45.6	95	46.1	
PCC	110	40.7	81	39.3	
GBV	108	40.0	71	34.5	

4.3.4 Men role in shaping women access to SRH services

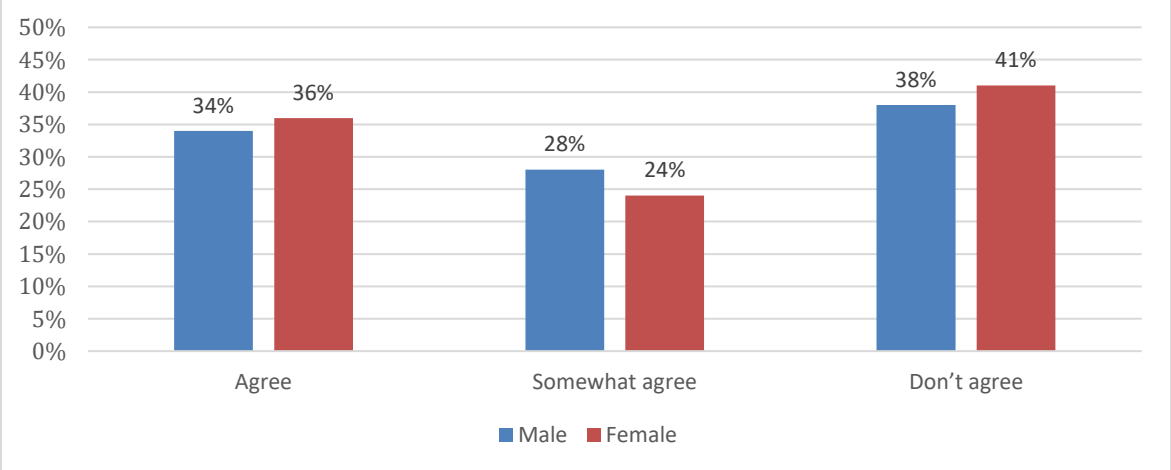
To better understand how much men are engaged or being supportive of SRHR health, our survey included a question exploring whether men do impose pressure on women and restrict their access to SRHS or not (see table 17). Shockingly, not only men don't actively participate in SRH, but they also restrict female access to these services. Findings show that the majority of men (62%) and women (60%) agreed or somewhat agreed that men impose restrictions on women's access to SRH. Among, adolescents, the proportions of boys (51%) and girls (57%) who agreed or somewhat agreed were slightly less than adults, possibly because they haven't tried SRH services yet. A recent study (UNFPA, 2021) found that about 55% of women can't decide on their own about seeking healthcare services, using FP, and refusing an intimate relationship at a given time. The study shows that about 75% of women have been experienced some sort of restrictions seeking healthcare (The study carried out in Africa and South/east Asia where women aged 15 to 49 years reported their own experiences) (ibid).

Table 17: Respondents' views about men's role in shaping women's access to SRHS in the community at large.

Variable	Male		Female		P value
	No	%	No	%	
Adults					
Men impose pressure on women and restrict their access to SRHS					
Agree	163	34.3	171	35.9	0.295
Somehow agree	133	27.9	112	23.5	
Don't agree	180	37.8	193	40.6	
Why do men and boys impose social pressure on girls and women to restrict their accessibility to SRHR service and information					
Feeling jealous	162	54.7	148	52.3	
Social norms	84	28.3	69	24.4	
Due to their own perceptions about masculinity	77	26	76	26.8	

Lack of safety in the community	77	26	56	19.8	
Fear that women use this to justify going out for un-needed services (laying to go out).	70	23.6	88	31	
Not trusting/appreciating services	59	20.0	49	17.3	
Beliefs that women should not leave their houses unless being accompanied	57	19.2	96	33.9	
Due to their own gender orientation	22	7.4	17	6.0	
No one is available to take care of children	18	6	22	7.7	
Lack of resources	16	5.4	14	4.9	
Influence of extended family	14	4.7	19	6.7	
Girls don't need services	11	3.7	13	4.6	
There are information sources available from in-laws	5	1.6	12	4.2	
Protecting family honour	3	1	1	0.3	
Others	31	10.4	38	13.4	
Adolescents					
Men impose pressure on women and restrict their access to SRHS.					
Agree	76	28.1	67	33.2	0.331
Somehow agree	61	22.6	49	24.2	
Don't agree	133	49.3	86	42.6	
Why men and boys impose social pressure on girls and women to restrict their accessibility to SRHR service and information					
Feeling jealous	88	64.2	73	62.9	
Lack of safety in the community	50	36.5	34	29.3	
Due to their own perceptions about masculinity	31	22.6	24	20.7	
Beliefs that women should not leave their houses unless being accompanied	29	21.2	23	19.8	
Social norms	24	17.5	28	24.1	
Fear that women use this to justify going out for un-needed services (laying to go out).	20	14.6	28	24.1	
Not appreciating services	20	14.6	22	18.9	
No one is available to take care of children	13	9.5	14	12.1	
Due to their own gender orientation	8	5.8	7	6.0	
Influence of extended family	5	3.6	6	5.2	
Lack of resources	4	3.0	8	6.9	
Girls don't need services	3	2.2	3	2.6	
There are information sources available from in-laws	2	1.5	1	0.8	
Protecting family honour	0	0.0	1	0.8	
Others	10	7.3	3	2.6	

Figure 12: Men impose pressure on women and restrict their access to SRHR services



4.3.5 Reasons for restricted women access to SRHS

Reasons given by men and women for men restricting women access (table 17) were consistent in some aspects like being jealous (reported by around 50%), restrictive social norms which were reported by 28% of males, 24% of females, 18% of boys, 24% of girls and perceptions about masculinity which was reported by 26% of adult respondents and by around one fifth of young people. Similarly, young people reported that jealousy is the main reason as reported by 64% of males and 63% of females. Around one third of boys (36%) and around a quarter of adult men reported a lack of safety in the community, which has been also reported by girls (29%) and women (20%), but in less frequency. Women more than (31%) men (23%) reported that men think that women use SRH visits to go outside the house although they don't need the services. The latter finding was also true about young people were 24% of girls and 15% of boys reported the same. Similarly, 34% of women reported that men believe that women should be accompanied when they go outside. Other reasons given by men include not appreciating/trusting services (20%), men's gender orientation (7.4%), no one is available to take care of children (6%), lack of resources (5.4%), and influence of extended family (4.7%). Mistrust for the services was also mentioned by 15% of boys and 19% of girls.

4.3.6 Actual participation in child-rearing practices

The traditional, and still prevalent Palestinian family model, sees men as the HH's main breadwinner and source of protection, and women as dependent housewives and the primary caregivers and nurturers of the HH particularly children. In congruence with research studies, our findings confirm that men play a limited in childrearing practices (Table 18). While only 16% of men indicated that they take part in the routine check-up of their children, 88% of women indicated doing that which confirms that child care is perceived more as a female task. However, when the child is sick, men participate more in taking care of children (30% indicated always participating) but still much less than women (65%). Findings flag a dissonance between what men say versus do, as although the majority of men (90%) and women (93%) reported that fathers and adult males should have a good share of childcare, still, their practices on the ground are different, indicating that cultural norms strongly determine what they do regardless of their personal convictions. Similarly, around a quarter of men (27%) and 83% of women reported contributing to taking care of little children below 3 years including feeding and taking care of his/her hygiene. With regard to appropriate (making a child smile) or even inappropriate practices (leaving the child alone with young siblings), that are not culturally gendered, no significant differences were noticed between men and women practices.

Table 18: Distribution of adults' responses related to child-rearing according to their actual experiences

Variable	Male		Female		P value
	No	%	No	%	
Taking part in the routine health check-up well-baby session					
Yes, always	78	16.4	403	84.7	0.001
To some extent	172	36.1	66	13.9	
Not really	226	47.5	7	1.4	
Taking part of the routine health check-up- Sick child services					
Yes, always	144	30.3	309	64.9	0.001

To some extent	249	52.3	147	30.9	
Not really	83	17.4	20	4.2	
Knowing how to get child smiles					
Yes	444	94.1	455	95.6	0.297
Not sure	23	4.8	14	2.9	
No	5	1.1	7	1.5	
It is okay to leave a child below 3 years old alone for a few hours with his/her 10 years old sister or brother					
Agree	122	25.7	113	23.8	0.762
Somehow agree	57	11.9	55	11.6	
Don't agree	297	62.4	307	64.6	
Contribution to taking care of little children below 3 years including feeding and taking care of his/her hygiene					
Yes, always	128	26.9	394	82.8	0.001
Yes, sometimes	187	39.3	31	6.5	
No	161	33.8	51	10.7	
Father and adult males should have a good share of childcare					
Agree	426	89.9	443	93.3	0.006
Somehow agree	43	9.1	21	4.4	
Don't agree	5	1	11	2.3	
Children wouldn't stop misbehaving without physical punishment					
Agree	60	12.7	83	17.4	0.116
Somehow agree	146	30.7	140	29.4	
Don't agree	269	56.6	253	53.2	
Use physical methods such as hitting or beating children below 14 years as disciplinary measures					
Often	22	4.6	42	8.8	0.001
Sometimes	198	41.6	246	51.7	
Seldom/None	256	53.8	188	39.5	
Use psychological methods such as yelling or scolding children below 14 years as disciplinary measures					
Often	160	33.6	263	55.3	0.001
Sometimes	227	47.8	172	36.1	
Seldom/None	89	18.6	41	8.6	
Use non-violent methods such as incentives, encouragement, and motivation (positive disciplinary measures) with your children					
Often	371	77.9	386	81.3	0.206
Sometimes	81	17	75	15.8	
Seldom/None	24	5.1	14	2.9	
Perspectives about child care					
I think that mothers are the ones to be blamed for any misconduct of their children					
Agree	160	33.6	184	38.6	0.249
Somehow agree	100	21.0	88	18.5	
Don't agree	216	45.4	204	42.9	
I think that the mother's role in raising male children is more important than the father's role					
Agree	212	44.6	186	39	0.145
Somehow agree	132	27.7	157	33	
Don't agree	132	27.7	133	28	
I think that father's role in raising male children is more important than the mother's role					
Agree	206	43.3	235	49.4	0.128
Somehow agree	181	38	169	35.5	
Don't agree	89	18.7	72	15.1	
I believe that parents should teach their sons that the good man is the caring rather than the aggressive one					
Agree	473	99.4	471	99	0.343
Somehow agree	1	0.2	4	0.8	
Don't agree	2	0.4	1	0.2	
The Outspread of the Corona virus has influenced your role in childcare					

Yes, increased	333	70	363	76.2	0.089
Yes, decreased	19	4	16	3.4	
No change	124	26	97	20.4	
Number of times respondents carry out positive parenting practices per week	**Mean**	**Median**	**Mean**	**Median**	
Read book, story, looked at pictures for the child(ren)	1.38	0	2.5	2	
Acknowledge his/her positive behaviours or provide incentives when disciplining him/her	4.49	5	4.8	7	
Tell stories or sing for child/ren	2.3	1	3.6	3	
Took them outside the house for a walk or playing	2.1	1	1.3	1	
Play with the children inside the house	4.4	5	3.9	3	
The average total number of times per week (child-rearing practices) were performed	**14.8**	**15**	**16.3**	**17**	**0.006**

With regard to disciplining practiced, 12% of men and 17% of women indicated reported that it is impossible to discipline children by using physical punishment. It seems because mothers are more engaged in disciplining practices, they tend to report higher proportions than men. Other than physical punishment, the majority of men and women reported using psychological disciplinary measures such as yelling which is more practiced by mothers (55% reported doing that many times) than fathers (34%). Non-violent discipline methods were also reported by both men and women (78% and 81% respectively). These findings are inconsistent with what has been reported by PCBS which indicates that the use of violent disciplining methods is almost universal (PCBS, 2020). More than half (see table 17) of men and women in this survey agreed/somewhat agreed that the mothers are the ones to be blamed for any misconduct of their children, only 45% of males and 43% of females didn't agree on that. More men (45%) than women (39%) agreed that the mother's role in raising male children is more important than the father's role. All agreed that the good man is the caring rather than the aggressive one. The male role in taking care of children has increased during Covid-19 as reported by 70% of men and 76% of women, possibly because of the lockdown measures.

With regard to positive rearing practices, overall, mothers performed more positive child-rearing practices (mean 16.3) than fathers (mean 14.8) and the differences between the two categories are statistically significant. Again, male participation in child-rearing is gendered as they participate more in playing with children (4.4 times per week) and taking children outside the house (2.1 per week). Findings imply that men's role in childcare is limited and both parents should be engaged in positive parenting practices including using non-violent disciplining practices.

4.3.7 Men involvement in specific SRHR experiences/services

In this section, we present findings related to men's and women's experiences with specific SRHR components. We present findings related to PCC, ANC, PNC, infertility, abortion, STIs in order to explore in-depth components at which men do participate versus not participate and also, barriers for participation in these components.

Preconception counselling

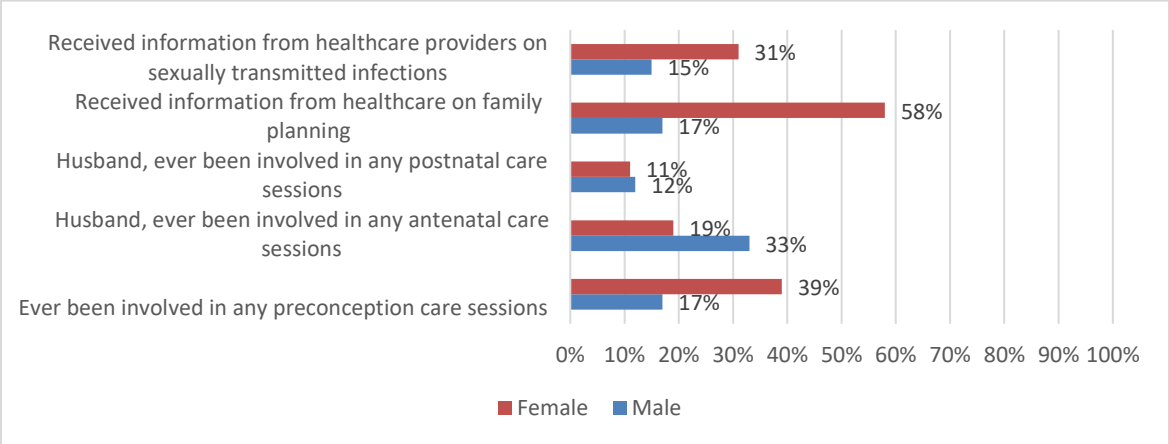
Despite experiencing many pregnancies (median 6), less than 40% of women reported ever receiving preconception care; only 17% of men indicated that they are aware or were

involved in preconception counselling services. Only around 7% of respondents from the two genders reported that men highly participate in preconception counselling services and another 26% indicated that men participate to some extent. Men and women responses were consistent with no significant differences among the two categories (table 19)

Table 19: Men and women experiences with preconception care

Variable	Male		Female		P value
	No	%	No	%	
Preconception care					
Ever received preconception counselling services	82	17.2	187	39.1	0.001
Degree men participate in preconception counselling services					
High extent	32	6.7	27	5.7	0.354
Moderate extent	125	26.3	124	26.1	
Poor	313	65.9	323	68.0	
Don't know	5	1.0	1	0.2	
Possible barriers that couples face when seeking preconception counselling service					
Belief in destiny	187	39.3	212	44.5	
Not aware of its availability	159	33.4	124	26.0	
Services are not important	138	29.0	182	38.2	
Services not available for males	102	21.4	100	21.0	
Husband disagrees	88	18.5	148	31.0	
Shyness and Embarrassment	47	9.8	21	4.4	
It is women Issue	39	8.2	49	10.2	
Busy at work	34	7.1	21	4.4	
Lack of knowledge and awareness	15	3.1	13	2.7	
Concerns about the gender of provider	14	2.9	27	5.6	
Hard economic situation and high cost	11	2.3	8	1.7	
Staff interactions are not supportive	9	1.9	3	0.6	
Quality of services is not good	7	1.4	5	1.0	
Others	7	1.4	12	2.5	

Figure 13: Features of men's participation in SRHR



Barriers mentioned restricting couples from receiving preconception services were diverse and including the following, belief in destiny and fate (39% among men 45% among women), lack of awareness about the existence of this service (33% among men),

and of its importance (29%). One fifth (21%) of males and females reported that the PCC service is not available for men. Not only men don't participate in preconception care, but also, they prevent their wives from receiving the services as 31% of women reported that their husbands don't agree to seek this service, and 19% of men reported that as well. It is worth noting that the PCC service is relatively new in Gaza, till now, only two service providers regularly provide this service. Many people are still not aware of this service and its importance therefore more effective marketing strategy should be in place.

Pregnancy and antenatal care

Male experiences during pregnancy are somewhat different than preconception care. Men's knowledge of pregnancy signs is similar to women's; 82% of men cited nausea and 79% mentioned vomiting. Strangely, only half of the men (51%) and two thirds of women (65%) reported an absence of menstruation. Knowledge of both men and women about signs of dangerous pregnancy was somewhat limited. Only half of the men (51%) knew that bleeding is a danger sign, 28% reported hypertension, 17% reported diabetes and 17% reported abdominal pain. Of men, only 3% or less reported convulsions and short breath, as danger signs of pregnancy. Interestingly, many of them mentioned are not regarded as danger signs, such as anaemia, diabetes, and hypertension. Very few participants mentioned the absence of foetal movement (less than 2%) and 18% of men reported not knowing any danger signs. This is an important area that requires greater attention by service providers to better inform couples as these might be life-threatening.
When asked if they ever participated in ANC, 32% of men said yes (often), only 19% of women reported that their husbands often participate in ANC. Among those who participated, mostly they accompanied their wives to the clinic (over 90%), less likely they participated in care sessions (63%) or counselling (51%). This indicates that participation is suboptimal and services should be redesigned to ensure that men are effectively involved in ANC (Table 20).

Table 20: Actual experiences of men and women regarding pregnancy

Variable	Male		Female		P value
	No	%	No	%	
Some of the early signs of pregnancy you may have heard about or you/your spouse ever experienced					
Nausea	389	81.7	402	84.4	0.025
Vomiting	377	79.2	359	75.4	0.003
Absence of bleeding/menstruation	244	51.2	309	64.9	0.001
Back pain	35	7.3	62	13.0	0.001
Dizziness and headache	30	6.3	46	9.6	0.001
Tiredness and lazy	24	5.0	27	5.7	0.388
More sleeping	21	4.4	70	14.7	
Abdominal pain	17	3.6	50	10.5	
Crave to eat certain types of food	17	3.6	12	2.5	
Loss of appetite	16	3.4	15	3.1	
Changes in psychological status	14	2.9	15	3.1	
Tender or breast pain	4	0.8	41	8.6	
Paleness	3	0.6	2	0.4	
Others	7	1.4	10	2.1	
Mean (out of the 5 signs)	2.20	44.0	2.46	49.2	0.001
Not knowing any sign	8	1.6	6	1.2	
Knowing 1 sign only	81	17	46	9.6	
Knowing 2 signs only	208	43.7	186	39.0	

Knowing =>3 signs	179	37.6	238	50.0	
Danger signs of pregnancy-					
Bleeding	243	51.0	268	56.3	
Hypertension	134	28.1	237	49.8	
Diabetes	82	17.2	166	34.8	
Abdominal pain	73	15.3	89	18.7	
Albuminuria	24	5.0	84	17.6	
Eclampsia	23	4.8	44	9.2	
Difficulty breathing	15	3.1	13	2.7	
Convulsions	14	2.9	16	3.3	
High fever	13	2.7	7	1.4	
Anaemia	13	2.7	22	4.6	
Oedema	9	1.9	21	27.6	
Lack of amniotic fluid	9	1.9	7	1.4	
Troubled vision	7	1.4	5	1.0	
Ectopic pregnancy	7	1.4	5	1.0	
Blood clots	5	1.0	12	2.5	
Absence of foetal movement	1	0.2	7	1.4	
Weight gain	1	0.2	6	1.2	
Placenta previa	1	0.2	9	1.9	
Others	15	3.1	26	5.4	
DK	87	18.2	15	3.1	
Mean (out of the 8 danger signs)	0.78	9.7	0.89	11.1	0.473
Not knowing any danger sign	184	38.7	168	35.3	
Knowing 1	221	46.4	206	43.3	
Knowing 2	63	13.2	87	18.3	
Knowing =>3	8	1.6	15	3.1	
The husband has been involved in antenatal care					
Yes, often	155	32.5	91	19.2	0.001
Yes, sometimes	178	37.4	149	31.4	
No/rarely	143	30.1	235	49.4	
Type of involvement in antenatal care (yes often and sometimes)					
Accompanied wives to the clinic	318	95.5	223	93	
Participated in care sessions	210	63	138	57.5	
Received counselling session	169	50.8	114	47.5	
Others specify	3	0.9	3	1.2	
Had an unplanned pregnancy	87	18.2	173	36.3	0.001
Reasons for the unplanned pregnancy					
It happened while using contraception method or lactation amenorrhea	38	43.6	74	42.7	0.240
Unprotected relation	30	34.5	46	26.6	
Forgotten dates or failure of rhythm method for contraception	14	16.1	47	27.1	
Not having access to FP methods	2	2.3	4	2.3	
Others	2	2.3	2	1.1	
Don't remember	1	1.1	0	0.0	
Reasons behind not using emergency contraceptive					
I was afraid to go against religious standards if I use it	34	39.0	68	39.5	
I did not doubt being pregnant for a while	25	28.7	45	26.1	
No, I don't know it is available	18	20.7	30	17.4	
Tried, but didn't know where to get it	2	2.3	4	2.3	
I doubt being pregnant but was unable to use emergency contraceptives against my husband will	1	1.1	3	1.7	
Tried, but the health centre didn't have it / wouldn't give it to me	1	1.1	7	4.0	
Other reasons	6	6.9	15	8.7	
Prevented from accessing SRH services at any pregnancy	4	0.8	15	3.1	0.013
Does your spouse or other family members restrict or put conditions on your access to ANC care					
Yes, often			21	4.4	

Sometimes			23	4.8	
No			432	90.8	
In case yes, who restricts or put a condition					
Husband			30	68.2	
Mother-in-law			9	20.4	
Others			5	11.4	

While 18% of men reported experiencing at least one unwanted pregnancy, 36% of women reported experiencing that, indicating inadequate awareness among men or gender differences in perceptions about what might be wanted versus unwanted pregnancies. As reported by participants, mostly unplanned pregnancies happened while using contraception methods or lactation amenorrhea (reported by 43% of men and women), unprotected relation (reported by 36% of men and 27% of women), or forgotten dates or failure of rhythm method which were reported by 16% of men and 27% of women. When asked why they didn't take emergency contraceptives, the most frequently cited factors were 'I was afraid to go against religious standards if I use it (cited by 39% of men and women), there was a doubt about pregnancy (29% reported by males and 26% by females) and not knowing about the availability of emergency contraceptives (as reported by 21% of males and 17% by females). Having an unplanned pregnancy is regarded as an unmet need for FP. The findings of this survey flag inadequate awareness about important aspects of SRH which require to be urgently addressed. Among the surveyed women, 10% reported that their spouses or other family members put restrictions on their access to ANC, mostly restrictions were imposed by husbands (68%), followed by mother-in-law.

Delivery and breastfeeding

Male involvement in childbirth influences pregnancy outcomes in several ways as it reduces maternal stress, enhances access to delivery services, and promotes positive parental practices. Our survey confirms that male contribution to delivery services is mainly manifested in facilitating access to delivery services as reported by 93% of men and 91% of women and providing better food and hygiene supplies, providing psychological support (84% as reported by men, 79% reported by women) and securing financial resources (93%). Taking more domestic responsibilities and care of children was less reported (66% as reported by men and 61% as reported by women). Nearly a quarter of male respondents and more than one third of female respondents (38%) indicated that men provide more support if the new-born is a boy. Very few mentioned that men played a constraining or even no role in delivery. Both men and women in this study reported that the husband's support was very useful (97%).

With regard to BF, among couples, almost two thirds of men (63%) and 77% of women indicated that they received information about BF. Reported support during BF was somewhat less than the support provided during labour. Securing financial resources was reported the most (89%) by men. Of men, 81% and 72% of women reported that husbands' contributions during BF were through providing better/more food, supplements, and hygiene items, 78% of men reported providing PSS support and backing to their wives during BF; 66% of women agreed with that. Taking more domestic responsibilities and care of children was reported by 60% of men and 50% of women. The level of support is also underpinned by the sex of the baby, as 20% of men and 28% of women indicated that the support provided by men was more noticeable when the baby is a boy (Table 21)

Table 21: Experiences of men and women about men engagement in delivery services and breast-feeding

Variable		Men			Women			P value
		Mostly	Sometimes	Rarely	Mostly	Sometimes	Rarely	
Husband's role during delivery								
Provide better/more food and needs such as supplements and hygiene	No	465	10	1	444	22	10	0.002
	%	97.7	2.1	0.2	93.3	4.6	2.1	
Facilitate timely access	No	442	23	10	431	31	14	0.370
	%	93.0	4.8	2.1	90.5	6.5	3.0	
Secure financial resources needed	No	441	29	5	426	34	15	0.059
	%	92.8	6.1	1.0	89.7	7.2	3.1	
Present when needed (PSS and backing)	No	399	72	3	374	75	27	0.001
	%	84.2	15.2	0.6	78.5	15.7	5.7	
Take more domestic responsibilities and care of children if needed	No	311	113	50	290	105	80	0.019
	%	65.6	23.8	10.6	61.0	22.1	16.9	
Provide more support if the new-born is a boy	No	125	40	310	184	39	253	0.001
	%	26.3	8.4	65.3	38.6	8.2	53.2	
Played a constraining role	No	1	0	456	8	7	442	0.002
	%	0.2	0.0	99.8	1.7	1.5	96.8	
Did nothing	No	0	10	463	7	14	450	0.020
	%	0.0	2.1	97.9	1.5	2.9	95.6	
Husbands' contribution during breastfeeding								
Secure financial resources needed	No	423	49	3	351	99	25	0.001
	%	89.0	10.3	0.6	73.9	20.8	5.3	
Provide better/more food and needs such as supplements and hygiene	No	386	70	20	340	97	38	0.002
	%	81.1	14.7	4.2	71.6	20.4	8.0	
Provide hygiene and supplies items related to BF	No	380	76	19	329	95	51	0.001
	%	80.0	16.0	4.0	69.2	20.0	10.8	
Provide PSS support and backing	No	369	91	14	312	119	45	0.001
	%	77.8	19.2	3.0	65.6	25.0	9.4	
Take more domestic responsibilities and care of children if needed	No	284	131	59	237	130	108	0.001
	%	59.9	27.6	12.5	49.9	27.3	22.8	
Provide more support if the new-born is a boy	No	97	52	326	131	54	289	0.026
	%	20.4	10.9	68.6	27.6	11.4	60.9	
Does nothing	No	3	11	457	12	11	448	0.064
	%	0.6	2.3	97.1	2.5	2.3	95.2	
Played a constraining role	No	0	3	449	7	6	439	0.017
	%	0.0	0.6	99.4	1.6	1.3	97.1	

		Men		Women		
		Agree	Somewhat agree/don't agree	Agree	Somewhat agree	
Husband's support during delivery is highly useful	No	457	14	461	11	0.540
	%	97.0	3.0	97.7	2.3	
The couple received/obtained information about breastfeeding	No	290	170	363	106	0.001
	%	63.1	36.9	77.4	22.6	

Post-natal care

PNC is regarded as the Cinderella of reproductive health; the most important yet neglected component of SRHR both in terms of coverage and the quality of services (Table 22). Our findings confirm that men are largely excluded from PNC services which are mainly targeting women. Both men's and women's responses indicate that only around one in ten men were involved in any PNC session at home or a health facility. Despite that, almost all men (98%), feel that they are good at supporting their wives and 90% of women feel that their husbands are supportive after giving birth. Generally, men have positive attitudes towards PNC, almost all (99%) reported that it is important that they get information about the PNC period to be able to support their wives and all (99%) think that their support contributes to positive family outcomes.

More than half (59%) of men respondents reported reading written educational materials about mother care when these were given to their wives; 69% of women confirmed that. This implies that men are concerned to know and participate more actively in PNC. Unfortunately, only around 40% of men reported receiving information about mother and baby nutrition, or about the psychological needs of women during the PNC period (37%). Similarly, a low proportion of men were given information about maternal health and hygiene (32%), or maternal danger signs (30%). Still, 25% of men and 30% of women believed that PNC is more of a female business.

Table 22: Distribution of responses about men ever engagement in PNC

Variable	Male				Female				P-value
	Yes		No		Yes		No		
	No	%	No	%	No	%	No	%	
Husband has ever been involved in any postnatal care sessions at home or health facility	47	12.3	336	87.7	50	10.5	424	89.3	0.488
During the postnatal period, did you feel well supported by your husband					430	90.4	45	9.4	
At postnatal period, do you feel you are doing good in supporting your wife	464	97.5	12	2.5					
It is necessary that husbands get aware of how they can support their wives during the postnatal period	472	99.2	4	0.8	470	98.8	6	1.2	0.525
I believe that husband's support contributes to enhanced health status of his wife	471	99.2	4	0.8	473	99.4	3	0.6	0.702

If mothers happen to dispose/receive written educational materials about mother care, did the husband read/watch them.	279	58.8	194	41.0	158	33.4	312	65.8	0.001
Received information about nutrition at the postnatal period	190	39.9	286	60.1	324	68.0	152	32.0	0.001
Received information about child nutrition	187	39.3	287	60.4	344	72.2	132	27.8	0.001
Received information about mother psychological status and needs	178	37.4	297	62.6	315	66.4	159	33.4	0.001
Received/obtained written or audio-visual information about maternal health at postnatal period	152	32.0	323	68.0	342	71.8	134	28.2	0.001
Received information about mother hygiene and self-care	151	31.7	325	68.3	312	86.9	162	34.1	0.001
Received information about maternal danger signs at the period following giving birth (Postnatal weeks)	142	29.8	333	70.0	301	63.3	174	36.7	0.001
I believe that postnatal care is women's business	119	25.0	346	72.8	144	30.3	321	67.6	0.191

Abortion

The actual incidence of abortion is not known in Gaza. Our survey (Table 23) indicates that more than half of couples had experienced abortion at least once (53% as reported by men and 56% as reported by women). When couples experienced abortion or miscarriage, 79% of men and 72% reported that husbands facilitate timely access to care; still, 18% of women reported that husbands never did that. Husbands' support was more around securing financial resources which were reported by 87% of men and 82% of women and securing foods, supplements, and hygiene-related supplies (88% by men, 80% by women). Providing PSS was less reported by both men (78%) and women (68%). Similarly, taking more domestic responsibilities and care of children was less reported by both men (64%) and women (56%). Around 10% of men admitted that they blamed their wives for the miscarriage, with more females reporting that (18%)

Table 23: Distribution of responses about the role of men during experiencing miscarriage or abortion

Variables		Male			Female			P value
		Always	Sometimes	Never	Always	Sometimes	Never	
Provide the wife with better/more food/supplements and hygiene	N	220	21	10	214	37	16	0.067
	%	87.7	8.4	3.9	80.1	13.9	6.0	
Secure financial resources needed	N	219	26	6	218	30	19	0.038
	%	87.3	10.3	2.4	81.7	11.2	7.1	
Assist/facilitate timely healthcare access to the wife	N	197	28	26	193	27	47	0.060
	%	78.5	11.2	10.3	72.3	10.1	17.6	
Present when needed, PSS and backing	N	196	43	12	181	53	33	0.004
	%	78.0	17.2	4.8	67.8	19.9	12.3	
Take more domestic responsibilities and care of children if needed	N	161	53	36	149	63	55	0.093
	%	64.4	21.2	14.4	55.8	23.6	20.6	
	N	15	11	223	30	19	216	0.034

Blame the wife for the miscarriage or abortion	%	6.0	4.4	89.6	11.3	7.2	81.5	
Did nothing	N	0	7	237	10	4	248	0.005
	%	0	2.9	97.1	3.8	1.5	94.7	
Played a constraining role	N	1	3	227	7	5	241	0.109
	%	0.4	1.3	98.3	2.7	1.9	95.3	

Infertility

The Palestinian culture highly values having children and some regard having male children as an economic and social investment as children provide social security in old age, making infertility a serious long-term issue related to the care of elderly family members and social security in the long run. When couples are unable to conceive, husbands provided financial support as reported by 78% of men and 73% of women and facilitated timely access to health care of women as reported by 74% of men and 71% of women (Table 24). Similarly, providing women with better food and supplementation was also reported by the same proportions. Providing psychological support was less reported than financial support, as it was reported by 63% of men and 55% of women. Playing a constraining role was reported by a considerable number of men (mostly 10% and sometimes by 14%) and women (mostly 17% and sometimes 13%).

In general, wives were more supportive than husbands in facilitating timely access to health care as reported by both men (83%) and women (86%). Similarly, the majority of husbands (86%) reported receiving better food and care from their wives, which was even reported by a higher percentage of wives (94%). Also, providing backing and psychological support from the wife side was also reported by 83% of men and 90% of women. The financial contribution was less reported by both men (53%) and women (58%), possibly due to the limited resources women have (Table 24).

Table 24: Distribution of responses about the role of men versus women during experiencing infertility

Variables	Men						Women						P value
	Mostly		Sometimes		Rarely		Mostly		Sometimes		Rarely		
	No	%	No	%	No	%	No	%	No	%	No	%	
Role of the husband													
Secure financial resources needed	365	76.7	96	20.1	15	3.1	347	72.9	107	22.4	22	4.6	0.305
Assist/facilitate timely healthcare access to the wife	353	74.1	113	23.7	10	2.1	338	71.0	118	24.7	19	4.0	0.195
Provide the wife with better/more food and needs such as supplements and hygiene	345	72.4	109	22.9	22	4.6	321	67.4	128	26.9	27	5.6	0.235
Present when needed, PSS and backing	298	62.6	149	31.3	32	6.7	261	54.8	171	35.9	44	9.2	0.064
Take more domestic	206	43.2	177	37.2	91	19.1	182	38.2	178	37.4	116	24.3	0.105

responsibilities and care of children if needed													
Played a constraining role	45	9.8	65	14.2	347	75.9	79	16.8	60	12.8	330	70.4	0.070
Does nothing	28	5.9	61	12.9	384	81.2	29	6.1	52	11.1	392	82.8	0.665
The role of the wife													
Provide the husband with better/more food and more care	407	85.6	53	11.2	15	3.2	449	94.3	23	6.7	4	0.8	0.001
Assist/facilitate timely healthcare access to the husband	393	82.9	64	13.5	17	3.6	411	86.3	51	10.7	14	2.9	0.340
Present when needed, PSS and backing	393	82.7	72	15.2	10	2.1	426	89.5	46	9.6	4	0.8	0.008
Take some of his responsibilities	293	61.8	152	32.0	29	6.2	336	70.6	118	24.8	22	4.6	0.017
Contribute to securing financial resources needed	250	52.6	177	37.2	47	9.8	276	58.0	163	34.2	37	7.8	0.218
Played a constraining role	11	2.4	58	12.5	393	85.1	11	2.3	38	8.0	417	87.7	0.088
Does nothing	6	1.2	50	10.6	414	8.8	9	1.9	43	9.0	421	89.1	0.555

Family planning

FP is an important component of SRH with positive impacts on both women and family health. While 58% of women stated that they received health information from any health care providers about FP, only 17% of men reported that (Table 25). Women are more likely (2.4 times) to receive information about FP than men indicating poor targeting of men in FP awareness programmes. Still, 96% of men heard of any method to delay, space, or avoid pregnancy and more than 95% of male and female respondents know from where to get information about FP. Adolescents' knowledge about FP was significantly lower than adults'; only 52% of boys heard of FP methods. Among men those who have had heard about any FP method, 91% of men heard about IUDs (50% among boys), 90% heard about pills (82% of boys), followed by male condom 67% (14% only by boys), injectable 22% (10% by boys) and standard days method (19%). Only 11% knew about withdrawal. Even for male-related methods like withdrawal and condoms, males' knowledge is significantly much less than females. Implants and lactation amenorrhea are less frequently known especially by males (7% and 2% respectively).

Table 25: Responses about adults' experiences with FP services

Variable	Male		Female		P value
	No	%	No	%	
Adults					
Attended session/received information from healthcare or social workers on FP	83	17.4	278	58.4	0.001
Heard of any methods to delay, space, or avoid getting pregnant	455	95.6	475	99.8	0.001
Type of methods respondent heard of					
IUD	412	90.5	463	97.5	0.001

Pills	408	89.7	448	94.3	0.001
Male condom	304	66.8	408	85.9	0.001
Injectable	98	21.5	284	59.8	0.001
Periodic abstinence	86	18.9	131	27.5	0.001
Withdrawal	49	10.8	92	19.3	0.001
Implants	32	7.0	105	22.1	
Female sterilization	29	6.4	31	6.5	
Lactation amenorrhea	11	2.4	27	5.7	
Male sterilization	3	0.6	3	0.6	
Emergency contraception	3	0.6	2	0.4	
Female condom	2	0.4	1	0.2	
Contraceptive vaginal suppositories	1	0.2	13	2.7	
Diaphragm/Foam/Jelly	0	0.0	1	0.2	
Refused	0	0.0	2	0.4	
Mean knowledge about methods (out of 16)	3.02	18.8	4.22	26.3	0.549
Knowing 0 Method	17	3.5	1	0.2	
Knowing 1-3 methods only	322	67.6	114	23.9	
Knowing 4-5	44	9.2	293	61.5	
6-8 (0ut of 16 methods)	13	2.7	68	14.3	
Currently using any contraceptive method	278	58.4	306	64.3	0.104
When you first used any contraception method					
Before first pregnancy	4	0.8	1	0.2	0.001
After the first pregnancy	369	77.8	417	87.8	
Haven't used it yet	98	20.7	57	12.0	
I don't remember	3	0.6	0	0.0	
Knowing from where to get information about the method the couples will use					
Yes	450	94.5	464	97.5	0.053
Not sure	11	2.3	6	1.2	
No	15	3.2	5	1.1	
Refused	0	0.0	1	0.2	
We decide together about our FP aspects such as the timing of pregnancy					
Yes	428	89.9	413	87.1	0.182
Sometimes	17	3.6	29	6.2	
No	31	6.5	32	6.7	
We decide together about our FP aspects such as the total number of children					
Yes	428	89.9	414	87.2	0.081
Sometimes	13	2.7	28	5.9	
No	34	7.2	33	6.9	
Refused	1	0.2	0	0.0	
We decide together about the FP method we will use					
Yes	440	92.4	420	88.4	0.066
Sometimes	10	2.1	21	4.4	
No	26	5.5	34	7.2	
I believe that wives should uphold the entire responsibility of using female contraception					
Yes	161	33.9	184	38.9	0.224
No	313	65.9	287	60.7	
No opinion	1	0.2	2	0.4	
Barriers that prevent a married couple from using appropriate contraceptive methods					
More offspring means more power and better social status of the extended family so more is better	264	55.4	246	51.7	
Still want more children	243	51.0	300	63.0	
Fear from side effects	234	49.1	291	61.1	
Faith, cannot go against God will	53	11.2	37	7.7	
Already have girls but want to have boys or more boys	51	10.7	63	1.3	
Cultural norms just used not to plan it	28	5.9	24	5.0	
Previously used them but failed	24	5.0	44	9.2	
High cost	24	5.0	16	3.4	

Women cannot decide on their own due to husband's or in-laws control/influence	21	4.4	38	7.9	
Fear that husband punish me	13	2.7	36	7.5	
Fear from being criticized by other family members	12	2.5	11	2.3	
Low availability	6	1.2	2	0.2	
Poor FP counselling service	4	0.8	9	1.9	
Low quality of FP services, bad treatment, or negative attitudes from providers	3	0.6	2	0.4	
Others	36	7.5	32	6.7	
Prohibited from using the FP method, you wanted to use					
Yes, many times	2	0.4	35	7.4	0.001
Yes, few times	6	1.2	35	7.4	
No	468	98.4	405	85.2	
Who prohibited you from using FP methods?					
Husband/ Wife	5	62.5	46	65.7	
Mother-in-law	0	0.0	3	4.3	
Father-in-law	0	0.0	2	2.8	
Other family members	0	0.0	1	1.4	
Others (clinic)	3	37.5	16	22.8	
Adolescents					
Aware of possible risks of pregnancy at an early age	104	38.5	124	60.2	0.001
Ever heard of any methods to delay, space, or avoid getting pregnant	139	51.5	158	76.7	0.001
What methods have you heard of-					
Pills	114	82.0	141	89.2	0.001
IUD	70	50.3	137	86.7	0.001
Male condom	19	13.7	28	17.7	0.001
Injectable	14	10.1	39	24.7	
Rhythm or periodic abstinence	7	5.0	19	12.0	
Female sterilization	6	4.3	11	6.9	
Male sterilization	3	2.1	0	0.0	
Implants	3	2.1	12	7.6	
Emergency contraception	1	0.7	1	0.6	
Withdrawal	1	0.7	10	6.3	
Female condom	0	0.0	0	0.0	
Lactation amenorrhea (breastfeeding)	0	0.0	3	1.9	
DK	9	6.4	1	0.6	
Mean (out of 12)	0.88	7.3	1.94	16.1	0.011
Knowing 0 method	141	52.2	48	23.3	
Knowing 1-2 methods only	106	39.2	88	42.7	
Knowing 3-5	23	8.5	70	33.9	
Knowing more than 5 methods	0	0.0	0.0	0,0	

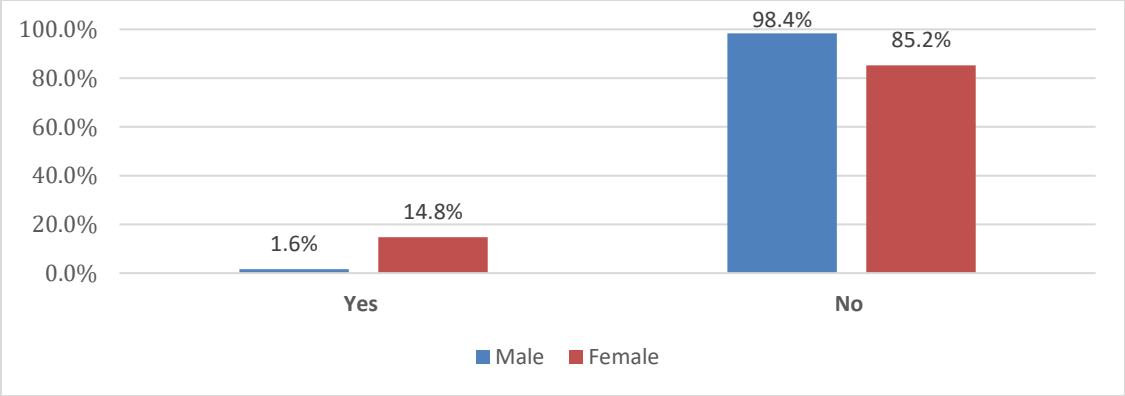
The prevalence of current contraception use by couples was 58% as reported by men, slightly less than what was reported by their wives (64%). It seems that some men are not aware or don't care if their wives are using FP or not, possibly due to the prevailing perception that FP is a women's business. The reported prevalence in this survey is close to what has been reported by PCBS (around 60%). More than three quarters of the respondents indicated that they used FP for the first time after having children (78% among men and 88% among women), the remaining, reported not starting using FP yet, almost none has reported using FP before their first pregnancy.

The majority of men and women respondents (87% as reported by women and 90% by men), reported that couples decide together about the timing of pregnancy and also about the total number of children (more than 87%). Also, 92% of men and 88% of women

reported that they decide together about the FP method they will use; still, 8% of women disagreed on that. It is worth explaining that when men provided examples during qualitative discussions about mutual FP decisions, their inputs denoted what we call a conscious subconscious male final say. For example, one of the participants said '*Yes, we decide together, I agree with her, every 3 years, a child, but the decision is mine, I notify her that it is enough*'.

Despite these favourable responses, 34% of men and 39% of women regarded FP as a woman's responsibility. When asked about barriers that prevent a married couple from using appropriate contraceptive methods, the following were cited by men; more offspring's mean more power and better social status of the extended family, so more is better (55%), still want more children (51%) fear from side effects (49%) faith, cannot go against God's will (11%), already have girls but want to have boys or more boys (11%), cultural norms, just not used to use FP methods (6%), previously used them but failed 5% and high cost (5%). Women respondents reported similar barriers with higher proportions; as 63% of women indicated wanting more children, fear of side effects (61%) and more offspring's mean more power and better social status of the extended family so more is better (52%).

Figure 14: Couples were prohibited from using the family planning method they wanted to



As shown in figure 13, of the total women surveyed, 15% indicated that they were prevented from using the FP method they wanted to use. When asked about who prohibited women from using the FP method they wanted, two thirds (66%) stated that husbands are the ones who practiced that.

Sexually transmitted infections

Discussion about STIs is regarded as a social taboo in the Palestinian context. Also, the prevalence of STIs remains largely unknown except for HIV. Table 23 depicts that only 15% of men and 31% of women reported ever attending any session about STIs; indicating that STIs are not given adequate priority in Gaza by awareness programmes. However, 74% of adult males and females, 45% of boys, and 50% of girls heard about STIs before. When those who reported that they heard about STIs, were asked about the STIs conditions they are aware of, the majority of men (91%), boys (97%), girls (91%), and women (87%) mentioned HIV. Other than HIV, few participants mentioned other

conditions for instance 21% of men and 33% of women mentioned inflammations. Small proportions of men respondents mentioned other STIs like HPV (14%), gonorrhoea (12%), and Syphilis (12%). Generally, women's knowledge about STIs is less than men's, and other than HIV, adolescents' knowledge about STIs is almost Zero. Around 4% of men and 9% of women reported experiencing or being treated for STIs in the last 12 months. Of the total surveyed adults, 19% of men and 16% of women confirmed that it's a women's responsibility to ensure preventing STIs.

4.3.8 Who participates more in SRHR and child-rearing?

When asked to name who among men participates more in SRHR and child-rearing, the responses listed educated, unemployed, husbands of working wives were reported by both male and female participants. There were similarities in men versus women perspectives indicating that participation is more culturally underpinned. Male residents from cities, and refugees are participating more. Responses reported by adolescents were also similar as educated, unemployed, and younger and residents of rural areas were reported to be more active in participation (see table 26).

Table 26: Distribution of responses regarding who among men participate more in SRHR and childcare

Categories	Male		Female		P-value
	No	%	No	%	
Adults					
Educated	251	52.7	296	62.2	0.001
Not working	101	21.2	102	21.4	0.874
When wife works	74	15.5	84	17.6	0.082
Younger	63	13.2	67	14	0.451
Conservative families	62	13	58	12.2	0.435
Liberal families	55	11.5	72	15.1	0.196
Married	54	11.3	59	12.4	0.317
Residents of big cities	49	10.3	33	6.9	0.001
Living in a nuclear family	38	7.9	41	8.6	
Working	35	7.3	16	3.3	
Lived abroad/outside Gaza	34	7.1	47	9.8	
Rich	28	5.9	23	4.8	
Older	23	4.8	22	4.6	
Non-educated	18	3.8	21	4.4	
Refugees	15	3.1	6	1.2	
Poor	14	2.9	12	2.5	
Couples in agreement and love	22	4.6	21	4.4	
Who have Reproductive problems	11	2.3	17	3.5	
Who cares about SRH and have knowledge	10	2.1	14	2.9	
Controlled Husbands by their wives	9	1.9	1	0.2	
who have curiosity	7	1.4	5	1.0	
Husbands who do not want their wives to go alone and not trust her	4	0.8	9	1.9	
Intellectuals	5	1.0	10	2.1	
Who married non-relative- or outside area or recently married	3	0.6	4	0.8	
Males from FHH	9	1.9	9	1.9	
Married to relatives	6	1.2	8	1.6	
Camp residents	4	0.8	4	0.8	
Un-married	4	0.8	1	0.2	
Living in extended family	3	0.6	2	0.4	

Residents of rural areas	2	0.4	3	0.6	
Non refugees	1	0.2	1	0.2	
Adolescents					
Educated	205	75.9	141	68.5	0.001
Not working	40	14.8	31	15.0	0.888
Younger	38	14.0	26	12.6	0.357
Residents of big cities	25	9.3	20	9.7	0.741
Conservative families	25	9.3	25	12.2	0.044
When wife works	24	8.9	25	12.2	0.022
Liberal families	23	8.5	23	11.2	0.054
Care in SRH, love his wife, and understanding couples	22	8.1	8	3.9	
Older	19	7.0	11	5.3	
Rich	18	6.7	11	5.3	
Working	17	6.3	9	4.4	
Lived abroad/outside Gaza	15	5.6	13	6.3	
Married	13	4.8	26	12.6	
Non-educated	11	4.1	3	1.5	
Living in nuclear family	8	3.0	14	6.8	
Married to relatives	5	1.9	5	2.4	
Unmarried	5	1.9	2	1.0	
Poor	4	1.5	3	1.5	
Camp residents	4	1.5	4	2.0	
Males from FHH	4	1.5	3	1.5	
Intellectuals	4	1.5	0	0.0	
Refugees	3	1.2	7	3.4	
Living in extended family	2	0.7	1	0.5	
Residents of rural areas	2	0.7	1	0.5	
Recently married	0	0.0	2	0.9	
Others	3	1.1	1	0.5	

4.3.9 A proxy indicator for practices around SRHR and child-rearing

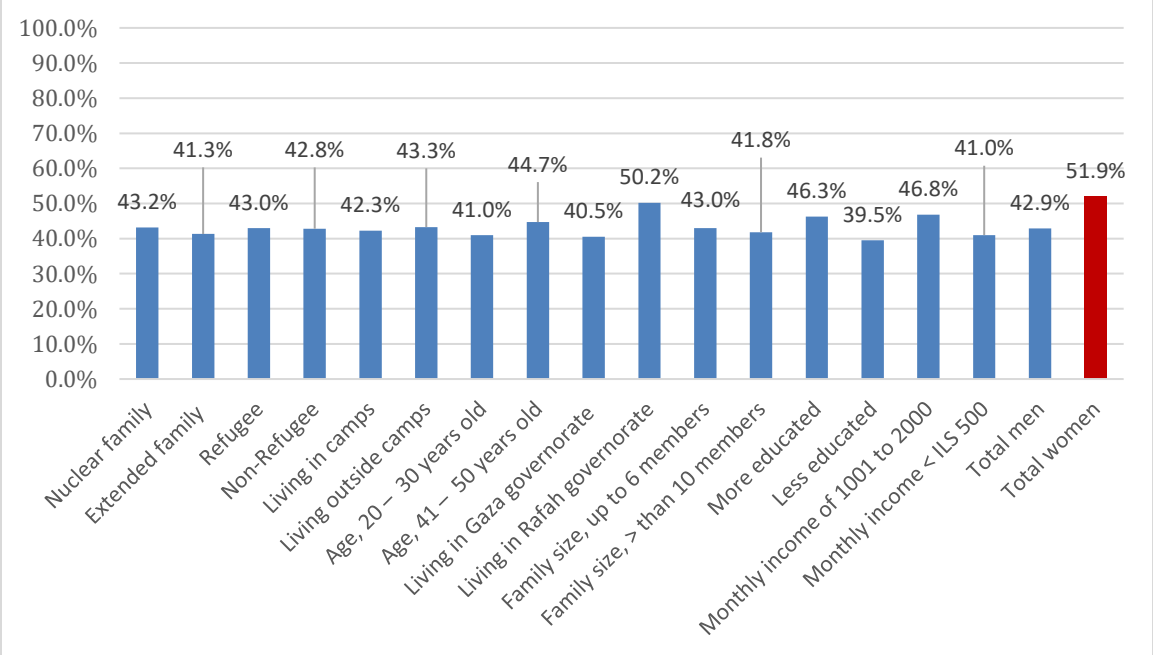
Similar to the process of creating an overall knowledge score related to SRHR, to estimate the overall practices around SRHR and child-rearing, we compiled selected practices (such as attending services, support to wives, taking part in childcare) to give an overall score (see Table 27). The mean percentage of the overall score for men stands at 42.9%, while women scored higher (51.9%) and differences between men and women are statistically significant. Men score 20% lower than women for participation in SRHR and child-rearing practices. Also, the men's score for practices is the lowest among the three KAP components.

Table 27: Proxy indicator for measuring overall practices on SRHR and child-rearing

Variable	Male		Female		P-value
	Number	%	Number	%	
Taking part in the routine health check-up well-baby session	78	16.4	403	84.7	0.001
Taking part in the treatment of little children – sick child services	144	30.3	309	64.9	0.001
Contributing to care of little children under 3 years, including feeding milk and other food and taking care of his/her hygiene	128	26.9	394	82.8	0.001
Using non-violent discipling methods such as incentives, encouragement and motivation (positive disciplinary measures) with your children	371	77.9	386	81.3	0.206

Supporting wife during menstruation days	433	91.0	345	72.8	0.001
Ever received preconception counselling services	82	17.2	187	39.1	0.001
Husband ever been involved in antenatal care	155	32.5	91	19.2	0.001
Assisted/facilitated timely healthcare access during miscarriage or abortion	197	78.5	193	72.3	0.060
Assisted/facilitated timely healthcare access when facing difficulty conceiving	353	74.1	338	71.0	0.195
Assisted/facilitated timely healthcare access when wife giving birth	442	93.0	431	90.5	0.370
Ever been involved in any postnatal care sessions at home or in a health facility	47	12.3	50	10.5	0.488
Ever attended session/received information from healthcare or social workers on family planning counselling service	83	17.4	278	58.4	0.001
Ever attended session/received information from healthcare or social workers on STIs prevention counselling service	72	15.1	146	30.6	0.001
Currently using any contraceptive method	278	58.4	306	64.3	0.104
Overall mean and mean percentage for practices	**6.01**	**42.9**	**7.27**	**51.9**	0.001

Figure 15: Differences in mean percentage of overall practice scores on SRHR and child-rearing, among men, by characteristic variables



NB: Blue bars pertain to men; the red bar pertains to women.

Findings indicate that some groups of men – those who are educated (46.3% for highest educated versus 39.5% for least educated), better off (46.8% versus 41%) and living in the southern part of Gaza (Rafah 50% and Gaza, the least, 41%) – are more likely to participate in SRHR and child-rearing. Justifications provided in the sections on 'knowledge' and 'attitudes' are also valid in explaining the observed variations among the different categories. Education and income differences were also frequently highlighted during FGDs and KIIs; many participants referred to higher aspirations of financially advantaged and educated parents for their children, which is why they tend to space them and have

fewer children overall. Also, key informants referred to a greater role for women in these families and more awareness in general.

Under the same theme "Who are the most progressive or involved men", our discussions brought similar ideas and added that men married to working women participate more in child-rearing , those who live away from the extended family (nuclear families), are younger, financially better off, those who had some exposure to raising awareness sessions, and interestingly happier men cited by our key informants to be more progressive about SRHR and child-rearing and more engaged in related activities. One of the key informants described that education supports positive practice saying '*My two daughters are married. They are well educated. They don't accept to adopt negative roles as their husbands, too, are well educated and supportive*'. The key informants underlined that sometimes, men participate more when they assume that their wives are not capable to approach or understand service providers on their own!. On the other hand, poorer, busy, and/or overwhelmed about sustaining the family members even if they don't work, educated but not aware such as who saw and lived non-participatory models among their parents, and older generations are the least progressive and engaged in SRHR and child-rearing activities.

4.3.10 Perspectives about SRHR services

Male knowledge, attitudes, and practices affect women's access to SRH services. Of the total women surveyed, 4.4% indicated that their husbands had denied their access to SRH. Interestingly, 52% of men and 46% of women indicated that SRH healthcare providers expect -even if they do not declare it- women should agree with the decision of their husbands. More than one third (36%) of women respondents reported that healthcare providers treat them in a more respectful manner when their husbands accompanied them. of the total surveyed adults, 18% of women and men reported knowing a man who felt embarrassed when visited SRH facility alone in the last 12 months, 10% of men and women reported knowing a man who has been maltreated or mocked when visited SRH facility alone in the last 12 months and a similar proportion reported knowing a man who has been maltreated or embarrassed when visited SRH facility along with his wife or female family member in the last 12 months. Moreover, 13% of men and 15% of women reported knowing a man who was turned without receiving the services he came for by a service provider when he visited an SRH facility along with his wife or female family member in the last 12 months. This implies that there are gaps in and at the supply side as SRH services are not prepared to serve men (Table 28).

Table 28: Distribution of responses related to experiences with SRH services

Variables		Yes		No		NA		P-value
		N	%	N	%	N	%	
Ever denied accessing any service related to SRHR by your husband	M							
	F	21	4.4	453	95.2	2	0.4	
Do you think that SR healthcare providers expect -even if they do not declare it- that women agree with the decision of their husbands	M	244	51.7	190	40.3	38	8.0	0.001
	F	219	46.0	243	51.0	14	3.0	
	M							

Have you noticed that when your husband accompanies you, healthcare providers treat you in a more respectful manner?	F	170	35.7	227	47.7	79	16.6	
Did you or a man you know felt embarrassed when visited an SRH facility alone in the last 12 months	M	86	18.1	348	73.3	41	8.6	0.001
	F	84	17.6	383	80.5	9	1.9	
Have you or a man you know been maltreated or mocked when visited an SRH facility alone in the last 12 months	M	45	9.5	416	87.6	14	2.9	0.010
	F	49	10.3	425	89.3	2	0.4	
Have you or a man you know been maltreated or embarrassed when visited an SRH facility along with his wife or female family member in the last 12 months	M	44	9.3	418	88.2	12	2.5	0.052
	F	51	10.7	422	88.7	3	0.6	
Have you or a man you know been turned away back home without receiving the services he came to receive by a service provider when he visited an SRH facility along with his wife or female family member in the last 12 months	M	61	12.8	400	84.2	14	3.0	0.022
	F	69	14.5	404	84.9	3	0.6	
In the last year, did a healthcare provider asked your husband to leave the room to give you more freedom to express your SRHR needs?	M							
	F	37	7.8	328	68.9	111	23.3	

Quality Perspectives about services provided to men versus women greatly varied, while 71% of women regarded services provided to females are very good or excellent, 39% of women regarded services provided to men as very good or excellent. Men's perspectives were similar to women's judgment that services provided to women (62% reported v good or excellent) are more satisfactory than men's (39%). Satisfaction about showing respect by service providers was reported by 83% of men 87% of women. Also, satisfaction with the availability of comprehensive SRH services in the same place was reported by nearly half of men (49%) and 67% of women. 67% of men and women regarded the services as v good or excellent (Table 29).

Table 29: Perspectives about accessibility and quality of SRH service you might have received.

Items		DK		Very bad		Bad		Neutral		V. Good		Excellent		P
		N	%	N	%	N	%	N	%	N	%	N	%	
Availability of services for females	M	16	3.3	38	7.9	30	6.3	66	13.8	246	51.6	80	10.5	0.002
	F	1	0.2	30	6.3	20	4.2	84	17.6	249	52.3	91	19.1	
Availability of services for males	M	36	7.5	62	13	99	20.8	93	19.5	160	33.6	26	5.4	0.580
	F	49	10.3	61	12.8	92	19.3	85	17.8	154	32.3	34	7.1	
Distance of nearest healthcare facility	M	1	0.2	24	5.0	57	11.9	80	16.8	228	47.9	86	18.0	0.763
	F	0	0.0	25	5.2	53	11.1	92	19.3	214	44.9	91	19.1	
Time spent and waiting time at the healthcare facility	M	8	1.6	27	5.6	104	21.8	155	32.5	158	33.2	24	5.0	0.002
	F	0	0.0	52	10.9	110	23.1	148	31.1	134	28.1	31	6.5	
Contact time with provider	M	11	2.3	11	2.3	39	8.2	100	21.0	264	55.4	51	10.7	0.011
	F	0	0.0	13	2.7	33	6.9	90	18.9	270	56.7	69	14.5	
Respect by service providers	M	2	0.4	8	1.6	18	3.7	51	10.7	277	58.2	120	25.2	0.161
	F	0	0.0	3	0.6	9	1.9	47	9.8	288	60.5	128	26.9	
Privacy, confidentiality and trust of medical professionals	M	5	1.0	5	1.0	20	4.2	62	13.0	273	57.3	111	23.3	0.012
	F	0	0.0	1	0.2	18	3.7	44	9.2	270	56.7	142	29.8	

Availability of comprehensive SRH services in the same place	M	4	0.8	9	1.9	46	9.6	135	28.3	207	43.4	73	15.3	0.047
	F	0	0.0	6	1.2	43	9.0	109	22.9	220	46.2	97	20.3	
Quality and safety of services	M	5	1.0	9	1.9	28	5.9	106	22.2	245	51.4	83	17.4	0.090
	F	1	0.2	4	0.8	18	3.7	91	19.1	272	57.1	89	18.7	
Availability of medications or materials (like FP methods)	M	11	2.3	22	4.6	80	16.8	84	17.6	180	37.8	99	20.8	0.001
	F	3	0.6	27	5.6	65	13.6	55	11.5	183	38.4	142	29.8	
Availability of appropriate counselling service	M	12	2.5	10	2.1	44	9.2	101	21.2	244	51.2	64	13.4	0.001
	F	2	0.4	14	2.9	23	4.8	76	15.9	277	58.2	83	17.4	
Affordability of services	M	2	0.4	16	3.3	59	12.4	94	19.7	208	43.7	97	20.3	0.729
	F	1	0.2	20	4.2	67	14.0	101	21.2	186	39.0	100	21.0	
Technical skills of the available staff	M	0	0.0	9	1.9	24	5.0	103	21.6	263	55.2	77	16.1	0.089
	F	0	0.0	6	1.2	16	3.3	78	16.3	280	58.8	95	19.9	
Infrastructure and amenities (toilet, water, space)	M	2	0.4	10	2.1	34	7.1	74	15.5	245	51.4	111	23.3	0.625
	F	0	0.0	13	2.7	29	6.1	66	13.8	249	52.3	118	24.7	
Equity, non-discriminatory practices of service providers	M	2	0.4	23	4.8	94	19.4	84	17.6	204	42.8	69	14.5	0.187
	F	0	0.0	32	6.7	71	14.9	94	19.7	203	42.6	75	15.7	
Your overall evaluation of service	M	2	0.4	6	1.2	23	4.8	121	25.4	253	53.1	67	14.0	0.127
	F	0	0.0	4	0.8	12	2.5	138	29.0	238	50.0	80	16.8	

4.3.11 Barriers towards the translation of attitudes into practice

The qualitative inputs on male participation and actual practices around SRHR and child-rearing aspects were not far from the survey results. As concluded, attitudes, although still frustrating, are better than practices (see figure 16). Men themselves estimate that those who participate in SRH activities stand at 10-20% or maybe 30% in the very best-case scenario. Not used to do that was frequently cited by the participants to explain low male participation in child-rearing activities. Regarding participation in SRHR services, besides cultural and structural barriers, the presence of others (mainly mothers and mothers-in-law) is considered sufficient as they support/accompany the wives to healthcare services so there is no need for men to be present, unless in critical situations. One of the men from North Gaza who had his wife going through difficult pregnancy said '*Since she is getting sick and has many problems, I go with her, although in principle, my mother should go. However, I insist to go because her pregnancy is difficult*'. That has been also mentioned by the key informants and service providers who confirmed poor and very poor participation of men in SRH service. A significant part of the small proportion who attend public healthcare services either at NGOs, UNRWA, or MoH facilities are those who deem their presence unavoidable. One of the MoH doctors said '*I noticed an improvement in general, especially when the wife is too shy or when she can't explain the problem on her own, so he comes with her*'. The majority of participants including service providers are indeed seeing improvement at the level of participation and service utilization by married men, mostly younger groups. However, a number of our key informants who acknowledge the improved attitudes among youth who were exposed to appropriate information still concerned about blocking the translation of these attitudes into practices because of the disabling community, one of them said '*Even after information and awareness, new knowledge and attitudes are not easily applied given that youth don't seem willing to contradict what older generation decide at this stage. They are expected to show consistency between attitudes and practices when they live alone or if they move to other*

less critical societies'. Our understanding from the inputs by males and females is that, for men, it is easier to act similar to others and to follow the main cultural stream than to take different actions. That is why men, although they may wish otherwise, rely on their mothers to accompany their wives to SRHR facilities because it is the norm that the mother or the mother-in-law is the companion there. This is an example of how the cultural norms prevent them from acting in a supportive manner and thus they remain perceived as unsupportive or selfish.

4.3.12 Men fall out of consideration in health education

Key informants attributed the lack of men's involvement in SRHR and child-rearing in part to a limited level of awareness and lack of information which in turn stabilizes and recycles stereotyped perceptions about manhood and masculinities. One of the key informants who work in the healthcare sector said '*It is mainly because men don't know the importance of their role, there is no information, and part of that is or fault, we don't talk to them*'. During our discussions with men, we observed that lack of information among men and women brought them into unfavourable or regrettable situations and sexual practices. One of the older groups (50 years plus) in Joher Aldeek, a rural area in Gaza indirectly mentioned a behaviour that he regrets saying '*We did not know, may Allah forgive us for that*'. Some service providers gave examples on how more information to men makes a difference at least at the level of supporting their wives. One of the nurses at NGO healthcare in east Gaza said '*It does make a difference when the husband is aware, we have received a call from a man saying his wife has a very bad mood, we followed up and she had a postpartum depression, the early intervention helped to have her get back to normal quickly, and he was supportive towards her and asked for help at the right time*'. In Jabalia, men shared stories, although limited, about new couples who assumed having a fertility issue because they spent the first few months of their marriage performing intercourse wrongly (annal sex) and therefore pregnancy did not occur, as mentioned by a specialized physician. Some other male and female participants regarded that male participation as a function of their own needs. In other words, they participate and seek services only when the issue touches their own needs or impacts their sexual satisfaction. Less weight goes to women's needs, partially because they don't recognize these needs or are not aware of them and partially because they show no interest in being supportive. Men in Rafah, Biet Hanoun, Jabalia, and Middle Gaza mentioned various levels of the negligence of women's needs and sometimes of their health status by men when it comes to men's desires. One of the participants in Qa'a Qreen area in the south of the Gaza Strip said '*There are men who demand [intercourse] while she [the wife] is sick*'. A urologist said '*Many men are preoccupied only with their own sexual satisfaction and orgasm. A man doesn't consider the needs of his wife, as if his role is to ejaculate semen. Forgive me to speak this way, we are not educated at all*'. At the other extreme, women don't express their needs in order to avoid unpleasant consequences which may include violence and being accused of having improper conduct.

Some participants indirectly referred to relevant disputes that were not surfaced enough during the discussions. Furthermore, one of the negative coping strategies with shutting down the sexual needs of adolescents and their low participation in SRH service is accepting the early marriage. Parents may agree on child marriage to avoid that the son practicing adultery/the haram (prohibited relations with girls) if he doesn't marry to satisfy

his sexual needs. A divorced lady, 39 years old, who was married at the age of 17 years and was against child marriage said '*My son who was about 19/20 wanted to marry his cousin, she is 17. I was against it because it is early and she is a relative. I was concerned about a disability among their children, but I reconsidered that. His father is not my relative and we have children with disabilities. I was also afraid that he might perform haram/forbidden actions since he desperately wanted to marry, so I agreed on his marriage*'. Alarmingly, given its sensitivity, some men come with complaints of rapid ejaculation, older people with problems of erection, come to change the anti-hypertensive medications saying that drugs cause problems. There are also misconceptions about the marriage and ability to conceive of some little girls with NCDs such as heart diseases and diabetes where women may hide such information to avoid decreasing their chance of marriage. Some of them had life-threatening conditions, still, they hide that to avoid the stigma associated with female illnesses. Therefore, people should learn that they can have a normal life if they use the correct counselling and the required precautions. In either situation, they should be sensitized about not hiding such information from their husbands/wives and their healthcare providers. This is also true for PWDs who have fewer chances to get the service and for good marriage opportunities.

4.3.13 Childrearing practices mirror the community attitudes

Regarding child-rearing activities, participation is also limited and estimated at a level of 20% at the best-case scenario based on participants verbatim in the qualitative component. Even more, the type of activities men engaged in are mostly not typically regarded as female tasks such as hygiene and feeding babies or taking care of them at night, it is unlikely that men participate in these tasks (selective participation). When they were asked about the reasons for not participating in child-rearing, a man in Jabalia said '*She is responsible for her son*'. Some men echo the larger community who described men who participate as 'controlled by their wives if they take part in certain childcare tasks, and thus they regard it as a question of status and prestige. A mother of children with disabilities shared how her husband reacts when she asks for his help saying '*My prestige doesn't allow me to do. Do you want me to be a nanny for your children?!*'. It is interesting to learn that boys see that norms prevent men's participation in child-rearing but they think it is better to participate in that role, maybe they will not do exactly as women do but they are willing to take a greater part than done by their parents, traditionally. Girls, boys, and mothers referred to various levels of participation of men in child-rearing and indicated that some men practice violent discipline methods. Although boys -who are exposed to a greater level of physical violence- condemn using violence, some of them understand that father's toughness serves as a good end, as it helps boys to be stronger and not spoiled. A youth in Nusirat Camp in the middle area, who himself exposed to violence said '*Maybe he [the father] does not give you money, or yield on you, he stresses on you, it is stressful, but you become a man at the end, not soft or spoilt*'. The ECD staff who participated in FGDs in South Gaza shared situations where fathers expose little children to different types of violence and that those children share what they saw at home with their teachers at preschools. ECD staff also mentioned that men start to show more interest than before in following up with their children, compared to a the no participation in the past years, there are a few men who accept the invitation from preschools. However, those remain limited. One of the supervisors said '*Facing 100 or 200 mothers, you see only 3 to 5 fathers attending*'. Preschools staff mentioned that fathers of many children, married to more than

one wife, and those who practice violence with mothers are the least interested and the most difficult fathers to talk to.

Men themselves indicated that those of them who do almost similar contributions to mothers are exceptional. A mukhtar commented on a psychiatrist who mentioned being highly involved in domestic and child-rearing tasks saying '*You are an exception*'. On the other hand, sub-fertile men in Biet Lahia considered that child-rearing is no longer stigmatized but the examples they provided remain within the least feminized tasks. A man said '*It is not like before. Now I see men in the street carrying their two- or three-year-old children and no one talks about them badly*'. Another said '*A friend of mine helps his wife in everything including hygiene and feeding babies. It is normal*' he illustrated that the friend was exposed to maltreatment and ignorance from his stepmother and father and wants to make sure that his children don't experience the negligence he went through. Men from Jabalia shared examples of cooperative men saying '*They do almost everything in the house. It is no longer weird. The wife works and she is the breadwinner so they [husbands] must do that*'. Older participants were more radical about men doing these tasks if they are forced by women. A 62-year-old grandfather described a man who does everything-including taking care of children-while his wife is sitting, relaxed (with her legs crossed) saying '*This man deserves to be burnt!*'.

Therefore, when couples live in nuclear families where the influence of others is less evident, have a small size family, and a higher level of education tend to participate more in child-rearing activities even if they don't demonstrate that to avoid being mocked. On the positive side, similar to SRHR activities, exposing men to more information in an engaging way reflects on improved behaviours, as one of the key informants who worked at a reputable NGO for long years with parents mentioned that the recent work on the concept of positive parenting show promising outcomes since it bridges information gap for fathers and engages them more than previous classical talks about ECD. She said '*Although the participation of women is more common, the initiative we did over the last three years about positive parenting shows good results. The concept remains new and the term is not widely heard. Since 2018, more men join the activities and said they were not aware of their role. Working with them before they turn mothers and fathers will bring even better results*'.

4.3.14 Support women access to SRHR service

Our qualitative discussions, congruent with survey results, concluded supportive attitudes among men for their wives and female family members at the critical times that women go through. A significant number of men also shared being affected when situations such as miscarriage or other unfavourable pregnancy outcomes. Faith and acceptance of God's will contribute to these attitudes according to male and female participants. While the majority of men reported accepting that as a matter of faith and supporting or at least not blaming their wives, it was noticed that sometimes, losing the baby due to miscarriage is a source of blame. For instance, men said they are supportive but they may blame their wives for not taking care of themselves while being pregnant. One of the participants in North Gaza referred to situations such as '*Going outside the house frequently, then had bleeding*' and another one said '*When she slips while going down the stairs, I blamed her for not watching her steps*'. This is usually reported by men as caring rather than punishing or

blaming, therefore, the concept of care and support possibly requires some reconsideration and could be an interesting topic for future male engagement programmes. Generally, women also agree that husbands are supportive in such situations and when they feel bad after giving birth but this support depends on how much the husband loves his wife and on his patience. A woman from Rafah talked about relevant experiences in her community saying '*They show support and understanding, for a few days, men get bored easily, if this lasts for longer than few days, they are no longer supportive*'. Blame also comes from extended family members, especially when the situation relates to fertility issues. One of the women who joined FGDs in Gaza City described the social suffering and blame she went through during the treatment of infertility saying '*Despite their knowledge that the problem is not mine and that it is an issue with my husband, the problems and pressure remain there. When a miscarriage happens after IVF, they accused me, blamed me, and tried to show that the problem is not with their son*'. When we talked to men and women about the support during menstruation days, they referred to support of securing needed hygiene pads. The majority show understanding of mood changes and fatigue but some men blame women indirectly for not being ready for them during the menstruation days. Despite admitting that women have no say about the menstruation days and that this cannot be a source of blame to them as it is part of the natural process, one man in North Gaza who seemed to be a mouthpiece of other participants in the group said '*I hate her [the wife] when she goes through the menses days*'.

4.3.15 Service utilization additional barriers

The structure and service delivery modalities are considered as the second largest male participation disabling factor preceded only by the impact of prevailed conservative cultural norms. SRHR services are usually provided and labelling under the Mother and Child Health (MCH) Department. This overlooks male-specific needs from the public services, UNRWA, and NGO interventions, and concerns about privacy, quality, and acceptability of services are among the most cited barriers by the study participants. Participants in the qualitative work provided plenty of examples for situations in which men were willing to participate but were turned back home by the service providers without receiving the SRHR services. The lack of services such as adolescent health and the systematic skipping of SRH relevant topics at schools are major barriers not only for service utilization but also for a well-supported puberty experience and safe transition from childhood to adulthood.

Unwelcoming men at healthcare facilities-No entry sign

In most of the public healthcare facilities in UNRWA and MoH clinics and hospitals, men are not welcomed or prevented from being at the MCH and FP service delivery sites. Key informants from the healthcare sector indicated that 'a no entry sign' has been there for years and was just recently removed. Other service providers said that men are allowed to attend certain services such as FP and PCC which are newly introduced in some facilities but they are asked not to be present for many other services such as ANC unless they insist. Therefore, men described their role as a concierge or concierge finance. One of the focus group participants in Khanyounis said '*I went with my pregnant wife once to a UNRWA clinic. The place is for women only, and I was waiting for her outside. I wasn't*

allowed to enter'. In Gaza, one of the school counsellors in his 30s commended on the labelling of services to women only saying '*Come on, how would you imagine that men can go there, the department at the clinic holds the name of mother and baby, not a place for men for sure*'. A teacher from Rafah added '*Even if you go among women there, they start saying that something wrong is going on, what the hell is he doing here? He must have a problem of sexual potency*'. A third participant commented saying '*It is true that going there is highly stigmatized so men avoid it and go to pharmacies instead*'. This also applies to the clinics operated by some NGOs as one of the staff said about men, '*They come with their wives and wait in the reception because it is forbidden to wait in the pregnant women's waiting hall. Recently, due to COVID measures, they are not allowed to enter the clinic so they wait by the main gate, outside*'.

The no-entry norm is not necessarily flagged by a sign, some men are also prevented by service providers at hospitals. During the discussions, some men expressed being disallowed from accompanying their wives during childbirth or NC. A 32-year-old husband from Jabalia who previously had his wife unnecessarily operated on and developed complications during her first delivery said '*I entered with her by force, I fought them [medical team] who prevented me and expelled me out but I insisted and called them to tell I am not leaving and will not allow more mistakes to happen. That is how I was allowed there. She had an easier process and was very much assured while I was there. I was assured as well*'.

Neglected male's needs

In response to the question about whether or not he received the physical examination before marriage at UNRWA or MoH clinics, a man who had undergone a medical examination of testis and semen analysis in North Gaza said '*Of course not! no no, these issues are only done at private clinics*'. A number of men were not aware that there is a doctor in MoH and UNRWA clinics who can be consulted about these issues, such as sexual dysfunction and rapid ejaculation. Even those who doubted it, think that it is not possible to seek these services due to lack of privacy and presence of female providers only. Instead, they approach pharmacies or private doctors. This is also true for fertility care and treating the sub-fertile people. In general, erection issues, stress, and rapid ejaculation are being discussed among friends who provide personal advice or with a pharmacist who proposes medical solutions and give medicines. The role of pharmacies was evident almost in every discussion with men, youth, and service providers including school teams. People approach pharmacies since privacy and quick solutions are granted according to participants. Youth, unmarried, learned from their newly married friends about the magical pills (Dapoxetine) which they call "The 60-minute pill" that sustains the intimate relationship for an extraordinarily long time and which is dispensed easily for a small amount of money. Alarmingly, some participants were willing to indicate the use of different drugs such as Lyrica to reduce the speed of ejaculation. The role of pharmacists, males in particular, as first-line contacts, trusted sources, and private settings could feed in providing information and promotion of SRH services at clinics. Services such as PCC and premarital counselling were never heard of by the majority of men. The very few participants who mentioned undergoing physical examination prior to marriage seek this service in the private sector and underwent only a few tests at MoH premises.

Limited healthcare services for adolescents

Limited-service provision to boys and girls at healthcare facilities was the easiest conclusion to make during our discussions with youth, service providers, key informants, and community leaders. Adolescents don't know what services they may find at clinics; they doubt that they can get quality services given that many patients are there and that they feel shy to seek services. One of the doctors at SRH clinic answered the question regarding the services they provide for the adolescents saying '*Nothing!*'. One of the UNRWA nurses who sounded having progressive and enthusiastic attitudes towards SRH education and adolescent health said '*Well, the boy is trapped in the middle of three parties; we as health teams don't talk to them about SH including hygiene and puberty. We assume that teachers will do. We know, however, that teachers feel embarrassed and don't talk about 1% of what they should cover. Teachers say let that these topics are for the parents to address their children with but the parents don't do either*. Another participant added '*We have no services and no clear messages for adolescents, we know what advice and instructions are to be conveyed to a parent, who comes for vaccination, we have clear PCC messages, so why not have clear adolescent health activities and messages for teenagers*'. Key informants on the other hand mentioned a few activities and willingness to invest in adolescent health units at UNRWA and possible MoH clinics. They mentioned youth committees that consist of CBOs and youth, 19 and 20 years old, who join monthly meetings but not necessarily around SRH issues. UNRWA and MoH plan to establish adolescent health departments but these are not active yet. Providers think that adolescents should receive more attention focused on education, PSS in transition to adulthood, and STIs such as inflammatory issues and hygiene concerns, orientation on FP, GBV, and highlighted the great need for pre-marriage counselling. A female doctor said '*There is an important message that we should make clear to girls and their families, that they should not hide health issues, that even those with some health problems can marry and have children on the condition that they undergo premarital counselling, PCC and good follow up, counselling is essential*' She added '*I dream of the day to see a male youth coming with his fiancée to the clinic and we receive them and explain things to them*'. The service providers also mentioned that, for youth, it is important to speak about the negative consequences of substance abuse (including unnecessary medications such as Sildenafil and Tramadol especially at an early age), to talk about FP too, and premarital counselling. From parent and adolescents' perspectives, the topics that adolescents need are protection from harassment and cyber harassment, puberty, the effect of masturbation which is common among adolescents and youth. A man from Shajeia said '*Yes, with awareness even at a young age, that suits their age and capacity to understand, because there are odd people who have odd thoughts, so I should teach them [boys] that if this incident happens, I will not accept it, of course not in everything, but only the information that suits this age*'.

4.3.16 Providers' attitudes, guidelines, and staff competencies

Service providers and key informants mentioned that for peace of mind and to avoid tackling sensitive issues, leaders in the healthcare sector and at schools tend to dump down SRH topics. A consultant at the MoH said '*This topic is key, we have serious defects, we did not open widely to it, and if we do, it needs courage and this should also be done wisely*'. Moreover, leaders, over the successive governments now and before, when GBV, STIs, and relevant services are presented to them, hesitated to invest in them according

to our key informants. In part, because they don't see their importance and/or they hold conservative attitudes around the SRHR theme. One of the consultants at MoH said *'The issue of STIs is not prioritized, the decision-makers at the MoH say it is not important, we have good norms and values, we are not in Africa, this is non-sense, I heard one of them talking about GBV, we will not charge in trite topics*' she added '*We need leaders to adopt and believe in that before approaching the providers and asking them to perform the job*'. Indeed, one of the interesting reflections about why the healthcare services do not privilege, at least for the time being, more services to men and adolescent boys, evolved around the contradictions the system suffers from. At the time healthcare providers agree on the importance of this service, they lag behind in presenting it, they miss the know-how, and also hesitate about tackling sensitive issues. Around the round tables, among managers, and within the first line staff, they don't ask the right questions and don't answer them honestly among themselves.

This manifests in the fluid or absence of guidelines that explicitly address male participation in SRH and capacity-building activities designated specifically to male involvement in SRH (All providers we talked to mentioned receiving training in the last three years but none of them was trained on male involvement strategies). In consequence, providers are confused, apply their or their surrounding preferences, and are unable to maintain standardized services. For instance, while all providers said that the FP guideline does not require a written approval/approval from the husband, in practice, many of them expect some sort of approval (even verbal) and ask the females if they have their husband's approvals, otherwise, they will not get the services easily. The staff proposes an invitation to the husband or sends the woman back to get his approval or convince him, however, if the woman insists, she gets the contraceptive "*obviously on her responsibility*". Similarly, when the staff faces GBV cases at MoH clinics they lack clear guidelines and referrals pathways.

Some providers explicitly expressed their inability to communicate suitable messages to their clients about what they regarded as sensitive topics. For instance, a nurse at an MoH clinic unclearly said '*A woman came to the clinic complaining from pain in the breast. I checked her, she had evident scars. I learned that the husband caused these scars (from suckling). However, I was not able to talk to him and tell him that his practices are harmful. I told the doctor but he also did not talk to the man. The doctor said, don't you see him, he seems too conservative to accept me talking to him about that. I cannot talk to him about that either.* Additionally, the clients, men, in particular, criticize service quality and staff competency and effective communication, especially that many services directed to men are actually mediated by their wives which turns communication even more ambiguous. As a result, trusting service and adherence to treatment may be negatively impacted. A married man from Tal sultan in Rafah said '*My wife went and put an IUD, it was not okay and she was hospitalized, I felt sick with her, then they gave her pills but she did not feel well also, finally, they gave her the condom, without instructions, she did not know how we should use it, neither did I, finally we went to a private doctor to explain it to us*'.

Having these issues uncovered, it is necessary to highlight that providers consider that they are working under a huge workload. One of the doctors said '*With 40 cases per day, it is not possible to invite the husband, bring them together, talk and provide counselling, let them see the photo of the baby and the husband caresses the head of his wife, no time for*

that'. Also, some providers shared concerns and incidents of attacks against them by husbands who either want or refuse some services to their wives.

4.3.17 The dilemma of STIs

The STIs are an area where the lack of knowledge, the gap between attitudes and practices, and the un-readiness of the healthcare system crosscuts to block appropriate STIs management. While men in most of the groups emphasized willingness and readiness to seek medical help, if they suffer from STIs as one of them in Joher Al Deek said '*There is no objection to accompany our spouses to see the doctor if necessary*'. Still, their presence to services is far suboptimal. The majority of women and service providers said that when recurrent infections occur for women, they receive treatment for them and for their husbands, who sometimes refuse to adhere to it. Men also refuse to attend services when the doctors send for them. A female participant from Rafah said '*I have a friend who brought a condom to her husband. He threw it away and told her to go do something on her own. They don't agree to use it, they dislike it*'. Also, a man in Biet Hanoun said about the use of condoms '*It is not okay at all, it affects the orgasm and prevents satisfaction, it is not okay*'.

Generally, as confirmed by our survey findings, the level of information and openness around STIs remain frustrating due to providers' and clients' attitudes. This has been expressed by services providers as one of them said *'STIs are lost, lost, completely'* she added *'Preventive measures in sexual relations remained closed and avoided, not only on this government but even before, almost never opened, they consider it a shame*'. One of the nurses working at a governmental clinic said '*We suffer from all, young and old clients. It happens that mothers come to us, complaining that her little daughter suffers from itching and discomfort but I feel embarrassed to bring her to the clinic. We say okay, go to room 1 to tell the doctor. She goes and if she finds a male in the room, she doesn't share the complaint of her daughter even when the daughter herself is not there. I don't say this applies to all but there are significant numbers of clients like that*'. Our findings highlight the frustrating level of services, awareness, openness, and the heavy burden of STIs and suggest that proper STIs management should be integrated with SRHR existing services without delays.

4.3.18 Financial barriers and far distance

The financial barriers are reported mostly by clients who need fertility management especially for couples who are unable to conceive who feel abandoned from the healthcare and fertility care services. One of the women in Gaza City said about her sub-fertile sister '*They don't go to the government [MoH clinics]. There is no attention. They only give folic acid, also there is no care for these aspects [fertility care] at the UNRWA, they must go to a private doctor. They pay a lot*'. The participants mentioned that some organizations provide financial support to sub-fertile couples but accused the majority of these to be not fair in selecting beneficiaries. Also, they feel that they are being abused by private providers who are, according to them, not always honest about the success chances of their proposed procedures.

During the COVID-19 crisis, some women referred to difficulty securing the out of the pocket money to purchase medications when medicines are not available at the clinic. Men who are living in underserved areas such as Joher Aldeek and Qa'a Qreen named the distance barrier where the closest UNRWA or MoH clinics require transportations (public transport is rare) and thus the family has to pay about NIS 10 per visit.

4.4 Issues under the spotlight

4.4.1 End of childbearing years

Menopause comes with a range of classical symptoms experienced by most women and includes several physiologic changes, which can become troublesome in daily life may affect a woman's quality of life. Our findings conclude that half of the male respondents think that husbands usually consider the emerging needs of their wives at menopause, only 39% of women agreed on that indicating that the majority of men don't show adequate understanding of women's needs during this critical period. Nearly 50% of males and females either agreed or somewhat agreed that menopause is the end of female SRHR life. Around one third (35%) of men reported that husbands think of second marriage when their wives reach menopause, 16% of females think so. Nearly half of male (48%) and female (51%) respondents reported that there are no services for females during menopause. Similar findings were reported regarding the availability of services for elderly males, which were reported by 50% of men and 47% of females (Table 30).

Table 30: Distribution of responses related to perspectives about menopause

Variable		Agree		Somehow Agree		Don't Agree		DK		P
		N	%	N	%	N	%	N	%	
I think that husbands usually consider the emerging needs of their wives at the menopause	M	239	50.6	107	22.6	117	24.7	10	2.1	0.002
	F	181	38.8	114	24.4	157	33.6	15	3.2	
I believe that the menopause is the end of women SRHR life	M	193	40.6	45	9.5	232	48.9	5	1.0	0.235
	F	199	41.8	31	6.5	244	51.2	2	0.4	
I understand that husband think of second marriage when his wife reaches the menopause	M	100	21.0	67	14.1	308	64.7	1	0.2	0.001
	F	42	8.8	33	6.9	401	84.2	0	0.0	
In my community there are specifically services for women at menopause	M	118	25.0	25	5.3	225	47.7	104	22.0	0.238
	F	128	26.9	16	3.4	243	51.0	89	18.7	
In my community there are specifically services for elderly males with SRH issues	M	108	22.8	27	5.7	239	50.4	100	21.1	0.025
	F	121	25.5	11	2.3	225	47.3	118	24.8	

Also, our qualitative findings concluded that in UNRWA and MoH clinics, following one year of no menstruation, the women's file at the SRH unit is closed and that women may still seek NCD and outpatient services. A nurse at UNRWA said '*When the lady is almost*

50 or older, we close her file in our clinic. The clinical guideline says one year no menstruation, we close the file. She goes later to the outpatient clinic for other services such as NCD and outpatient'. Another provider said '*This group is neglected, some of them come with complaints about dryness and painful intercourse, those whose files are already closed, they are left with no medication and sometimes with no health education, they are lost*'. While this is a frustrating demeanour, it remains explainable within a system that materializes its services. Reconsidering the SRHR needs of all groups over the entire life course should be considered as an unpostponable priority.

4.4.2 Comprehensive Sexuality Education

Studies have demonstrated that CSE programmes are important to provide accurate information about normal reproductive development, reduce the rates of sexual risk behaviours, STIs, and unwanted pregnancy. Also, CSE is useful to orient people about healthy sexual and nonsexual relationships, gender identity, and preventing sexual violence.

Table 31: Distribution of adult perspectives about CSE

Variables		Male			Female			P value
		Agree	Somehow Agree	Don't agree	Agree	Somehow Agree	Don't agree	
CSE is social taboo, parents won't want to go against prevailed norms.	N	192	49	235	230	45	201	0.044
	%	40.3	10.3	49.4	48.3	9.4	42.3	
Concerns about age appropriateness of the contents.	N	268	78	130	323	59	94	0.001
	%	56.3	16.4	27.3	67.9	12.4	19.7	
Concerns about gender appropriateness of the contents.	N	265	82	129	276	83	117	0.665
	%	55.7	17.2	27.1	58.0	17.4	24.6	
Early exposure to such information is risky.	N	286	76	112	326	56	94	0.027
	%	60.3	16.0	23.7	68.5	11.7	19.8	
Girls should not be taught about CSE but it is possible for boys	N	60	28	383	36	22	418	0.016
	%	12.7	5.9	81.4	7.5	4.6	87.9	
It will be okay if CSE is presented in an appropriate way that respects religion and positive cultural values.	N	439	10	25	445	5	23	0.409
	%	92.6	2.1	5.3	94.1	1.0	4.9	
Parents may doubt the competencies/motives of educators	N	154	99	221	154	72	249	0.052
	%	32.5	20.8	46.7	32.5	15.1	52.4	
Parents don't really think that CSE is needed at young age.	N	177	83	214	220	66	189	0.017
	%	37.3	17.5	45.2	46.3	13.9	39.8	

Nearly half of men (51%), agreed or somewhat agreed that CSE is a social taboo and parents won't go against prevailed norms, with women agreeing more on that than men (58%). Nearly three quarters (73%) of men and 80% of women (80%) reported concerns about the age appropriateness of the contents (agreed and somewhat agreed). Concerns about gender appropriateness of the contents were reported by 73% of male respondents and by 75% of female respondents.

The vast majority of men (76%) and women (80%) reported their concerns that early exposure to such information is risky. With regard to gender differences, 19% of men reported that girls should not be taught about CSE but it is possible for boys; 12% of women agreed on that. Interestingly, 95% of men and women respondents agreed that it will be okay if CSE was presented in an appropriate way that respects religious and cultural values. Nearly half of respondents (53% of men and 48% of women) agreed/somewhat agreed that they doubt the competencies and motives of CSE educators which constitutes a barrier for CSE. Finally, around 55% of parents think that CSE is not needed at a young age. It could be concluded that parents admit that their children lack appropriate information, however, they are concerned about the content and methods of conveying CSE. More efforts are needed to induce a change in social norms around SRH and it is also important to engage more with parents and ensure the appropriateness of CSE materials which should be considering the community's norms and perspectives (Table 31)

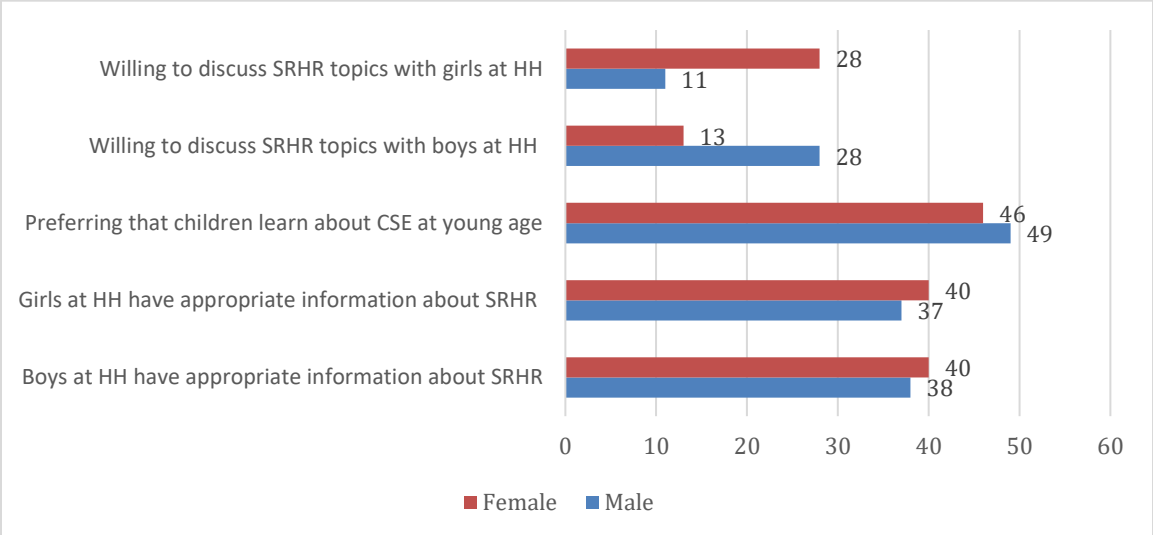
Findings indicate that only 38% of men and 40% of women think that boys have appropriate information about SRH and a similar percentage were reported about girls also indicating that parents think there are serious gaps in knowledge level among adolescents. Due to the cultural stigma around sexuality, even when parents are assured about the content of CSE and competencies of providers, they are still sceptical about teaching CSE to their children at a young age, less than half of them would like their child to learn CSE at a young age (49% of men are supportive and 46% of women are supportive). In line with that, only 28% of men and 13% of women are willing to discuss SRHR topics with male adolescents in their families, a considerable proportion is somewhat willing to discuss these issues (38% among males and 32% among females). The proportion who are willing to openly discuss these issues with a female adolescent within their families is much less than with male adolescents as only 11% of males and 28% of females are willing to do that. More than half of adult males (54%) and 15% of adult females declared that they are not open to discuss these issues with female adolescents whose sources of information are culturally bounded (Table 32).

Table 32: Distribution of responses related to adequacy of SRH information among young people and willingness to discuss SRH issues with young people

Variable	Male		Female		P value
	No	%	No	%	
Adolescents at your household have appropriate information about SRHR (Boys)					
Agree	182	38.2	189	39.7	0.062
Somehow agree	95	19.9	115	24.2	
Don't agree	198	41.6	167	35.1	
DK	1	0.2	5	1.0	
Adolescents at your household have appropriate information about SRHR (Girls)					
Agree	177	37.2	191	40.1	0.132
Somehow agree	105	22.1	118	24.8	
Don't agree	193	40.5	163	34.2	
DK	1	0.2	4	0.8	
Assuming that parents are assured about the content and competencies of CSE providers, would they like to have their children learn about CSE at a young age					
Yes, sure	228	48.8	218	46.1	0.734
Maybe, not sure	101	21.6	100	21.1	

No, I don't think so	136	29.1	152	32.2	
Don't know	2	0.4	3	0.6	
To which degree you are open/willing/may take the initiative to discuss SRHR topics with male adolescents at your family					
Very open	118	27.9	56	12.6	0.001
Somehow open	162	38.4	140	31.5	
Hesitant	49	11.6	104	23.4	
Not open	93	22.1	145	32.6	
To which degree you are open/willing/may take the initiative to discuss SRHR topics with female adolescents at your family					
Very open	46	10.8	125	28.3	0.001
Somehow open	82	19.2	195	44.1	
Hesitant	67	15.7	56	12.7	
Not open	232	54.3	66	14.9	

Figure 16: Responses related to adults' perspectives about teaching SRH issues to young people



Adolescents' perspectives about SRH information

Boys' and girls' perspectives about who should learn more about puberty were diverse, 87% of boys and 84% of girls reported that they should learn equally. Girls reported that they should learn more, 15% of them, which was only reported by 7% of boys who also believed that girls should learn more. The level of satisfaction regarding the comprehensiveness and convenience of the information acquired from any/all sources about puberty and associated changes was much higher among girls (29%) than boys (18% highly satisfied). Almost none of the boys and girls were aware of any provider who offers pre-marriage counselling. When asked what may prevent them as young people from using the service, around half (51% boys and 49% girls) said they don't need it, the service is not available (24% among boys and 34% among girls), no one cares about that (16% of boys and 13% of girls) and embarrassment (7% of boys and 10% of girls).

According to the respondents in our survey, boys (79%) reported receiving SRH information from any source much less than girls (87%), and the differences between the two groups are statistically significant. Nearly three quarters of boys and girls reported that they would like to see CES integrated with the school curriculum. Moreover, adolescents suggest introducing that at the age between 15-16 years or grade 10. The most likely visited digital sources by adolescents were Google, Tik Tok, and Facebook (see table 33). Nearly one fifth (21%) of boys and one quarter (26%) of girls are aware of social media influencers who promote topics such as healthy relationships and sexual health and the majority of adolescents especially girls think their role is very important and positive (57% among boys and 76% among girls).

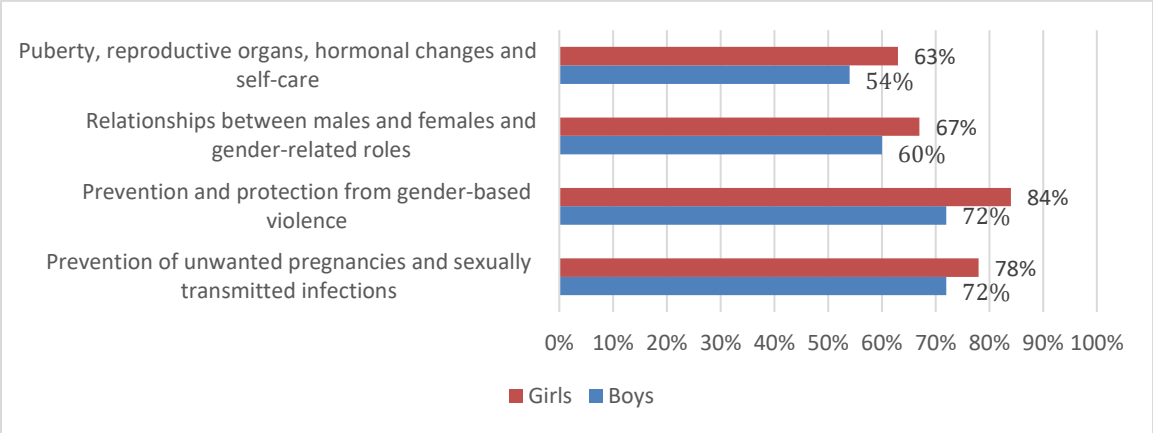
Interestingly, when adolescents were asked about the topics, they are interested in learning more about the mentioned important topics, including prevention of undesired pregnancies and STIs (72% by boys and 78% of girls), prevention of and protection from GBV (72% of boys and 84% of girls), gender issues and relationships between males and females (60% of boys and 67% of girls) and puberty and its associated changes and self-care which were reported by 54% of boys and 63% of girls. In all the mentioned topics, girls reported their interest to learn, more than the boys.

Table 33: Adolescents' responses about SRH information

Variable	Male		Female		P value
	No	%	No	%	
Who needs to learn more about puberty issues in your opinion					
Girls	17	6.3	30	14.6	0.002
Boys	18	6.7	4	1.9	
Equally both	235	87	172	83.5	
Comprehensiveness and convenience of the information acquired from any/all sources about puberty and associated changes					
Very satisfied	49	18.1	60	29.1	0.009
Satisfied	144	53.3	112	54.3	
Neutral	46	17.0	19	9.2	
Unsatisfied	29	10.7	14	6.8	
Not satisfied at all	2	0.7	1	0.5	
Are you aware of any provider who offers pre-marriage counselling services in your community					
Yes	4	1.5	3	1.4	0.982
No	266	98.5	203	98.5	
What may prevent you from accessing such services					
I don't need it	138	51.1	100	48.5	
I never heard about it; it is not available	66	24.4	70	34.0	
None Mind	43	15.9	27	13.1	
It is embarrassing to ask for such service	19	7.0	21	10.2	
Others	16	5.9	10	4.8	
I will consult my family about the bride/groom and that is enough	13	4.8	16	7.7	
I don't think going there will be useful	7	2.6	6	2.9	
If I propose that to my fiancé s/he will mostly refuse	2	0.7	1	0.5	
Received information about sexual health either at home by parents, at schools, or healthcare facilities	212	78.5	179	86.9	0.013
Would like to see CSE in the school curricula	204	75.6	151	73.3	0.733
	Mean	**Median**	**Mean**	**Median**	**P value**
The appropriate age for introducing CSE at schools	15.61	16	15.83	16	0.005
The appropriate grade for introducing CSE at schools	9.96	10	10.20	10	0.001

Regarding digital sources, what is/are the most visited or consulted outlets					
Google	113	41.8	92	44.6	
YouTube	99	36.7	75	36.4	
Social media pages on FB	65	24.0	43	20.8	
Nothing	54	20.0	38	18.4	
Social media on Instagram	16	5.9	7	3.4	
Social media Tik Tok	9	3.3	4	1.9	
Social media on WhatsApp	9	3.3	8	3.9	
Blogs and official webpages governmental, UN, NGO sites	9	3.3	12	5.8	
Vlogs and films	5	1.8	7	3.4	
Social media Twitter	1	0.3	0	0.0	
Broadcast	1	0.3	1	0.5	
Telegram	1	0.3	1	0.5	
Refuse	1	0.3	0	0.0	
Social media, Flicker	0	0.0	2	0.9	
Books	0	0.0	1	0.5	
learn about the existence of social media influencers, those who promote topics	56	20.7	54	26.2	0.006
Do you think their role is					
Very important and positive	32	57.1	41	75.9	
Very important but negative	5	8.9	1	1.8	
Somehow important/--	4	7.1	2	3.7	
Somehow important/+	9	16.0	6	11.1	
Not important	5	8.9	4	7.4	
DK	2	3.5	0	0.0	
Topics you wanted or still want					
Prevention of undesired pregnancies and STIs	195	72.2	160	77.6	0.198
Prevention and protection from gender-based violence	193	71.5	172	83.5	0.002
Relationships between males and females and gender related roles	161	59.6	137	66.5	0.125
Puberty, body composition and reproductive organs, hormonal changes and self-care practices.	146	54.0	130	63.1	0.048
Other	3	1.1	1	0.5	
Possible concerns that may make you or people at your age hesitant about CSE					
I will feel embarrassed talking about SH in groups.	204	75.6	163	79.1	0.262
Parents may get upset because they don't recognize its importance	148	54.8	116	56.3	0.572
Fear of being stigmatized or mocked by friends.	131	48.5	104	50.5	0.362
It is early for me and people my age to join CSE classes	118	43.7	100	48.5	0.176
CSE is against our social norms and religion.	99	36.7	72	34.9	0.882
Girls should be taught about CSE but boys are already knowledgeable.	70	25.9	53	25.7	0.838
School teachers themselves have no appropriate information	65	24.1	49	23.8	0.680
Teachers do not respect our confidentiality.	62	22.9	38	18.4	0.431
CSE is imported from western communities and not made for us.	58	21.5	28	13.6	0.069

Figure 17: Topics adolescents would like to learn more about in relation to SRHR



Our qualitative findings revealed that SRHR education at school is disappointingly sub-optimal. The module on environment and health has been cancelled, teachers have no guidelines to follow if they are willing to explain SRHR issues, and the teams dedicated/assigned for health education are too little to cover all schools in Gaza. Being on the margin of MoE priorities, according to school health teams, SRH related activities are ad hoc and depend largely on projects rather than systematic plans. Service providers indicated that school health involves few routine services related to SRH; they named physical examination, vaccination (included rubella vaccination for girls at 6th grade but that transferred to clinics five years ago), and environmental and health education where some sessions are provided around SRH to secondary schools, however, this type of activity seems to be concentrated within girl schools. School health sessions talk about puberty focusing on physical change during this stage for boys and girls and present some information only for girls about FP. One of the doctors who has been working for longer than 7 years with the school health team said '*We go to schools, mainly some secondary girl schools, and talk to them about the so-called FP. They don't name it birth control, we say FP. We give girls an example of a woman with 7 or 8 children and another with 2 or 3 children and compare the services they get and their life issues in general*'. During FGD with adolescents, girls, almost in all areas in Gaza have mentioned some sort of being lectured about puberty, hygiene, female reproductive organs, and much less about pregnancy, FP, and STIs. Girls have shared that when it came to male reproductive organs and puberty, no explanations were given at all. A 17 years old girl from east Rafah described how teachers spoke to her class about puberty and male reproductive organs saying '*In science class, there were some definitions, not explained at all during the class, the teacher skips them, we have to learn them by heart, only for the sake of exams if we happen to have questions, we write down the definition as presented in the book*'. During these lectures or regular lessons of science and religion where a little information about intercourse, menstruation, and Tahara is presented, girls do not raise questions, the majority of them laugh or hide their faces down as they feel shy to listen to or ask for more information. Girls, who reported no need to learn about puberty of boys at a young age (or before a girl get engaged), reported, however, that they receive much more information than what boys receive.

Boys on the other hand were relatively more open to learning about puberty experiences for girls and boys. However, the vast majority of FGD participants aged less than 19 years reported not participating in lectures or regular classes about SRH. Both school health teams and teachers themselves confirmed that boys are seldom given the chance to participate in sufficient sessions at schools. When we talked to teachers of science, religion, and counsellors, they described the services presented to boys at schools as '*Zero, nothing at all, nil, or very few*' except for science lessons which present an overview of reproductive organs without further explanation. During the last two years, almost no relevant classes were carried out due to limited time and remote distance-learning. Boys who attended lessons (some attended one or more lessons at 7th or 8th grades at schools) referred to irregular sessions, superficial topics, too few details, and an unfriendly way of explanation. Unlike the majority, some boys in Rafah and Biet Hanoun shared that some of the teachers explained the topic of physical change at puberty that was presented in science lessons at 10th grade. Teachers, especially teachers of science or religion classes, were willing to answer questions about personal hygiene and Taharah.

However, it is not easy for boys to raise other questions either because of lack of privacy or because of fear of punishment. During our discussions, one of the teachers described how difficult it was for the boys to raise questions about SRHR saying '*I duplicate my colleagues in this room who say we as teachers have a problem. I remember once that the English language teacher has beaten a boy in 9th grade just because the boys asked him about the meaning of the word kiss. The teacher beats him badly and wondered why a boy asks about that. It is not a boy's business, the teacher said… The boy at this stage felt confused as he was beaten for asking about a word. Would you imagine that he asks about SRHR later? Of course not. Even if he does, the teachers will not respond. The teachers say it is not our business, we better not open it up, it is sensitive, we better not allow the boys to talk about it*'.

Currently, despite the recent reduction in budget, at UNRWA schools, the majority of schools hire one or two counsellors in very big schools who are partially responsible for curative, preventive, and supportive guidance for students (80% of schools in Gaza obtain a counsellor). In reality, the counsellor who possibly divides his time between two schools has to accommodate too many subjects for too many classrooms (groups) over the school year! In most cases, only a constringent margin is allowed for talking about physical and psychological changes associated with puberty. Also, counsellors focus only on pupils with academic or discipline-related issues. In many cases, they are perceived more as part of the school administration and rarely show any understanding of puberty and its associated changes. Also, their role in awareness-raising is limited. As aforementioned, there is no guideline for SRHR or health education issues. Teachers and counsellors used to have a guideline before 2007, yet, this booklet has been cancelled. Moreover, the curriculum of science (which presents 6 lessons about reproduction and details reproductive organs, puberty, menstruation, pregnancy, and contraception for boys and girls in 10th grade) is now limited for illustration of reproductive organs without addressing information about menstruation and puberty or other topics where instead of 6 lessons under this chapter, only one or two are taught. Teachers also shared that female teachers skip talking about male organs for female students. Both male and female teachers pass by the topics superficially, skip some parts, use very few illustrative techniques (even if they opt to use them, there is a shortage of assistive resources such as 3-D shapes or educational videos), or ask students to study the topics solely at homes.

Boys were extremely unhappy regarding the role of counsellors who do not show up during the classes to at least invite boys to raise questions if they happen to have some. Our participants almost in all areas in Gaza were disappointed about the no-show of counsellors! Boys said '*It is embarrassing to go by yourself to ask, he [the counsellor] should encourage us'*. Boys also referred to the lack of privacy although the entire school community recognizes how sensitive it is to raise SRHR questions, counsellors were not available in friendly settings where they sit all the time either with secretaries, headmaster, or other teachers chatting according to the participants. Boys added '*There are barriers, however, even if you want to go talk to him, you find him among 700 other persons so you return back without talking*'.

One of the counsellors shared a time when a boy had a flash disc with sex videos or photos and described how the headmaster handled the situation saying '*It happened, once the headmaster knew about it, he applied the disciplinary measures and dismissed/expelled the boy from the school, if it was for me to decide, I would have handled that differently, I would have reminded the boy of the correct conduct and supported him to stop this behaviour at school. we usually do that even when the boy returns from his period of punishment*'.

Concerns about CSE

Many concerns were reported by young people who participated in this study which make them hesitant about CSE. Feeling embarrassed talking about SH in groups were reported by 76% of boys and 79% of girls, fear that their parents may get upset because they don't recognize its importance (59% of boys and 56% of girls), Fear of being stigmatized or mocked by friends (49% of boys and 51% of girls). Boys and girls also reported concerns around school teachers' competencies (24% among boys and girls) and doubts about teachers' ability to maintain confidentiality (23% among boys and 18% among girls). Interestingly, more boys (22%) than girls (14%), believe that CSE is not suitable to the local context, they think it is imported from western communities and not made for Gaza. Findings that emerged from the study provide very useful information to design appropriate CSE including targeting parents not only adolescents, using diversified awareness outlets, and allowing space for adolescents to privately discuss their concerns. Also, tailoring the CSE curriculum and training teachers is highly important (Table 30) Parents who participated in the FGDs shared concerns about opening SRH issues at schools in order not to open the eyes of boys and girls on sexual life. Men think that girls are at greater risk if they think about or enter into a relationship with boys. A man married to a child-wife in south Gaza indicating that because girls are exposed to sexual information, they misbehave. He shared what seemed to be an echo of his own illusions saying '*Girls aged 10 or 12 talk about sexual events in the streets*'. Also, a mother from Rafah said '*The girl is a girl and the boy remains a boy. Even if he misbehaves, it is different than girls*'.

4.4.3 Gender-based violence

According to PCBS, GBV is widely spread in Gaza. A considerable proportion of male respondents (32%) and 39% of female respondents reported knowing a friend or a relative

in the last 12 months who were humiliated by their husbands after giving birth to a baby girl. A quarter of women respondents reported being forced by their parents to accept maltreatment from their husbands or in-laws. More men (22%) than women (18%) think that parents should approve that a brother disciplines his sister even if she is the same age or older than him. Among women surveyed, 12% agreed that they would feel unable to express their needs related to SRHR and services if their husbands accompany them. Nearly one third of men (37%) and women (31%) believe that unmarried girls don't need to attend sessions on SRHR. Moreover, around 40% of men and 45% of women admitted that they believe in the myth/common belief that a girl's burden is a life course burden and the daughter needs to inherit a sense of submissiveness. About 44% of men reported that in their community it is not acceptable that an invasive examination procedure is performed for an unmarried girl even if her medical condition necessitates that, 53% of females reported that. When the same questions were asked to adolescents nearly half agreed or somewhat agreed (56.1% of boys and 53% of girls) that the unmarried girls who need invasive gynaecological services are denied access to these services (Table 34).

Table 34: Gender-based violence

Variables		Yes		No		NA		P value
		N	%	N	%	N	%	
Knowing a friend or a relative who was humiliated by her husband after giving birth to a baby girl in the last 12 months	M	151	31.8	323	68.0	1	0.2	0.035
	F	187	39.3	289	60.7	0	0.0	
Being pressured by parents to accept maltreatment from your husband or in-laws?	M							
	F	120	25.2	356	74.8	0	0.0	
Believing that parents should approve that a brother can discipline his sister even if she is the same age or older than him	M	103	21.7	354	74.5	18	3.8	0.041
	F	86	18.1	381	80.2	8	1.7	
Thinking that if your husband accompanies you, you feel unable to express your SRHR needs and services.	M							
	F	59	12.4	351	73.7	66	13.9	
I believe that unmarried girls don't need to attend sessions on SRHR.	M	174	36.6	293	61.7	8	1.7	0.027
	F	149	31.3	325	68.3	2	0.4	
Believing about the myth/common belief that a girl's burden is a life course burden inherit daughter a sense of submissiveness	M	193	40.6	275	57.9	7	1.5	0.189
	F	215	45.2	258	54.2	3	0.6	
In my community, it is not acceptable that an invasive examination procedure is performed on an unmarried girl even if her medical condition necessities that.	M	208	43.9	252	53.1	14	3.0	0.001
	F	251	52.7	222	46.7	3	0.6	

Our services providers and participants from youth have frequently mentioned violence that happens sometimes inside the healthcare facilities. One of the UNRWA staff said '*I feel like violence is normalized in our culture. I had a patient who has signs of bruising on her face, I asked her: have you been beaten? Her mom answered: No, he [the husband] doesn't beat her, only the normal things, it was only a slap. She was speaking as if nothing happens or as if that is the typical way of disciplining from a husband for his wife!!!*'. In a more blatant spectacle, one of the healthcare providers shared that she has received a pregnant woman in her 7th month of pregnancy and was shocked by the signs of beating and bleeding from some parts of her body, the staff said '*She came to us and was wounded, we dressed her wounds quickly and called the ambulance to get her to the hospital since she*

was in bad status and she is 7 months pregnant. Her husband followed her to the clinic and forced her to get off the ambulance, he kicked her and took her in a private car. By law and by norms, he has the right to stop her and prevent her from going to the hospital! Of course, we reported the incident to the protection department who followed up with her through home visits. We learned later that her husband is a school headmaster!! That is why I don't think violence or domination is linked a lot to education level'. The lawyers and human rights activists who we talked to confirm that according to law, men have the right to prevent women from seeking services. The legal frame is yet not supportive as the marriage definition (indirectly defined) by itself is a form of violence and paves the way for oppressions where the prevailing interpretation of the laws related to marriage implies that marriage is the enjoyment of a man with his wife (استمتاع الرجل بالمرأة) and defines the role of a man with paying/responsible for expenses and the wife as obedient. That is how the legislative frame deepens the gaps towards positive change. '*Under this law, how would you convince a man that forcing his wife on having intercourse against her will is a form of rape! He bought her [referring to the dowry and clarified, despite that, in Islam, dowry, despite being a requirement, it aims at being a symbolic marriage gift]*' said a lawyer and human rights activist during a KII. Another key informant said '*Men consider women as a reproductive object so they do not consult her about her decisions*!'. However, Islam stipulates that marriage must be a consensual agreement entered into by free will with no threat of force from any party, including parents (Islamic Relief Worldwide, 2018). Indeed, Qur'an clarifies that both forced marriage and violence against women are proscribed. Such progressive religious values could be used as entry points to control GBV given the centrality of religion in sociocultural norms.

In most cases, GBV is dealt with by Mukhatars (community leaders) using tribal but not legal mechanisms for conflict resolution. It is true that Mukhtars do not support violence against women and try to stop it through tribal Islah procedures. One of them said '*We don't encourage/congratulate them (husbands who commit violence]*' but the community leaders still admit that in many cases, women don't get their full rights because their fathers decide to be tolerant to the mistake of their sons-in-law (Husbands of victim daughter) in order to maintain the marriage of their daughters. However, the community leaders referred to seeing more and more parents who insist on preserving the rights of their daughters and mentioned an improvement in this regard. There is no clear referral pathway for violence survivals, on the contrary, courts may send complaints to Islah committee for social/tribal solutions. The family law is one of the most difficult to pass leaving the aforementioned legal frame constraining positive change. One of the key informants commented on that saying '*So we keep working with the mentality of that period*. As aforementioned, community leaders think that women want more children to secure themselves, or for feeling jealous, and that men don't care about the number of children as their interest concentrates around their sexual satisfaction. Leaders also shared situations where men care only about their satisfaction while women's needs are ignored but this happens in silence and is also sometimes muted by the leaders themselves who referred to that as '*a wise intervention*'. The inputs from our study participants and our analysis profess the need for an unrelenting position from the set of antiquated laws and unsupportive conflict resolution mechanisms.

4.4.4 SRHR and child-rearing particular experience of people with disability

Women married to men with disabilities have a particular experience where the wives seem to have more ability to decide about FP, they, however, are not supported at all when it comes to STIs, fertility care, and maternal and child care in general. One of them in North Gaza said '*We decide, personally I don't ask him [her husband] because it is only me who bears the entire responsibility*'. Another participant who seemed to share the opinion with the majority of the group said '*FP decision is taken by both of us, but we as women decide more since we feel tired and overwhelmed and they accept our opinions, we convince them*'. At the access to service level, women married to men with disabilities have similar experiences to many other women where they believe access to service is similar to persons without disability but there is no proactive engagement or special treatment for them. Men with a disability, based on the inputs of their wives, attribute not going to SRH or child-rearing activity by "their situation" as they consider that no one will understand them or they will not be able to answer the questions they may have. One said '*It will be embarrassing for them. Mostly a female doctor will be there and that makes the situation even worse*'. Men with a disability don't feel welcomed at service provision places, they are sensitive to their disability and sometimes they use it to push away seeking SRH services or schools. They accept to free women from house chores in order to avoid going outside and confront/encounter service providers. Some men with a disability give aggressive responses to their wives when it comes to STIs service. A wife said that her husband used to say '*You go see yourself*. Go take care of your stuff yourself' and another participant added '*or he says you go bring me the treatment, and even if the doctor asks for sperm analysis, we send it to the lab and do all the needed follow up*'. Only a few participants indicated that men agree to go to the clinic when they have STIs and the doctor asks to see them.

Culture is stronger than personal experiences, as even women who achieving very well in at the family and personal levels, these achievements are not yet helping them to fulfil their potentials and raise their self-esteem. For instance, one of the wives of men with disabilities said '*We raised our kids good enough so as to think they were raised by a great man*'. Compared to other married women from similar age groups, the women who are married to men with a disability or have children with a disability do more autonomous decisions in trade-off with too much more responsibility. Despite having some more autonomy, wives to men with a disability are not supported, they use more FP and spacing but they bear the responsibility about that alone. On the contrary to wives' inputs, fathers of children with a disability considered that they have a very good share of child-rearing responsibility.

4.5 Strategies suggested by participants to promote male participation in SRHR and child-rearing activities

When asked about possible scenarios to increase male participation in SRH and childrearing, both men and women respondents agreed with the list of provided scenarios. In general, there were consistencies and harmony between male and female perspectives about what might increase male participation (Table 35). The most frequently popular scenarios were providing incentives in the form of milk and diapers for new fathers who

attend a certain number of SRHR and child-rearing sessions (94% among men and 95% among women), launching one-week paid community work for all male and female youth 19-30 years old where they do services related to SRHR and child-rearing at PHC in governmental, UNRWA and NGO healthcare facilities and at the community level (92%) (92% among men and 94% among women) and reducing the family contributions to consultation fees and the cost of medications at MoH facilities if men and youth male present at SRHR visits (91% among men and 92% among women). Besides the instrumental incentives approach, at the awareness level, around 87% of both males and females recommended adding SRHR at school curricula for boys and girls at high schools, more than what is being currently provided. Females largely suggested (92%) introducing mandatory classes at university such as one week each year to receive information about SRHR and child-rearing at the university, which is also suggested by 86% of men. Around 83% of men and women suggested sending materials using social media outlets with SRHR and child-rearing content to fathers. Similarly, more than 81% of men and women suggested initiating a mobile application for SRHR and child-rearing information and FQA. On a side note, there is an application launched recently in cooperation between UNFPA and PMRS that is yet to be promoted (at refining phase so have limited number of users), through which, how to talk about SRHR to my offspring was the one most frequently visited topic. Moreover, 79% of men and 76% of women recommended launching out awareness strategy about the importance of involving men in SRHR and child-rearing using mass media, TV, and radio. To be successful, according to key informants and female participants, these messages should be adopted for long periods, presented nicely without provoking men and community members, be continuous and intensive and supported by religious opinions. Another important strategy suggested by participants (87% of women and 77% of men) included incorporating health education messages related to SRHR and child-rearing into the health education programmes at service delivery points. The distribution of information kits such as booklets and flyers about the male's role in SRHR and child-rearing was reported by 78% of men and women.

Table 35: Proposed ideas to promote men participation according to the survey respondents

Variable	Male		Female		P value
	No	%	No	%	
Adults' perspectives					
Provide incentives in the form of milk and diapers for new fathers who attend a certain number of SRHR and child-rearing sessions	447	93.9	453	95.1	0.467
Launch one-week paid community work for all male and female youth 19-30 years old where they do services related to SRHR and child-rearing at PHC in governmental, UNRWA and NGO healthcare facilities and at the community level	438	92	446	93.7	0.314
Reduce the family contribution in consultation fees of cost of medication at MoH facilities if men and youth male present at SRHR visits	434	91.2	438	92	0.660
Add SRHR at school curricula for boys and girls at high schools (extra to what is being provided)	418	87.8	412	86.5	0.504
Introduce mandatory classes at university such as one week each year to receive information about SRHR and child-rearing at the university	407	85.5	436	91.6	0.003
Sending materials using social media outlets with SRHR and child-rearing content to fathers	399	83.8	394	82.7	0.664

Initiate a mobile application for SRHR and child-rearing information and Frequently Questioned Answers (FQA)	397	83.4	386	81.1	0.385
Combine the first vaccination visits of new-born babies with 30-minute SRHR and child-rearing counseling sessions for their fathers	384	80.6	396	83.2	0.345
Introduce mandatory classes for youth males and females contemplating marriage as a condition for obtaining the marriage certificate 'similar to thalassemia test'	381	80	397	83.4	0.180
Launch out awareness strategy about the importance of involving men in SRHR and child-rearing using mass media, TV, and radio	378	79.4	364	76.4	0.274
Sending text messages with SRHR and child-rearing content to their mobile numbers	375	78.8	369	77.5	0.594
Distribution of information kits such as booklets and flyers about men role in SRHR and child-rearing	371	78	371	78	1.000
Incorporate health education messages related to SRHR and child-rearing into the health education programmes at service delivery points	366	76.9	416	87.4	0.079
Approach young married men at homes to communicate SRHR and child-rearing information	364	76.5	385	80.9	0.097
Introduce one mandatory SRHR and child-rearing session to obtain the birth registration certificate of new-born	359	75.4	392	82.3	0.009
Introduce one mandatory SRHR and child-rearing session prior to school registration of a child at first primary grade if the first child or the last child registered before more than two years	355	74.5	369	77.5	0.314
Adolescents' perspectives					
Provide incentives in the form of milk and diapers for new fathers who attend a certain number of SRHR and child-rearing sessions	257	95.2	176	85.4	0.615
Introduce mandatory classes for youth males and females contemplating marriage as a condition for obtaining the marriage certificate 'similar to thalassemia test'	255	94.4	157	76.2	0.066
Reduce the family contribution in consultation fees of cost of medication at MoH facilities if men and youth male present at SRHR visits	248	91.8	184	89.3	0.345
Launch one-week paid community work for all male and female youth 19-30 years old where they do services related to SRHR and child-rearing at PHC in governmental, UNRWA, and NGO healthcare facilities and at the community level	248	91.8	196	95.1	0.155
Introduce mandatory classes at university such as one week each year to receive information about SRHR and child-rearing at the university	236	87.4	166	80.6	0.032
Incorporate health education messages related to SRHR and child-rearing into the health education programmes at service delivery points	236	87.4	173	84.0	0.241
Add SRHR at school curricula for boys and girls at high schools (extra to what is being provided)	232	85.9	169	82.0	0.255
Combine the first vaccination visits of new-born babies with 30-minute SRHR and child-rearing counselling sessions for their fathers	224	82.9	175	84.9	0.479
Initiate a mobile application for SRHR and child-rearing information and FQA	221	81.8	151	73.3	0.025
Introduce one mandatory SRHR and child-rearing session to obtain the birth registration certificate of new-born	221	81.8	162	78.6	0.381
Approach young married men at homes to communicate SRHR and child-rearing information	218	80.7	177	85.9	0.136
Sending materials using social media outlets with SRHR and child-rearing content to fathers	218	80.7	162	78.6	0.643

Introduce one mandatory SRHR and child-rearing session prior to school registration of a child at first primary grade if the first child or the last child registered before more than two years	218	80.7	168	81.5	0.822
Launch out awareness strategy about the importance of involving men in SRHR and child-rearing using mass media, TV, and radio	208	77.0	156	75.7	0.739
Distribution of information kits such as booklets and flyers about men role in SRHR and child-rearing	207	76.7	148	71.8	0.231
Sending text messages with SRHR and child-rearing content to their mobile numbers	205	75.9	154	74.7	0.769

Also, a widely suggested strategy includes introducing mandatory classes for youth males and females contemplating marriage as a condition for obtaining the marriage certificate 'similar to thalassemia test' which was recommended by 80% of men and 83% of women. The latter was also suggested by community leaders and a significant number of participants in the FGDs. A fewer number of the providers were against tincturing SRHR education with a mandatory nature and called for more incentive/promotion to encourage male attendance. In addition to that, very interesting ideas were presented such as gradually introducing system change and policy fine-tunes, improvement of physical setting at healthcare facilities so as to welcome more men without inconvenience or discomfort to women audience, training of providers and provision of guidelines, intensified outreach and home visits by healthcare staff and partners, investment in training and assigning baby care tasks for men at the PNC visits, and possibly selecting the acceptable umbrella under which SRHR and child-rearing education and services are presented where men and services providers said, by name, all services are about mother or women health so it is logical to see only women attending there. The participants named religious people as strong influencing partners who could help to correct and passing the accurate messages about SRHR and child-rearing to the male community. Responding to and/or supporting men unmet needs of fertility care or early examination and treatment of dysfunction in friendly physical and professional settings will not only encourage their service utilization but also introduce a balanced vision that will help to dismiss/muting any possible cultural doubts about the intention behind male engagement and introducing SRHR education. Generally, our participants referred to a slow positive change pertaining to male participation over the last decades and envisaged this to continue in the future. However, many men, women and key informants including the most enthusiastic about greater roles for men in the SRHR and child-rearing expect this change to move slowly and to take a long time even if boosted in very correct ways. According to key informants and our reading to youth inputs, the process remains susceptible to possible relapse if further hardships and insecurities tear down the community members in the Gaza Strip, where, according to our key informants, due to stifling restrictions, oppression, siege and poverty, the community members no longer tolerate what they used to accept easily when the livelihood aspects went with relative certainty and security.

With regard to young people, adolescent boys most frequently cited strategies to improve male involvement in SRH and child-rearing, including providing incentives in the form of milk and diapers for new fathers who attend a certain number of SRHR and child-rearing sessions (95%), followed by introducing mandatory classes for youth males and female contemplating marriage as a condition for obtaining the marriage certificate similar to thalassemia test (94%), reducing the family contribution in consultation fees of cost of medication at MoH facilities, if men and youth male present at SRHR visits (92%) and launching one-week paid community work for all male and female youth 19-30 years old

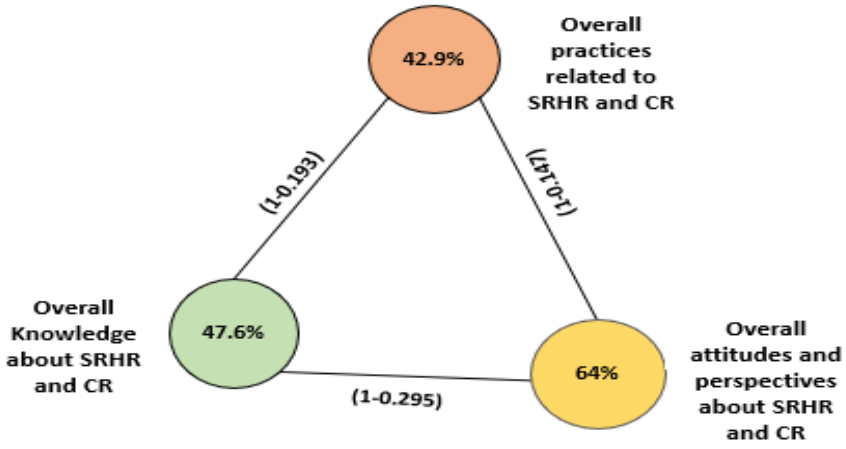
where they do services related to SRHR and child-rearing at PHC in governmental, UNRWA and NGO healthcare facilities and at the community level (92%). It seems because of the economic hardship conditions in Gaza, participants focused on financial incentives, however, the finding that young people had reported high interests in mandatory courses for youth who are about to marry is promising indeed (Table 32).

5. Conclusions and Recommendations

5.1 Conclusions

The findings from both qualitative and quantitative activities pointed out that the general perceptions around SRHR and child-rearing among men and women, boys and girls, and among service providers and policymakers are hyper-materialized and so are the services and laws. We believe that in addition to cultural factors which are the major suppressers of men's engagement in SRHR and child-rearing aspects, the low level of accurate information around SRHR contributes largely in articulating such perceptions among the community members and service providers. As the findings also confirm that the actual level of knowledge among survey respondents about SRHR aspects and child-rearing roles is very low, lower than what they think. It is obvious that the poorly informed individuals hold more conservative attitudes around SRHR and child-rearing where positive attitudes were partially mediated by education and age as denominators of exposure to information and interaction. The inappropriate or shallow information among younger and adolescent participants and consequently the shockingly negative attitudes they hold around SRHR issues raise a red flag around access to information and SRHR services for young and not married individuals. At the participation front, as subjectively reported, the majority of men admit that their participation, in general, is limited. Based on selected participation items, the overall proxy mean percentage of participation in SRHR is only 43% among adult men. Those who have free time, married to working women, and younger men participate more in SRHR activities according to the survey result, this has been confirmed with qualitative discussions which also highlighted that younger, who have a good income, and are more educated are more progressive and more engaged in SRHR activities.

Figure 18: Correlations between knowledge, attitudes, and practices on SRHR and child-rearing



As Figure 18 shows statistically significant, although weak to moderate, positive correlations between knowledge, attitude, and practice (KAP) triangle in general; the correlation test plotted attitudes closer to knowledge than to practices as denoted from a

stronger correlation between knowledge and attitudes than between knowledge and practice which is stronger than the correlation between attitudes and practice (Attitude knowledge r= 0.295, p= 0.000; attitude practice r= 0.147, p= 0.000; and knowledge practice r= 0.193, p= 0.000).

Our qualitative discussions provided a number of explanations about why the three KAP corners cannot draw an equilateral triangle; the issue is not only the distance between the sides of the triangle but the value of its corners (figure 18). We stress again that, besides the heavy shadow of cultural norms on male engagement and being not targeted, the level of active engagement of men remains frustrating. It is obvious that, regardless of their own choice, men cannot seek SRH services easily because of the restrictions on their entry and participation. Also, the fact that the majority of services are designed to serve females, current service provision constrains men's participation and obscures the care providers' ability to serve/engage them. Men approach the private sector and pharmacies for male-specific issues such as dysfunction, rapid ejaculation, and potency issues in general. At the providers' level, there is no clarity about the technical guidelines, male presence, and approval for SRHR, and GBV. That leads to non-standardized practices and/or interpretation of the existing guidelines. Equally alarming, the participants reported a high magnitude of violence against women, some men but very few are exposed to violence too, the UNRWA has referral mechanisms but the MoH has not reported any actions taken in case women victims refer to SRHR services.

The majority of participants referred to the importance of further engagement of men and young males in SRHR and child-rearing activities. They stressed the necessity to serve men and to invite them to healthcare facilities for SRHR services. However, there is a fear that since male presence at the clinic is stigmatized and that if they were present the women would not feel safe or will be insecure, in case of inviting men, to inappropriate places and working this way is a threat; women may withdraw the services or might be prevented to come. Therefore, it is necessary to upgrade and redesign the service provision and physical settings at which services are presented. Service redesign and improvement should also extend to infertility management which is overlooked in the public sector (UNRWA, NGOs, and government). The journey of infertility treatment is usually associated with stress, feelings of negligence, and financial overwhelmingness. In addition to fertility care, the promotion of and presenting quality premarital counselling will enhance greater male engagement, especially among the young population. The findings also uncovered a disappointing reality where the technical guidelines ignore the SRHR needs for older groups and "terminate/stop" the services to women after menopause. Likewise, the PWDs feel unwelcomed and not appreciated at the public healthcare facilities and schools so men avoid taking part in services or following their children at schools.

The engagement of and services to male adolescents and youth were at the core of this report. The findings confirm that schools and healthcare providers are the least, yet the most trustworthy sources of information about puberty and SRHR aspects for youth. At the family level, mothers provide information mainly to girls but boys are left uninformed. The ICT and social media sources are increasing but this raises parents' concerns about the content and the need to observe adolescents while accessing these outlets. More restrictions are imposed on girls despite boys being frequent users.

At schools, there are no guidelines for SRHR education therefore a systematic approach towards presenting sound SRHR curriculum or extracurricular activities is not there unless projects are dictating a number of actions. In addition to that, training about SRHR or CSE is seldom organized while only a small number of teachers have received any training in the last three years. UNRWA staff joined more training compared to MoE staff. Our conversations with school teams concluded that the attitudes of teachers copy those of the community at large. Both teachers and counsellors hold massive considerations to the views of the most conservative groups in the community. They believe that they should protect themselves from being blamed by the community members. The team observed relatively more progressive attitudes around SRHR education among school health team members who belong to the MoE more than those who belong to MoH. Besides human resources issues, there is a shortage of illustrative resources and equipment available for SRHR education.

Despite the concerns they expressed, we conclude that parents, community leaders, and young participants agree on the importance of SRHR education but they have proposed different channels for that. In general, it is important to covey the messages about CSE to parents in an assuring manner, speaking to and addressing their concerns about false information from the online sources and the risk that non-informed adolescents of exploration may help the buy in of parents to SRH education. Also letting people know to which end do these services aim and how helpful it can be.

The majority of participants referred to positive but slow change and more positive practices among young couples and new parents. They also confirmed that the breakthrough cultural norms require consolidated efforts, long-term, smooth, gradual, and participatory approach where media and religious figures should take good part. They key informants reflected on lessons learned from previous experiences related to gender norms and named folding the religious factor as one of the pitfalls. That is why utilizing a religious approach in raising awareness and increasing the demand for SRHR services seems very effective and useful. Actors could benefit from the religious values and conducts which present a number of positive entry points such as mutual enjoyment at marriage, settlement, serenity, positive child-rearing practices, good nutrition, etc. It is wise to let people learn about the negative consequence of preserving the taboos pertaining to SRHR issues and the possible gains by educating people about these issues. For instance, our findings marked that, due to social norms and lack of information, the first day of marriage, for many young people, is a nightmare sometimes for both men and women, there are young men who don't know how to behave, there are many false ideas, and girls feel scared or suffer a trauma. There is also limited information about hygiene, basic information before, during, and after the intercourse. Consequently, the marriage experience is either threatened to end by divorce or to witness unpleasant and violent situations. Therefore, spearing the knowledge around that may contribute to the buy-in by the community members for greater men roles and support in SRHR and child-rearing. The section below proposes a few actions for more participation of men and young males in SRHR and child-rearing activities in light of the aforementioned conclusions.

5.2 Action points and recommendations

While we admit that the contextual and deeply rooted cultural barriers that impede greater engagement of men and young males in SRHR and child-rearing activities are enormous, our report attempts to collect and present evidence about interventions for a breakthrough to support and sustain the positive change. Most of those mirrors and/or build on the inputs of our participants and resonate with the global and national evidence from previous studies mainly the recent and youth-focused reports such as Sayej, (2018) Sarras (2020) and Alshawish (2019). Part of the recommended interventions aimed at achieving "quick-wins" small but durable wins that feed and go alongside more fundamental/structural improvements and policy actions to sustain and scale up men's engagement in SRHR and child-rearing. In doing so, the authors of this report stress the overlapping nature of these interventions and the need to launch a national multisectoral strategy to increase male involvement in SRH and translate this strategy into practical programmes with assigned responsibilities and budgets. Much more progress needs to be made in formulating, implementing, and enforcing policies to promote gender equality. Involving boys and men in these efforts, and promoting their positive masculinities, is very essential. It is indispensable to track and monitor male users with appropriate and proactive surveillance systems. Involving diverse actors such as the MoH, MoE, UNRWA, Ministry of Women Affairs, human rights and women organizations, NGOs, community entities, media, religious institutions, and community neighbourhoods at municipalities is a bottom-line for a successful strategy. A few starting points are presented here below.

Area of intervention	Quick wins/short-term actions	Longer-term actions
Overarching interventions		
Advocate on and strive to address the contextual factors that hinder male involvement (men and boys) in SRHR and child-rearing	● The ongoing political conflict and repeated outbreaks of intense fighting, alongside economic and social challenges, reinforce deeply rooted conservative norms, including inappropriate masculinities, increased GBV and social inequalities. Therefore, during crises, proactively target and support the most affected groups. ● Advocate on the socioeconomic determinants of SRHR, including monitoring the effects of the blockade and economic collapse on increasing vulnerabilities, especially in relation to SRHR. ● Provide assistance to mitigate the impact of political turbulence, economic collapse, and increasingly conservative norms through effective social protection programmes that go	● Delivering improvements in male participation is closely linked to other contextual issues such as ending the occupation and its de-development policies, political resolution of the Palestinian case, economic growth, community empowerment, civil peace, democracy, social justice, gender equity, decent employment opportunities, access to university education, and women's empowerment – which all need to be constantly strived for by all actors. ● Ending the occupation and political resolution of the Palestinian case. ● Supporting economic growth at HH and community level. ● Addressing restrictive cultural norms by reforming discriminatory laws, raising awareness and inducing social change. ● Tackling other determinants for SRHR such as women's

	beyond the traditional relief model, such as the 'Cash-Plus' approach.	empowerment, promoting access to university education, civil peace, democracy and social justice.
Launch a national multi-sectoral strategy to increase male involvement in SRHR and child-rearing	● Advocate for the development of a multi-sectoral strategy for male involvement in SRHR and child-rearing. ● Conduct stakeholder mapping and PESTELE analysis to identify and liaise with interested and influential actors. ● Develop agreement on the process, scoping and vision for the intended strategy. ● Launch the development of the designated strategy as soon as possible.	● Develop a multi-sectoral strategy for male involvement in SRHR and child-rearing and translate this strategy into practical programmes with assigned responsibilities and budget. It is essential to involve men and male youth in these efforts and promote positive masculinities. ● Track and monitor male service users with appropriate and proactive M&E systems.
Induce change towards more age- and gender-equitable social norms (age-tailored messages are needed)	● Conduct mapping to identify target audiences/ beneficiaries and address them through appropriate channels. ● Use different approaches to change norms, including social media, peer-to-peer approaches, community mobilization programmes, awareness programmes implemented in schools, by NGOs, media channels and religious organizations. ● Utilize the large number of social workers in social protection programmes like the PNCTP, teachers, health workers and youth groups like Y-peer to influence social norms, targeting poor and uneducated population groups. ● Involve mass media, CBOs, NGOs, religious institutions, schools and universities to influence social norms and address inequalities.	● Social and cultural norms play a key role in driving male involvement, so it is vital to work towards gradual and progressive social change that promotes more egalitarian age and gender norms. ● Reform laws and policies to eliminate discrimination and promote age and gender equity. ● Awareness efforts should pay greater attention to people with disabilities, divorced women, older unmarried women and women going through menopause.
Reforming the personal status and family laws and legal framework, and activating social protection systems	● Support a community-based non-provoking dialogue around GBV, gender equity, legal age of marriage, social norms, and cultural preferences pertaining to SRHR and child-rearing to advocate for changes in family and personal laws.	● Reforming the personal status law must be a key priority in tackling gender inequality as it shapes so much of what men and women can (and can't) do. Efforts are also needed to tackle discriminatory laws and norms, including educating parents and raising community awareness.

	● Liaise with influential stakeholders including parliamentarians, human rights activists, women's organizations and religious leaders to change discriminatory laws and policies. ● Raise awareness about the positive impact of adopting gender- and age-equitable policies and also the negative consequences of social inequalities.	● Ensure that social protection systems are development-oriented, effective and sensitive to address people's social and economic vulnerabilities, particularly the most disadvantaged groups, including people with disabilities and elderly people, as they are being left behind. They should not have to rely on more children and sons to be their source of social security.
Encourage programmes to comply with evidence-based policies	● SRHR programmes should comply with policies and plans, including setting of priorities, standards, codes of conduct, and a robust M&E system that allows for reflection and learning. ● Develop standard policies/frameworks for SRHR services to enhance the quality of services and promote better governance. ● Enhance licensing processes, supervisory functions and M&E according to the developed standards.	● Stakeholders, including regulators, service providers and donors, should advocate for adopting policy research and evidence-based programming. ● Funds should be channelled based on clear SRHR and child-rearing improvement strategies, based on a clear framework with maximum of coordination efforts in place. ● Invest in developing effective systems for monitoring, evaluation, accountability and learning (MEAL) in the SRHR domain.
Information and services for adolescents and youth		
Ensure access to appropriate information	● Health and education sectors should be more engaged in designing and implementing age- and gender-appropriate packages of information to be delivered to young people at schools, universities, health centres and community spaces. ● Establish counselling units at health facilities and counselling services at schools and universities. ● Liaise with health education and school health teams to focus more on SRHR and child-rearing as part of their routine work. ● Scale up the roles and responsibilities of social workers within social protection programmes and health facilities to go beyond	● Invest in creating a more supportive culture within the HH, in schools and the wider community to support boys and girls as they go through puberty, particularly with issues around menstruation and sexual relationships. ● Initiate a long-term programme at the MoH and MoE to inform adolescents about SRHR and child-rearing issues.

	focusing on economic issues and engage more in addressing non-economic social inequalities. ● Train service providers, including health staff, school teachers and counsellors, social workers and staff working at NGOs and CBOs, to deliver age- and gender-appropriate messages. ● Involve religious leaders, youth leaders, youth groups and media professionals. ● Make greater use of ICT and mass media using adolescent-friendly approaches to reach and engage adolescents and youth. ● Communicate the positive impact of accurate information.	
Collective efforts for community buy-in to CSE	● MoE, in coordination with MoH and other relevant sectors, should build a consolidated vision on CSE. It should be able to clarify the intentions and content of the CSE curriculum. ● MoE should begin conversations among parents focusing on those who have more progressive positions on CSE to create a critical mass for change. ● Information should be presented gradually, starting with physical and psychological changes at the onset of puberty, through till marital life and FP, as students are about to finish their schooling. This requires putting in sufficient time, and assigning and training staff and school counsellors. ● There is a need to recruit and allocate resources for an optional class on CSE within Palestinian universities.	● Engaging religious leaders (after they are exposed to appropriate training), clubs and NGOs will be necessary to support community dialogue around CSE. ● Enhancing internal disciplinary policies at schools will help dismiss suppressive measures and reinforce supportive interventions by counsellors, such as greater privacy and more adolescent-friendly conversations with counsellors, and guidance/manuals for counsellors and teachers to tackle SRHR issues with boys and girls in an appropriate manner. ● Perform routine evaluations around CSE among students and their families and update interventions accordingly. ● Universities should start to think about orienting final -year students who will graduate as teachers and counsellors on CSE.
Scale up school health services	● Encourage school health teams to provide age- and gender-appropriate SRHR information.	● Reform the current package of school health services, which is currently not sensitive enough to SRHR issues.

	• Train and involve teachers and counsellors in school health activities. • Scale up school health screening (currently testes examination only) to incorporate a comprehensive SRHR health check-up, nutrition, and PSS. • Strengthen appropriate referrals for boys and girls who need specialized services. • Produce and disseminate brochures, pamphlets and other educational materials, including messages that can be posted using ICT and social media. • Involve parents in awareness sessions and orient them about common health issues affecting adolescents and how to manage them.	• Improve school infrastructure, to provide adolescent- friendly spaces and services for boys and girls, especially access to menstrual hygiene resources. • Develop a protocol for school health services.
Augment support to adolescent health services and information	• Continue to support plans to establish an adolescent health department within health services. • Introduce adolescent counselling services at PHC centres. • Train health providers to provide age- and gender-sensitive services for adolescents. • Utilize the family medicine and family health team model to target the entire family, including adolescents. • Provide more information for adolescents on puberty experiences, menstrual hygiene management, negative health aspects and consequences of frequent masturbation, prevention and management of STIs, prevention and protection from GBV, anti-harassment (including cyber harassment) or self-protection guidance, promotion of other services such as pre-marital counselling, FP and	• Develop adolescent health services package that are integrated within PHC services. • Increase coordination among different actors to frame the provision of adolescent health services. • Redesign services to support non-maternity services, and services for unmarried girls. • Develop guidelines and protocols for adolescent health.

	preconception care, safe sexual relationships, basics of positive parenting, and PSS during the transition to adulthood.	
Greater participation by men and boys in SRHR and child-rearing		
Promote male accessibility to SRHR services and information Redesign service provision at healthcare facilities	● Remove any unwelcoming signs or behaviours. There should be welcoming and engaging messages for men to take up SRHR services on their own or with their wives. ● Communicate the change in policies to encourage male participation to a wide spectrum of audiences. ● Urgently adapt physical spaces to allow more privacy and a conducive environment for men to access SRHR services. ● Train service providers to show welcoming attitudes to men taking up SRHR services.	● Redesign physical spaces at service delivery points to facilitate men's greater engagement and participation. ● Ensure that male staff are available at SRHR service delivery points as much as possible. ● Ensure availability of commodities and supplies needed to meet men's SRHR needs.
Introduce and link 'male specific and age-tailored' SRHR needs to existing programmes	● Provide pre-marital screening, support treatment of sexual dysfunctions, and introduce fertility care at least at the counselling stage. ● Invest in more male staff to be present in waiting areas or during home visits to demonstrate small tasks for baby care and mother support. ● During contact with men, counsel them on SRHR issues, including danger signs during pregnancy and postpartum issues; inform men about the types of support and needs of women/ consequences of unmet needs for women and men and children, or for women during pregnancy. ● Counsel men about the positive impact of their engagement with the health status of the entire family. ● Engage positive role models to advertise and promote men's participation in SRHR and child-rearing. ● Utilize community pharmacists as first-line contact with men	● Acknowledge and respond to male SRHR needs as a key factor and entry point to increase service utilization. Partial or full services are required at fertility care, providing pre-marital screening and treating dysfunction. Regulate private sector fertility care (both quality and safety of interventions). Agree a formula to subsidize a number of interventions such as covering the costs of fertility management for the poorest families. ● Spreading information on men's SRHR needs not only serves the best outcomes of SRHR care but also builds client–provider relationships and enhances the overall client experience.

	to raise awareness about SRHR topics. ● Offer SRHR orientation and training to recent graduates of health colleges and those doing an internship.	
Revisit technical instructions and guidelines and enhance healthcare providers' competencies on men's engagement	● Update technical instructions and guidelines to incorporate men's involvement as an integral component of SRHR. ● Train front-line staff and supervisors on updated guidelines, including on issues related to FP, GBV, STIs, sexual dysfunction, and men's role in SRHR. ● Develop supervisory tools like checklists to monitor staff adherence to protocols. ● Support service providers as they transition from an unwelcoming to a welcoming strategy for men and boys to access services.	● Stakeholders should develop a long-term strategy for male engagement in SRHR and child-rearing. ● Introduce guidelines and technical instructions in the curricula of health colleges. ● Alongside developing guidelines, introduce essential services that are not currently provided for men's SRHR needs such as counselling, infertility management and management for sexual dysfunctions. ● Strengthen referral networks and the continuum of care. ● Ensure complementarity and effective coordination among different actors. ● Develop national indicators with clear targets and an M&E system to track men's engagement with SRHR services.
Greater investments in raising awareness about SRHR for males and females	● Beside investment in CSE, it is critical to raise awareness about SRHR and child-rearing strategically at different levels, as a basic human right, through a wide range of formal and informal platforms. ● Men, boys, community leaders, religious leaders and staff working in the social sector (including health, education and welfare services) should be proactively targeted through a range of communication channels including mass media, online platforms and social media. ● Because girls and boys have limited access to information and services at health facilities, there should be more opportunities within schools, universities and the wider community for adolescents to	● Develop a behavioural change and communication strategy with clear and consistent messages to raise awareness and disseminate information about the benefits of male engagement in SRHR and child-rearing. ● Increase coordination among the different actors involved in disseminating information on SRHR. ● Develop a monitoring plan to assess the impact of the communication strategy in encouraging men's participation.

	have access to appropriate information about their SRHR issues and rights, and parents and community leaders should be involved in outreach efforts. ● Revise the content of educational materials to ensure that they promote men's participation and engagement in SRHR. Ensure that educational materials incorporate specific components about men's participation. ● Build on progressive religious values that encourage positive masculinities, caring and non-violent male behaviours. ● Better utilize outreach activities to disseminate awareness messages, including through midwives carrying out PNC home visits, social workers employed by social protection programmes, and community animators from CBOs/NGOs.	
Introduce and promote pre-marital counselling, preconception care counselling, and resource centres (under acceptable names/shapes)	● Design and advertise pre-marital counselling services, for couples planning to marry. ● Enhance preconception care for male and female youth at universities, healthcare facilities, through social media, in high schools, in preschools when parents attend for registration of children, and in mosques. ● Share an invitation for services and/or training course the day of performing the thalassemia test (which is a requirement for the marriage certificate). ● To encourage participation in pre-marital training, a symbolic marriage/wedding gift may be presented upon completion of the courses and/or when the participant invites another couple to attend upcoming courses.	● Gradual advocacy for a mandatory pre-marital training course for male and female youth contemplating marriage. ● Outsource pre-marital sessions to youth groups (small entrepreneur groups) in the long term. They will be able to design age-appropriate messages to deliver to new couples or youth peers. ● Continue to support and scale up mobile apps and other ICT ideas for pre-marital counselling and preconception care and counselling.

	• Create an online module for those planning to marry (possibly via sending a link to the mobile phone of groom/bride if their information is obtained through the thalassemia test form) so that they can complete the module in their own time, gaining a certificate after a short quiz. This can be linked to social media promotion to make the courses popular and fashionable among the youth community, in ways that will not be considered in appropriate by older generations.	
Adopt a life-cycle approach for provision of SRHR services		
Support access to SRHR services for all people, men and women, boys and girls, of all ages	• Technical guidelines should consider the SRHR needs of all groups, including currently overlooked categories (adolescents, menopausal women, older unmarried women, divorced women, sub-fertile couples and people with disabilities). • The practice of closing women's personal health files when they cease menstruation should be ended, and replaced by provision of age-appropriate SRHR counselling and services.	• Revisit policies to address safe and joyful sexuality for elderly people, especially women at and after the end of childbearing age, and men and women with disabilities, to accommodate their needs (focus on physical access and effective communication with providers). • Proactively target neglected groups such as people with disabilities, sub-fertile couples and unmarried women.
Encourage more roles for men in child-rearing and promote positive parenting in general		
Provide, scale up and support positive parenting practices among men to encourage greater male involvement in child-rearing activities	• Reinforce positive parenting within existing ECD programmes targeting caregivers at PHC centres, preschools, schools, NGOs and community entities, and scale up these programmes to target parents of older children and adolescents. • Caregivers should receive training and awareness on child-rearing, and non-violent discipline practices to make these practices socially acceptable.	• Develop policies for child protection (safeguarding policies) and ensure their implementation. • Promoting positive parenting practices should not be the responsibility of ECD and preschool actors only, it should extend to other service providers. • Develop a national surveillance system to register and report safeguarding cases. • Strengthen referral services to support survivors of violence and inappropriate disciplining practices.

	● Train service providers (health staff, teachers and counsellors) to recognize, report and manage exposure to violence. ● Break the vicious circle of violence practiced within the HH, community and institutions through awareness, efforts to change norms and provide safe platforms for reporting child abuse.	
Programmes should be driven by policies, rather than the other way around	● Programmes should adapt to and comply with policies and plans, which include setting of priorities, codes of conduct, sound MEAL functions, and continuous learning.	● Stakeholders (including regulators, service providers and donors) should advocate for the adoption of policy research and evidence-based programming. Funds should be channelled based on clear SRHR and child-rearing improvement strategies, with maximum coordination in place.

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7. Summary in Arabic

دراسة حول المعرفة والتوجهات والممارسات المتعلقة بالصحة الجنسية والإنجابية والحقوق المرتبطة بها بين الذكور في قطاع غزة

ينفذ صندوق الأمم المتحدة للسكان في فلسطين ومنظمة اليونيسف ومنظمة الصحة العالمية وبتمويل من الوكالة الفرنسية للتنمية برنامج صحة الأم والمواليد والأطفال والصحة الجنسية والإنجابية وصحة اليافعين والشباب والذي يهدف إلى تحسين إمكانية حصول السكان في قطاع غزة على خدمات مستدامة وذات جودة عالية في مجال الصحة الجنسية والإنجابية والحقوق المتعلقة بها. وتأتي هذه الدراسة القاعدية في نطاق عمل البرنامج الممتد عبر ثلاث سنوات.

خلفية وأهداف الدراسة

في الوقت الذي تتنامى فيه المؤشرات والأدلة حول الآثار الإيجابية لمشاركة الرجال في أنشطة وخدمات الصحة الجنسية والإنجابية والحقوق المتعلقة بها وتربية الأطفال على سلوك وصحة عائلاتهم بشكل عام، تبقى المعلومات المتوفرة حول المستوى الفعلي لمشاركة الرجال من قطاع غزة في تلك الأنشطة شحيحة وغير كافية. لذلك، تهدف هذه الدراسة لرصد وجهات النظر ومستوى المعرفة والممارسات والسلوكيات المتعلقة بتربية الأطفال وبالصحة الجنسية والإنجابية والحقوق المتعلقة بها بين الذكور – خاصة الرجال – في قطاع غزة.

كما وتسعى الدراسة لفهم العوامل والظروف التي ساهمت وتساهم في تشكيل المعرفة ووجهات نظر وممارسات الرجال بهذا الخصوص من أجل تقديم التوصيات الملائمة حول السياسات والبرامج الهادفة لرفع مستوى المشاركة الإيجابية للرجال في مجالي تربية الأطفال والصحة الإنجابية والجنسية بما في ذلك الجانب الحقوقي.

بالإضافة إلى ذلك، تقدم النتائج قاعدة بيانات أساسية لقياس أثر التدخلات والبرامج التي ينفذها صندوق الأمم المتحدة للسكان وشركاؤه على مستوى المعرفة والتوجهات والمشاركة لدى الرجال في المستقبل.

منهجية الدراسة

اعتمدت الدراسة على المنهجية المختلطة حيث تم دمج أسلوبي البحث النوعي والكمي. قام فريق البحث بجمع البيانات الكمية من خلال إجراء مقابلات وجاهية مع عينة عنقودية عشوائية لتعبئة استمارة للبالغين من الرجال والنساء (أكثر من 19 عام)، بالإضافة إلى استمارة مخصصة لليافعين من الجنسين تراوحت أعمارهم ما بين (15 إلى 19) عاماً. حيث بلغ عدد المستجيبين نحو 1428 شخصاً منهم 476 رجلاً، 476 امرأةً، 270 ذكراً يافعاً و206 أنثى يافعة، تم اختيارهم من 476 أسرة من مختلف مناطق ومحافظات قطاع غزة. كذلك استنار فريق البحث بآراء عدد (18) من الخبراء والعاملين في مجال الصحة الإنجابية، التعليم، تربية الأطفال والطفولة المبكرة، وكذلك صناع القرار وواضعي السياسات. كما أجرى الفريق 41 حلقة نقاش مع مجموعات بؤرية مركزة ضمت 317 شخصاً منها 34 مجموعة من الرجال، والسيدات، واليافعات، و7 مجموعات من مقدمي الخدمات والقيادات المجتمعية من السيدات والرجال.

جُمعت البيانات النوعية والكمية بين شهري مارس ومايو 2021 وتم تحليلها عبر البرنامج الإحصائي SPSS للبيانات الكمية وعبر تقنية التبويب المفتوح للبيانات النوعية، وقد التزم فريق البحث بكافة المعايير الأخلاقية والمهنية خلال أنشطة الدراسة كافة.

أهم النتائج

المعرفة حول الصحة الجنسية والإنجابية والحقوق المتعلقة بها وتربية الأطفال

بحسب نتائج المسح، أفاد حوالي ثلثي المستجيبين من الرجال (66%) وما يقارب نصف اليافعين من الذكور (46%) بأنهم على دراية بما يعنيه مصطلح الصحة الجنسية والإنجابية والحقوق المتعلقة بها، بينما كانت نسبة الإناث (80% من النساء و67% من اليافعات) اللواتي أفدن بمعرفتهن بهذا المصطلح أعلى من الذكور عموما، وكانت الفروقات بين الرجال والنساء ذات دلالة إحصائية. يتركز مفهوم الصحة الجنسية والإنجابية لدى نسبة مرتفعة من عينة الدراسة حول القضايا المتعلقة بصحة الأم وخاصة فيما يتعلق بالحمل والولادة وصحة المواليد فقد تمت تسمية رعاية ما قبل الحمل من قبل 62% من الرجال و58% من اليافعين الذين أفادوا بأنهم على دراية بمفهوم الصحة الجنسية والإنجابية. أما تنظيم الأسرة والرعاية أثناء الولادة فقد ذكرت من قبل 49% و41% من الرجال وبدرجة أقل من اليافعين الذكور بنسبة 37% و45% على الترتيب. الرجال أنفسهم عبروا عن التباس في المفهوم بالنسبة لهم فقد أفادت أجابتهم خلال النقاشات البؤرية بأن الصحة الإنجابية تتعلق بالعلاقة بين الزوجين وتنظيم الحمل ورعاية الحامل كما أوضح عدد من الرجال عدم معرفتهم من خلال تعليقاتهم حيث قال أحدهم من جباليا "*أنا لا أعرف، لم أسمع به بشكل جيد من قَبل*" وأضاف آخر "*لا أعرف بصراحة ولكن إن كنتم تقصدون تنظيم الأسرة، يمكنني أن أقول أنا أُفضل إنجاب العديد من الأبناء*". وفي منطقتي قاع القرين والمغراقة جنوب ووسط غزة، قال المشاركون وهم آباء سواء لطفل أو لأكثر خلال حضورهم لجلسة النقاش البؤرية الخاصة بالبحث بأن هذه هي المرة الأولى التي يستمعون فيها لآراء مختلفة حول مفهوم الصحة الجنسية والإنجابية والحقوق المتعلقة بها وعلاقة ذلك بالرجال.

الصحة الجنسية والإنجابية الخاصة بالرجال

الجدير بالذكر أن مفهوم الصحة الجنسية والإنجابية الخاصة بالرجال بالنسبة لغالبية المستجيبين كان أكثر غموضاً من مفهوم الصحة الجنسية والإنجابية العام لكلا الجنسين، حيث عبر فقط 39% من الرجال و36% من النساء عن درايتهم بالصحة الجنسية والإنجابية الخاصة بالرجال. وقد تمحورت إجابات المستجيبين حول قضايا الخصوبة والعقم (45% رجال، 47% نساء)، الضعف الجنسي (39% رجال، 56% نساء)، والحاجة إلى خدمات تنظيم الأسرة (38% رجال، 30% نساء)، بينما كان المفهوم أكثر غموضاً بالنسبة لليافعين حيث أن أقل من 20% من الذكور، 17% من الإناث أفادوا بأنهم على دراية بالصحة الإنجابية الخاصة بالرجال لقد كان رد فعلهم الأول لدى الحديث عن هذه القضايا سواء للرجال أو النساء خلال المجموعات البؤرية بأنه "عيب" حسب تعبيرهم حيث إن هذا الموضوع خاص بالنساء.

معلومات شحيحة حول قضايا مهمة

غالبية الرجال وكذلك عدد كبير من النساء ليس لديهم إحاطة مناسبة بعدد من الأمور الصحية رغم أهميتها سواء لهم أو للنساء في أسرهم، فمثلاً أقل من ثلث الرجال على دراية بالتغيرات الهرمونية لدى النساء والتقلبات المزاجية/الاحتياجات المعنوية المصاحبة لها في أوقات معينة (17% من الرجال لديهم معلومات عن التغيرات في مرحلة ما بعد الولادة، 33% قبل الدورة الشهرية، 40% خلال الحمل، وأقل من 3% لدى انقطاع الطمث). وكان الوعي بخصوص علامات

الخطر خلال الحمل قليلاً جداً حيث أن 13% فقط أو تقريباً رجل واحد من بين كل عشرة رجال يعرف علامتين من علامات الخطر خلال الحمل، بينما بقية الرجال إما أنهم يعرفون علامة واحدة فقط (46%) أو لا يعرفون أي علامة من علامات الخطر أثناء الحمل (39%). تجدر الاشارة أن مستوى المعرفة بين النساء لم يكن أعلى منه لدى الرجال بكثير، مما يستدعي ضرورة نشر المعلومات حول علامات الخطر خلال الحمل بين جمهور النساء والرجال. والأمر ذاته ينطبق على مستوى المعرفة بالأمراض والعدوى المنقولة جنسياً فقد كانت –رغم انتشارها– من بين أقل الموضوعات التي ذكرها المستجيبون (أقل من 11%) وبالكاد تم ذكرها من طرف المشاركين في المجموعات البؤرية فيما عدا مقدمي الخدمات الذين أشاروا بكثير من القلق إلى المستوى المنخفض من الوعي حولها وكذلك صعوبة علاجها نتيجة لعدم تعاون الأزواج بهذا الخصوص.

اليافعون أقل وصولاً للمعلومات الموثوقة

بعكس ما اعتقد بعض الآباء والأمهات الذين قالوا خلال المجموعات البؤرية أن "*هذا الجيل بعرف كل شيء*"، أكدت النتائج أن المشاركين الأصغر سناً هم الأقل إحاطة بالمعلومات حول الصحة الجنسية والإنجابية، وأن المعلومات المتوفرة لديهم، خاصة الفتيان والشباب أقل من 24 عاماً إما سطحية وإما غير دقيقة بحسب المدرسين والأهالي وحتى عدد من الفتيان والفتيات أنفسهم. اعتبر 80% من اليافعين أن المدرسة مصدر المعلومات الأول لهم حول مرحلة البلوغ بحسب نتائج المسح وكانت المدراس (87%) والأمهات (79%) المصادر الأكثر ذكراً من قبل الفتيات. في الواقع يخبرنا المسح عن مصادر المعلومات ولكنه لا يخبرنا عن نوع وحجم وطريقة الحصول على تلك المعلومات وهي حسب وجهة نظر الفتيان مجرد معلومات عامة وتتعلق بالجانب العضوي لجسم الأنسان بينما لا تتطرق للتغيرات البيولوجية والنفسية الأخرى وهذا ما يصفه أحد المشاركين في النقاشات البؤرية بقوله "*إن الأساتذة لم يتحدثوا مطلقًا، وان تحدثوا فلا يتجاوز من 30% من المنهج أو من المفترض أن يتحدثوا عنه*؛ كذلك أضاف مشارك آخر "*مرات في حصص الدين بيحكو عن البلوغ خاصة عن أمور الطهارة والنظافة الشخصية*". وتم تأكيد ذلك من قبل مقدمي الخدمات في المدارس الذين أفادوا "*أن هذا الجزء تم إلغاؤه من المنهج وأن المتبقي هو فصل واحد في مادة العلوم فقط لكن أغلب الأساتذة يقومون بشرحه باختصار أو يتجاوزوه خاصة أثناء التعليم عن بعد*" وعزى أحد المرشدين ذلك لضيق الوقت من ناحية، وعدم اهتمام الوزارة بالموضوع من ناحية أخرى، ولتجنب اللوم الاجتماعي حيث قال "*الأساتذة بيقولوا للطالب روح خلي اهلك يشرحوا لك، لأنه بدوش يفتح هيك مواضيع إذا فتحت ما بتتسكر وبدوش مشاكل*". ولأسباب مشابهة يتعذر تعاون المدارس مع الجمعيات الأهلية المعنية بهذا الموضوع بحسب تعليق احدى العاملات في تلك الجمعيات.

الجدير بالذكر أيضاً هو ضعف دور الرعاية الصحية في مجال نشر المعلومات لليافعين (أقل من 5%) والملاحظ أيضاً أنه بينما اعتبر 40% من الآباء بأنهم مصدراً أساسياً لأبنائهم للمعلومات حول البلوغ، فإن أقل من 20% من اليافعين أنفسهم أفادوا بذلك بفارق يتخطى 50% بين تقديرات الأهل وأبناءهم. أفاد اليافعون بأن الأصدقاء والمصادر الرقمية/الإلكترونية تشكل مجتمعة ما يفوق 50% من مصادر المعلومات لديهم. ورغم استخدام المشاركين لهذه المصادر إلا أن عدداً معتبراً منهم بدا متحفظاً على دقة المحتوى الذي تقدمه هذه المصادر وملائمته للقيم الأخلاقية في المجتمع. برز ذلك بشكل واضح خلال النقاشات مع الذكور وخلال تحفظ الأهالي والعاملين في الرعاية الصحية على هذا المحتوى خاصة المُقدم عبر وسائل التواصل الاجتماعي وكان تطبيق ' تيك توك' الأكثر ذكراً خلال

المجموعات البؤرية. من اللافت أيضاً الاختلاف بين وجهة نظر الباحثين خلال المسح عنه في المجموعات البؤرية، فقد أفاد اليافعون مستخدمو وسائل التواصل الاجتماعي كمصدر للمعلومات (26% من الإناث، 21% من الذكور يستخدمون وسائل التواصل الاجتماعي كمصدر للمعلومات حول الصحة الجنسية والإنجابية) بأنهم يثقون بالمحتوى المطروح على هذه المنصات وكانت الثقة أعلى لدى الفتيات (75%) عنها لدى الذكور (57%)، ربما يكون أحد التفسيرات لذلك أن الفتيات أقل بحثاً في المواقع التي يتحفظ المشاركون على محتواها وهن كذلك لم يشرن إلى استخدام تلك المواقع بكثرة خلال النقاش في المجموعات البؤرية.

التعليم الجنسي الشامل

على الرغم من ادراك ما يفوق 40% من الأهالي أن اليافعين ليس لديهم معلومات مناسبة، وعلى الرغم من تردد أو رفض ما لا يقل عن ثلث الآباء والأمهات الخوض في حديث مع أبناءهم حول الصحة الجنسية والإنجابية ، إلا أن اثنين من كل خمسة رجال وواحدة من كل سيدتين لازالوا يعتقدون أن التعليم الجنسي الشامل يصنف كأحد المحرمات الاجتماعية وأنهم ليسوا على استعداد للخوض فيه رغم ورود العديد من الأمثلة على لسان المشاركين في المجموعات البؤرية التي تشير إلى تشجيع الدين الإسلامي على الانفتاح على مثل هذه المعلومات والخدمات التي تساهم في تحسين العلاقات الأسرية. اعتبرت نسبة كبيرة من الآباء والأمهات (أكثر من 90%) أنه لا بأس بإدراج التعليم الجنسي الشامل في المدارس شريطة أن يراعي القيم الدينية والأخلاقية وأن يكون ذلك في سن مناسب (عند بلوغ 16 سنة تقريباً) وهذا ما عبر عنه المشاركون في المجموعات البؤرية أيضاً وكانوا أقل تحفظاً حول طرح التعليم الجنسي الشامل في المدارس حيث قالت بعض الأمهات "*من الأفضل أن يبدأ التعليم عن هذه الأمور في سن مبكرة خاصة للفتيات مثلاً 11 عام لأنهن يحتجن ذلك قبل الذكور على أن يكون بالتدريج ومناسب لأعمارهن*". اليافعون أنفسهم تحفظوا على التعليم الجنسي الشامل في سن مبكرة (أكثر من ثلث المستجيبين لا يؤيدونه في سن مبكرة) رغم أن لديهم رغبة في الحصول على المعلومات حول العدوى المنقولة جنسياً، الحد من العنف المبني على النوع الاجتماعي، ومرحلة البلوغ. بينت النقاشات البؤرية بوضوح وجود تردد لدى الذكور والإناث حول أهمية معرفة التطورات الجسمية والنفسية والعاطفية خلال البلوغ لدى الجنس الآخر وكان الذكور أكثر انفتاحاً على ضرورة الإلمام بالمعرفة الكافية عن هذه المراحل من أجل علاقات ملائمة في المستقبل (عند الزواج) رغم أن بعضاً منهم أفاد بأن المعرفة عن بعض قضايا الفتيات ليست مهمة، كقول أحد الشباب عند الحديث عن الدورة الشهرية ودعم الفتيات خلالها "*هذا بلزمش*" وأضاف آخر "*مش شغلنا بيعنيناش*".

الثقافة السائدة تحدد نوع وحجم المعلومات

من خلال قراءة النتائج الكمية والنوعية، لاحظ معدو التقرير تأثير الثقافة المجتمعية السائدة على نوعية وحجم المعلومات التي يحصل عليها الأفراد سواء البالغين أو اليافعين، فالفتيات مثلاً لديهن معلومات أكثر عن قضايا الصحة الإنجابية مقارنة بالذكور وتلعب الأمهات دوراً كبيراً في ذلك، بينما لا يعرفن ويترددن في الوصول للمعرفة عن قضايا البلوغ عند الذكور، وكذلك تقوم المعلمات في المدارس بتجنب مناقشة المواضيع الخاصة بالذكور حتى وان كانت ضمن المناهج الدراسية. على الجانب الآخر، يعرف اليافعون الذكور عن العلاقات الحميمة ويشوب هذه المعرفة الكثير من عدم الدقة كونهم يتعرفون عليها من مصادر غير موثوقة كقولهم "*من الشارع*" أو "*صاحب متجوز وبيحكي*". أما مقدمي الخدمات الصحية فإنهم يتحاشون الخوض في هذه القضايا رغم الحاجة الملحة لها حسب رأيهم ورغم المستوى المرتفع من القلق

حيال المعلومات المغلوطة لدى اليافعين وحتى لدى المتزوجين حديثاً. هذا التناقض بحسب تعبير احدى المشاركات في المجموعات البؤرية وهي من الفريق الصحي في إحدى العيادات الصحية يفسر جزئياً لماذا يتُرك اليافعون تائهين حيث قالت *"المدارس بدهمش يحكو بيقولو للولد روح خلي أهلك يشرحوا لك، والأهل مش ممكن يحكوا بالموضوع، واحنا في الصحة بنعملش اشي، وبيضلوا الولاد تائهين بين الكل"*.

مؤشرات مختارة حول معرفة الرجال في جوانب الصحة الجنسية والإنجابية والحقوق المتعلقة بها

تظهر النتائج بعضاً من الاختلاف بين ما يعتقده المستجيبون حول مستوى معرفتهم العامة وبين معرفتهم الفعلية عند سؤالهم عن بعض القضايا المحددة حيث قام الفريق باختيار عدد من المتغيرات المعرفية الأكثر دلالة (14 متغير) عن الصحة الإنجابية وتربية الأطفال وبينت النتائج –رغم كونها خاضعة للتغيير بتغير المتغيرات المختارة– أن متوسط نسبة المعرفة فيها هو 47.6% بين الرجال مقابل ما أفادوا به بنسبة 66% عند السؤال عن الموضوع بشكل عام.

يشار أن تحليل النتائج بوجه عام أظهر عدداً من الفروقات في المعرفة بالنظر للعوامل الديموغرافية وأغلب هذه الفروقات كانت ذات دلالة إحصائية، فمثلاً كانت النساء أكثر معرفة من الرجال، وكذلك البالغين أكثر معرفة من اليافعين. يعرف اللاجئين ومن يقطنون المخيمات عن قضايا الصحة الإنجابية أكثر من غيرهم، وينطبق الأمر ذاته على الأُسر الأقل عدداً، الأسر النووية، والمنتمين للأسر الأعلى دخلاً. كما كان الأعلى في المستوى التعليمي أكثر إحاطة بالمعلومات الخاصة بالصحة الجنسية والإنجابية.

وجهات النظر والتوجهات إزاء الصحة الجنسية والإنجابية والحقوق المتعلقة بها وتربية الأطفال

تؤكد النتائج وجود علاقة ارتباطية بين المعلومات والتوجهات وكلاهما يتشكل تحت تأثير الثقافة السائدة. قام فريق البحث بطرح بعض الأسئلة المتعلقة بوجهات النظر باستخدام مقياس دولي يعكس التوجهات الخاصة بالعدالة الجندرية للرجال (GEM) بالإضافة إلى أسئلة حول استغلال الوقت كما توضح الفقرات التالية.

مقياس العدالة الجندرية لدى الرجال

بينت النتائج أن النساء بوجه عام يحملن وجهات نظر أكثر ميلاً لأدوار جندرية عادلة لكل من الرجال والنساء في الأنشطة المتعلقة بالصحة الجنسية والإنجابية وتربية الأطفال. حصل الرجال على متوسط 1.28 (على مقياس من 0–2) أي بنسبة مئوية (64%) بينما حصلت النساء على متوسط 1.38 أي بنسبة مئوية (68.5%)، وفيما يتعلق ببعض القضايا اعتبر ما يفوق نصف المستجيبين من الرجال (55%) أن الدور الأهم للمرأة هو رعاية البيت وإعداد الطعام مقابل 46% من النساء أيدن ذلك. أكثر من ثلث الرجال (38%) وربع اليافعين الذكور (23%) وحوالي 17% من النساء يرون بأنه هناك أوقات تستحق النساء فيها أن تُضرب. في المقابل، سجل اليافعون من الذكور المتوسط الأدنى على المقياس بواقع 1.23 بنسبة مئوية (61.5)، بينما فاقت الفتيات جميع الفئات الأخرى بمتوسط 1.39 أي بنسبة مئوية (69.95). وكان الفتيان بالعموم الأكثر تحفظاً في وجهات النظر والأقل ميلاً لأدوار جندرية عادلة فقد بلغت نسبة الفتيان الذين يرون الدور الأهم على الإطلاق للمرأة هو رعاية البيت وإعداد الطعام 56% مقابل 41% من الفتيات وافقن على ذلك، وحوالي ثلاثة أرباع عدد المبحوثين من جميع الفئات يعتبرون أن رعاية الطفل مثل النظافة والتغذية تقع على عاتق الأم. بالرغم من ذلك، فإنهم لم يؤيدوا ظاهرة ممارسة العنف والاعتداء البدني على النساء خلال المجموعات البؤرية ولكنهم في الوقت نفسه أظهروا الكثير من التساهل مع الأمر كقول أحدهم بنبرة متسامحة *"كل الرجال بضربوا نسوانهم، أنا بأيدش هاد الاشي"*. يعتقد معظم المشاركين من جميع الفئات أن الكلمة

الأخيرة حول القرارات الخاصة بتنظيم الأسرة واستخدام وسائل منع الحمل تكون للرجل بينما اعتبر نصفهم أن تنفيذ القرار الذي أتخذه الرجل وتجنب الحمل هو مسئولية الزوجة. يشار أن وجهات النظر كانت أكثر ميلاً للعدالة الجندرية بين الجنسين عندما يتعلق الأمر بتربية الأطفال والتوافق على وسائل تنظيم الأسرة.

استغلال الوقت

توضح إجابات المبحوثين حول استغلالهم للوقت لفروق واضحة بين الذكور والإناث، فالإناث في يوم معتاد يمضين قرابة الأربع ساعات في الأعمال المنزلية بينما يمضي الرجال أقل من ساعة في ذلك حالهم حال الذكور اليافعين، أما الفتيات فيمضين ما يقارب الساعتين في أداء الأعمال المنزلية. وهذه الفروقات تتشابه أيضاً مع الوقت المستنفذ لرعاية الأطفال أو تقديم العناية لأفراد الأسرة الآخرين. مما يوضح أثر العرف الاجتماعي على التوجهات والممارسات في المجتمع. فبحسب قول أحد المخاتير خلال المجموعات البؤرية "*أن الزوجة نفسها هي من ترفض أن يساعدها زوجها في المنزل*" وأعزى ذلك لكون هذه الزوجة "*بنت أصول*". وبالمقابل وجد بعض المشاركين في شمال غزة أن "*الرجل اللي بيشتغل في البيت ومرته قاعدة وحطة رجل على رجل أنه رجل بده حرق*". لهذا، فإن عدداً من المشاركين ورغم قناعتهم الشخصية بأهمية المشاركة وتقاسم الأعباء، إلا أنهم لا يقومون بذلك خوفاً من الانتقاد أو تماشياً مع السلوك السائد في المجتمع كما عبروا عن ذلك خلال المجموعات البؤرية.

الممارسات والسلوك اتجاه الصحة الجنسية والإنجابية والحقوق المتعلقة بها وتربية الأطفال

وافق غالبية المبحوثين على أن مشاركة الرجال في الصحة الجنسية والإنجابية محدودة وضعيفة حيث أن 68% من الرجال و72% من النساء وافقوا على ذلك، والنسبة كانت متقاربة جداً بخصوص المشاركة في تربية الأطفال حيث أن 64% من الرجال و71% من النساء يرون أن مشاركة الرجال ضعيفة للغاية وهذا ما أيده المشاركون في المجموعات البؤرية حيث أفادوا بأن مشاركة الرجال لا تتجاوز 20 إلى 30 بالمئة في أفضل الأحوال. وقد لاحظ الباحثون أن بعض الرجال يبالغون في تقدير مساهماتهم ومشاركتهم في الأنشطة المتعلقة بالصحة الجنسية والإنجابية وتربية الأطفال حيث جاءت إجاباتهم عن تقديم المساندة وتلقي الخدمات دائماً أعلى من تقدير زوجاتهم للدور الذي يلعبوه.

مظاهر المشاركة في استخدام خدمات الصحة الجنسية والإنجابية

تتأثر مشاركة الرجال بوضوح بالأدوار التي توافق عليها المجتمع وباتت تشكل جزءاً من الموروث الثقافي والتقاليد السائدة، فقد أفاد الرجال أنهم يشاركون في الذهاب مع زوجاتهم للخدمات عند الولادة (75%) رغم أن بعضهم أوضح أنه نادراً ما يتمكنوا من الدخول لمكان تقديم الخدمة وأن دورهم بمثابة "*الناطور*" أو "*الناطور الذي يدفع التكاليف*" بحسب قولهم. الرجال أيضاً حريصون على المشاركة عندما يتعلق الأمر بالقضايا الحساسة التي تهمهم شخصياً مثل قضايا ضعف الخصوبة (72%) والضعف الجنسي (73%) والذي بحسب قول الرجال المشاركين في المجموعات البؤرية هم مستعدون لعمل أي شيء لحلها، حتى أن أحدهم قال وأيده الباقون "*والله بحرق الأرض يا زلمة عشان هادا الموضوع*". ليس فقط الرجال بل غالبية المشاركين أشاروا بشكل مباشر أو غير مباشر للعلاقة بين القدرة الجنسية و/أو الخصوبة وبين "الرجولة" ودلل على ذلك أحد الرجال من رفح عندما دفعته والدة زوجته للفحص المبكر لجهازه التناسلي على خلاف رغبته حيث قال "*قالت لي لتكون خربان ولا مش نافع*". لأن زيارة خدمات الصحة الإنجابية في المرافق الصحية العامة أمراً يعتبره المجتمع خاصاً بالنساء فقط حسب أقوال الرجال في وسط غزة، فإن معظم الرجال يختارون – وان كانت الاختيارات شبه قسرية لشح الخدمات للرجال وعدم الترحيب بهم في المرافق الصحية العامة – الذهاب إلى

العيادات الخاصة أو الصيدليات العامة حفاظاً على الخصوصية وتجنباً للانتقاد سواء من النساء المستفيدات من الخدمات في المرافق العامة أو من المجتمع أكثر منه لاعتبارات خاصة لجودة الخدمات. الجدير بالذكر أن الرجال بخلاف ما عبروا عنه خلال المجموعات البؤرية ليسوا مستعدين لزيارة العيادات الخاصة وتلقي العلاج بخصوص العدوى المنقولة جنسياً حيث تقوم النساء في أغلب الأحوال بلعب دور الوسيط بينهم وبين الطاقم الصحي لتوصيل ومتابعة العلاج وهذا ما اعتبره مقدمو الخدمات أحد التحديات الواجب معالجتها من أجل مكافحة العدوى المنقولة جنسياً.

مظاهر المشاركة في تربية الأطفال

يؤيد حوالي 90% من الرجال أن لهم دوراً هاماً في تربية الأبناء ويجب أن تكون لهم مساهمة فاعلة في ذلك، بينما وضح 27% منهم فقط أنه يساهم بشكل جيد في العناية بالأطفال بما في ذلك التغذية والنظافة الشخصية الخاصة بالأطفال. فقط 16% من الرجال يساهمون في الفحص الصحي الدوري لأطفالهم (التطعيم والميزان). فيما يتعلق بممارسة التربية الإيجابية من قبل الوالدين، فإن النساء تمارس مسلكيات إيجابية مع الأطفال أكثر مما يفعله الرجال قليلاً (متوسط 16.3 ممارسة إيجابية أسبوعيا للنساء مقابل 14.8 للرجال). وتأخذ مساهمة الرجال الأشكال المقبولة مجتمعياً مثل اللعب مع الأطفال، قراءة القصص، واصطحابهم للخارج بينما تتولى النساء أمور النظافة الشخصية والتغذية.

تنظيم الأسرة وحصول النساء إلى الخدمات

بلغ الاستخدام الفعلي للمبحوثين لأحد وسائل تنظيم الأسرة وقت إجراء المسح 58% كما أفاد الرجال و62% كما أفادت النساء وهذا يعكس أن بعض الرجال لا يعلمون أو لا يهتمون لذلك الأمر أو كلاهما. كما أشارت النتائج بأن 88% من النساء و92% من الرجال يرون أن قرار استخدام وسائل تنظيم الأسرة يجب أن يكون مشتركاً بين الرجل والمرأة ورغم ذلك فإن ما يزيد عن ثلث المبحوثين يحملُّون مسئولية تنفيذ هذه القرارات للنساء. في الواقع صرحت الغالبية العظمى من الرجال والنساء وكذلك مقدمي الخدمات أن الكلمة الفصل في مسألة استخدام وسائل تنظيم الأسرة هي للرجل وأنه بعد اتخاذ قرار استخدام وسائل تنظيم الأسرة وتوقيت استخدامها، لا يتدخل في نوع الوسيلة حيث تقررها المرأة أو مقدم/ة الخدمات ما لم يكن في استخدام تلك الوسيلة مصدر إزعاج للزوج أو ضرر صحي على المرأة بحسب الرجال المشاركين في المجموعات البؤرية. لذلك يلعب الرجال دوراً أساسياً في حصول النساء على خدمات تنظيم الأسرة والقرار بشأن جنس وعدد الأطفال وتوقيت إنجابهم، ويحد العرف المعمول به من إمكانية اتخاذ النساء لقرارات تنظيم الأسرة حيث يحرص الفريق الصحي على التثبت من موافقة الزوج وإن لم يكن منصوصاً على ذلك في تعليمات العمل. وحسب نتائج المسح، فإن حوالي 60% من الرجال والنساء يظنون أن الرجال يفرضون بعض القيود على حصول النساء على خدمات الصحة الجنسية والإنجابية وأن 15% من النساء المبحوثات قد مُنعن بالفعل من الحصول على خدمات تنظيم الأسرة وكان الزوج هو الشخص الذي منعهن من ذلك كما أفاد ثلثا تلك النساء. وأشارت طبيبة في عيادة تنظيم الأسرة بإحدى مراكز الرعاية الأولية بمدينة غزة أنها خلال عملها تلاحظ عدداً (وقد أيد باقي مزودي الخدمات ذلك برغم عدم اتفاقهم أو ربما اختلاف تقديراتهم حول حجم الظاهرة) من حالات تعرض النساء للعنف نتيجة أو خلال طلبهن لخدمات الصحة الإنجابية وتحدثت عن أحد الحوادث حول سيدة حامل منعها زوجها من الانتقال للمشفى قائلة "*جاءت وكل جسمها مغطى بالدماء وتنزف، هي حامل بالشهر السابع، واضح على جسدها آثار الضرب الشديد، ضمدنا جروحها سريعاً وطلبنا الإسعاف لنقلها للمستشفى وبينما هي تصعد للسيارة، جاء زوجها وأجبرها على*

النزول، ضربها وركلها برجله وسط العيادة وأخذها في سيارة خاصة وذهب". ورغم الإبلاغ عن الواقعة لبرنامج الحماية ووجود إجراءات خاصة متبعة لذلك في المؤسسات الصحية إلا أن عدداً من المشاركين أوضح أنه يحق له ذلك بالقانون _أي منعها من الذهاب للمشفى – بحسب بعض المشاركين.

الأكثر مشاركة من الرجال

خلصت النتائج عموماً إلى تواضع المشاركة الفعلية للرجال في قضايا الصحة الجنسية والإنجابية والجوانب الحقوقية ذات العلاقة وتربية الأطفال (43% تقريباً)، وبين تحليل البيانات ترابطا وثيقا بين مستوى المعرفة و درجة تبني مفاهيم وتوجهات جندرية عادلة والمشاركة الفاعلة في نشاطات الصحة الجنسية والإنجابية فقد كان الرجال في الأربعينات (30–40 عام تقريباً)، من يقطنون المخيمات واللاجئين، والرجال من الأُسر الأقل عدداً، والأسر النووية، والمنتمين للأسر الأعلى دخلاً والأعلى تعليماً والرجال من محافظتي خانيونس ودير البلح هم الأكثر مشاركة. من اللافت أيضاً ما ذكره مقدمي الخدمات وعدد كبير من المشاركين ملاحظتهم لتغيير تدريجي إيجابي في كل من التوجهات والسلوكيات لدى المقبلين على الزواج (المخطوبين) وحديثي الزواج ومن لديهم عدد قليل من الأطفال نحو أدوار أكثر فاعلية ومشاركة أفضل في نشاطات الصحة الجنسية والإنجابية ورعاية الأطفال. يذكر أيضاً أن التحليل الإحصائي يشير إلى ارتباط ايجابي متوقع بين المعلومات، الاتجاهات، والسلوك غير أن السلوك في بعض الأحيان لا يرتبط بشكل محكم مع الاتجاهات الشخصية وقد يكون ذلك لأن أثر الثقافة أقوى من الاتجاهات الشخصية على سلوك بعض الأفراد.

الاستنتاجات والتوصيات

كما بينت النتائج أعلاه، أن مساهمة العادات والتقاليد والموروث الثقافي في تشكيل المعرفة والوعي والسلوك حول الصحة الجنسية والإنجابية والحقوق المرتبطة بها ورعاية الأطفال أكبر وربما مختلف في بعض الأحيان عن القيم الدينية. وتلعب الأطر القانونية ونظم فض النزاعات الاجتماعية (وضع حلول حسب العرف والعادات) دوراً في تشكيل هذه التوجهات والمعارف والسلوكيات الهادفة. ولا يقل دور خدمات الرعاية الصحية والتعليم أهمية في نشر المعلومات وتشكيل وجهات نظر وتقديم الخدمات ذات العلاقة لتعزيز مشاركة الرجال في نشاطات الصحة الجنسية والإنجابية وتربية الأطفال. رغم ملاحظة بعض التحسن البطيء في توجهات الرجال وفي مستوى مشاركتهم في أنشطة الصحة الجنسية والإنجابية وتربية الأطفال، إلا أن الثقافة المجتمعية السائدة ونظم تقديم الخدمات خصوصاً في قطاعي الرعاية الصحية والتعليم لازالت تشكل تحدياً أساسياً يحد من المشاركة الإيجابية للرجال.

أهم التوصيات

- تظافر الجهود بين القطاعات الصحية المختلفة والتعليم والإعلام والمنظمات غير الحكومية ودور العبادة خصوصاً المساجد ورجال الدين من أجل تفنيد ودحض الموروث الثقافي المعيق لمشاركة الرجال واليافعين في أنشطة الصحة الجنسية والإنجابية وتربية الأطفال على أن يتم الاسترشاد بالقيم الدينية والمجتمعية التي تعزز ثقافة وتقاليد داعمة لتشارك الأدوار والمساهمات من طرف الرجال والنساء في الصحة الإنجابية وتربية الأطفال.
- تمكين الرجال والذكور اليافعين من الحصول على معلومات صحيحة موثوقة وبطريقة متوائمة مع احتياجات الذكور والإناث خلال المراحل العمرية المختلفة وخاصةً مرحلة المراهقة.

- تحسين البنية الهيكلية للخدمات الصحية ويشمل ذلك تحسين البنية التحتية وموائمة أماكن تقديم الخدمات بحيث تكون ملائمة أكثر للرجال دون أن تتعارض مع خصوصية النساء وملائمة المرافق لهن، توفير قدر مناسب من الخصوصية للرجال والنساء أو للزوجين معاً، توفر الخدمات الخاصة بصحة الرجال وتقديم العلاج المناسب لهم خاصة قضايا الضعف الجنسي وعدم القدرة على الإنجاب والعدوي المنقولة جنسياً، وتدريب الطاقم الصحي بشكل مناسب على تقديم خدمات ملائمة تراعي العمر والنوع الاجتماعي.
- ضرورة تطوير البروتكولات الوقائية والعلاجية بحيث تضمن توفير خدمات الصحة الجنسية والإنجابية المناسبة للرجال ولجميع الفئات الأخرى على أن تولي اهتماماً خاصاً بالمجموعات الأكثر احتياجاً مثل ذوي الإعاقة والسيدات غير المتزوجات، ضحايا العنف، ومن هم بحاجة لعلاج ضعف الخصوبة، وللنساء بعد انقطاع الطمث.
- دعم جهود تدشين برنامج خاص بصحة المراهقين على أن يترافق ذلك مع جهود مجتمعية لتوضيح أهمية التعليم الجنسي الشامل للأهالي وللیافعين أنفسهم، واستمرار وتوسيع خدمات الصحة المدرسية بحيث لا تكون مقتصرة على الفحص العضوي للطلاب بل تقدم خدمات التوعية والإرشاد حول الصحة الجنسية والإنجابية والحقوق المتعلقة بها والدعم النفسي بما في ذلك خدمات إحالة للحالات التي تحتاج لذلك.
- تقديم المعلومات الصحة الجنسية والإنجابية بطريقة ملائمة ضمن منهج مدرسي تفاعلي تلعب فيه الجمعيات الأهلية دوراً مسانداً حيثما أمكن. كما يمكن الاستفادة من وسائل التواصل الاجتماعي والمنصات الرقمية لنشر المعلومات الصحيحة حول مفاهيم الصحة الجنسية والإنجابية وتوضيح أهمية المشاركة فيها.
- تدشين خدمات استشارات ما قبل الزواج وإقرار دورة تدريبية للمقبلين على الزواج يمكن أن تكون مرافقة لفحص الثلاسيميا، والترويج لخدمات ما قبل الحمل، وتنظيم الأسرة وإدراجها ضمن الخدمات القائمة حالياً على أن تتم جميع هذه الإجراءات ضمن رؤية شاملة مدعومة بنظام ترويج جيد ونظام متابعة وتقييم فاعل.

Annexes

Annex 1

TERMS OF REFERENCE FOR INDIVIDUAL CONSULTANT

TERMS OF REFERENCE (to be completed by Hiring Office)	
Hiring Office:	UNFPA Palestine
Purpose of consultancy:	The purpose of the study is to generate reliable evidence on knowledge, attitudes and practices (KAP) among men in the Gaza Strip related to sexual and reproductive health and rights (SRHR) and child rearing. The study will collect in-depth qualitative and quantitative information on the underlying social, cultural and economic factors that drive prevailing social norms on SRHR and child rearing. Its findings are expected to provide those working on SRHR and positive and balanced parenting with a wider evidence base upon which to develop more effective interventions to involve men and boys in SRHR and child rearing, which resonate with families and communities and are perceived as legitimate. The findings will also provide insight on the KAPs among men on decision making mechanisms within families on if, when, and how many children to have, as well as choice of contraception and women/girls' decision-making power and access to SRHR services. The results will help inform interventions to support women's agency in decisions regarding reproduction. The findings of this research will inform an ongoing three-year joint program funded by Agence Française de Développement (AFD) being implemented by UNICEF, UNFPA, and WHO, in partnership with local partners, to improve the continuum of care for sexual, reproductive, maternal, neonatal, child, and youth and adolescent health (SRMNCHAH) nutrition and development in Gaza. Beyond the ongoing joint program, the findings of this study will be used by UN agencies and relevant national stakeholders to plan and implement interventions in line with national goals and strategies for SRHR, gender equality, and child rearing.
Scope of work: *(Description of services, activities, or outputs)*	<u>Background:</u> UNFPA, UNICEF and WHO are implementing a three-year joint program (2020 - 2023) on SRMNCHAH in Gaza, funded by AFD. The program aims to improve access to quality and sustainable sexual and reproductive health, child health, nutrition and early childhood development services in Gaza. Within the program, UNFPA is commissioning a researcher or team of researchers to carry out a study on knowledge, attitudes, and practices on SRHR and childrearing among men in Gaza in order to inform future interventions and to contribute to national goals and strategies, such as the national SRH Strategy (2018-2022). The study will be based on existing knowledge and research on the subject. The study will be used by the UN, local authorities, and NGOs to enhance interventions and engagement of men and boys. The

research should be in line with UNFPA global guidance on involvement of men and boys in SRHR.

The National Sexual and Reproductive Health Strategy 2018-2022 outlines three main objectives:

1. To ensure availability and access to high quality SRH services

2. To promote SRH across different ages through community awareness and adopting healthy behaviors and preventive care

3. To promote sustainability and governance of the SRH sector

In Gaza, men and extended families have significant decision-making power regarding how many children to have and when to have them. This impacts use of family planning, IVF services, maternal health, and access to other SRHR services and information. Global research has found that male engagement initiatives on SRH, including maternal health and gender-based violence, and child rearing can have significant behavioral and health outcomes for their partners and children. This study will identify drivers behind these practices, in order to develop targeted interventions towards men and boys.

Objectives of the consultancy:

1. Work with UNFPA, UNICEF, and WHO to undertake research on the KAP of boys and men, specifically in their role in SRHR.
2. Collect a high-quality methodology and data set that can be used as a baseline. There will be a follow up midline assessment carried out in 2022-23. The baseline and midline are not intended to evaluate specific interventions carried out under the project, as there will be alternative M&E mechanisms for the project funded by AFD. However, the baseline and midline will be able to evaluate societal changes as a whole over the course of the project period. UNFAP will plan to have a follow up assessment towards 2030 to assess long term changes, as societal changes take a long time.
3. Write a concise study report that can be used by UN agencies, NGOs, and the government of Palestine to design and implement interventions to achieve national goals outlined in the SRH National Strategy and committed during ICPD25 (details in Annex 1). The study report should be reader friendly and a maximum of 40 pages, in order to ensure wide usage and dissemination of results.
4. Provide recommendations to UNFPA and partners on priority activities for interventions targeting men and boys and SRHR and child rearing.

Components of the study must include:

1. KAP on SRHR among men with wives, daughters, or other close family members living with disability.
2. KAP among adults on SRHR for young people, building on a recent social norms study carried out by UNFPA. For example, what are the KAP among adult men towards young people accessing SRHR information and services.
3. Topics including, but not limited to, menstruation, family planning, child rearing practices, care during and after pregnancy, IVF, how to

care the baby at home, gender-based violence prevention, including son preference. After conducting the desk review the researcher(s), UNFPA, and UNICEF should discuss the final topics to be addressed in the research. The angle in which to address these topics should be in line with the workshop held with key stakeholders to identify the research questions and methodologies.

4. The research must apply the "do no harm" principle, so as to avoid any risk to study participants.

Methodology requirements (minimum):

- The study should be mixed methods, with the primary focus on qualitative methods. Depending on the final research questions, the methodology should be developed with approval from UNFPA and UNICEF.
- Desk review
- Key informant sources to include interviews and review of global guidance on male involvement in SRHR / child rearing, and KAP among men and boys and SRHR
- Focus group discussions with the following groups (minimum)
    - Married and unmarried men and boys in different age groups from 15 and above. Some should be fathers and brothers to unmarried girls. The FGDs should be split by appropriate age groups and categories (ie. young men, fathers of certain age categories, etc.)
    - Male community and religious leaders
    - Men with family members (particularly children) that are living with disability
    - Women and girls to document their views on their expectations from men and boys related to SRHR.
- The study should include a minimum of 40 focus group discussions and 15 key informant interviews. This should be adjusted based on the proposed methodology in the inception report and based on feedback and inputs from relevant colleagues at UNFPA and UNICEF.
- The study should involve participants from all governorates in Gaza, refugees and non-refugees, access restricted areas, rural and urban, and different socio-economic status'.

The study will consist of four phases:

1. **Inception phase** including:

- Desk review of available literature and national and international guidance on male involvement in SRHR and child rearing. The KAP study should build on existing evidence, including key documents such as a recent study on social norms and SRHR among young people, the child marriage strategy, IVF studies, UNFPA male involvement strategy, and others. UNFPA and UNICEF will provide relevant documents, as a starting point for the review.
- Preliminary discussions, including two joint workshops to ensure a common understanding of the scope and focus of the study and to refine the methodology;

1. With UNFPA Palestine, UNICEF Palestine, and relevant colleagues at UNFPA and UNICEF regional offices,
2. With women's NGOs in Gaza

- Submission of required ethical clearances to the appropriate ethical review boards.
- Inception report preparation. The inception report should be in English and approved by UNFPA, in coordination with the advisory board, prior to data collection. Provision of input from UNFPA/UNICEF and the advisory board may take up to 1 month. During this time, the consultant should begin to hire/prepare the data collection team. The inception report must include:
    a. Introduction, context and purpose (based on desk review)
    b. Methodology, including all data collection tools (full list of questions to be used in any survey/FGD/KII interview questions), identification of key informants and specific settings, sampling methods, limitations. Data collection tools should also be submitted in Arabic.
    c. Analysis of risks and identification of mitigating measures. Risks related to ethical issues, especially in consideration of the involvement of young people in data collection;
    d. Work-plan detailing schedule, team members' roles and responsibilities, and logistics;
    e. Outline of the final report.
    f. Annexes (TORs, KAP matrix, data collection tools)

2. **Data collection and analysis phase**: Data collection and analysis will be mixed methods, with qualitative and quantitative methods. Qualitative and quantitative data analysis should be computer-based, using designated data analysis software. The Consultant is expected to specify the data analysis software and approach in the proposal. A thorough training should be conducted to train enumerators on data collection.
3. **Reporting phase:** The consultant will be required to submit at least one draft report (in English with executive summary in Arabic) to be submitted for comments to UNFPA and the advisory board, which is under the AFD project Steering Committee. UNFPA and the advisory board will provide feedback, which the consultant will be expected to incorporate before the final report is prepared. This phase should allow sufficient time for consultation and feedback processes. The final report should be submitted in a reader friendly and aesthetically pleasing format and should also include a Powerpoint or Prezi presentation that UNFPA can use in the future to present study results.

   During the reporting phase, the consultant, in coordination with UNFPA/UNICEF should prepare a dissemination plan for the study to reach targeted NGOs and institutions.
4. **Dissemination phase**: The consultant will be expected to conduct dissemination event(s), led by UNFPA, with partners and study participants to share study results. Pending the status of COVID19, this event may be in person or virtually (to be decided in consultation with UNFPA).

	The final report must be in English and include the following items, at a minimum: 1. Executive Summary (English and Arabic) 2. Background, based on desk review 3. Methodology (including sampling and analysis methods and measures taken to address ethical issues) 4. Key Findings responding to research questions 5. Conclusions and Recommendations 6. Annexes The report should be maximum 40 pages, plus annexes and references. Possible limitations include, but are not limited to: ● The Covid-19 Pandemic may restrict field visits during data collection, which will necessitate the use of alternative data collection approaches such as virtual tools. ● The study has proposed the use of qualitative data collection which is not statistically representative and has limitations in investigating causality ● The response rate may be low in certain areas
Duration and working schedule:	The consultant will be expected to start as soon as possible (likely 1 December 2020). All deliverables are expected to be completed by June 30 2021. The working schedule is based on outputs and is flexible.
Place where services are to be delivered:	Gaza and online
Delivery dates and how work will be delivered (*e.g.* electronic, hard copy etc.):	December 1, 2020: Start assignment December 2020: Desk review, consultations with UNFPA/UNICEF on methodology January 4, 2020: Submission of inception report to UNFPA and the relevant AFD technical working group and/or Steering Committee. UNFPA and steering committee will review and provide feedback to be incorporated before initiating data collection January - February: Data collection and analysis March - April 2021: Reporting phase April 30, 2021: Submission of first study draft to UNFPA and the relevant AFD technical working group and/or Steering Committee. UNFPA and committee will provide comments within several weeks. May 31, 2021: Submission of final report and presentation to UNFPA and the relevant AFD technical working group and/or Steering Committee, after incorporation of feedback June 2021: Dissemination phase June 30, 2021: Completion of all deliverables

	Payment 1 (30%): Paid upon delivery of inception report Payment 2 (40%): Paid upon delivery of first study draft Payment 3 (30%): Paid upon finalization of report and completion of dissemination activities, as per the agreement with UNFPA The schedule can be adjusted, based on consultation and approval with UNFPA.
Monitoring and progress control, including reporting requirements, periodicity format and deadline:	The assessment will be conducted under the direct supervision of the UNFPA AFD Project manager in close collaboration with other relevant colleagues in UNFPA and UNICEF. The consultant will be expected to work closely with the relevant technical working group from the AFD project, which includes technical staff of Participating UN Organizations, MOH, and other relevant key stakeholders. In addition, the consultant will work with an advisory board consisting of national and international research experts who will work with the consultant on the design, implementation, and analysis of dissemination of results of the study.
Supervisory arrangements:	The consultant and her/his team will be directly supervised by the UNFPA AFD project manager, based in Gaza City, with support from the rest of the SRHR UNFPA team. In addition, the consultant will be expected to work closely with the relevant colleagues at UNICEF and WHO in Gaza under the guidance of the AFD project technical working group.
Expected travel:	Throughout Gaza, while following MOH guidelines on COVID19.
Required expertise, qualifications and competencies, including language requirements:	The study should be carried out by a research team, which should include a minimum of: **Team leader:** Her/his role is to coordinate the team, lead the preparation of the inception report, the data collection procedures in the field, and the preparation of the draft and final reports. The team leader also liaises with the commissioning team. Must have proven experience in qualitative data collection and KAP studies. ● Postgraduate degree in public/global health, medicine, gender studies, development studies, sociology, anthropology, or other relevant social science ● Proven experience in leading research teams (at least 8 full years) ● Proven experience in conducting and reporting ethnographic research ● Proven experience in qualitative research, conducting FGDs/KIIs ● Proven experience in analysis and report writing ● Fluency in English and Arabic **Subject Matter Expert:** The subject matter expert is from and based in Gaza, with proven experience in the area of SRHR and gender with a research record on social norms related to SRHR. Experience with men and SRHR is preferred.

Her/his role is to advise on the SRHR and gender related content of data collection tools, procedures, analysis and reports.

- Post graduate degree in public health, medicine, gender studies, development studies, sociology, anthropology, or other relevant social science
- Proven experience in research and reporting on sexual and reproductive health and gender issues related to health in Gaza

Enumerators: At least 4 enumerators should be included. Their role is to contribute to the study, in the framework of the process described above and depending on how the team envisions the distribution of responsibilities. Enumerator(s) will also interview key informants and conduct FGDs. The number of enumerators should sufficient to allow required data to be collected within specified scope, scale and time allocated for the study

They should have the following background, expertise and skills:

- Graduate degree in public health, medicine, gender studies, development studies, sociology, anthropology, or other relevant social science
- Proven experience in qualitative research, conducting FGDs/KIIs (at least 5 years)
- Experience in conducting and reporting computer-assisted qualitative data analysis.
- Demonstrable extensive experience in conducting and contributing to gender and health focused research.

Research assistants (2): One male and one female. UNFPA works to build the capacity of young people. One of the ways UNFPA is supporting young people is to build the capacity of young Palestinian researchers to conduct quality research on SRHR. In this regard, if the lead researcher of this project is above the age of 35, the researcher will be expected to hire 2 research assistants (one male and one female) in Gaza between the ages of 18 - 35 to support the entire research process. The research assistants should be heavily involved in the entire research process, in order to build their capacity, but also to ensure that the study takes youth needs properly into account, including the way that the study will reach young men and ask questions in a way that are youth friendly.

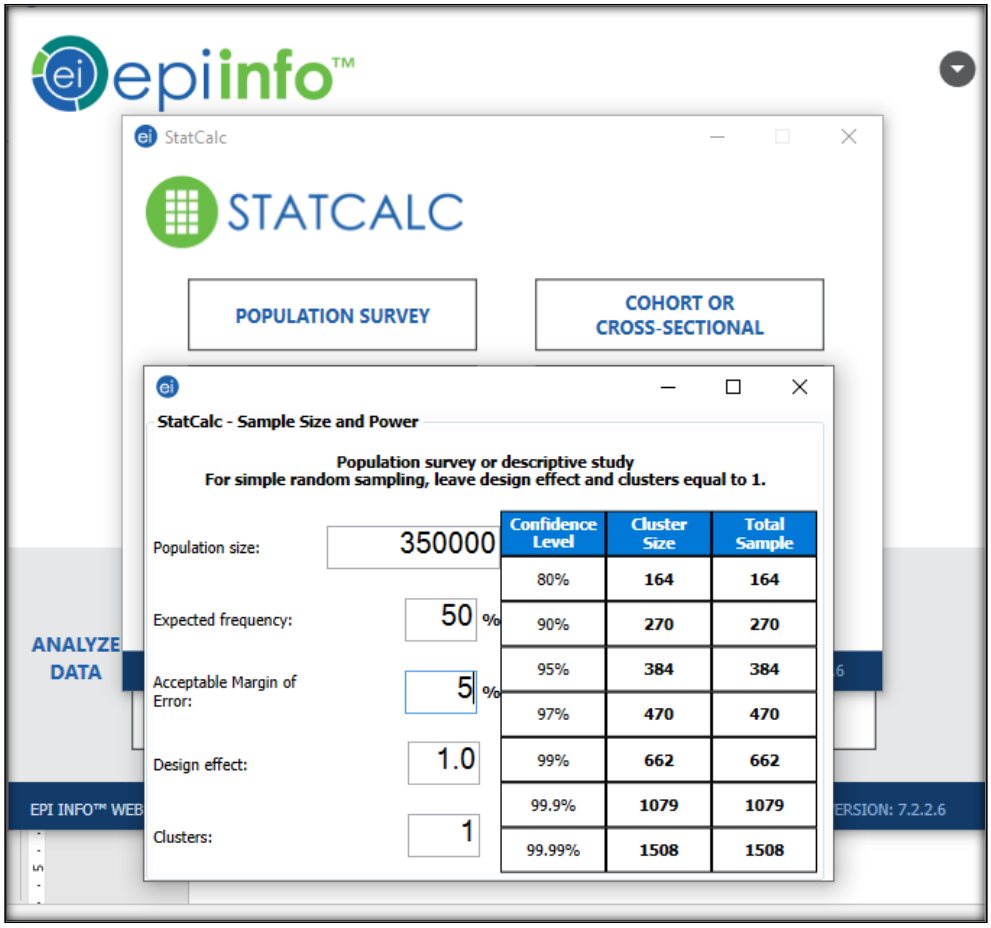
- Graduate degree in gender studies, development studies, education, sociology, anthropology, or other relevant social science
- Effective communication skills and ability to write clearly
- Excellent use of Word, PowerPoint and Excel

Skills and personal qualities: All team members should have:

- Deep understanding and sense of ethics with regard to human rights, different cultures, local customs, religious beliefs and rituals, personal interaction and gender roles, sexual identity and orientation, disability, age and ethnicity.
- Excellent analytical, organizational and interpersonal communication skills.

	● Evidence of being skilled at working in close cooperation with national and international actors and facilitating coordination of the process within the determined deadlines. ● Computer literacy International and national researchers are welcome to apply. Palestinian researchers are strongly encouraged to apply. If an international researcher wishes to apply, they are required to partner with a Palestinian institution / research team in Gaza. The partnership (details of the partners, roles, responsibilities, etc.) must be included in the proposal.
Inputs / services to be provided by UNFPA or implementing partner (e.g support services, office space, equipment), if applicable:	UNFPA will facilitate meetings and interviews with relevant stakeholders, such as the Ministry of Health and Ministry of Social Development, as needed.
Other relevant information or special conditions, if any:	The consultant will be responsible for providing all necessary IT equipment (laptops, mobile phones, etc.), transportation, personal protection equipment (masks, gloves), and hiring all research assistants and data collectors. The research team will be required to follow all MOH guidelines for COVID19 to ensure that both the research team and the study participants remain safe from COVID19. The research team should develop a backup plan for how to carry out the study, in case of significant COVID19 outbreak and inability to conduct in person research activities. In this case, the research team will be expected to discuss the plan of action with UNFPA. UNFPA will conduct a small follow up study in 2022-2023 based on this study, as the baseline. All research materials, such as questionnaires, focus group discussion guidelines, etc., must be submitted to UNFPA to be used in the follow up research. All materials developed under this research are owned by UNFPA.
Signature of Requesting Officer in Hiring Office: Date:	

Annex 2: Output of the calculated sample for quantitative survey (Number of households)



Annex 3-Questionnaire

KNOWLEDGE, ATTITUDES AND PRACTICES AMONG MEN AND BOYS IN THE GAZA STRIP RELATED TO SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS (SRHR) AND CHILD

Good time,

1) I am "Your name", a member of research team and willing to obtain your views on SRHR (which includes school health about puberty, reproduction, health services and health counselling before, during and after pregnancy, family planning, management of STI, issues related to miscarriage, abortion and labour, and other experiences couples may have around this domain) and childrearing for research purpose. Your views will help the research to suggest recommendations for national and international actors to promote sexual and reproductive health and mother and child health.

2) The research is being carried out for UNFPA, WHO and UNICEF under (SRMNCHAH) project funded by AFD.

3) This interview may take up to 60 minutes. You may skip any questions you don't like to answer and you may terminate the interview at any point of time without mentioning the reasons.

4) There is no wrong and right answer, you are kindly requested to give your views freely as they first come to your mind. Your views are valuable and will never be evaluated or judged.

5) Your household reference will not be mentioned at any stage of the study or afterwards.

6) The team has already obtained the required ethical approvals to conduct this study from nationally recognized bodies.

7) You may ask me to repeat any questions or to explain any part of them.

8) Although your participation is highly appreciated, taking part in this study is completely voluntary, you have the right to refuse participation. Refusal to participate will not affect your entitlements or access to any services and will not affect you in anyway. .

- Are you willing to take this interview? Please repeat this for every respondent at the HH.

  □ Yes, fill the cover information and continue

  □ No, fill the cover information and thank the participant

- Date of the interview (dd/mm/yy) = [___|___]/[___|___]/[___|___]
- Start time (hh:mm) = -----:----- am/pm End time (hh:mm) = -----:----- am/pm
- Status of this questionnaire;

1) Completed by □ Adult male □ Adult female □ Younger female □ Younger male
2) Refused participation
3) Incomplete and will be completed; □ No □ Yes; with whom
4) Early terminated and data can be used
5) Early terminated but data cannot be used

9) Should you have any questions now or at any other time about this research and your participation, please feel free to ask. You can contact Dr Bassam Abu Hamad by phone [0599351515] or email him [ghsrcb@gmail.com].

Note: If the respondent opt to terminate the interview at any point of time, please get his/her permission to use or not to use the data already obtained and indicate this in questionnaire status.

Data collector comments at the end of the interview

Household code[9] [___|___|___] **Researcher code [___|___|___]**

Section A: Socio-demographic, general health and education characteristics – Adult males and adult females		
A.01 Socio-demographic characteristics		
1. Sex of the respondent	□ Adult male	□ Adult female
2. Respondent age in years	[___|___]	[___|___]
3. Marital status		

[9] HH code consists of governorate code, community structure, HH identification on kish grid

01 = Married 02 = Divorced 03 = Separated 04 = Widowed 05 = Never married 06 = Engaged but not yet married 99 = Refused						
4. Family type, is this a … Family? 01 = Nuclear 02 = Extended						
5. Are you … ? 01 = Refugee 02 = Non-refugee						
5.1 Governorate, you currently live in 01= North 02=Gaza 03= Deir Al Balah 04 = Khanyounis 05 = Rafah						
6. Do you live in … 01 = Camp 02 = Outside camp 03 = ARA						
7. Family size, currently, how many members live together at this household?						
7.1 Of them, how many members aged 15 to 19 years?	[___|___]					
7.2 Of them, how many members aged under 5	[___|___]					
8. For your ideal family size, how many boys and how many girls you would ideally think of?	Boys = [___|___] Girls = [___|___]			Boys = [___|___] Girls = [___|___]		
9. In our community, we see many differences in family size and the ways people plan and think about the number of children. Regarding family size**,** who decide about the number of children? A) At your household B) The norm in your community C) Your ideal preference 01 = Husband 02 = Wife 03 = Both 04 = Parents in-law 05 = Everyone mentioned 06= Other, Specify	A	B	C	A	B	C
A.02 Education and ICT knowledge/use						
10. What is your highest attained education level? 01 = School grade, *please specify in the response box the last grade completed* 02 = University/college	Grade_____ University, level_____			Grade_____ University, level_____		
11. Do you have personal accounts on social media outlets? 01 = Yes, number: _____ 02 = No 99 = Refused						
12. Do you have PC/laptop available for you anytime?	01 = Yes	02 = No		01 = Yes	02 = No	
13. You have smartphone and/or tablets?						
14. Do you have internet connection at the house?						
15. Do you know what SRHR means in general? 01 = Yes 02 = No, skip to question 16						
15.1 If yes, what is included in SRHR ***Don't read the options, select all that applies***						
01 = PCC 02 = ANC 03 = NC 04 = PNC and child care 05 = FP (modern contraceptives) 06 = prevention and management of HIV and other sexually transmitted infections 07 = Early detection of the most important cancers in women, especially (cervical cancer - breast cancer) 08 = Post-Abortion Care Services 09 = Premarital Medical Examination 10 = menopause care 11 = adolescent/youth health 12 = Addressing issues of sexual and gender-based violence 13 = Information, advice and services related to fertility and infertility 14 = information, advice and services on sexual health and wellness 15 = other, select						
16. Do you know what SRHR means for **men** in particular? 01 = Yes 02 = No, skip to question 17						
16.1 If yes, what is included in reproductive SRHR **for men** in particular ***Don't read the options, select all that applies***						

01 = Information and Consulting 02 = need for contraception 03 = prevention and treatment of HIV and other (STIs) 04 = sexual dysfunction 05 = Infertility 06 = male reproductive health related cancer 07 = other, select				
17. Do use the ICT to get knowledge about SRH 01 = Yes 02 = No, skip to question 18				
17.1 If the answer is yes, the app you use mostly ***(choose everything that applies,do not read the options)***				
01 = YouTube 02 = Social media Tik Tok 03 = Vlogs and films 04 = Social media Twitter 05 = Social media pages on FB 06 = Social media, Flicker 07 = Social media on Instagram 08 = Social media, WhatsApp 09 = NGO Youth platform 10 = Broadcast 11 = Blogs and official webpages governmental, UN, NGO sites 12 = Other, specify: ----------	01 02 03 04 05 06 07 08 09 10 11 12		01 02 03 04 05 06 07 08 09 10 11 12	
A.03 Work status and economic conditions				
18. Work status in the last four weeks (paid work) 01 = Employed ≥ 35 h 02 = 35 > Employed >15 h 03 = Employed < 15 h 04 = Unemployed, ever worker 05 = Unemployed, starter 06 = Inactive; study 07 = Search for work 08 = Inactive; retired, health, etc.				
18.1 Did you decide about work (to work or not and nature of work) on your own? 01 = Yes 02 = No 88 = Don't know 99= Refused	To work or not	Nature of work	To work or not	Nature of work
18.2 How much you agree or disagree that men and women should have equal chances to access to work opportunities? 01 = Agree 02 = Somehow agree 03 = Don't agree				
19. In your household, who is the primary breadwinner? 01 = Husband 02 = Wife 03 = Both parents 04 = Other adult members 05 = Members below 18 years old				
20. Would you roughly estimate the total household monthly income in ILS				
21. According to your perspective, your household belong to which economic class? 01 = Rich (good) 02 = Middle 03 = Poor				
22. Did your income change after the Covid-19 pandemic? 01 = increased 02 = Decreased 03 = No Change				
23. When the family faces certain difficulties managing the household expenses, who decides/prioritize facets of expenditure? 01 = Husband 02 = Wife 03 = Both parents 04 = Other adult members 05 = No one does				
A.04 General health	Adult male		Adult female	
24. Do you have a valid health insurance? 01 = Yes, private 02 = Yes, governmental 03 = Yes, both 04 = No				
25. In general, would you say your health is… 01 = Excellent 02 = Very good 03 = Good 04 = Fair 05 = Poor				
26. In general, do you have certain difficulties or disabilities? 01 = Yes 02 = No.				

26.1 What are the barriers for you to access SRHR? *Tick all that apply, don't read options* 01 = Don't know where to go 02 = Services are not provided to my gender 03 = Getting permission to go (from someone else) 04 = Distance and travel arrangements 05 = Staff attitudes and behaviours 06 = Poor interaction with providers 07 = Facilities are not equipped with the needed resources 08 = medications are not available 09 = Staff not adequately trained 10 = Services are not available in my area 11 = Costs 12 = Family members are not allowing/ supporting it 13 = Not willing to go alone, no one is available to go with me 14 = Quality of services is not good 15 = Concerns about the Gender of the provider 16 = Too Embarrassed to go 17 = Services will not help me/no value of going there 18 = Services are not important 19 = No barriers 20 = Other, specify _____	01		01	
	02		02	
	03		03	
	04		04	
	05		05	
	06		06	
	07		07	
	08		08	
	09		09	
	10		10	
	11		11	
	12		12	
	13		13	
	14		14	
	15		15	
	16		16	
	17		17	
	18		18	
	19		19	
	20		20	
27. Do you think females with disabilities have more accessibility barriers than males with disabilities when seeking SRH services/information**?** 01 = More than males with disabilities 02 = Same 03 = Less than males with disabilities 88 = Don't know	Service	Info	Service	Info
28. Do you think that PWDs (males and females) face more accessibility barriers for seeking SRH services/information than people without disability**?** 01 = More than people without disabilities 02 = Same 03 = Less than people without disabilities 88 = Don't know	Service	Info	Service	Info
28.1 Where do you get the majority of healthcare services including SRHR for yourself? 01 = Governmental PHC 02 = UNRWA PHC 03 = NGO clinic or hospital 04 = MOH Outpatient clinic/hospital 05 = Private sector 06 = others, specify				
29. Before marriage or before first pregnancy, have you attended information sessions about SRHR by a health provider? 01 = Yes 02 = No 03 = I wanted but was unable to go	Before marriage	Before 1st pregnancy	Before marriage	Before 1st pregnancy

Section B: Sexual and reproductive health and rights – Adult married males and females *In this section, some questions address only men or women only. In such case, only the response box that corresponds to the addressed respondent is open while other boxes are blacked.*		
B.01 Marriage and child marriage		
1. Are you and your current/any spouse relatives? 01 = Yes 02 = No		
2. At what age - in years - you have got married for the first time?		
3. To how many wives you are currently married?		

4. Has an intermediary person arranged your marriage? 01 = Yes, a parent 02 = Yes, relative 03 = Yes, Khatba 04 = No				
5. Were you ready to marry or would you have rather waited? 01 = Ready 02 = Rather wait 88 = Don't know 99= No answer				
6. Regarding your marriage, have you been pressured by your family, friends or relative to take this decision? 01 = Yes 02 = No 88= Don't know 99 = Refused				
7. According to your information, is there a minimum legal age below which girls and boys are not allowed to get marry? 01 = No 02 = Yes, what age? Note the age as indicated by respondent	Age girl	Age boy	Age girl	Age boy
8. Do you agree, partially agree or disagree with the following statement: "a woman should decide free of pressure or influences when to marry" 01 = Agree 02 = Somehow agree 03 = Don't agree				
9. Do you agree, partially agree or disagree with the following statement: "a man should be free to decide whether he wants to marry or to remain unmarried" 01 = Agree 02 = Somehow agree 03 = Don't agree				

B.02 Parents experience, information, support and attitudes around puberty including menstruation						
	You	Girls	Boys	You	Girls	Boys
10. According to your best knowledge, what are primary sources of information about puberty and associated body changes for you and younger members at your HH? 01 = Mother 07 = Radio/TV/Films/Videos 02 = Father 08 = Schools/teachers 03 = Brother(s) 09 = Health workers 04 = Sister(s) 10 = Friends 05 = Online sources 11 = Information sessions/NGOs 06 = Books, magazines 12 = Other, specify						
11. Menstruation is a periodic situation at which girls/women have certain needs. Could you name 3 of these needs? *Don't read options aloud* 1- Hygiene supply and sanitary pads 2- More sleep and physical rest 3- More privacy 4- Understanding of psychological situation 5- Pain killers 6- Herbal remedies 7- Good nutrition and drinks 8- Less burden in HH chores 9- I don't know 10- Other, specify _____ 99 = Refused						
11.1 Do men know when a female member at the HH is at menstruation days? 01 = Yes 02 = No 99 = Refused						
11.2 What type of supplies do you use during your period (don't read the list of answers)? 01= Disposable pads 02= Tampon 03= Reusable pad 04= menstrual cup 05= fabric and/or other homemade supplies 99 = Refused						
11.3 Have you ever heard of reusable menstrual hygiene products? 01 = Yes 02 = No 99 = Refused						
11.4 Would you be willing to use reusable pads? 01 = Yes 02 = No 03 = Maybe, with more information						
11.5 Would you be willing to use menstrual cups? 01 = Yes 02 = No 03 = Maybe, with more information						
		Yes	No		Yes	No

12. As a parent or a caregiver, at the menstruation days of a female member in your HH, do you ….? *Read all the statements and record the answers in the corresponding box* 1- Provide pads and sanitary supplies 2- Pain killer/natural remedies if needed 3- Secure hygienic supplies 4- Give priority in using toilets/Bathrooms 5- Acknowledge psychosocial needs 6- Respect privacy 7- Ensure other members don't annoy her 8- Allow her to sleep or rest as she needs 9- Reduce HH chores 10- Provide support 11- Do nothing 12- Blame or played a constraining role specify ---------- 13 = does not apply (no female in adulthood) 99 = Refused	1			1		
	2			2		
	3			3		
	4			4		
	5			5		
	6			6		
	7			7		
	8			8		
	9			9		
	10			10		
	11			11		
	12			12		
	13			13		
12.1 Do you agree, partially agree or disagree with the following statement: "it is important that male members of the family show support to females during their menstruation days" 01 = Agree 02 = Somehow agree 03 = Don't agree						
13. Do you support your wife during the menstruation days (for female does your husband support you during menstruation), such as bring her hygiene supplies, acknowledge and support her psychological needs, etc? 01 = Yes 02= Sometimes 03 = No						

B.03 Preconception counselling, prenatal, antenatal and post-natal care *(Note: All the following questions were drawn from PCBS/UNICEF MICS survey, 2014; WHO meeting proceedings on building consensus around preconception care, 2012 bb3b77_fb72d9e1339b4e44a1c2bd0fdd19bed6.pdf (preparingforlife.net); and experts inputs at the study consultative workshop on 16 Dec, 2020 organized by UNFPA Palestine office)*						
In this section, please take careful attention to address questions to the targeted respondent as instructed	**Male**			**Female**		
14. In some communities, healthcare services include preconception-counselling services, a service for couples contemplating a first or any later pregnancy. Have you ever received preconception counselling services? 01 = Yes 02 = No						
14.1 According to your information, to which degree do men participate at preconception counselling services? 01 = high extent 02 = moderate extent 03 = poor 88= Don't know						
15. What are possible barriers that couples face when seeking preconception **counselling** service. *Tick all that applies* 01 = Not aware of its availability 02 = Services not available for males 03 = Husband disagrees 04 = Family members disagree 05 = Services are not important 06 = Belief in destiny 07 = Staff interactions are not supportive 08 = Quality of services is not good 09 = concerns about the gender of provider 10 = Other, specify _____ 88 = DK	01			01		
	02			02		
	03			03		
	04			04		
	05			05		
	06			06		
	07			07		
	08			08		
	09			09		
	10			10		
Conception/pregnancy						

16. Would you please name some of the early signs of pregnancy you have might heard about or you/your spouse ever experienced? Give 3 examples if possible. *Don't read options aloud.* 01 = Nausea 02 = Vomiting 03 = tender or breast pain 04 = back pain 05 = absence of bleeding/menstruation 06 = other, specify_____		
17. Would you please name some of the signs of **danger** signs of pregnancy you have might heard about or you/your spouse had ever experienced? Give me 3 examples of possible. *Don't read options aloud.* 01 = Bleeding 02 = Abdominal pain 03 = convulsions 04 = respiratory disorder 05 = troubled vision 06 = high fever 07 = other, specify _____		
18. Would you please name one or two of the possible risks associated with pregnancy at early age, female below 19 years old, you have might heard about? *Don't read options aloud.* 01= premature baby 02 = preterm labor 03 = maternal morbidities, 04 = psychosocial risks 05 = other, specify _____		
Questions 19 to 31 are addressed only for respondents with previous or current pregnancy/children **19.** Total number of pregnancies?		
Only for respondents with previous or current pregnancy/children **19.1** Has the husband being ever involved in antenatal care (care during pregnancy)? 01 = Yes, often 02 = Yes, sometimes 03 = No/rarely skip to Q20		
19.2 if yes, how did the husband involve in antenatal care? *Tick that all applies* 01 = Accompanied wives to the clinic 02 = Participated in care sessions 03 = Received counselling session 04 = Others specify ----------	01 02 03 04	01 02 03 04
Only for respondents with previous or current pregnancy/children **20.** Have you (your wife) ever experienced a miscarriage or abortion? 00 = No; go to question 21 or type in the number of times it has ever occurred in the answer box.		
Only if yes in question 20 *20.1* During the unpleasant events (miscarriage or abortion), different couples react differently in these situations. For you case; please indicate the role the husband has played? (*01 = always, 02 = sometimes, 03 = never ..)* a) Assist/facilitate timely healthcare access to the wife b) Provide the wife with better/more food and needs such as supplements and hygiene c) Present when needed, PSS and backing d) Secure financial resources needed e) Take more domestic responsibilities and care of children if needed f) Blame the wife for the miscarriage or abortion g) Did nothing h) Played a constraining role specify ---------- i) Others specify, _____	01 02 03 a. b. c. d. e. f. g. h. i.	01 02 03 a. b. c. d. e. f. g. h. i.
Only for respondents with previous or current pregnancy/children **21.** Have you ever had an unplanned pregnancy? 01 = Yes 02 = No, skip to Q23		

Only for respondents with previous or current pregnancy/children **22.** How was that, was it due to … *read the options to the respondent and record **one** answer only.* 01 = unprotected relation 02 = forgotten dates or failure of rhythm method for contraception 03 = it happened while using contraception method or lactation amenorrhea 04 = Not having access to family planning methods 05 = other, please specify_____ 06 = Don't remember		
Only for respondents with previous or current pregnancy/children **23.** At that time, why did not you use emergency contraceptive? *Don't read options aloud* 01 = No, I don't know it is available 02 = I did not doubt being pregnant for a while 03 = I doubt being pregnant but was unable to use emergency contraceptive against my husband will 04 = I was afraid to go against religious standards if I use it 05 = Tried, but didn't know where to get it 06 = Tried, but the health center didn't have it / wouldn't give it to me 07 = other reasons, specify please _____		
Only for respondents with previous or current pregnancy/children **24.** Have you (husband and or wife) ever been prevented from accessing SRH services at any pregnancy? 01 = Yes 02 = No 99 = Refused		
Only for respondents with previous or current pregnancy/children **25.** Does your husband or other family members restrict or put conditions on your access to ANC care? 01 = Yes, often 02 = Sometimes 03 = No 99 = Refused		
25.1 In case yes, in question 25, who restricts or put condition 01 = Husband 02 = mother-in-law 03 = father-in-law 04 = other family members 05 = others specify, _____		

Ask this question to relevant persons from Q 20 *For 26, 26.1, and 27* Read all the statements aloud and indicate the response as O = Often; F = few times; and N = Never or rarely *Only for respondents with previous or current pregnancy/children* **26.** During unfavourable conditions (difficulty of conceiving), please indicate the role the husband plays? a) Assist/facilitate timely healthcare access to the wife b) Provide the wife with better/more food and needs such as supplements and hygiene c) Present when needed, PSS and backing d) Secure financial resources needed e) Take more domestic responsibilities and care of children if needed f) Does nothing g) Played a constraining role specify ---------- h) Others specify, _____		O	F	N		O	F	N
	a				a			
	b				b			
	c				c			
	d				d			
	e				e			
	f				f			
	g				g			
	h				h			
26.1 in your community, during circumstances that couples may experience (e.g. difficulty of conceiving, SRH issues related to the husband), please indicate the role the wife plays? a) Assist/facilitate timely healthcare access to the husband b) Provide the husband with better/more food and more care c) Present when needed, PSS and backing d) Contribute to securing financial resources needed e) Take some of his responsibilities f) Does nothing g) Played a constraining role specify ----------		O	F	N		O	F	N
	a				a			
	b				b			
	c				c			
	d				d			
	e				e			
	f				f			

h) others, specify_____	g				g			
	h				h			
		O	F	N		O	F	N
Only for respondents who had full term pregnancy/delivery **27.** At giving birth, had the husband a) Assist/facilitate timely healthcare access b) Provide better/more food and needs such as supplements and hygiene c) Present when needed, PSS and backing d) Secure financial resources needed e) Take more domestic responsibilities and care of children if needed f) Provide more support if the new-born is a boy g) did nothing h) Played a constraining role specify ---------- i) others, specify_____	a				a			
	b				b			
	c				c			
	d				d			
	e				e			
	f				f			
	g				g			
	h				h			
	i				i			
Only for respondents who had full term pregnancy/delivery **28.** Husband's support during delivery is/was/would have been highly useful overcoming this situation? 01 = Agree 02 = Sometimes 03 = Don't agree 88 = Don't know								
Only for respondents with previous or current pregnancy/children **29.** Have the couple received/obtained information about breastfeeding? 01 = Yes 02 = No 88 = Don't know								
		O	F	N		O	F	N
Only for respondents with previous or current pregnancy/children **30.** During breastfeeding, the husband contributes through … Read all the statements aloud and indicate the response as O = Often; F = few times; and N = Never or rarely a) Provide better/more food and needs such as supplements and hygiene b) Provide hygiene and supplies items related to BF c) provide PSS support and backing d) Secure financial resources needed e) Take more domestic responsibilities and care of children if needed f) provide more support if the new-born is a boy g) Does nothing h) Played a constraining role specify ---------- i) others specify, _____	a				a			
	b				b			
	c				c			
	d				d			
	e				e			
	f				f			
	e				e			
	g				g			
	h				h			
	i				i			
Only for respondents with previous or current pregnancy/children **31.** Following the last or any previous labor, has you personally ever..? 01 = Yes 02 = No 88 = Don't know		01 Yes	02 No	88 DK		01 Yes	02 No	88 DK
a. Received information about mother hygiene and self-care?	A				A			
b. Received information about maternal danger signs at the period following giving birth (Postnatal weeks)	B				B			
c. Received information about nutrition at the postnatal period	C				C			
d. Received information about child nutrition	D				D			
e. Received information about mother psychological status and needs	E				E			
f. Received/obtained written or audio-visual information about maternal health at postnatal period	F				F			
g. If mothers happen to dispose/receive written educational materials about mother care, did the husband read/watch them.	G				G			
h. At postnatal period, did you feel well supported by your husband.					H			
i. At postnatal period, do you feel you are doing good in supporting your wife	I							
j. Do you feel that attention to mother health is trade-off for the sake of baby care and health	J				J			

k. It is necessary that husbands get aware of how they can support their wives at the postnatal period	K				K			
l. I believe that husband's support contributes to enhanced health status of his wife	L				L			
m. I believe that postnatal care is women's business	M				M			
Only for respondents with previous or current pregnancy/children **31.1** Has the husband ever been involved in any Postnatal care sessions at home or health facility 01 = Yes 02 = No 88= Don't know								

B.04 Family planning and use of contraceptives and STIs						
32. Ever attended session/received information from healthcare or social workers on FP and/or STIs prevention counselling service?		Yes	No		Yes	No
	FP			FP		
	STI			STI		
33. Have you ever heard of any methods to delay, space or avoid getting pregnant? 01 = yes 02 = No						
33.1 What methods have you heard of? Write down in response boxes all that apply indicated by the respondent. *Do not read list aloud*. 01 = Female sterilization 02 = Male sterilization 03 = IUD 04 = Injectable 05 = Implants 06 = Pill 07 = Male condom 08 = Female condom 09 = Emergency contraception 10 = Standard days method / rhythm Periodic abstinence 11 = Lactation amenorrhea (frequent breastfeeding) 12 = Withdrawal 13 = Diaphragm/Foam/Jelly 99 = Refused 88 = Don' t know						
33.2 Are you currently using any contraceptive method? 01 = Yes, which _____ 02 = No 88 = Don't know 99=Refused						
Only for respondents with previous or current pregnancy/children **34.** When you first used any contraception method? 01 = Before first pregnancy 02 = After the xth (____) pregnancy, define # 03 = haven't used it yet						
35. I know where from to obtain and get information about the correct use of the contraception method I or my spouse select to use 01 = Yes 02 = Not sure 03 = No 99 = Refused						
36. We decide together about our FP aspects such as timing of pregnancy 01 = Yes 02 = sometimes 03 = No 99 = Refused						
36.1 We decide together about our FP aspects such as and total number of children 01 = Yes 02 = Sometimes 03 = No 99 = Refused						
36.2 We decide together about FP method we will use 01 = Yes 02 = Sometimes 03 = No 99 = Refused						
37. I believe that wives should uphold the entire responsibility of using female contraception. 01 = Yes 02 = No 88 = No opinion 99 = Refused						
38. In your opinion, what are the most important barriers that prevent a married couple from using appropriate contraceptive methods? *Don't read options aloud and ask the respondent to name as many as s/he thinks about*						
01 = Previously used them but failed 02 = Fear from side effects 03 = Low availability 04 = High cost 05 = Doubts about religious opinions 06 = Low quality of FP services, bad treatment or negative attitudes from providers 07 = Cultural norms, just used not to plan it 10 = Fear from being criticized by other family members 11 = Still want more children 12 = Poor FP counselling service 13 = Already have girls but want to have boys or more boys 14 = More offspring means more power and better social status of						

08 = Faith, cannot go against God will 09 = Fear that husband punish me 88 = Don't know 99 = Refused	the extended family so more is better 15 = Women cannot decide on their own due to husband's or in laws control/influence 16 = Other, specify _____				
38.1 Have you ever prohibited from using family planning method, you wanted to use? 01 = Yes, many times 02 = Yes, few times 03 = No, skip to Q39					
38.2 Who prohibited you from using family planning methods? 01 = Husband 02 = mother-in-law 03 = father-in-law 04 = other family members 05 = others specify, _____					
39. Have you heard about the STI before? 01 = Yes 02 = No, skip to Q40					
39.1 Like what? Name any one you know please *don't read options aloud* 01 = HIV/AIDS 03 = Gonorrhoea 02 = Chlamydia 04 = Herpes 05 = Syphilis 06 = HPV 07 = HBV 08 = other, specify _____					
39.2 Have/do you experienced and/or treated for STI in the last 12 months? 01 = Yes, once only 02 = Yes, more than 2 times 03 = No, skip to 39.4 88 = Don't know, skip to 39.4 99 = Refuse, skip to 39.4					
39.3 If yes, did you seek health services anywhere including a community pharmacy? 01 = Yes 02 = No					
39.4 How much you agree or disagree that its women's responsibility to ensure preventing STI 01 = Agree 02 = Somehow agree 03 = Don't agree					
40. This is general question about the moments at which women experience some insecurities or bad mood due to hormonal or psychological influences. Would you give names or examples about such moments *don't read options aloud and ask the respondent to name as many as s/he thinks of* 01 = During the menstrual period - Bleeding stage 02 = A few days before monthly menstrual cycle 03 = When she is pregnant 04 = Postpartum phase 05 = During hormonal treatment 06 = At the menopause 07 = Other, specify _____					

B.06 Comprehensive sexuality education and influence of social media *(Note: questions in this section are drawn from the international technical guidance on sexuality education, UNESCO, 2018 and the expert input at the study consultative workshop on 16 Dec 2020 organized by UNFPA Palestine office)*		
According to the research done by UN agencies and INGOs active in healthcare and education, lack of accurate reliable information about SRHR increases the chances for risk taking behaviors such as unsafe abortion, STIs, childbearing at young age, etc. Young people are specially affected by lack of information. In this section, we would discuss the ways that SRHR information can be appropriately communicated to different groups of people.		
41. Do you think adolescents at your household have appropriate information about SRHR? 01 = Agree 02 = somehow agree 03 = don't agree 88 = DK	Boys = [___|___] Girls = [___|___]	Boys = [___|___] Girls = [___|___]
42. According to you, at what age adolescents should start receiving information about sexuality and reproductive health?	Boys = [___|___] Girls = [___|___]	Boys = [___|___] Girls = [___|___]

43. Among this list, what are the possible concerns which may make parents hesitant about CSE at young age? Indicate the responses as A = Agree B = Somehow agree C = Don't agree 01 = CSE is social taboo, parents won't want to go against prevailed norms. 02 = Concerns about age appropriateness of the contents. 03 = Concerns about gender appropriateness of the contents. 04 = Early exposure to such information is risky. 05 = Girls should not be taught about CSE but it is possible for boys. 06 = It will be okay if CSE presented in appropriate way that respects religion and positive cultural values. 07 = Parents may doubt the competencies/motives of educators. 08 = Parents don't really think that CSE is needed at young age.		A	B	C		A	B	C
	01				01			
	02				02			
	03				03			
	04				04			
	05				05			
	06				06			
	07				07			
	08				08			
44. Assuming that parents are assured about the content and competencies of CSE providers, would they like to have their children learn about CSE at young age? 01 = Yes, sure 02 = Maybe, not sure 03 = No, I don't think so 88 = Don't know								
45. To which degree you are open/willing/may take the initiative to discuss SRHR topics with male adolescents "AM" and to female adolescents "AF" at your family? 01 = Very open 02 = Somehow open 03 = Hesitant 04 = Not open	With AM		With AF		With AM		With AF	

B.07 Access and quality of SRHR including influence of provider attitudes

In this section, I will ask quick questions about your evaluation to the accessibility and quality of SRH service you might have received. May you please indicate your views as

00 = I don't know **01 = very bad, not satisfied at all** **02 = Bad, Unsatisfied** **03 = text, neutral** **04 = Very good, satisfied** **05 = Excellent or very satisfied**

46. Availability of services for females		
47. Availability of services for males		
48. Distance of nearest healthcare facility		
49. Time spent and waiting time at the healthcare facility		
50. Contact time with provider		
51. Respect by service providers		
52. Privacy, confidentiality and trust of medical professionals		
53. Availability of comprehensive SRH services in the same place		
54. Quality and safety of services		
55. Availability of medications or materials (like FP methods)		
56. Availability of appropriate counselling service		
57. affordability of services		
58. Technical skills of the available staff		
59. Infrastructure and amenities (toilet, water, space)		
60. Equity, non-discriminatory practices of service providers		
61. Your overall evaluation of service		

B.08 Special issue; healthy sexuality for aging

In this section, please indicate the responses as 01 = Agree 02 = somehow agree 03 = don't agree 88 = DK

62. I think that husbands usually consider the emerging needs of their wives at the menopause		
63. I believe that the menopause is the end of women SRHR life		
64. I understand that husband think of second marriage when his wife reaches the menopause		
65. In my community there are specifically services for women at menopause		
66. In my community there are specifically services for elderly males with SRH issues		
B.09 GEM (Gender Equitable Men) scale for generic gender perspective towards SRHR	**Adult male**	**Adult female**
67. For the following statements[10], *ask the respondent to define his/her view and record the answer* *01 = Strongly agree 02 = Somehow agree 03 = Don't agree*		
1. Woman's most important role is to take care of her home and cook		
2. There are times when a woman deserves to be beaten		
3. Changing diapers, giving kids a bath & feeding kids are mother's responsibility.		
4. It is a woman's responsibility to avoid getting pregnant		
5. A man should have the final word about decisions in his home		
6. A woman should tolerate violence in order to keep her family together		
7. A man and a woman should decide together what type of contraceptive to use		
8. To be a man, you need to be tough		
9. The participation of the father is important in raising children		
10. It's important for men to have friends to talk about his problems		
11. Couple should decide together if they want to have children		

Section C: Childrearing and childcare roles – Adult males and adult females

Questions in this section are designed based on PCBS time allocation from gender perspective and MICS indicators, WHO and UNICEF framework for monitoring and evaluation of interventions; 2010, and ECD baseline assessment in the Gaza Strip, ANERA; 2013

C.1 Time allocation and care	**Adult male**		**Adult female**	
1. I take part of the vaccination of the little children 01 = Yes, always 02 = To some extent 03 = Not really 99 = Refuse 88 = NA				
1.1 I take part of the and the routine health check-up/ treatment of the little children	Well baby session		Well baby session	
	Sick child services		Sick child services	
2. Would you please roughly describe how your time is spent in a typical day, how much time -in hours- do you spend doing the following activities *(Note: This question is adapted from PCBS use of time by HH members 10 years old and above from gender perspective, 2017)*				
a. Domestic chores and housekeeping including cooking for the family and shopping for the household (Unpaid work)	[___|___]		[___|___]	
b. Watching TV, reading books or other entertainment time.	[___|___]		[___|___]	
c. Surfing social media outlets or telecommunication with others.	[___|___]		[___|___]	
d. Childcare including feeding, hygiene, dressing them up, helping homework, seeking healthcare, and playing with them (Unpaid work)	[___|___]		[___|___]	
e. Taking care of other family members such as PwD or old age (Unpaid work)	[___|___]		[___|___]	

[10] Items 1 to 20 are selected from the GEM scale (2008). Coding and weight from UN women article 1 tool

C.2 Parenting skills and childcare.		
3. I am pretty sure that I know how to get my child to smile 01 = Yes 02 = maybe 03 = No		
4. It is okay to leave a child below 3 years old alone for a few hours with his/her 10 years old sister or brother. 01 = Agree 02 = somehow agree 03 = don't agree		
5. Do you contribute to taking care of little children below 3 years including feeding milk and other food and taking care of his/her hygiene 01 = Yes, always 02 = Yes, few 03 = No		
6. Father and adult males should have a good share of childcare, what do you think about that? 01 = Agree 02 = somehow agree 03 = don't agree		
7. It is no way children stop misbehaving without physical punishment? 01 = Agree 02 = somehow agree 03 = don't agree		
8. How often do you use physical methods such as hitting or beating children below 14 years as disciplinary measures? 01 = Many 02 = Few 03 = Seldom/None		
9. How often do you use psychological methods such as yelling or scolding children below 14 years as disciplinary measures? 01 = Many 02 = Few 03 = Seldom/None		
10. How often do you use non-violent methods such as incentives, encouragement and motivation (positive disciplinary measures) with your children? 01 = Many 02 = Few 03 = Seldom/None		
11. On average, how often during one week (number of times per week) do you….		
a. Read book, story, looked at pictures for the child(ren)		
b. Acknowledge his/her positive behaviors or provide incentives when disciplining him/her?		
c. Told stories or sang songs for your child/ren		
d. Took them outside the house for a walk or playing		
e. Played with the child/ren inside the house		
12. I think that mothers are the ones blamed for any misconduct of their children 01 = Agree 02 = somehow agree 03 = don't agree		
13. I think that the mother's role in raising <u>male</u> children is more important than the father's role. 01 = Agree 02 = somehow agree 03 = don't agree		
14. I think that father's role in raising <u>male</u> children is more important than mother's role. 01 = Agree 02 = somehow agree 03 = don't agree		
15. I believe that parents should teach their sons that good man is caring rather than aggressive 01 = Agree 02 = somehow agree 03 = don't agree		
16. Has the outspread of Corona virus influenced your role in childcare? 01 = Yes, increased 02 = yes, decreased 03 = No change		
17. During Corona outspread, I think that boys should be protected more than girls 01 = Agree 02 = somehow agree 03 = don't agree		

B.10 Domestic, partner, healthcare provider violence, protection and underlying norms *For this entire section, please indicate the responses as 01 = Yes, 02 = No unless otherwise indicated*		
18. Have you ever denied accessing any service related to SRHR by your husband Indicate services ever denied	[redacted]	----------

19. Do you think that SR healthcare providers expect -even if they do not declare it- that women agree with the decision of their husbands.		
20. Have you noticed that when your husband accompanies you, healthcare providers treat you in a more respectful manner?	[redacted]	
20.1 Did you or a man you know felt embarrassed when visited SRH facility alone in the last 12 months		
20.2 Have you or a man you know been maltreated or mocked when visited SRH facility alone in the last 12 months		
20.3 Have you or a man you know been maltreated or embarrassed when visited SRH facility along with his wife or female family member in the last 12 months		
20.4 Have you or a man you know been turned away back home without receiving the services he came to receive by a service provider when he visited SRH facility along with his wife or female family member in the last 12 months		
21. Did you learn in the last 12 months about a friend or a relative who were humiliated by her husband after giving birth of a baby girl		
22. Have you been pressured by your parents to accept maltreatment from your husband or in laws?	[redacted]	
23. I think that parents should approve that a brother discipline his sister even if she is same age or older than him		
24. In the last year, did a healthcare provider asked your husband to leave the room to give you more freedom to express your SRHR needs?	[redacted]	
25. If your husband accompanies you, you feel unable to express your needs or will about your SRHR and services.		
26. I think that the myth/common belief that girl's burden is a life course burden inherit daughter a sense of submissiveness		
27. I believe that unmarried girls don't need to attend sessions on SRHR.		
28. In my community it is not acceptable that invasive examination procedure is performed to unmarried girl even if her medical condition necessities that.		
29. In our region, studies show that men participation in SRHR is limited,how much you agree with that 01 = Agree 02 = Somewhat agree 03 = Don't agree, skip to Q31		

29.1 Some reasons may make men reluctant about SRHR services, in your opinion, what are possible reasons why men and youth males don't actively participate in SRHR? *Tick all that apply*

	Male responses		**Female responses**	
01 = Lack of awareness about the importance of men involvement	01		01	
02 = Shyness, shame and embarrassment	02		02	
03 = The perception that SRH is more a women business	03		03	
04 = Don't know about the existence of SRH services for men	04		04	
05 = SRH Services don't target them/exclude them	05		05	
06 = Health providers don't engage them	06		06	
07 = Health providers are not trained to serve men	07		07	
08 = Most SRH providers are women (gender of provider)	08		08	
09 = Physical space at health facility is not appropriate	09		09	
10 = Due to their own perceptions about masculinity	10		10	
11 = Fear of being stigmatized by the community	11		11	
12 = Fear of being stigmatized by parents/in laws	12		12	
13 = Personal characteristics like limited education	13		13	
14 = Other, specify _____	14		14	

30. According to your knowledge, who among men are the most likely in your community to participate in SRH activities? *Ask the respondent to name as many as categories s/he might think of*

		Male		Female	
01 = Educated	12 = Camp residents				
02 = Non-educated	13 = Residents of big cities				
03 = Lived abroad/outside Gaza	14 = Residents of rural areas				
04 = Older	15 = Working				

05 = Younger 06 = Refugees 07 = Non refugees 08 = Living in nuclear family 09 = Living in extended family 10 = Poor 11 = Rich 24 = Others named by male, who_____	16 = Not working 17 = Conservative families 18 = Liberal families 19 = males from FHH 20 = males from MHH 21 = Married to relatives 22 = Married 23 = Unmarried 25 = Others named by female, who _____				

31. The literature points that sometimes in certain contexts, men impose pressure on women and restrict their access to SRHS. How you agree with that?
01 = Agree 02 = Somewhat agree 03 = Don't agree, skip to Q33

31.1 Why you think men and boys impose social pressure on girls and women to restrict their accessibility to SRHR service and information? *Ask the respondent to name as many as reason s/he might think of*

		Male		Female	
01 = Due to their own perceptions about masculinity 02 = Social norms 03 = Influence of extended family 04 = Lack of resources 05 = Not appreciating services 06 = Not trusting services 07 = Feeling jealous 08 = Beliefs that women should not leave their houses unless being accompanied 09 = Protecting family honor 10 = Due to their own gender orientation	11 = Lack of safety in the community 12 = No one is available to take care of children 13 = Girls don't need services 14 = There are information sources available from in laws 15 = Fear that women use this to justify going out for un-needed services (laying to go out). 16 = Others by male _____ 17 = Others by female _____				

32. The literature shows that men are not active in participation in child rearing activities. How much do you agree with that?
01 = Agree 02 = Somewhat agree 03 = Don't agree, skip to Q34

32.1 Why men don't actively participate in child rearing activities? *Ask the respondent to name as many as reason s/he might think of*

		Male		Female	
01 = Their perception about masculinity 02 = Shyness and embarrassment 03 = Influence of extended family 04 = Fear of being stigmatized by the community 05 = Fear of being stigmatized by parents or in laws 06 = Personal characteristics like limited education 07 = Not experienced to take a part 08 = It is mothers' business 09 = There are other females in the HH to do that	10 = Mothers prevent them from doing that 11 = Lack of awareness about the importance of participation 12 = Busy in work outside the HH 13 = Never trained on that 14 = Having many children 15 = Tired 16 = Impatient like mothers 17 = Fear for their image in front of children 18 = Others by male _____ 19 = Others by female _____				

33. Which among the SRH components men are usually less engaged with or less supportive to in the community? *Read options and tick all that apply Yes = more or high participation and No = Less or low participation*

		Male responses						Female responses					
01 = Family planning 02 = Fertility care 03 = Infertility care 04 = Abortion 05 = PCC 06 = ANC 07 = NC 08 = PNC	09 = Child health 10 = STIs 11 = Sexual dysfunction 12 = GBV 13 = Counselling service in general 14 = Adolescents' health needs	[redacted]	Yes	No	[redacted]	Yes	No	[redacted]	Yes	No	[redacted]	Yes	No
		01			08			01			08		
		02			09			02			09		
		03			10			03			10		
		04			11			04			11		
		05			12			05			12		
		06			13			06			13		
		07			14			07			14		

34. What can be done to increase men participation or support to SRHR activities and childrearing activities? ***01 = Yes 02 = No***		
	Male	Female
a. Approach young married men at homes to communicate SRHR and CR information		
b. Distribution of information kits such as booklets and flyers about men role in SRHR and CR		
c. Initiate a mobile application for SRHR and CR information and FQA		
d. Sending text messages with SRHR and CR content to their mobile numbers		
e. Sending materials using social media outlets with SRHR and CR content to fathers		
f. Reduce the family contribution in consultation fees of cost of medication at MOH facilities if men and youth male present at SRHR visits		
g. Introduce mandatory classes for youth males and female contemplating marriage as a condition for obtaining the marriage certificate 'similar to thalassemia test'		
h. Add SRHR at school curricula for boys and girls at high schools (extra to what is being provided)		
i. Introduce mandatory classes at university such as one week each year to receive information about SRHR and CR at the university		
j. Launch one-week paid community work for all male and female youth 19-30 years old where they do services related to SRHR and CR at PHC in governmental, UNRWA and NGO healthcare facilities and at the community level		
k. Combine the first vaccination visits of newborn babies with 30-minute SRHR and CR counselling sessions for their fathers		
l. Provide incentives in the form of milk and diapers for new fathers who attend certain number of SRHR and CR sessions		
m. Introduce one mandatory SRHR and CR session to obtain the birth registration certificate of newborn		
n. Launch out awareness strategy about the importance of involving men in SRHR and CR using mass media, TV and radio		
o. Incorporate health education messages related to SRHR and CR into the health education programmes at service delivery points		
P. Introduce one mandatory SRHR and CR session prior to school registration of a child at first primary grade if first child or the last child registered before more than two years		
34.1 We appreciate any other suggestion you might have, *Please add any input the respondent likes to share and indicate the inputs come from the male, female or both respondents*		

End of the adults' survey.

Thank the respondent and fill in the necessary data in the questionnaire cover sheet.

Younger males and females Survey

For adolescents 18 years and above, get the consent of the participant using the explanatory letter at the beginning of the document (no need for guardian consent). For children under 18, get the approval of guardian first and then the approval of the child-both should agree that you talk to the adolescent.

Section A: Socio-demographic, general health and education characteristics – Younger males and females members aged 15 years up to 19 if available at the HH		
Dear Participant, I would like to remind you that this survey is confidential, and your answers will only be shared with the research team. We are asking this information to help gain understanding about the issues facing adolescents in your community. Now, I would like to ask you some questions. Please remember that we can skip any questions that make you feel uncomfortable.		
A.01 Socio-demographic characteristics		
1. Sex of the respondent	□ Male	□ Female
2. Respondent age in years	[___|___]	[___|___]
3. In some communities, child marriage is not rare especially among girls, therefore I would like to ask some questions about marriage, even if these might be sensitive for some people. **Marital status, are you currently ……** 01 = married 02 = Divorced 03 = Separated 04 = Widowed 05 = Never married, skip to 4 06 = Engaged or marriage certificate but not yet married, skip to Q4		
3.1 Have you (or your wife) ever got pregnant? -*ask for ever married only* 01 = Yes, # of pregnancies 02 = No never		
4. What is the ideal number of girls and boys in the family according to your opinion?	Boys = [____] Girls = [____]	Boys = [____] Girls = [____]
4.1 Family size, how many people live together in this family?		
4.2 Are you..... 01 = Refugee 02 = non-Refugee		
4.3 Do you live in ... 01 = Camp 02 = Outside Camp 03 = Access Restricted Areas		
A.02 Education and ICT		
5. If you are enrolled in education, at which year/level are you? 01 = Not currently enrolled 02 = Yes, enrolled at …. Indicate the response in the box		
5.1 What is the highest/last grade you have completed 00= None, otherwise indicate the number of last school grade completed		
5.2 What is the highest level of education a father has received?		
5.3 What is the highest level of education the mother has received?		
6. Do you have personal accounts on social media outlets? 01 = Yes, number: ….. 02 = No, skip to Q7 99 = Refused, skip to Q7	[___|___]	[___|___]
6.1 If yes, indicate the platform you are using *(tick all that apply)* 01 = WhatsApp 02 = Facebook 03 = Instagram 04 = Telegram 05 = TikTok 06 = Snapchat 07 = Other, specify _____		
7. Do you have PC/laptop available for you anytime? 01 = Yes personal 02 = yes, for the use of HH members 03 = No	[___|___]	[___|___]
8. Do you have a personal smartphone and/or tablet? 01 = Yes 02 = No	[___|___]	[___|___]
9. Does your IT knowledge is enough to carry out the functions you like?	[___|___]	[___|___]

01 = Yes 02 = Somehow 03 = No		
A.03 Work status and economic conditions		
10. Do you currently work for pay? 01 = Yes 02 = No		
10.1 Estimate of the monthly income of the family approximately in shekels from all sources		
11. When your family or families around you face certain difficulties managing the household expenses, who decides/prioritize facets of expenditure? 01= Father 02 = Mother 03 = Both parents 04 = Others, who _____ 88 = DK 99= Refused		
A.04 General health		
12. In general, would you say your health is … 01 = Excellent 02 = Very good 03 = Good 04 = Fair 05 = Poor		
13. Do you have certain difficulties or disabilities? 01 = Yes 02 = No 99 = Refused		
Section B: KAP on SRHR among younger cohort		
B.01 Marriage and child marriage		
1. What is the minimum legal age –in years- for boys/girls' marriage? 88 = DK, otherwise, note the response in years	Boys = [____] Girls = [____]	Boys = [____] Girls = [____]
1.1 What is the age below which boys/girls should not get marry according to your opinion? 01 = No minimum age, otherwise, indicate the response in years	Boys = [____] Girls = [____]	Boys = [____] Girls = [____]
1.2 What about you, you may consider marriage at what age? -for not married only		
2. This question is agree / disagree - Families and relatives should not put any pressure or influences on boys or girls regarding when or whom to marry. 01 = Agree 02 = Somehow agree 03 = Don't agree	Boys = [____] Girls = [____]	Boys = [____] Girls = [____]
3. This question is agree / disagree - Females who decide to remain unmarried should not suffer any social blame, stigma, or mocking. 01 = Agree 02 = Somehow agree 03 = Don't agree	Boys = [____] Girls = [____]	Boys = [____] Girls = [____]
B.02 Adolescent KAP around puberty including menstruation		
4. Have you attended sessions or received information at schools, healthcare facilities or NGO about puberty, this includes body composition of boys and girls, physical and psychological changes, signs of puberty for girls and boys, etc.? 01 = Yes 02 = No 88 = DK 99 = Refused		
5. What are your primary sources of information about puberty and associated body changes for boys and girls? ***Don't read the answers, select everything that applies*** 01 = Mother 02 = Father 03 = Brother(s) 04 = Sister(s) 05 = Other family members 06 = Friends 07 = Schools/counselors 08 = Health workers 09 = Sessions at youth program 10 = Radio/TV/Films/Videos 11 = Books, magazines 12 = Internet 13 = Social media 14 = Other, specify: _____ 99 = Refused		
6. Do you know what SRHR means in general?		

01 = Yes 02 = No, skip to question 7			
6.1 If yes, what is included in reproductive health, sexuality and rights ***(choose all that applies, do not read the options)***			
01 = PCC 02 = ANC 03 = NC 04 = PNC and child care 05 = FP (modern contraceptives) 06 = prevention and management of HIV and other sexually transmitted infections 07 = Early detection of the most important cancers in women, especially (cervical cancer - breast cancer) 08 = Post-Abortion Care Services 09 = Premarital Medical Examination	10 = menopause care 11 = adolescent/youth health 12 = Addressing issues of sexual and gender-based violence 13 = Information, advice and services related to fertility and infertility 14 = information, advice and services on sexual health and wellness 15 = other, select		
7. Do you know what SRHR means for **men** in particular? 01 = Yes 02 = No, skip to question 8			
7.1 If yes, what is included in reproductive health, sexuality and rights **for men** in particular ***(choose all that applies, do not read the options)*** 01 = Information and Consulting 02 = need for contraception 03 = prevention and treatment of HIV and other (STIs) 04 = sexual dysfunction 05 = Infertility 06 = male reproductive health related cancer 07 = other, select			
8. Who is your most trusted person to talk to about SRH issues?			
9. At what age you have had your first menstrual cycle "menarche"?		[redacted]	
9.1 What type of supplies do you use during your period (don't read the list of answers)? 01= Disposable pads 02= Tampon 03= Reusable pad 04= menstrual cup 05= fabric and/or other homemade supplies 99 = Refused		[redacted]	
9.2 Have you ever heard of reusable menstrual hygiene products? 01 = Yes 02 = No 99 = Refused		[redacted]	
9.3 Would you be willing to use reusable pads? 01 = Yes 02 = No 03 = Maybe, with more information		[redacted]	
9.4 Would you be willing to use menstrual cups? 01 = Yes 02 = No 03 = Maybe, with more information		[redacted]	
10. Have you experienced any sort of anxiety at menarche due to insufficient information? 01 = Yes 02 = No 99 = Refused		[redacted]	
11. Do you think boys should receive information about menstruation and puberty about girls and how it affects girls 01 = Yes 02 = No 88= Don't know			
12. It is important that girls have some knowledge about puberty relevant changes for boys 01 = Yes 02 = No 88= Don't know			
13. How much you agree, partially agree or disagree, in your community that never married girls who need invasive gynaecological services married are denied access to these services 01 = Agree 2 = somewhat agree 03 = don't agree			

14. If you happen to get confused about certain issues related to puberty, how easy for you to approach … for advice? 01= Very difficult 02 = Difficult 03 =Possible 04 = Easy 05 = Very easy	a- Mom		a- Mom	
	b- Dad		b- Dad	
	c-Health centre		c-Health centre	
	d-School counselor		d-School counselor	
	e-others specify		e-others specify	
15. At the menstruation days, do you have what you need of: 1- Sanitary pads and personal hygiene supplies 2- Pain killer 3- Natural remedies 4- You feel your emotional needs are respected 5- Your privacy is respected 6- You do less HH chores or rest if needed 7- Emotional Support 8- Others, specify _____	[redacted]			

	Yes	No
1		
2		
3		
4		
5		
6		
7		
8		

16. How much you agree or disagree with the statement, it is important that male members of the family show support to females during their menstruation days, what do you think about that? 01 = Agree 02 = Somehow agree 03 = Don't agree		
17. Who need to learn more about puberty issues in your opinion? 01 = Girls 02 = Boys 03 = Equally both 88 = Don't know		
18. To which extent are you satisfied versus not satisfied about the comprehensiveness and convenience of the information you acquired from any/all sources about puberty and associated changes? 01 =Very satisfied 02 = Satisfied 03 = neutral 04 = Unsatisfied 05 = Not satisfied at all		
B.03 Pre-marriage counselling		
19. Pre-marital counselling is a service composed of assessment of partners' expectations around future essential issues. Counselling aims at putting prospectus couple in agreement/awareness about these expectations to increase the likelihood of successful future marriage. Are you aware of any provider who offer pre-marriage counselling service in your community? 01 = Yes, Who? _____ 02 = No		
20. What may prevent you from accessing such services? *3 choices* 01 = I don't need it 02 = If I propose that to my fiancé s/he will mostly refuse 03 = I will consult my family about the bride/groom and that is enough 04 = I don't think going there will be useful 05 = It is embarrassing to ask for such service 06 = I never heard about it, it is not available 07 = Other, specify: _____		

21. Who in your Community usually decides on when to have children?
01 = Husband 02 = wife 03 = both 04 = mother in-law

22. Do you agree with this norm?
01 = Yes 02 = no

B.04 Family planning and use of contraceptives and STIs

23. Are you aware of possible risks of pregnancy at early age?
01 = Yes, give an example please: _____
02 = No

24. Have you ever heard of any methods to delay, space, or avoid getting pregnant?
01 = yes 02 = No

25. What methods have you heard of? Write down in response boxes all that apply indicated by the respondent. *Do not read list aloud.*

01 = Female sterilization
02 = Male sterilization
03 = IUD
04 = Injectable
05 = Implants
06 = Pill
07 = Male condom
08 = Female condom
09 = Emergency contraception
10 = Rhythm or Periodic abstinence
11 = Lactation amenorrhea (breastfeeding)
12 = Withdrawal
13 = Diaphragm/Foam/Jelly
88 = DK
99 = Refused

26. Have you heard about the STI before?
01 = Yes 02 = No, Skip to 30

27 Like what? *Do not read list aloud.*
01 = HIV/AIDS
02 = Chlamydia
05 = Syphilis
07 = HBV
03 = Gonorrhea
04 = Herpes
06 = HPV
08 = Other, specify: _____

28. Who is the responsible for prevention of STI in your opinion?
01 = Wife 02 = Husband 03 = Both 88 = DK

29. Regarding STIs, what do you think about the accuracy of the following statements;
01 = Are transmitted only through reproductive organs, for example oral sex does not cause infection.
02 = Can be transmitted from mother to baby
03 = The majority are asymptomatic and therefore require periodic medical examination
04 = Can cause serious consequences for couples and babies such as infertility, blindness, and maybe death
05 = Although not all STI can be prevented, the use of condom does reduce many of them

	01 Yes	02 No	88 DK		01 Yes	02 No	88 DK
1				1			
2				2			
3				3			
4				4			
5				5			

B.05 Comprehensive SRHR education and influence of social media
(Note: questions in this section are drawn from the international technical guidance on sexuality education, UNESCO, 2018 and the expert input at the study consultative workshop on 16 Dec 2020 organized by UNFPA Palestine office)
CSE is the pedagogy concerned by safe and appropriate information about sexual health, relationships, STIs prevention, etc.

30. Have you received information about sexual health either at home by parents, at schools, or healthcare facilities?
01 = Yes 02 =No

31. Would you like to see CSE in the school curricula?

01 = Yes 02 =No 88 = DK					
31.1 What is the appropriate age for introducing CSE at schools? At which grade? *Ask the respondent to define grade and note the response as number*	Grade:..... . Age:..... .			Grade:..... . Age:..... .	
32. Regarding to digital sources, what is/are the most visited or consulted outlets? ***Don't read options***	01			01	
	02			02	
01 = YouTube 02 = Social media Tik Tok	03			03	
03 = Vlogs and films 04 = Social media Twitter	04			04	
05 = Social media pages on FB 06 = Social media, Flicker	05			05	
07 = Social media on Instagram 08 = Social media on WhatsApp	06			06	
09 = NGO Youth platform 10 = Broadcast	07			07	
11 = Blogs and official webpages governmental, UN, NGO sites 12 = Other, specify: ----------	08			08	
	09			09	
	10			10	
	11			11	
	12			12	
33. Do you learn about the existence of social media influencers, those who promote topics such as healthy relationships, human development and life coaching and many other topics. Have you heard/know some names or accounts talking about sexual health? 01 = No 02 = Yes					
33.1 Do you think their role is … 01 = Very important but negative 02 = V important and positive 03 = Somehow important/-- 04 = Somehow important/+ 05 = Not important 06 = Don't know					
34. Which are the topics you wanted or still want to learn about regarding SRHR? *Tick all that apply* 01 = Puberty, body composition and reproductive organs, hormonal changes and self-care practices. 02 = Relationships between males and females and gender related roles 03 = Prevention and protection from gender-based violence 04 = Prevention of undesired pregnancies and STIs 05 = Other, specify _____	Item	Yes		Item	Yes
	01			01	
	02			02	
	03			03	
	04			04	
	05			05	
35. What are the possible concerns that may make you or people at your age hesitant about CSE? Indicate the responses as Yes/No for each statement (01 = Yes, 02 = No) 01 = CSE is against our social norms and religion. 02 = I will feel embarrassed talking about SH in groups. 03 = It is early for me and people at my age to join CSE classes 04 = Girls should be taught about CSE but boys are already knowledgeable. 05 = School teachers themselves have no appropriate information 06 = Parents may get upset because they don't recognize its importance 07 = Teachers do not respect our confidentiality. 08 = Fear of being stigmatized or mocked by friends. 09 = CSE is imported from western communities and not made for us. 10 = Others, Specify _____	01			01	
	02			02	
	03			03	
	04			04	
	05			05	
	06			06	
	07			07	
	08			08	
	09			09	
	10			10	

36. B.06 GEM scale selected items 01 = Strongly agree 02 = Somehow agree 03 = Don't agree	Male	Female
1. Woman's most important role is to take care of her home and cook		
2. There are times when a woman deserves to be beaten		
3. Changing diapers, giving kids a bath & feeding kids are mother's responsibility.		
4. It is a woman's responsibility to avoid getting pregnant		
5. A man should have the final word about decisions in his home		
6. A woman should tolerate violence in order to keep her family together		
7. A man and a woman should decide together what type of contraceptive to use		
8. To be a man, you need to be tough		
9. The participation of the father is important in raising children		
10. It's important for men to have friends to talk about his problems		
11. Couple should decide together if they want to have children		

Section C: Time allocation and domestic roles – younger cohort

Questions in this section are designed based on PCBS time allocation from gender perspective, MICS indicators and GERNDER SCALE

C.1 Time allocation and care	**Male**	**Female**
1. Would you please roughly describe how your time is spent in a typical day, how much time -in hours- do you spend doing the following activities (0 – 24 Hours)		
a. Domestic chores and housekeeping including cooking for the family and shopping for the household	[__|__]	[__|__]
b. Watching TV, reading books or other entertainment time.	[__|__]	[__|__]
c. Surfing social media outlets or telecommunication with others.	[__|__]	[__|__]
d. Childcare including feeding, hygiene, dressing them up, helping homework, seeking healthcare, and playing with them	[__|__]	[__|__]
e. Taking care of other family members such as PwD or old age	[__|__]	[__|__]
For Q from 2 to 18 how much you agree, somewhat agree or disagree with the following questions, please use 01 = Agree 02 = Somehow agree 03 = Don't agree		
2. Men and women should have equal opportunities to study and to attain any education level they want?		
3. Men and women should have equal opportunities to work for pay inside or outside the house?		
4. Men and women should share the domestic chores?		
5. It is no way children stop misbehaving without physical punishment		
6. I think SRHR education are essential for boys and girls since young age		
7. I believe that parents should not allow girls to receive CSE at young age to protect them		
8. I believe that parents should not allow boys to receive CSE at young age to protect them		
9. I think people should consider conflict between married as private matter and don't intervene even if violence happens		
10. I believe that when couples give birth to a baby girl, it is normal that mothers are the ones to be blamed.		

11. Personally, I would like to receive pre-marriage counselling when I got married (for unmarried)		
12. Personally, I would like to participate (my husband/future husband) in preconception care		
13. Personally, I would like to participate (my husband/future husband) in antenatal care session		
14. Personally, I would like to participate (my husband/future husband) in postnatal care session		
15. Personally, I would like (my husband/future husband) to play a supportive role in breast feeding		
16. Personally, I would like (my husband/future husband) to be involved in family planning		
17. Personally, I would like (my husband/future husband) to attend or be involved in natal care/delivery		
18. Personally, I would like to participate in childcare		

19. Some reasons may make men reluctant about SRHR services, in your opinion, what are possible reasons why men and youth males don't actively participate in SRHR? *Tick all that apply read all*

	Male responses		**Female responses**	
01 = Lack of awareness about the importance of men involvement 02 = Shyness, shame and embarrassment 03 = The perception that SRH is more a women business 04 = Don't know about the existence of SRH services for men 05 = SRH Services don't target them/exclude them 06 = Health providers don't engage them 07 = Health providers are not trained to serve men 08 = Most SRH providers are women (gender of provider) 09 = Physical space at health facility is not appropriate 10 = Due to their own perceptions about masculinity 11 = Fear of being stigmatized by the community 12 = Fear of being stigmatized by parents/in laws 13 = Personal characteristics like limited education 14 = Other, specify _____	01		01	
	02		02	
	03		03	
	04		04	
	05		05	
	06		06	
	07		07	
	08		08	
	09		09	
	10		10	
	11		11	
	12		12	
	13		13	
	14		14	

20. According to your knowledge, who among men are the most likely in your community to participate in SRH activities? *Ask the respondent to name as many as reason s/he might think of*

		Male		Female	
01 = Educated 02 = Non-educated 03 = married 04 = Unmarried 05 = Lived abroad/outside Gaza 06 = Older 07 = Younger 08 = Refugees 09 = Non refugees 10 = Living in nuclear family 11 = Living in extended family 12 = Poor 13 = Rich	14 = Camp residents 15 = Residents of big cities 16 = Residents of rural areas 17 = Working 18 = Not working 19 = Conservative families 20 = Liberal families 21 = males from FHH 22 = males from MHH 23 = Married to relatives 24 = Others named by male, who _____ 25 = Others named by female, who_____				

21. The literature reports that sometimes, men imposed restriction on women and girls access to SH. How much you agree, somewhat agree or disagree with that
01 = Agree 02 = somewhat agree 03 = Disagree skip to Q 22

21.1 Why you think men and boys impose social pressure on girls and women to restrict their accessibility to SRHR service and information? *Ask the respondent to name as many as reason s/he might think of*

		Male		Female	
01 = Their own perception about masculinity 02 = Social norms 03 = Influence of extended family 04 = Lack of resources 05 = Not appreciating services 06 = Not trusting services 07 = Feeling jealous 08 = Beliefs that women should not leave their houses unless being accompanied 09 = Protecting family honor 10 = Inappropriate gender orientation	11 = Lack of safety in the community 12 = No one is available to take care of children 13 = Girls don't need services 14 = There are information sources available from in laws 15 = Fear that women use this to justify going out for un-needed services (laying to go out). 16 = Others by male _____ 17 = Others by female_____				

22. The literature reports that sometimes men participate and sometimes they don't participate in child rearing activities. How much men in your community participate in childrearing practices?

01 = Largely participate-skip next question 02 = Somewhat participate
03 = Don't participate

22.1 Why men don't actively participate in child rearing activities? *Ask the respondent to name as many as reason s/he might think of*

		Male		Female	
01 = Their perception about masculinity 02 = Shyness and embarrassment 03 = Influence of extended family 04 = Fear of being stigmatized by the community 05 = Fear of being stigmatized by parents or in laws 06 = Personal characteristics like limited education 07 = Not experienced to take a part 08 = It is mothers' business 09 = There are other females in the HH to do that	10 = Mothers prevent them from doing that 11 = Lack of awareness about the importance of participation 12 = Busy in work outside the HH 13 = Never trained on that 14 = Having many children 15 = Tired 16 = Impatient like mothers 17 = Fear for their image in front of children 18 = Others by male _____ 19 = Others by female _____				

23. Which among the SRH components men are usually less engaged with or less supportive to in the community? *Read options and tick all that apply Yes = more or high participation and No = Less or low participation*

01 = Family planning
02 = Fertility care
03 = Infertility care
04 = Abortion
05 = PCC
06 = ANC
07 = NC
08 = PNC
09 = Child health
10 = STIs
11 = Sexual dysfunction
12 = GBV
13 = Counselling service in general
14 = Adolescents' health needs

	Male responses						Female responses					
	Yes	No		Yes	No		Yes	No		Yes	No
01			08			01			08		
02			09			02			09		
03			10			03			10		
04			11			04			11		
05			12			05			12		
06			13			06			13		
07			14			07			14		

24. What can be done to increase men participation or support to SRHR activities and child-rearing activities? ***01 = Yes 02 = No***

	Male	Female

a. Approach young married men at homes to communicate SRHR and CR information		
b. Distribution of information kits such as booklets and flyers about men role in SRHR and CR		
c. Initiate a mobile application for SRHR and CR information and FQA		
d. Sending text messages with SRHR and CR content to their mobile numbers		
e. Sending materials using social media outlets with SRHR and CR content to fathers		
f. Reduce the family contribution in consultation fees of cost of medication at MOH facilities if men and youth male present at SRHR visits		
g. Introduce mandatory classes for youth males and female contemplating marriage as a condition for obtaining the marriage certificate 'similar to thalassemia test'		
h. Add SRHR at school curricula for boys and girls at high schools (extra to what is being provided)		
i. Introduce mandatory classes at university such as one week each year to receive information about SRHR and CR at the university		
j. Launch one-week paid community work for all male and female youth 19-30 years old where they do services related to SRHR and CR at PHC in governmental, UNRWA and NGO healthcare facilities and at the community level		
k. Combine the first vaccination visits of newborn babies with 30-minute SRHR and CR counselling sessions for their fathers		
l. Provide incentives in the form of milk and diapers for new fathers who attend certain number of SRHR and CR sessions		
m. Introduce one mandatory SRHR and CR session to obtain the birth registration certificate of newborn		
n. Launch out awareness strategy about the importance of involving men in SRHR and CR using mass media, TV and radio		
o. Incorporate health education messages related to SRHR and CR into the health education programmes at service delivery points		
P. Introduce one mandatory SRHR and CR session prior to school registration of a child at first primary grade if first child or the last child registered before more than two years		
25 We appreciate any other suggestion you might have, *Please add any input the respondent likes to share and indicate the inputs come from the male, female or both respondents*		

26. **If you have a single wish about your relationship with your parents, what would it be?**	

End of younger cohort survey.
Thank the respondent and fill in the necessary data in the questionnaire cover sheet.

Annex 4 Qualitative tools- English

KII – All participants		
Section/theme	**Questions with key probes**	**Notes for qualitative researchers**
Introduction/ General	• Intro • Please tell about your yourself, your position, responsibilities, your organization, and what does your organization do, especially in relation to SRHR and child rearing services. Elaborate about catchment area, who your organization serves, who is targeted and how? With whom you coordinate/refer needy people? Reflect more about your personal engagements in issues related to SRHR and child rearing practices.	Ask the questions for all in general, but zoom on the questions related to organizations for KIIs who are affiliated to organizations that are directly engaged in SRHR and child rearing
KAP	• From your experience and observation, to what extent men/youth participate in SRHR at HHs, community and health facility levels? Probe for who is usually more versus less engaged? Reflect on the different components of SRHR and childrearing packages (use data collection card for probing). • Are there areas where you think men and boys want / could be more involved, but they aren't given the opportunity? • Please tell me to what extent men and male youth in the community facilitate and support SRHR or childrearing practices and services? What are the characteristics of the men and boys who are positively involved (there could also be men and boys who are negatively involved by making all the decisions for example)? probe for who is more versus less supportive to SRH and child rearing. Reflect on the different components of SRH (provided in a card) • How much there is consistency versus dissonance between what men, and male youth know, believe in and practice with regard to SRHR and child rearing? Which categories most likely show consistencies and which categories are showing dissonant behaviours? Can you elaborate more why? Please reflect on the characteristics of both groups	For international experts ask about LMIC, MENA, conflict affected context For KI specialized in child rearing focus on childcare questions For technical people probe for more details and examples from the field
Underlying reasons behind men's KAP about SRHR and child rearing	• From your perspectives, what are factors and barriers that influence/affect men and male youth KAP related to SRHR and child rearing and in which direction (positively and negatively) drivers for participation versus constrainers)? And for whom in particular? Probe for family norms, dynamics, family decision making process, social norms and hierarchies (age and gender), masculinity attitudes, cultural norms, political and economic factors, legal and regulatory frame, people's characteristics, gender and social inequalities.	For all KIIs Focus more on the evidence from other similar contexts for international experts
Services and programmes	• Can you please tell me about the locally available services and programs that target men and involve them in SRHR? Probe for: How adequate, accessible, acceptable and ensure effective coverage are these programs? Reflect on providers attitudes, composition of service package, services orientation	For all KII, yet focus with relevant persons.

	• Can you elaborate on comprehensive sexuality education, how much it is provided, what are the barriers facing its implementation? • What are the challenges facing programs aiming at increasing the involvement of men and boys in SRHR activities. Please give examples on who (as specific as possible with names, companies, organizations, etc) are barriers to your programs • How much these programs are successful in increasing men's involvement in SRHR and child rearing? • Elaborate in the strength and weaknesses of these programs. Which programs or initiatives you think worthwhile to be scaled up? Whom these programs should target?	
Concluding questions	• Considering the complicated context in Gaza, what cost effective strategies can be adopted to increase men awareness, improve their positive attitudes and involve them in SRHR related issues? • Who are the major stakeholders to ally with (be specific as much as possible with names, organizations, etc.)? Can you think of any people working in the private sector and/or media that would be a good ally to work with on issues around men/boys involvement with SRHR (ie. people that influence large groups of people and may be willing to speak more about SRHR issues)? • How can we/did you benefit from 'lessons learned' to increase the buy-in or contain the barriers of furthering supportive roles for men and boys in SRH. • What should be the starting point for that, and with home we should liaise? • What are the assumptions (including the resources) and risks we should consider?	For all
	Final recommendations or comments from your side to the study team and audiences Asking the participant is he or she has questions for us Thanking the participant for his/her time	For all

FGD – Service providers			
Theme	**Key questions**	**Possible probe**	**Note for the researcher**
Introductory/ General overview	• Intro 1. Would you please introduce yourself and what/where you work, since when? 2. Please tell us about the SRHR or childrearing services that your facilities provide. 3. Please tell us about SRH education you provide.	2.1- would you please name the service, describe it briefly, describe the targeted population, catchment area, and since when you have been participating in these services at the said place, in which role. 2.2- Probe about services presented to men and boys versus women and girls. 3.1- At what age, to which groups, who present these services at schools.	Use the standard intro, obtain consent, fill in the roster data sheet, take permit for audio recording. -Address Q2/Q3 to relevant participants

Landscape of service users and how they are served	* You have mentioned that the services are targeting mainly xxx, would you please explain your targeting approach?	- Probe for differences in reaching men vs women, why these differences exist. - In reality who comes; who attends information sessions?	- With schools, focus on which topics are presented to which groups, at what age, and why.
	* To which services do men present to childrearing OR SRHR services such as FP, STI management, PNC, and fertility care.	- If we take men coming with a STI, how they are served; how do you counsel them; what is the conversation you may have with him? How they react to your advices? - If women come with a STI, do you follow the same method of managing her complaint; what about involving her husband, tell us please about the conversation you may have and the reaction of women	- Irrelevant to schools - This is general overview from provider perspective so don't spend time on generating a list of services to which males present.
	*When and for which services female are often accompanied? By whom and why?	-Probe: Are there differences you as providers practice when couples versus sole female/girl seek services? Probe for time of service, nature, quality, sensitive issues are addressed in which ways in case of couples vs female solely or accompanied by other members?	- Irrelevant to schools - Focus on childrearing with relevant providers
	*Assuming that you felt/suspected that the client you are serving is forced to take or not to take certain services, how do you react to this situation?	- Probe: why you do that, how different if the client presents sole or accompanied, what role the "who is the accompanying person" plays in influencing your actions.	-Irrelevant to schools
	*As counselors or teachers, would you please recall times you addressed sensitive needs, questions, concerns of girls and boys; how do you tackle such situations? give an example please.	- Probe: who are involved from the school admin or families with resolving certain (which) situations. - How often you perform, how likely you **want** versus **can** organize activities with parents about their offspring needs related to sexual health and reproductive life.	-Irrelevant to healthcare
Factors influencing service uptake.	*How would you rate men and boys participation in SRHR or childrearing in general?	- Probe: what are the factors that encouraged or discouraged their participation? Probe here for social norms, appropriateness of facilities, gender and quality of providers, etc	For all
	* Based on your personal and professional experiences, how do you handle difficult situations such as inacceptance to SRHR services or advices given to the clients; provide some examples please	- Indirect probe: How often do providers encounter situations where women went through or were willing to undergo/tried unsafe abortion; what were the motives behind that?	For healthcare providers only.

	*What are the training courses, orientations, instructions you have received during the last three years about men involvement in SRHR or childrearing?	- Probe, how you think they contribute to your/your colleagues capacities to play your intended roles. - If you haven't receive enough/any training, what your needs for training are?	- Try to get specific training needs.
	In some situations the provider finds himself/herself stretched between the clinical or professional guidelines, his/her personal perspectives, his/her professional experience, and the acceptance/willing of clients and/or his or her family members to receive or refuse certain services. *Would you please give some examples of such situations if you/your collogues happen to encounter them , and tell us how do providers react?		Optional question; if the previous part did not provide reasonable inputs about the influence of provider attitudes on service provision
Challenges and gaps	*When you present information to students, how easy/difficult for you to address sensitive points?	- Probe to learn if there are differences between male and female teachers; trained versus untrained; younger versus older, UNRWA versus Government or private schools.	- For schools only.
	* What and where are the gaps –if any- between what you provide and what you should ideally provide?	Probe: in your opinion, do you think services such as pre-marriage, preconception counselling, FP information, risky vs safe relationships should be made available to unmarried males and females?	For all
	* What are the topics where adolescents **need** information about and not yet covered, what are the topics they **want** to learn about?	- Probe: where are the barriers to providing those services? whether it is things such as staffing levels and training, equipment availability, too many patients/students, disagreement with the protocols or curriculum, moral objections such as staff don't want to provide such services or families don't want to receive them, etc.?	For all
	*How often your clients hold false information about SRHR areas such as risky abortion, STI occurrence and consequences or contraceptive effects	- Probe: how easy/difficult or challenging for you to correct/contradict/reform false perception about sexual relations and reproductive health	For all
	* How feasible/ to alter stereotyped information and practices pertaining to childrearing among your clients? Where are the most difficult part, with whom, and what you do to overcome such challenge.		-For childrearing and schools

Change over time	*What are evolving needs of adolescents given the IT and generational changes, which pace, do provider go equally fast/upgrade services, encoding of information, methods of communication, etc.	-For schools only
Change pathways and debriefing	*What can be done to improve ✓ Adolescent access to information pertain to CSE and safe/healthy relationships ✓ Men and boys involvement in SRHR ✓ Females' agency/informed autonomy or voice in relation to SRHR ✓ Men and boys contribution to childrearing activities *Would you name any relevant theme in SRHR or childrearing that we should unfold with next participants please.	For all

FGD – Married and older males including male community leaders			
Key theme	**Principal questions (stem)**	**Possible probe**	**Hints and instructions**
KAP on SRHR (introductory and level of participation)	* Intro * When we speak about sexual and reproductive health and rights, what comes to your mind?		Conclude and rephrase participant inputs to elaborate on SRHR components (see box 1 in the qualitative guide).
	* What types of Sexual and Reproductive Health and Rights service do people in your community need?	- Probe for different stages of life course - Probe for young boys, young girls, adult unmarried young men, adult unmarried women, and married people.	Focus on PwD, divorced, widowed, .. with correspondent groups.
	* What is the level of participation of men and young males in sexual and reproductive health services?	- Probe for when and how often men seek services for themselves such as counselling service, STI management, and the utilisation by men for services such as counselling or information during and after pregnancy of their wives - Probe: Among men, who participate more in each of these activities/services and why. - Probe: what are the factors (facilitate or block) that lead to this level of participation (like gender of provider, facility settings, low availability of services to men, stigma, etc) - Probe: how do men contribute in shaping or influencing service utilization by women	
	* At the time of crisis such as COVID-19 pandemic or military hostilities, some services decreased such as care during pregnancy, STI management, and family planning services, how do	-Probe: Who takes the lead/decide in managing this situation and how this happens?	Do not spend time on changes due to COVID. The purpose of this question is to understand how people

	families cope with this change?		manage/adapt to change relevant to SRHR and who is/are the persons involved in this process.
KAP – Information and services to youngest	* From your perspectives, what are the essential information and services needed during the transition phase from childhood to adulthood? At schools, at home, and at healthcare facilities.	- Probe for differences between a) little girls below 13 years versus older girls like 14 years and older; b) little vs older boys; c) differences between boys and girls in general. - Why these differences exist? - Have these needs changed over time? If yes, how is that and what is the change that occurred, for which groups, and why?	Don't spend time on stem question The objective is to probe how do the group think that girls/boys, youngest/older are different in needs and why and how did that **change over time**
	* Which methods people use to ensure that boys and girls get appropriately informed about puberty transitional stages and needs before marriage?	- Who speaks about that at home and in the community in general? with boys and with girls? - Probe: for different sources of information, which are the most used and who decide which sources can be approached? what is the level of observation/freedom parents allow for their children while using the internet to search for SR information? how is that different between boys and girls and why.	- Same as previous question; probes are more important than stem. - Reformulate with groups without children to reflect their opinion when having children in the future. - Don't ask this Q to community leaders.
	Would you please imagine that a school is holding a parent meeting to discuss whether the teachers and counsellors should organize sessions for students about sexual and reproductive health or not. They want also to hear from parents about the best way to carry out these sessions. *From your perspective, how likely fathers will attend this meeting? What are the questions fathers may pose to decide to support such idea or not? And what are the advices that fathers may give to the school administration?	- Probe: for why father may like or hesitate to participate in such meetings. - Probe also about who decide who should attend similar meetings and why?	- Organize inputs on flipchart for ease.
KAP – Information, attitudes, and participation of adults and married men and women	*If we focus a little on certain services such as FP needs that we just talked about, would you please tell us about the methods you, your wives, or possibly families in similar situations to you use? Please	-Probe: for newly married without children, married with first child or two males vs females, married with more than 3 children, married and both couple work, married not working, poor, rich, refugees,	-Reformulate with groups without children to check on fertility care and learn about their perception of

	tell us about your roles in deciding which method and when you or your spouse use a contraceptive.	camps vs rural or urban residents, education level, other social factors such as extended versus nuclear family, coming from big vs small family, etc. For each group, why the participants think FP are needed or not needed. - Probe to solicit details on; how do families decide upon where and when to use contraceptives. - How the decision around consulting healthcare centers for family planning is taken, what are the factors which or influencers who shape this decision.	families around them. - Reformulate with PwD as relevant.
	Another area of SRH is the STI management, STIs are common in many communities and they have a lot of consequences on both couples and possibly the baby. * Would you please tell us about STI, what are possible consequences and what is the role men play in treating and preventing them.	- Probe: What are the factors which make it easy/difficult for men to participate in STI management.	- The researcher should observe who among men is keen about participation in SRHR activities and why.
	Sometimes, couples live stressful events such as loosing babies due to abortion or miscarriage. Also, some women feel depressed after giving birth. * In your experience or the experience of people around you, how do men feel in such situations? * What are possibly the forms of **support** or **blame** associated with similar situations?	- How would you evaluate the level of **support** or **blame** men practice/give and how would you evaluate the level of support they receive. - How do other family members react to these situations and how they intervene?	Pay particular attention with PwD, divorced and married at young age or from child wives.
KAP- child rearing practice and roles	Childrearing is a demanding role, with different needs over the life course of children. *In your households or families similar to you, what is the role males (fathers and adult brothers) play in childrearing?	- Probe for which activities and how much males contribute in childrearing (ask the participants to name the activities they do with little children below 3 years old; 3 to 6 years, 6-10 years, and older than 10 years); for each activity ask them to give a percentage like for example male do x% in feeding children or hygiene. - Probe for the disciplinary roles, what males do and why they assume /don't assume big share in childrearing and discipline.	-Reformulate this set of questions with men who have no children to reflect their attitudes and knowledge; ask all questions with focus on last probe.

		-Probe for what are the factors which shape males contribution; social; work; skills, cultural; etc.	
Change pathways	*In this part of our discussion, we will take few steps back to learn about how the situation was 10-15 years ago, then how it seems now and in 10 years in the future 1) The position/power for each partner in deciding about the time and number of children they have/will have. 2) Males contribution in childrearing activities other than disciplinary roles 3) Views about introducing sexual health education at (8th grade) for both boys and girls.	- Probe to understand how did/do the **social norms** evolved to alter the situation in the past, now and in the future.	- Organize quick inputs on flipcharts - Try to obtain as many details as you can about the change in social norms behind the change relevant to the three aspects (DM, men role in childrearing, and CSE).
	*Imagine you are the head of community friendship committee of an organization, what will you propose to advance the services to encourage men involvement.		- Organize quick inputs on flipcharts
	*Let's assume that you are in charge of writing a promo about one of SRHR areas to engage men in its implementation, what will you write and to whom, which way (ad format, digital, in streets, etc), who will distribute that and where?		Optional question if previous questions don't generate reasonable ideas.
	* As community leaders, you might been approached by men and women to resolve situations relevant to SR aspects; would you please tell us about some examples of these situations; who comes to you the most, around which problems, and how do you react?	Probe: in which situations you may prefer to refer people to other parties or organizations? How often does that happen and who are your network of referral?	For community leader only
Debrief	* Please describe how you feel about our discussion today, in a few words pls. * Please name one issue or one point that we should have talked about.	Follow up: if the idea seem interesting, ask the group; do you think we should talk about that with other groups, if yes, why, if no, why not.	For all

FGD – Married and older females including female community leaders			
Key theme	**Principal questions (stem)**	**Possible probe**	**Hints and instructions**
KAP on SRHR (introductory and level of participation)	* Intro * When we speak about sexual and reproductive		Conclude and rephrase participant inputs to elaborate on

	health and rights, what comes to your mind?		SRHR components (see box 1 in the qualitative guide).
	* What types of Sexual and Reproductive Health and Rights service do people in your community need?	- Probe for different stages of life course - Probe for young boys, young girls, adult unmarried young men, adult unmarried women, and married people. - What are the services presented to unmarried females?	Focus on PwD, divorced, widowed, .. with correspondent groups.
	* From your perspective, what is the level of participation of men and young males in sexual and reproductive health services?	- Probe: Among men, who participate more in each of these activities/services and why. - Probe: how do men contribute in shaping or influencing service utilization by women	
	* At the time of crisis such as COVID-19 pandemic or military hostilities, some services decreased such as care during pregnancy, STI management, and family planning services, how do families cope with this change?	-Probe: Who takes the lead/decide in managing this situation and how this happens?	Do not spend time on changes due to COVID. The purpose of this question is to understand how people manage/adapt to change.
KAP – Information and services to youngest	* From your perspectives, what are the essential information and services needed during the transition phase from childhood to adulthood? At schools, at home, and at healthcare facilities.	- Probe for differences between a) little girls below 13 years versus older girls like 14 years and older; b) little vs older boys; c) differences between boys and girls in general. - Why these differences exist? - Have these needs changed over time? If yes, how is that and what is the change that occurred, for which groups, and why?	Don't spend time on stem question The objective is to probe how do the group think that girls/boys, youngest/older are different in needs and why and how did that **change over time**
	* Which methods people use to ensure that boys and girls get appropriately informed about puberty transitional stages and needs before marriage?	- Who speaks about that at home and in the community in general? with boys and with girls? - Probe: for different sources of information, which are the most used and who decide which sources can be approached? what is the level of observation/freedom parents allow for their children while using the internet to search for SR information? how is that different between boys and girls and why. If parents practice a sort of observation, what is the role of mothers vs fathers in	- Reformulate with groups without children to reflect their opinion when having children in the future. - Don't ask this Q to community leaders.

		that? What about Female headed households?	
	Would you please imagine that a school is holding a parent meeting to discuss whether the teachers and counsellors should organize sessions for students about sexual and reproductive health or not. They want also to hear from parents about the best way to carry out these sessions. * From you perspective, who will attend these meetings, the father or the mothers? Who decides about which parent is going to attend?	- Probe: for why father may like or hesitate to participate in such meetings. - Probe also about who decide who should attend similar meetings and why? - If you as mothers attend this meeting, what are the questions you may pose to decide to support such idea or not? And what are the advices that you may give to the school administration? - When you return back home, what type of conversation you may have about this meeting, with whom?	- Organize probe inputs on flipchart for ease.
KAP – Information, attitudes, and participation of adults and married men and women	*If we focus a little on certain services such as FP needs that we just talked about, would you please tell us about the methods you, your wives, or possibly families in similar situations to you use? Please tell us about your roles in deciding which method and when you or your spouse use a contraceptive.	-Probe: for newly married without children, married with first child or two males vs females, married with more than 3 children, married and both couple work, married not working, poor, rich, refugees, camps vs rural or urban residents, education level, other social factors such as extended versus nuclear family, coming from big vs small family, etc. For each group, why the participants think FP are needed or not needed. - Probe to solicit details on; how do families decide upon where and when to use contraceptives. - How the decision around consulting healthcare centers for family planning is taken, what are the factors which or influencers who shape this decision. - What influence the gender of the first/other offspring have on using FP for you, for your spouses, for the community in general. Why is that?	-Reformulate with groups without children to check on fertility care and learn about their perception of families around them. - Reformulate with PwD as relevant.
	Another area of SRH is the STI management, STIs are common in many communities and they have a lot of consequences on both couples and possibly the baby. * Would you please tell us about STI, what are possible consequences and what is the role men play in treating and preventing them.	- Probe: What are the factors that make it easy/difficult for you to participate in STI management.	

	Sometimes, couples live stressful events such as loosing babies due to abortion or miscarriage. Also, some women feel depressed after giving birth. * In your experience or the experience of people around you, how do men feel in such situations? * What are possibly the forms of **support** or **blame** associated with similar situations?	- Probe, who among women receive the most level of support or blame. Probe also about the role of men; in general they contribute in supportive or depressive ways, in which situations men are more/least supportive. - How do other family members react to these situations and how they intervene?	Pay particular attention with PwD, divorced and married at young age or from child wives.
KAP- child rearing practice and roles	Childrearing is a demanding role, with different needs over the life course of children. *In your households or families similar to you, what is the role males (fathers and adult brothers) play in childrearing?	- Probe for which activities and how much males contribute in childrearing (ask the participants to name the activities they do with little children below 3 years old; 3 to 6 years, 6-10 years, and older than 10 years); for each activity ask them to give a percentage like for example male do x% in feeding children or hygiene. - Probe for the disciplinary roles, what males do and why they assume /don't assume big share in childrearing and discipline. -Probe for what are the factors which shape males contribution; social; work; skills, cultural; etc.	-Reformulate this set of questions with women who have no children to reflect their attitudes and knowledge; ask all questions with focus on last probe.
Change pathways	*In this part of our discussion, we will take few steps back to learn about how the situation was 10-15 years ago, then how it seems now and in 10 years in the future 1) The position/power for each partner in deciding about the time and number of children they have/will have. 2) Males contribution in childrearing activities other than disciplinary roles 3) Views about introducing sexual health education at (8th grade) for both boys and girls.	- Probe to understand how did/do the **social norms** evolved to alter the situation in the past, now and in the future.	- Organize quick inputs on flipcharts - Try to obtain as many details as you can about the change in social norms behind the change relevant to the three aspects (DM, men role in childrearing, and CSE).
	*Imagine you are the head of community friendship committee of an organization, what will you propose to advance the services to encourage men involvement.		- Organize quick inputs on flipcharts

	* As community leaders, you might been approached by men and women to resolve situations relevant to SR aspects; would you please tell us about some examples of these situations; who comes to you the most, around which problems, and how do you react?	- Compared to male community leaders, how would you evaluate your capacity/power to intervene in solving problems around SRHR? Please tell us if and why difference exist and what effect it has on the outcomes of your interventions. - Probe: in which situations you may prefer to refer people to other parties or organizations? How often does that happen and who are your network of referral?	For community leader only
Debrief	* Please describe how you feel about our discussion today, in a few words pls. * Please name one issue or one point that we should have talked about.	Follow up: if the idea seem interesting, ask the group; do you think we should talk about that with other groups, if yes, why, if no, why not.	For all

FGD unmarried and younger participants	
Section/theme	**Questions with key probes**
Introduction/ General	* Intro. * When we speak about sexual and reproductive health and rights, what comes to your mind? * What are the services correspond to that in your opinion, please think at the level of health centers, schools, community organizations such as NGOs, clubs, or any other actors you think they are involved. Which groups (boys-girls) are better served and why?
KAP – transition to adulthood	*We pass through several stages of development from childhood to aging. Each stage is associated with physical, psychological and hormonal changes. In addition, the context influences our access to information, services and practicing rights.* * Could you tell us about your experience of puberty? At the onset of puberty phases, how did your life change? Probe: looking back, how would you describe that experience? What are the good events and what are the bad events you had experienced at that time, link these events to your age? Please tell me about the level of information you had at that time. * From where you got the information about puberty at that time? How was useful the information you obtained? What are the things you were wondering about? *How familiar you are of the puberty signs/experience/psychological development of the opposite sex (boys knows about changes girls pass and vice versa)? To what extent it is important to know about that? * Would you reflect on social changes triggered by reaching puberty; what were sources of stress and what were sources of relief (events and people/ for example family support, gain more freedom or the other way opponents, more family or community restriction). * According to your knowledge, how do girls manage their menstruation? Who supports girls during that period (particularly among males)? *For girls only; what sort of support you receive during menstruation? How much you have the resources you need? What kind of support you need but you don't receive it during mensuration days? Probe for at home, at school, if financial resources are limited, and if the HH is crowded.
Services, programmes and information access	* Have relationships, sexual health, risky sexual or reproductive behaviors and/or contraception ever been spoken about at school? Who talked about them, did others from out of school come and talk to you? At which grade and what type of participation was that; regular classes, exceptional classes, boys only, girl only, interactive or lecturing? How do you think about this experience if you ever been part of? Do you learn about friends, siblings younger than you or at your age who attended similar activities? Otherwise tell me would you loved to participate in

	such activities? Do you learn about youth programs which address these issues, you or a friend of yours took part? * How much health services target unmarried youth female compared to adult women? * Have you ever been to any services for help and advice about relationships, contraception, STIs, sexual relationships etc? * We learned that youth at your age receive/obtain information about sexual relations, puberty, STIs, and other reproductive health aspects from different sources. What are the most sources you approach? How available and accessible these sources are? What may probably limit your source options? *Do you follow certain media influencers? Who is the one or two examples that inspire you or you trust the contents they present. Probe: what are the most visited topics from your opinion; do you think that the opposite sex search different sources or for different topics. *Are you aware about NGOs or community education programs that support youth access to information about healthy sexual and reproductive life? *Will you be willing to join such activities.
Underlying reasons behind men's KAP about SRHR and child rearing	* What does it mean to be a good man? How would you describe the ideal man'? What characteristics they have? Do you have some examples from your community? If we ask this question to (opposite sex – girls/boys), would you imagine how they will describe the ideal man. Family wise. * What about a good or ideal women? Will the opposite sex hold similar views? * Would you imagine what older generation think about ideal man and woman? * How perceptions about masculinity influence SRHR and child rearing (probe for FP, child care and distribution of HH chores, pregnancy, number of children, accessing sexual and reproductive health services, child marriage, multiple marriages)? *Would you tell us from what you learn about your relatives or friends at your age or a little older, have been there times they have felt unable to make their own choices about their sexual health, when to marry, and when to have children, and if so, what happened, how did they handle it? Probe: Did the situation ever become violent? * What do you think about improving, increasing, scaling up CSE curriculum at schools? * Ideally, to which extent men are expected to contribute to childrearing activities such as taking care of children, playing with them, support their self-esteem, etc? In reality what is the actual participation at your HH or HH around you.
Gaps and challenges	* At this stage of your development, would you please share what are your SRHR needs or the needs of your peers? What are the services you look for, how does the surrounding environment inhibit or promote satisfying these needs? Tell me please do you think the needs/potentials of people at your age are shut down? If this is the case, why? * For participants younger than 19 years old; What are the topics you want to learn about for this period of your development, what are your SRHR needs; do you think there are differences between boys and girls? * How do you evaluate the information and counselling services at schools; where are the positive sides, like what and where are the sides which require further improvement, like what? * How do you evaluate the SRH services provided to unmarried individuals (boys in particular) at healthcare facilities if you learn about personal or friend experiences; where are the positive sides, like what and where are the sides which require further improvement, like what?
Concluding questions and debriefing	* In the near future, what is the situation you anticipate about youth decision making capacity? Probe: will reflect the same current situation; better; worse; why do you think that particular way? * Please describe how you feel about our discussion today, in a few words pls. * Please name one issue or one point that we should have talked about

Annex 5

المجلس الفلسطيني للبحث الصحي

Palestinian Health Research Council

تعزيز النظام الصحي الفلسطيني من خلال مأسسة استخدام المعلومات البحثية في صنع القرار

Developing the Palestinian health system through institutionalizing the use of information in decision making

Helsinki Committee

For Ethical Approval

Date: 2020\12\07 **Number:** PHRC/HC/792/20

Name: Bassam Abu Hamad الاسم:

We would like to inform you that the committee had discussed the proposal of your study about: نفيدكم علماً بأن اللجنة قد ناقشت مقترح دراستكم حول:

Knowledge, Attitudes and Practices (KAP) among Men in the Gaza Strip Related to Sexual and Reproductive Health and Rights (SRHR) and Child Rearing

The committee has decided to approve the above mentioned research. Approval number PHRC/HC/792/20 in its meeting on 2020\12\07 و قد قررت الموافقة على البحث المذكور عاليه بالرقم والتاريخ المذكوران عاليه

Signature

Member **Member**

Chairman

Genral Conditions:-

1. Valid for 2 years from the date of approval.
2. It is necessary to notify the committee of any change in the approved study protocol.
3. The committee appreciates receiving a copy of your final research when completed.

Specific Conditions:-