



Social Norms and Sexual and Reproductive Health Among Youth in Palestine

June 2020



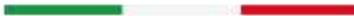

Consulate General of Italy
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Abstract

This study explores the social norms and attitudes hindering youth in Palestine from accessing sexual and reproductive health information, education and services. The quantitative data set on which this study is based, comprises mainly of an online survey of 861 young persons in Palestine. The results are supported by several qualitative Focus Group Discussion and in-depth interviews. The findings show that young people in Palestine are open and ready to have age-specific, scientific and medical information regarding their SRH. More than 90% of respondents are in favour of including age-appropriate comprehensive sexual education in school curricula.

Young people reported receiving little or no information at home or at school regarding the bodily and psychological changes they go through during puberty. They view teachers, parents and society at large as the main blockers hindering their access to information. Young people feel left in the dark, and some are seeking diverse external sources that are not always fitting with their needs nor context. While SRH topics are perceived as a sensitive issue in Palestinian society, this study shows that young people are ready and eager to break the silence and work on mainstreaming and normalizing SRH topics and claiming their rights to information and proper services.

1. Background, scope and objective

According to the Palestinian Central Bureau of Statistics (PCBS), youth between 18-29 years of age comprise 23% (1.13 million) of the total population. The latest census of 2017 indicated that more than one third of the Palestinian population (38.9%) is the age category 0-14 years of age ¹. The PCBS defines youth in the age category between 18-29 years of age, while the United Nations defines the youth as the individuals in the age group (15-24 years).²

According to the UNFPA³ definition, sexual and reproductive health SRH is “a state of complete physical, mental and social well-being in all matters relating to the reproductive system. It implies that people are able to have a satisfying and safe sex life, the capability to reproduce, and the freedom to decide if, when, and how often to do so”. Young people acquire their sexual knowledge from their direct environment is what is called sexual socialization. Parents take centre stage in the sexual socialization of their children⁴.

Throughout the Mena region adolescents and young people systematically lack access to sexual and reproductive health information and services. Restrictive social and cultural norms, lack of personal rights and the many myths and misconceptions on sexuality education often leave young people, especially young women unable to obtain the information and services needed, lacking an open safe space to engage on SRH issues, leaving them susceptible to risky behaviours, practices and STIs.

The situation in Palestine is not far away from the reality of the rest of the Mena region. In a previous study conducted by Palestinian Medical Relief Society (PMRS) and UNFPA Palestine, 73.3% of a group of 300 girls and women surveyed indicated embarrassment as the main reason why they do not discuss SRH issues with others. 42% said they do not know where to start, and 20.3% reported not having adequate information about what to ask. ⁵.

Young people are often left in the dark when it comes to SRH information and education. Sexual and reproductive health curricula at schools are basic, often limited to a biology lesson, and do not meet the needs and questions youth might have at this critical time of their lives. Often schools and educators are hesitant or not cooperative when it comes to covering SRH lessons in their classrooms. Most parents prefer not to address these topics with their children either for social or religious reasons or simply because they lack the tools and knowledge of how to address these topics with their children. As a result, young people receive little or no information from these channels and must rely on external sources such as peers or the media for information.

¹ PCBS 2017 National Census <http://www.pcbs.gov.ps/Downloads/book2383.pdf>

² <http://www.pcbs.gov.ps/post.aspx?lang=en&ItemID=3528#>

³ <https://www.unfpa.org/sexual-reproductive-health>

⁴ Ward, L. (2003). Understanding the role of entertainment media in the sexual socialization of American youth: a review of empirical research. *Developmental Review*, 23(3), 347-388. [https://doi.org/10.1016/S0273-2297\(03\)00013-3](https://doi.org/10.1016/S0273-2297(03)00013-3)

⁵ The Palestinian Medical Relief Society (PMRS) “The Social Norms Related to Sexual and Reproductive Health and Rights of Young Girls (January 2019).

Within the social and cultural traditions of the Palestinian community, young people are expected to abstain from any sexual experience until marriage. This condition is amplified for girls and women who are expected to remain virgins until marriage. The female's virginity is equated with the family's honour and in some cases, losing one's virginity before marriage has led to honour killings. Premarital sexual relations are strictly forbidden for girls, and mostly tolerated for boys and young men. Yet young people are sexually active even within a society that upholds strict social norms and values regarding sexual experiences before marriage.

Previous research has shown that some youth in Palestine are sexually active or have had a sexual experience. A sexual experience refers to a broad array of sexual activities that include kissing, sexual touching, and sexual intercourse (oral, anal, vaginal). A report published by UNFPA "Youth in Palestine", 2017, indicates that "25% of older (19-24) unmarried male youth and 22% of younger (17-18) male youth report having had any sexual experience. Rates for females were generally similar. Rates for sexual intercourse remain lower (9.5% of older unmarried males and 7% of females)"⁶.

Previous studies in Palestine also indicated that there are 17 active organisations in the field of SRH. However, these organisations do not have systematic and comprehensive and holistic programs to address SRH of young people in specific and that further collaboration, partnership and coordination is needed between these organisations ⁷. Youth are cross cutting in all programming, which also means that there are few, or no specific programs or services designed for this age group. Recently the Palestinian Adolescent Health coalition has been created to coordinate the efforts of local organisations and international agencies working on improving services and programs targeting adolescents and youth.

This research focuses on exploring and understanding the perspectives of young people (15-29 years) at large in the West Bank, Gaza Strip, and East Jerusalem with regards to sexual and reproductive health and the social norms surrounding them. It is a follow up on a previous study conducted in 2018 by the Palestinian Medical Relief Society (PMRS) titled "The Social Norms related to Sexual and Reproductive Health and Rights (SRHR) of young women and girls". It also builds on the "Mapping Adolescent and Youth Sexual and Reproductive Health Services in Palestine" study, conducted in January 2019, also by PMRS.

There are several theoretical approaches to defining social norms⁸. A **social norm** is defined here as what people in a group believe to be 'normal' in the group, that is, believed to be a typical action, an appropriate action, or both⁹. Social norms are shared beliefs about what is typical or appropriate

⁶ "Youth in Palestine" UNFPA 2017, https://palestine.unfpa.org/sites/default/files/pub-pdf/Youth%20in%20Palestine%20-%20Oct%202017_0.pdf

⁷ "Mapping Adolescent and Youth Sexual and Reproductive Health Services in Palestine, PMRS 2019".

⁸ Cislighi, B; Shakya, H (2018) Social Norms and Adolescents' Sexual Health: An Introduction for Practitioners Working in Low and Mid- income African countries. African journal of reproductive health, 22 (1). pp. 38-46. https://www.researchgate.net/publication/325023835_Social_Norms_and_Adolescents'_Sexual_Health_An_Introduction_for_Practitioners_Working_in_Low_and_Mid-income_African_countries

⁹ Paluck, Elizabeth Levy and Ball, Laurie (2010). Social norms marketing aimed at gender-based violence: A literature review and critical assessment. New York: International Rescue Committee.

behaviour in a group. Social norms are taught, spread, and reinforced by various “norm-setters” such as the media, pop culture such as tv soaps, as well as family, teachers, peers, and religious leaders. Further, social norms can be positive, or negative. Social norms are related to behaviour and attitude. A person’s behaviour is how someone acts or does things. A person’s attitude is how someone feel or judge a certain behaviour. Both attitudes and behaviours of an individual are shaped by many factors including by the social norms they grow up with in their community¹⁰. A social norm can be a descriptive norm (doing what others do) and an injunctive norm (doing what others think one should do). Social norms are social expectations within a group of people, often called a reference group. These norms are maintained by social approval or disapproval of a certain behaviour or attitude by the reference group.

This study strives to address and map out social norms, attitudes and behaviours of young people in relation to their SRH through different methodologies. To highlight the existing attitudes and behaviours, and how young people are affected by the ‘negative’ social norms around them. It looks deeply into the social norms that prevent or hinder them from reaching and obtaining reliable information and feeling comfortable in addressing their SRH information and services they need in a restrictive setting.

The objective of this research is to better understand the social and cultural norms and perceptions preventing or hindering youth in Palestine from seeking or obtaining SRH information, education, and services. It seeks to create a body of evidence on social norms and understanding the needs and attitudes of youth regarding their SRH information and education. The research will establish a knowledge base with regards to the social norms that might have an influence on the accessibility to SRH by young people age between 15 and 29.

The research focuses on the following questions:

- What is the status of SRH education and services by youth in Palestine?
- Where do youth access information and services on SRH?
- What are the social norms and attitudes that youth face or have which affect their access to SRH information, education, and services?
- What are the main sources of information and channels that youth rely on to obtain SRH information, education and services? And what sources and methods do they prefer with regards to SRH education and information?
- What are youth’s attitudes and perception of comprehensive sexuality education in schools and universities in Palestine?
- Who are the key influential community figures, and organisations that promote SRH among youth? And what are the challenges they face in addressing SRH of youth in Palestine?

<http://static.squarespace.com/static/5186d08fe4b065e39b45b91e/t/52d1f24ce4b07fea759e4446/138949076406%205%20Paluck%20Ball%20IRC%20Social%20Norms%20Marketing%20Long.pdf>

¹⁰ Mackie, G., Moneti, F., Shakya, H., & Denny, E. (2015). What Are Social Norms? How Are They Measured? San Diego: UNICEF / University of California, San Diego, Center on Global Justice
http://www.unicef.org/protection/files/4_09_30_Whole_What_are_Social_Norms.pdf

- What are youth's demands and recommendations and concrete interventions to improve quality and access to SRH information, education and services?

2. Research Methodology

The research methodology of this study consisted of three major data sets in order to collect a broad set of data and validate it. A Quantitative method was used in an online survey reaching a wide public. Qualitative methods were used in the form of Focus Groups Discussions; key persons interviews with Executive Directors (EDs) of organizations addressing SRH of youth in Palestine were used to validate the data obtained from the online survey. Furthermore, a general desk review was conducted to scope the previous studies conducted with regards to youth and SRH in Palestine.

2.1 Online Survey

The main body of data for this study was obtained through an online survey¹¹. The survey was disseminated among young people in Palestine. It consisted of 29 questions (see Annex 1) covering questions ranging from socio-demographic characteristics, knowledge and access to SRH services and information, to social norms and SRH concepts from a personal perspective and SRH education and services available and required by young people.

There were several iterations of the survey with input from Sharek Youth Forum and UNFPA Palestine team, as well as a small pilot conducted among 22 persons in Ramallah. Feedback and suggestions were considered for the final version of the survey.

The main survey was posted online and was publicly available and targeting the age group (19-29). It was then disseminated also online through the Facebook page of Sharek Youth Forum as well as through the pages of Y-peer groups. The link to the survey was also sent to local CSOs interested in the topics such as the Palestinian Medical Relief Society (PMRS) and Juzoor. The online survey was active for a period of more than 3 weeks (19 February until 15 March 2020) and was promoted during that period with a social media marketing budget of 270 USD. The post then reached 29K persons (reach means presented in the newsfeed). All engagement on the social media post on the survey were positive (likes, shares).

Participation in the survey was entirely on a voluntary basis and there was no incentive given in return for participation. Online space provides a direct, private, and confidential space for respondents to engage without feeling pressured or embarrassed to address SRH topics. At the same time, it gives the researchers less control and no direct interaction with the respondents.

In addition to the above-mentioned data set (survey), two extra data collection opportunities were used in order to validate the findings amongst two specific target subgroups. This included two main groups: 1) a group of 10 young Palestinians living in marginalized areas including a Bedouin setting of Jahalin *عرب الجهالين* known for their nomadic lifestyle as well some participants from Palestine Valley *الأغوار الفلسطينية*. And 2) An Additional validation set of data was collected from a group of 10 adolescents ages 15-18 to validate the information of this age group in the survey as this category was slightly underrepresented in the main survey results.

¹¹ Survey on Facebook <https://www.facebook.com/157889064247366/posts/2827095910659988/?d=n>

2.2 Focus Group Discussions

Six validation Focus Group Discussions (FGDs) were held in three different locations.

The Gaza Strip: 18 persons total (8 females and 10 males)

East Jerusalem: 16 persons total (10 females and 6 males)

Ramallah: 19 persons total (9 females, and 10 males)

The FGDs were conducted by staff members and volunteers of the Sharek Youth Forum's networks. Participants were recruited through an open call upon Sharek's network and beneficiaries, and Y-peer teams in the West Bank, Gaza Strip and East Jerusalem. Basic training of how to conduct an FGD session, as well as detailed instructions and templates were provided to the FGD local facilitators, recruited by Sharek, see Annex 5 for FGD discussion guide. Separate sessions were held for women and men to provide a safe environment for both groups to share as openly as possible, except for East Jerusalem sessions that were mixed groups. All participants signed an informed consent form prior to participation in the discussion.

	All	Males	Females
19-24 years of age	45	21	24
25-29 years of age	7	5	2
30 years and older	1	0	1
Totals	53	26	27

2.3 Interviews

Thirdly, key informant interviews with experts from active SRH organisations or influencers were conducted. Examples are Juzoor, Sawa, Y-peer network, and PFPPA. These organisations or groups were chosen for 2 reasons: firstly, these are active organisations working on SRH of youth in Palestine, and secondly, they were all named by survey respondents as sources on SRH in Palestine that some youth rely on for information.

2.4. Research limitations

Sexual and Reproductive Health issues can be perceived as a sensitive topic within the cultural and religious context of Palestine. However, the main data set collected via online surveys provided a safe and private space for individuals to speak their minds anonymously. In addition to direct questions, several social norms and attitudes were addressed with the user in the form of statements and positions to agree or disagree. This served to understand the social norms and values of respondents and their attitudes towards sensitive topics such as virginity, pornography,

living with HIV, as examples. This was done mostly in question 19 of the survey which presented respondents with 14 statements which they were asked to agree, disagree, or opt out on.

When piloting the survey with a small group, questions were received by Sharek Youth Platform. Parental consent was needed when piloting the survey with young respondents ages 15-18 years of age. One of these questions was on the inclusion of a third option under the question “Sex: “Male, Female, Other”. This question was not changed. Another question was regarding the use of the word pornography in the survey which some felt uncomfortable with during the piloting. The term was replaced by “visual sexual content”.

Due to the outbreak of Covid-19 virus in Palestine in March 2020, and the resulting travel restrictions on Sharek Youth Platform team, the FGD in East Jerusalem was conducted online and not face to face as was done in the Ramallah and Gaza Strip FGDs.

The online survey was promoted online for the target group. The age group 15-18 was the lowest participating group online. It was not possible to commercially target the online survey to age groups under 18 years of age due to the nature of the content of the survey. Although online advertising is possible starting age 13, the nature of the survey could have been considered sexual content by Facebook or attracted potential complaints by online users. Therefore, no risk was taken in targeting under 18-year olds online as it could have affected reaching the entire target group. Therefore, an additional data collection point was designed to validate the survey outcomes with the target group 15-18-year olds. This additional data set was compared to the existing data set on 15-18 years of age in the main survey. In case of major differences, this was noted in the research results below.

As the survey was disseminated online, and on various CSO pages in Palestine, there was little control of the age groups participating. As a result, 29% of the participants of the online survey reported to be 30 and above, clearly falling outside the target group of the survey. The dataset of this age group has been retained in the survey for the purpose of comparison with other age groups.

With regards to the FGDs participants, 85% (n=45) of all male and female participants were youth in the age range of 19-24 years of age. FGD participants were recruited through purposive sampling from Sharek’s program beneficiaries and Y-Peer network. This was both a benefit and a disadvantage at the same time. It was a benefit because Y-peer educators brought in some of the challenges and successes they had in organising sessions at schools and youth meet-ups, and a disadvantage in the sense that it might have missed a validation with youth at large who have not been exposed and sensitized to reproductive and sexual health topics before. However, this was compensated with in two ways: first by opening the online survey publicly to all youth in Palestine and targeting the online marketing to cover the entire area of the West Bank, Gaza Strip and East Jerusalem. And secondly by validating the outcomes of both the survey and the FGDs through personal interviews with youth from marginalized areas (see section 2.0 Research Methodology).

3. Results and Discussion

The following section gives a snapshot analysis of the online survey results, presented by four main areas of research. These are: Level of information and awareness on SRH; The various sources and channels used to access information and services on SRH; Social norms and attitudes affecting access to SRH information and services; and finally a fourth area of research to explore the solutions and suggestions of youth participants on how to increase and improve SRH information and services in Palestine.

The analysis also incorporates finding from the FGDs which were largely organised in order to validate the survey findings and deep dive more into the answers received online.

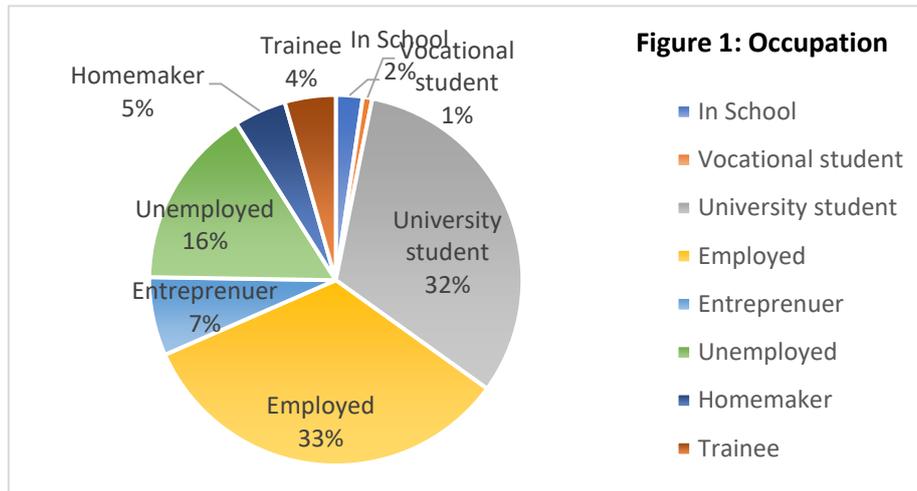
3.1 Survey demographics

A total of 861 respondents filled the online survey. As seen in table 2 below, young females were the majority respondents in the survey with 57% females (n=490), and 43% males (n=369). A total of 2 respondents identified themselves as “other” sex, a category that is not often used in surveys in Palestine.

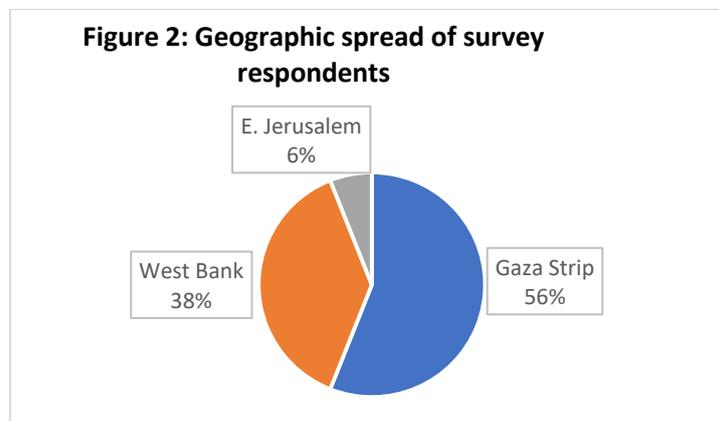
The respondent rate of the online survey was high. Out of a total of 2213 persons who opened the link of the survey, 861 (39%) persons completed filling the survey. This percentage is usually under 10% in commercial surveys. While the common perception that participation in such survey might be sensitive, one can conclude that the high percentage of participation indicate a need and willingness from young people to give their views and participate, and do not necessarily view SRH topics as a sensitive topic that is off limit.

	<i>Count</i>			<i>Percentage</i>		
	All cases	Males	Females	All cases	Males	Females
15-18 years of age	21	6	15	2%	2%	3%
19-24 years of age	385	125	259	45%	34%	53%
25-29 years of age	207	96	110	24%	26%	22%
30 years and older	248	142	106	29%	38%	22%
Totals	861	369	490	100%	43%	57%

More than two-thirds of the respondents (69%) were in the target group age category of 19-29 years of age. The percentage of female participation was significantly higher than that of male participation (57% females and 43% males) in all cases, with the age category 19-24 years of age having the biggest discrepancy of 53% females and 34% males.

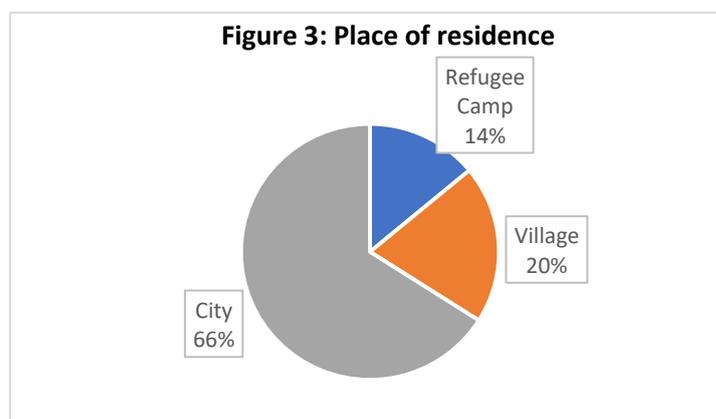


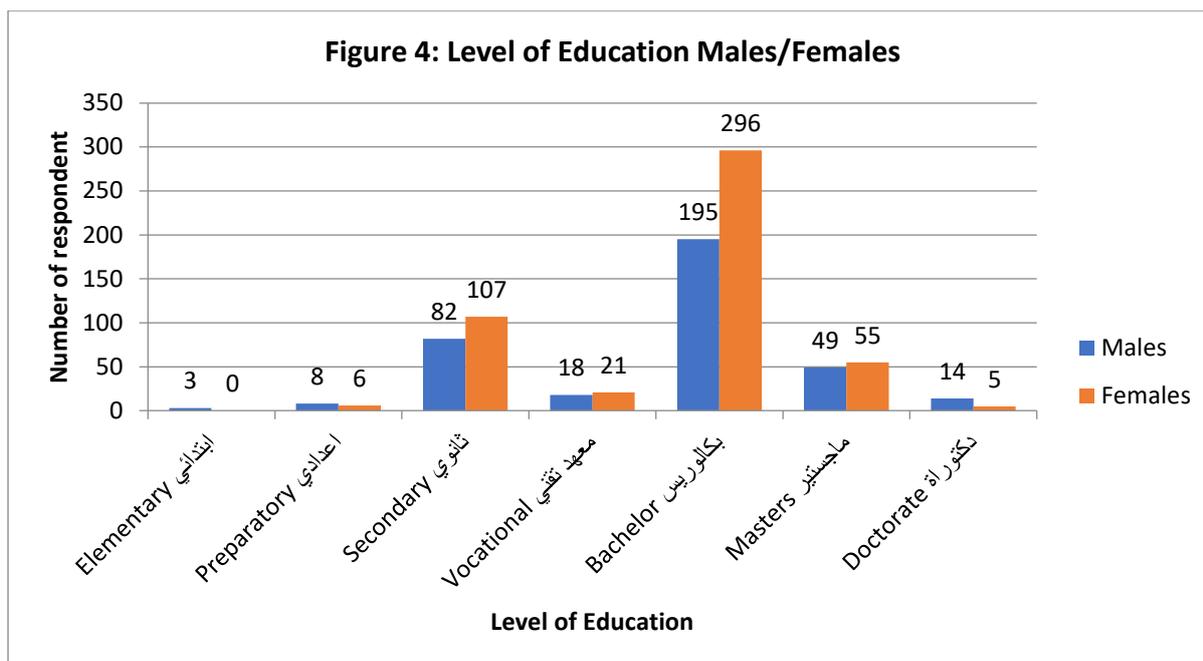
With regards to geographic spread, more than half the respondents 56% came from Gaza Strip (n=481), 6% (n=51) came from East Jerusalem, while 38% (n=329) came from the governorates in the West Bank.



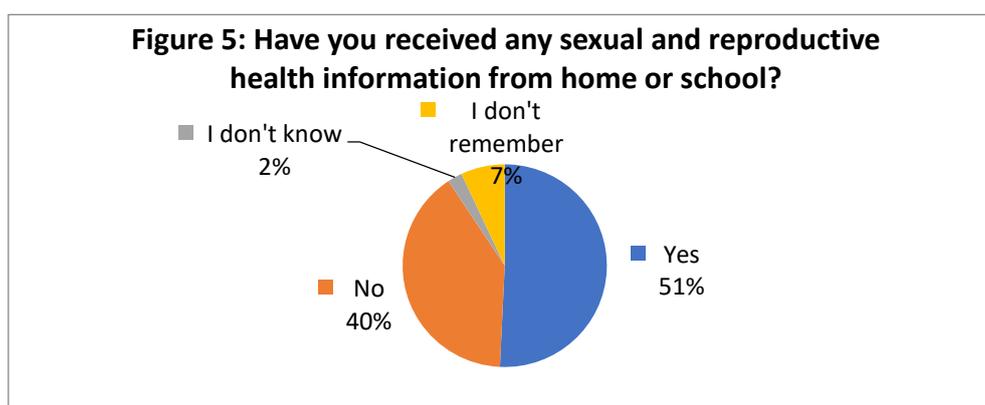
Two percent (n=14) of all respondents identified themselves as people with disability. The percentage of males with disability was much higher than females (13 males and 1 female).

In terms of the social/marital status of the respondents, the vast majority of them 61% (n=522) identified as single, 5% (n=40) as engaged said they are either engaged or in a relationship, 32% (n=273) reported to be married while 3% (n=26) said they are divorced or widowed. Most respondents reported living in an urban setting, city (66%) (n=570), while 20% (n=174) reported living in a village and 14% (n=117) reside in a refugee camp setting.





3.2 Knowledge on Sexual and Reproductive Health



A series of questions was put forward in the survey to better understand how respondent evaluate their current knowledge on SRH. When asked whether they have received information and education on sexual reproductive health at school or at home, a small majority of 51% (n=437) said they have received some information. While 40% (n=344), said they have not received information, 2% said no, they do not know if they have received this information, while 7% said they do not recall receiving this information, (n= 20), and (n= 60) respectively. It is worth noting that a higher percentage of females 54% said they **have** received this information, compared to 46% of males reported to have received this information at school or the home. This could indicate that young women have better access to this information than young men. A similar assumption was made by males during the focus group discussions.

Males who participated in the FGDs said that in their opinions, females usually have more information and face less challenges in obtaining this information. “They have their mothers whom they are closer to than boys in general”. One participant spoke of an assumption that female’s body changes start earlier (with menstruation) and therefore they obtain information on reproductive

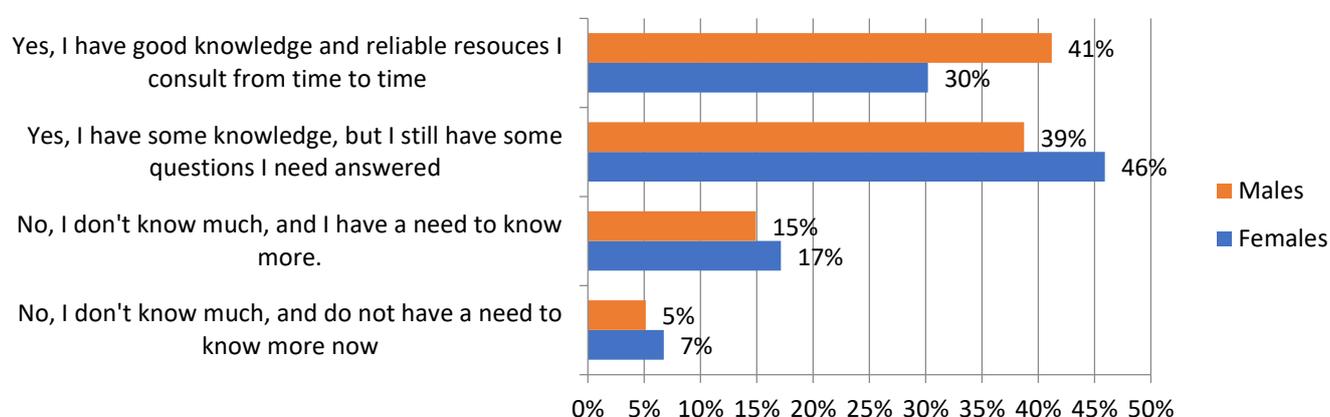
health earlier than boys. Another participant said that because females marry earlier, they usually have more information and need reproductive health services earlier than males. In addition, health centres focus more on women and mother’s health than on males as indicated by several respondents in Gaza who gave examples of women’s centres in the Gaza Strip.

Table 3: Have you received any sexual and reproductive health information from home or school? (Detailed segmentation by age and sex)

Value	All cases	15-18 yrs.	19-24 yrs.	25-29 yrs.	30+ yrs.	Males	Females
Yes نعم	51 % (437)	33 % (7)	53 % (203)	49 % (101)	51 % (126)	46 % (170)	54 % (266)
No لا	40 % (344)	52 % (11)	35 % (135)	46 % (95)	42 % (103)	44 % (162)	37 % (181)
I don't know لا أعرف	2 % (20)	5 % (1)	3 % (13)	1 % (2)	2 % (4)	2 % (9)	2 % (11)
I don't remember لا أتذكر	7 % (60)	10 % (2)	9 % (34)	4 % (9)	6 % (15)	8 % (28)	7 % (32)
Total	Ø 1.7 (n=861)	Ø 1.9 (n=21)	Ø 1.7 (n=385)	Ø 1.6 (n=207)	Ø 1.6 (n=248)	Ø 1.7 (n=369)	Ø 1.6 (n=490)

The following graphic (Figure 6) shows how males and females evaluated their current knowledge of their sexual and reproductive health matters. Respondents were asked to evaluate their **current** knowledge of sexual and reproductive health issues and answer the question: Do you currently have enough information? A higher percentage of males reported that they have good knowledge and reliable resources than females. This result was also confirmed in the second category where fewer males reported to have questions than females. Males *seemed* more confident that they have the right amount of information while females reported a need to know more.

Figure 6: Do you consider yourself knowledgeable regarding your sexual and reproductive health?



A similar trend was observed in the focus group discussions where males were asked to grade their knowledge on sexual and reproductive health. Males tended to give themselves higher grade than females when it comes to how much they know and how much other information they need. This result could reflect pre-existing perception that males' knowledge is an expression of their masculinity, power and reputation. These results are also confirmed by another study conducted by Al-Quds University that showed "students at Al-Quds University were moderately knowledgeable of sexual education; females had a lower knowledge of sexual education than males"¹².

But while males rated themselves higher in knowledge around SRH they still reported that females have more knowledge on SRH than males and are likely to have this information at an earlier stage in their life, mostly be due to the fact that they go through puberty earlier than males. Males' assumption is that females obtain this information from their mothers, and that the sexual socialization of girls happen at an earlier age.

3.3 Sexual and reproductive Education at Schools and Universities

Survey respondents were asked to evaluate the quality and comprehensiveness of the sexual and reproductive health information and education they received at schools and universities. Respondents were asked to rate the quality and comprehensiveness of SRH education on a scale from 1 to 10, with 10 being excellent. The average score of all respondents was 3.7 grades, which is a clear insufficient. Males scored an average of 3.8, while females an average of 3.7. This result shows a high level of dissatisfaction with the quality and comprehensiveness of school and university curricula. The current information available does not meet the expectations and needs of young people when it comes to sexual and reproductive health. The age group 15-18 gave the lowest score with an average of 3.2.

A similar sentiment was iterated in all focus group discussions with some exceptions. Very few participants said that they obtained a good level of information. One participant from Ramallah said that it all depends on what sort of teachers you have and that he benefited a lot from one teacher who did not shy away from the topic.

Respondents noted that in some schools the teacher delivering this topic is not always the biology or health teacher, who is trained and whose mandate is to deliver this material as part of the approved curricula of the Ministry of Education. "Imagine, the religion teacher shows up one day unexpected to cover biology lesson in reproductive health", said an FGD participant from Gaza Strip adding that not all teachers are well prepared or trained to deliver this material.

Another FGD respondent from Ramallah also noted that while she attended a girls-only school, the teacher was hesitant and somewhat embarrassed to talk to her female students. "We went instead to the history teacher, whom we were much closer to. She gave us information and even told us about the hymen. It was the first time all of us heard about the hymen".

Two FGD male participants from Gaza recalled how much they were looking forward to their biology lesson on sexual and reproductive health. They still remember the chapter in the *Health* curricula¹³

¹² https://www.researchgate.net/publication/333718164_Sexual_Education_of_Palestinian_University_Students_Between_Perceptions_and_Cultural_Barriers

¹³ <http://www.moe.pna.ps/services/educational-services/Curriculum#>

that is supposed to explain to them about the reproductive system. They were greatly disappointed when the teacher simply skipped that section and told them to read it at home.

When asked about whether they are in favour of including sexual and reproductive health information and education in school curricula, most survey respondents 90% (n=772) agree with including sexual and reproductive health as a subject in schools. Only 6% said no (n=54), while 4% (n=35) said they do not know whether SRH education should be included in school curricula. This question was validated with a group of young people living in marginalized areas, all 10 participants were in favour of including sexual and reproductive health information in favour of including this theme in school curricula as well.

A closer look at the figures show that the youngest participants ages 15-18 years of age were slightly less in favour of including SRH in school curricula (71% as opposed to 90% scored by older age groups). However, the same age group (15-18 years of age) were also the highest in scoring “I don’t know” 19% as opposed to 3 – 4% in other age groups. This could be an indication that they have not yet formed an opinion about the matter, and that the older age groups are more sure of their position since they might have by now realized the advantages or disadvantages of having sexual and reproductive health education in schools, and how that might affect their lives and choices later in life.

Value	All age groups	15-18 yrs	19-24 yrs	25-29 yrs	30+ yrs
نعم Yes	90 % (772)	71 % (15)	90 % (347)	90 % (186)	90 % (224)
لا No	6 % (54)	10 % (2)	6 % (24)	6 % (12)	6 % (16)
I don't Know	4 % (35)	19 % (4)	4 % (14)	4 % (9)	3 % (8)
لا أعرف					
Total	Ø 1.1 (n=861)	Ø 1.5 (n=21)	Ø 1.1 (n=385)	Ø 1.1 (n=207)	Ø 1.1 (n=248)

3.4 Sources of Information on Sexual and Reproductive Health

“When you are in grade 5 and 6 you start looking forward to grade 7 when they will finally explain these things to you. You get to this lesson and you realize that your own information that you have gathered so far, is more than what the textbooks offer you at this point”.

The youth survey was designed to understand how young people seek information on sexual and reproductive health. What is currently their used channels and sources? And do they have a preferred channel? In other words, who do they trust the most and what channels do they prefer when obtaining this information or

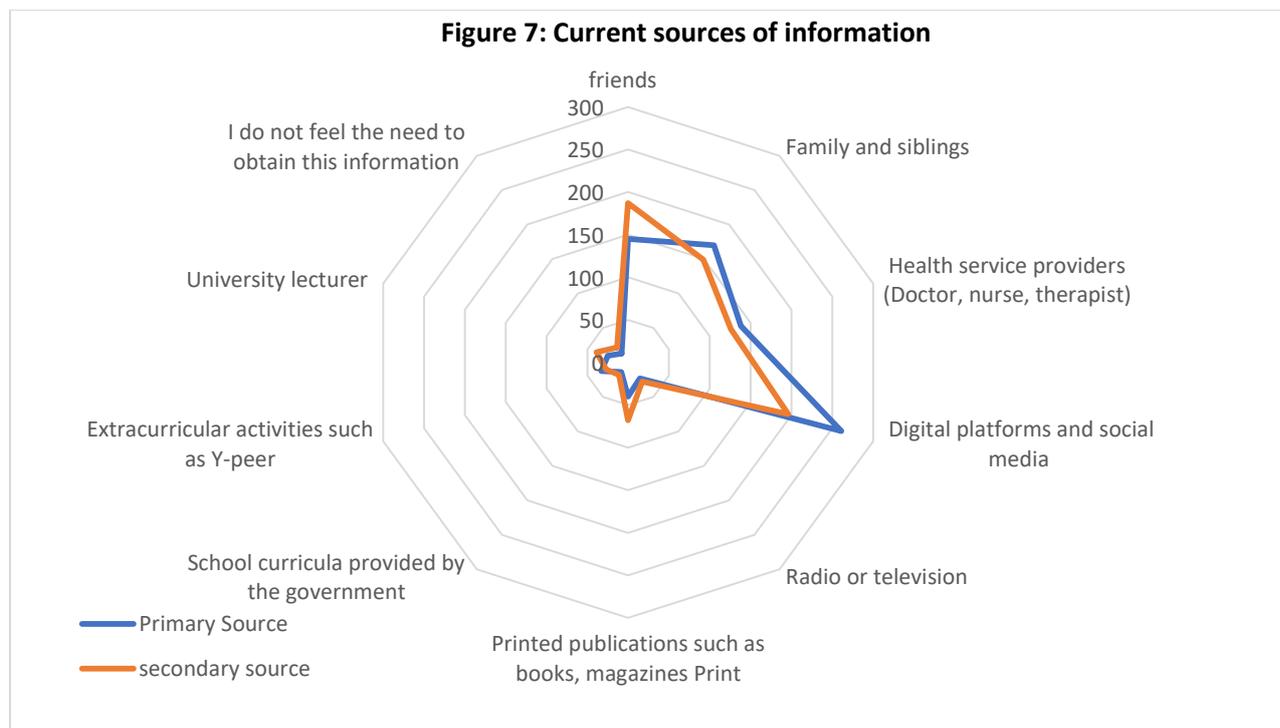
service.

When asked about the **current** sources of information on SRH, a significant number of respondents (n=261) chose internet platforms and social media as the current main source of information,

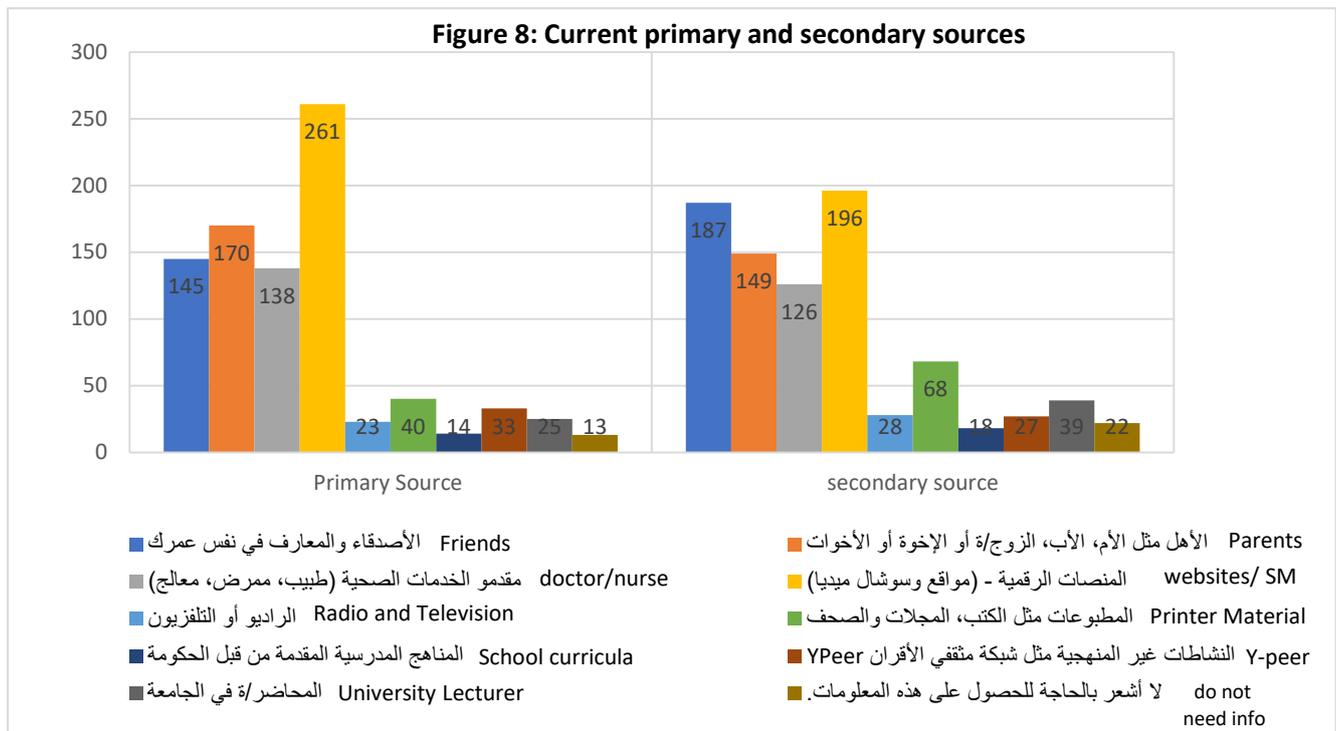
followed by friends and peers, and family, and doctors and service providers in the fourth place. It is important to consider here two facts: one that the question was about the **current** sources (later in the survey the question of preferred source is raised separately) and secondly that this survey differentiated between the internet as a source of information on one hand and as a medium or channel to transfer or receive this information on the second. This will be handled further in the next section.

The spider diagram below (Figure 7) shows the primary and secondary choices of information **currently** most used by respondents. There is a clear tendency to lean towards sources on the right-hand side of the diagram (friends, family, service providers and digital platforms), while sources such as school curricula, university curricula, and peer-to-peer education were ranked lowest among the respondents. It is also worth noting here that there was not a significant difference in the choices made by males and females in this question as both sexes leaned towards the internet, peers, family, and medical staff as the main sources of information.

What are currently your sources of information that you rely on when it comes to reproductive and sexual health?



Another visual representation for the informational sources that survey respondents rely on currently here below clearly indicates that youth scored school curricula the lowest as a source of information.

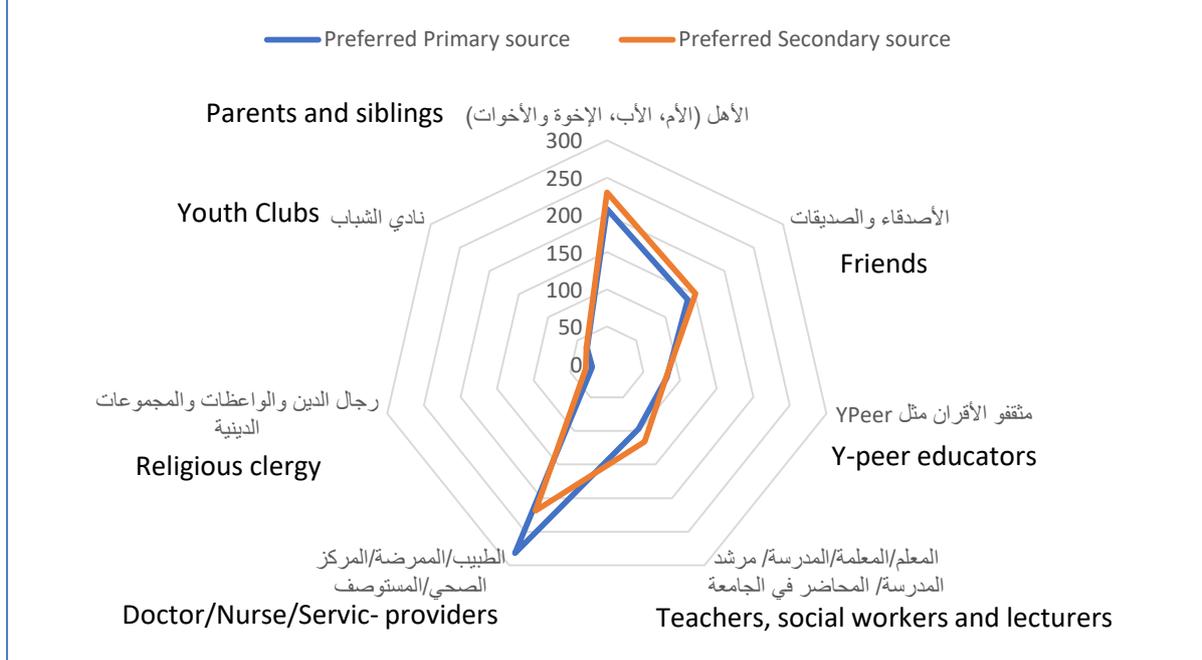


The FGDs confirmed the results of the Youth Survey. Male participants said that most of their knowledge came from peers, friends and other family members who are older, confirming the results of the survey as well. One participant from Gaza said: “At home I got the main headlines, very little info which left me searching and asking friends for more information. Each friend, especially when they are older have more information, and so you collect your new knowledge from here and there, by interacting with others and listening to their stories”.

One respondent commented: “When you are in grade 5 and 6 you start looking forward to grade 7 when they will finally explain these things to you. You get to this lesson and you realize that your own information that you have gathered so far, is more than what the textbooks offer you at this point”. Another male in the Ramallah FGD explained how a lot of the information he got from experienced peers was wrong and has led him to wrong practices and affected him not only physically but also psychologically.

When asked about their preferred persons/groups that young people want to engage with on sexual and reproductive health information and services, it was clear that the most trusted and reliable person(s) where respondents want to obtain information are the medical personnel, doctors, nurses and health centres in the first instance. Compared to the diagram on current sources (Figure 7 above), there is a clear shift towards medical personnel. This also confirms the results from previous study on “Social norms related to SRHR of young women and girls, UNFPA January 2019) which showed that women and girls, ages 25-29 preferred health care providers as the source of information, and that younger age groups preferred mothers. See the diagram Figure 9 below.

Figure 9: Preferred person(s): Primary and Secondary (A)

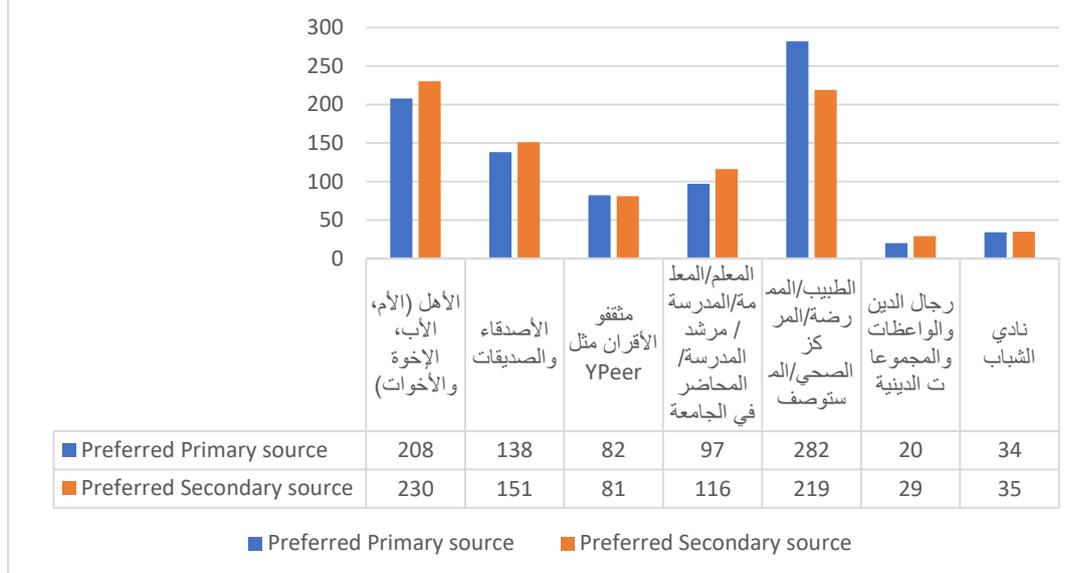


Doctors, nurses and staff of medical centres were the most preferred source of information, followed by family and siblings, friends and peers, and by schoolteachers and university lecturers as the fourth preferred source or persons to engage on these topics.

This preference was also validated in the FGDs as well as the group of youth 15-18 and those living in marginalized areas. Participants prefer to obtain this information from experts and doctors who have the knowledge and ability to address the topic from a health point of view. This is also reflected in the final two questions of the survey where participants were asked to share their suggestions on how to improve the sexual and reproductive health information and education, and how to raise awareness of these topics in the Palestinian society. A considerable number of responses saw that platforms that offer information and advice by experts and medical personnel as one of the main interventions of addressing the lack of information and access to services.

The following chart is a numerical representation of the previous spider diagram (Figure 9), presented in exact figures of respondents who chose the primary and secondary persons they see as the most preferred for delivering sexual and reproductive health information.

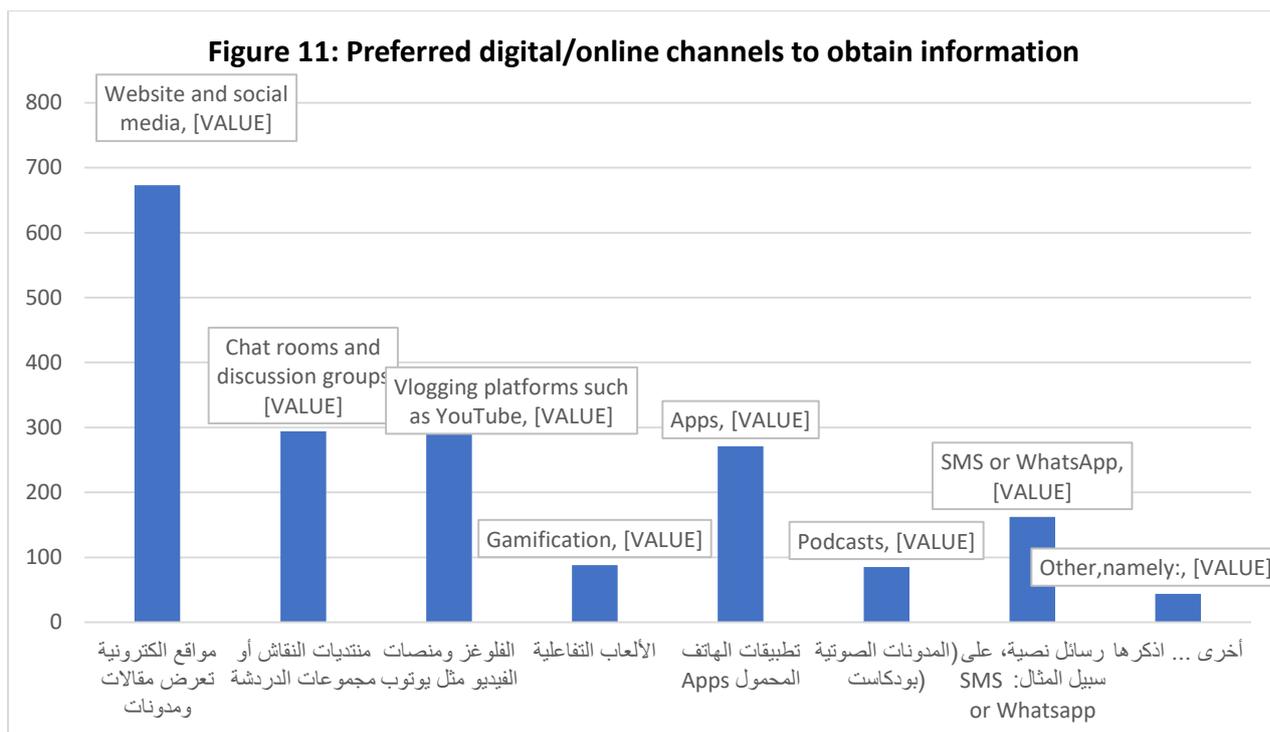
Figure 10: Preferred persons(s): Primary and Secondary (B)



3.5 Digital and Online Channels

Digital and online channels were **currently** the most used mechanisms to obtain SRH information. Some focus group respondents also reported using “The Internet” and “Google” as a source of information. In order to unravel what exactly they mean by the Internet, all respondents were then asked to list their preferred digital/online platform or channel to obtain and engage in information regarding sexual and reproductive health. It is important to distinguish here that channels are only a method, and a way to obtain the information and is not a source on its own. For example, a doctor who has a vlog on YouTube is the source, while the channel is YouTube. This distinction was made in order to differentiate sources and avoid answers such as “Google” or “internet” to obtain detailed insights.

In order to better understand the mechanism of how young people prefer to obtain the information, a follow-up question was put forward asking: Which digital/online channels do you prefer to find this information. Respondents were asked to choose the top 3 preferred channels (or ways to obtain information and education). Online channels are channels that require internet access, such as accessing a website, watching a YouTube channel, or receiving WhatsApp messages online, while digital channels can be channels that do not require you to be online all the time such as offline mobile applications and SMS services, these are digital channels but do not require ongoing online (internet) access.



A clear preference was given to digital online platforms and social media that offer articles and blogs on sexual and reproductive health. In the second and third places came both online discussion forums and chat groups/rooms where young people can ask questions and interact with experts or peers, as well as vlog platforms such as YouTube. The fourth place was given to mobile Apps, followed by short messages such as SMS or WhatsApp channels. The least chosen channels were gamification channels and podcasts.

Respondents were given a chance to comment further on this question and name other online/digital channels. Responses included specific channels they prefer to use such as: Telegram, Instagram, Facebook, online websites of the ministries (health, education, and religious affairs), and google search engine. In addition, there was no significant or major difference between choices of channels preferred by males as opposed to channels preferred by females. Pornography was another source named by two respondents in the FGDs. One male participant from Gaza Strip mentioned the role of online pornography in his sexual education process: “We started watching porn in grade 5 already. Once you watch the first video, YouTube and Facebook starts to suggest similar videos”.

3.6 Information and Service Needs of Youth

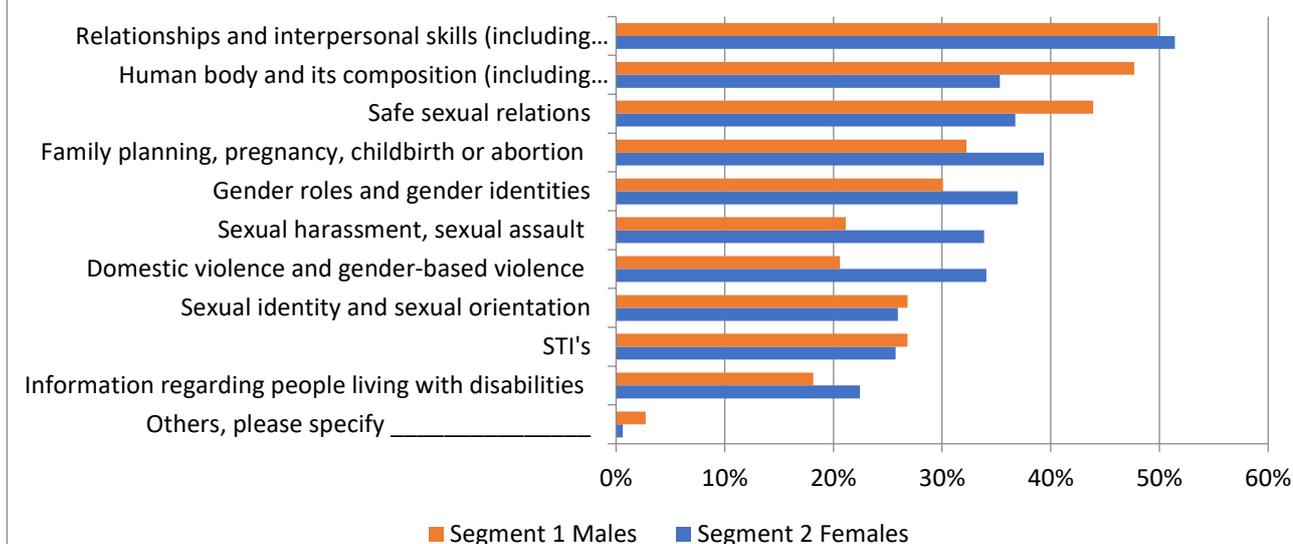
When it comes to specific topics and thematic information that young people need, respondents were asked to choose up to three topics related to sexual and reproductive health where they needed further information. The most popular topics included: relationships and interpersonal skills within the relationship (including friendships, family relations, and communication between the sexes) in the first place. The second place was occupied by information on the human body, its functions including the reproductive system and puberty as examples). The third most important topic chosen is safe sexual relations, followed by family planning, and gender as the fourth and fifth

places

respectively.

The following graph shows a difference between males and females when it comes to topic choices and informational needs. Males leaned more towards “physical topics” more often, including topics such as the human body, safe sex, sexual identity, and STIs. Whereas females’ informational needs focused on building relationships and relating to the other, gender-related topics, domestic violence, harassment, as well as family planning methods, and reproductive health needs of people with disability.

Figure 12: Informational Needs of Respondents



This difference in informational needs between males and females was slightly present in the FGDs, and one could not say that it confirmed or validated the difference in informational needs. For example, females from Ramallah highlighted the importance of education around healthy relationships within the family and direct surroundings. One female participant explained: “It is important for a young girl to be able to differentiate and speak out if she is being molested by someone close to her”. However, there is no convincing evidence to conclude that females had significantly different informational needs from their male counterparts. It is probable here to conclude from the survey results that female are socialized to be in the role of caregivers and peacemakers within the relationship, and therefore feel a need to obtain information and soft skills such as communication and negotiation within the relationship. While males on the other hand might be socialized to focus more on the physical aspects of manhood, and that prevailing social norms may lead males to think it is more ‘manly’ to be focused on the physical issues and not the ‘softer’ relationship related topics.

3.7 Social Norms and SRH

Several statements regarding attitudes and social norms towards sexual and reproductive health and rights of young people were put forward during the survey. The question identified that there is no

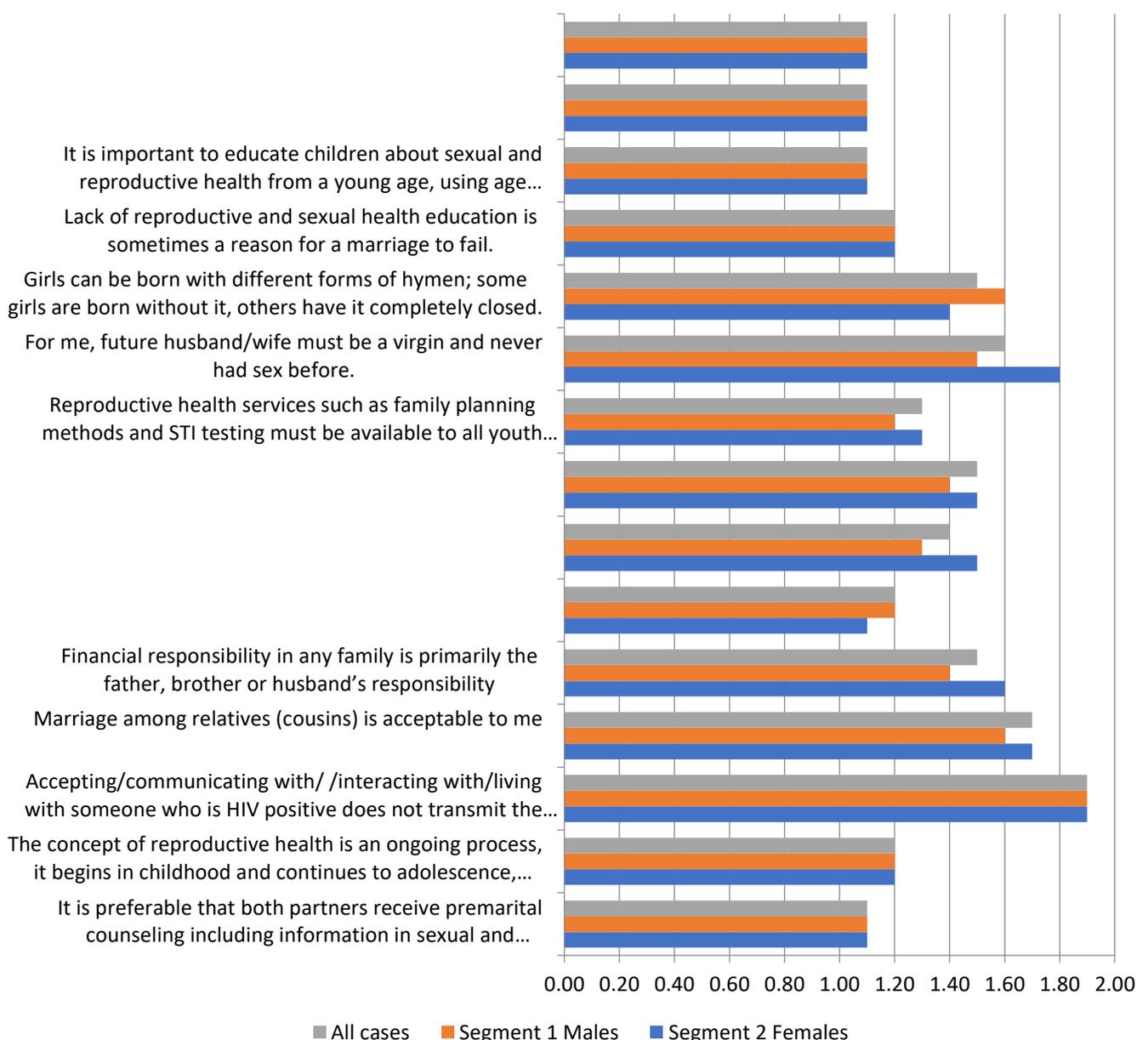
right or wrong answer to these statements as they served to understand how young people in Palestine view different issues regarding their sexual reproductive health and rights. Respondents had the choice to agree, disagree, or opt for the option “I don’t know”. A full list of these statements is available in Annex 2.

Both males and females responding to the survey, as well as the FGDs participants expressed progressive attitudes towards reproductive and sexual health issues such as the need to introduce SRH education at an early age; that having this knowledge contributes to a better future; that lack of SRH education could lead to marital problems.

There was a clear agreement between both males and females on 6 statements, namely: Most of the respondents (91.9%) (n= 789) agreed with the statement “It is preferred for both future husbands and wives to be aware and educated about their sexual and reproductive health before marriage”.

A similar result was identified in the statement: “Family Planning is a joint responsibility of both partners and is not the sole responsibility of the woman only”. 95% of respondents (n=812) agreed while only 3% disagreed and 2% said they don’t know.

Figure 13 : Social Norms Statements (Q19 of survey)



Other statements that received agreement from all respondents included: 95% of all respondents agreed that “It’s important to gradually educate children with age-appropriate material on their sexual and reproductive health from a young age.” 87% of all males and females agreed that the lack of reproductive and sexual health information for couples can lead to failure in the marriage. 86% agreed that sexual and reproductive health education is an ongoing process that begins with childhood and continues beyond the reproductive age. 96% of all respondents agreed that sexual and reproductive health awareness contributes to a healthier and better future for all.

However, there were some significant discrepancies on other statements and a clear difference of opinion between both male and female respondents. These differences focus on topics related to their perception of virginity, gender roles, pornography (visual sexual material), marrying within the family, and gender roles. Two examples are given below to illustrate attitudes toward virginity, and towards pornography.

Figure 14: My future partner must be a virgin – statement F

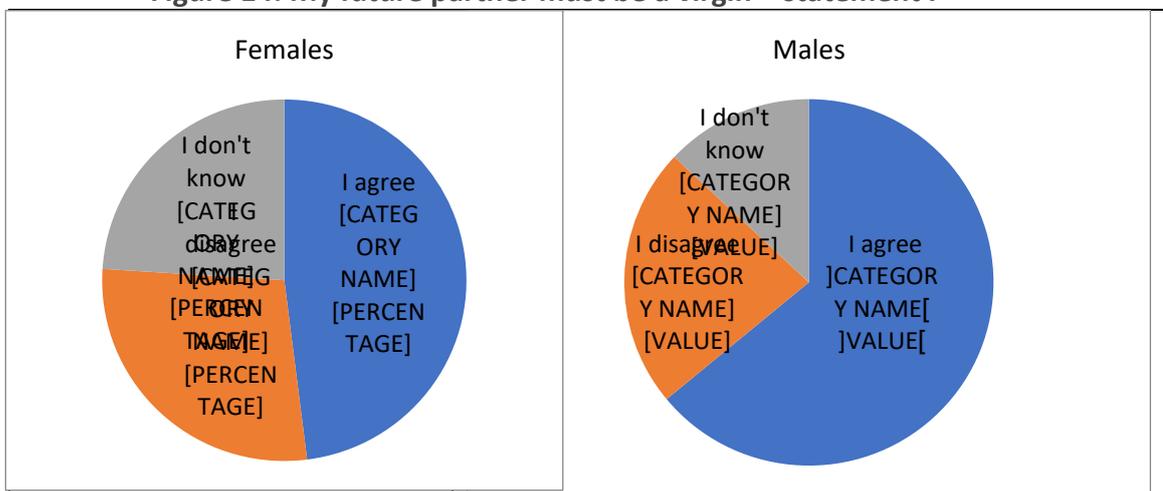
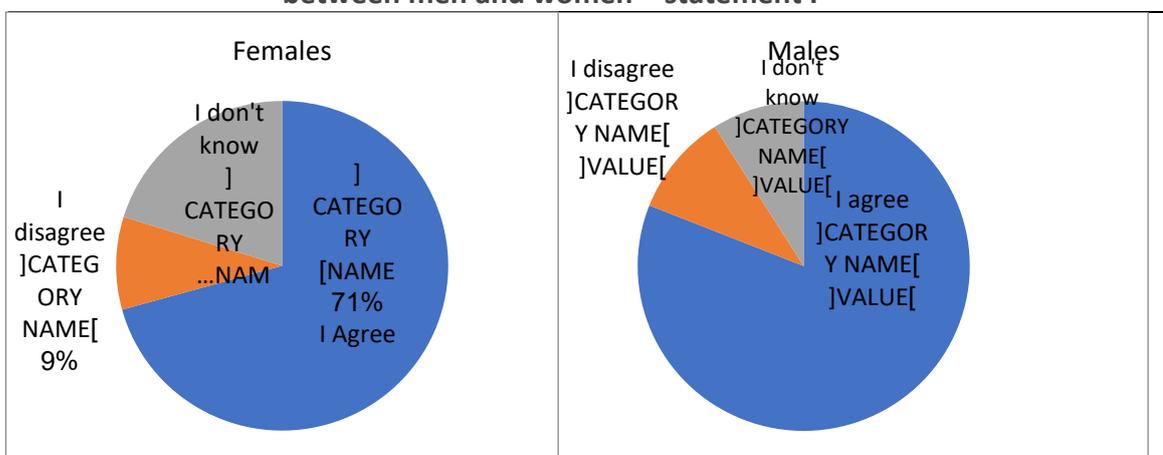


Figure 15: Pornographic material does not reflect the real relationship between men and women – statement I



3.8 Attitudes Towards Sexual and Reproductive Health Education in Schools

The survey investigated the attitudes of young surveyed persons with regards to their openness to receiving comprehensive sexuality education (CSE) at schools. The UNESCO International technical guidance on sexuality education defines comprehensive sexuality education as “A curriculum-based process of teaching and learning about the cognitive, emotional, physical and social aspects of sexuality. It aims to equip children and young people with knowledge, skills, attitudes and values that will empower them to: realize their health, well-being and dignity; develop respectful social and sexual relationships; consider how their choices affect their own well-being and that of others; and, understand and ensure the protection of their rights throughout their lives.”¹⁴.

Almost **one-third** of all respondents (n=248) are in favour of including CSE curricula in school curricula at least starting at 4 years of age. A total of 15% of all respondents agreed to include sexual and reproductive health information and education in schools starting age 8 (equivalent to third-grade 3rd grade elementary school), while more than half agree to start engaging young people on sexual and reproductive health as of age 12 (beginning of preparatory school or grade 7).

Within the group that chose to start at age 4 and beyond, the percentage of females in favour was higher than males (33% females, and 24% of males). This can indicate a higher receptiveness and of females to this information. Another significant difference was in the percentage of males who agree with including sexual and reproductive health information and education in schools starting at 16 years of age and above. Almost one-third of males agreed (29%), while the percentage of females was significantly lower at 20%. This could also be a confirmation of previous results where it is seen that females have a higher interest in obtaining and finding information and are more in support of including this information in schools in general and starting at a lower age group in specific. Previous field survey among 300 Palestinian girls and women indicated that 64% of the surveyed women expressed their need to have earlier exposure of sexual and reproductive health education and preferred this to be before reaching the age of 15¹⁵. In this study 72% of all respondents were in favour of addressing these topics before the age of 16.

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¹⁵ “The social norms related to Sexual and Reproductive Health and Rights (SRHR) of young women and girls, PMRS, 2019).

Figure 16: All Respondents: What do you think is the appropriate age to begin with sexual and reproductive health education?

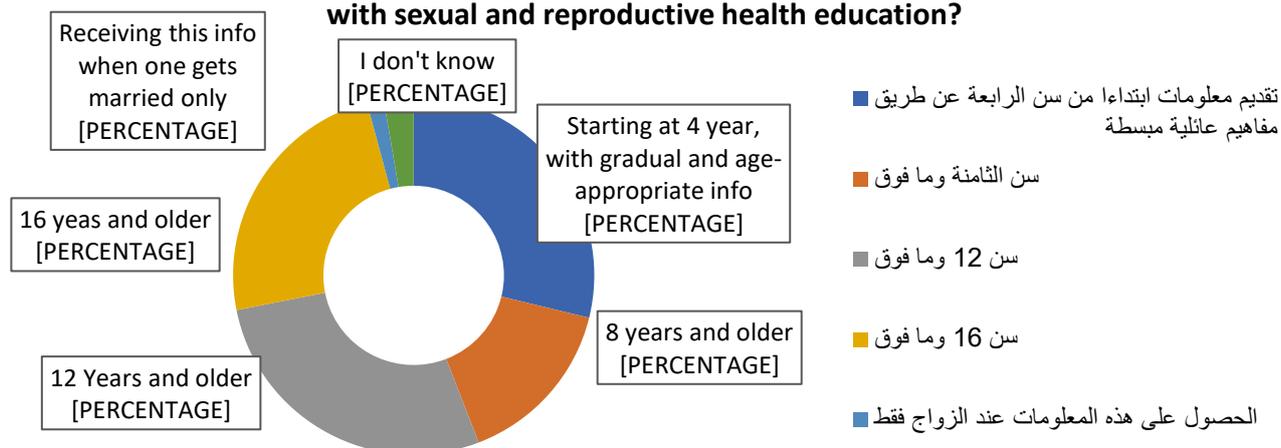


Table 5: What do you think is the appropriate age to begin with sexual and reproductive health education, by age category and sex:

Value	All cases	15-18 yrs.	19-24 yrs.	25-29 yrs.	30+ yrs.	Males	Females
Starting at 4 year, with gradual and age-appropriate info	29 % (248)	29 % (6)	28 % (109)	28 % (57)	31 % (76)	24 % (88)	33 % (160)
8 years and older	15 % (132)	10 % (2)	13 % (51)	14 % (30)	20 % (49)	15 % (54)	16 % (77)
12 years and older	28 % (239)	33 % (7)	29 % (111)	24 % (49)	29 % (72)	29 % (107)	27 % (132)
16 years and older	24 % (206)	14 % (3)	25 % (97)	29 % (60)	19 % (46)	29 % (107)	20 % (98)
Receiving this info when one gets married only	2 % (13)	0 % (0)	2 % (8)	1 % (2)	1 % (3)	1 % (5)	2 % (8)
I don't know	3 % (23)	14 % (3)	2 % (9)	4 % (9)	1 % (2)	2 % (8)	3 % (15)
Total	Ø 2.6 (n=861)	Ø 2.9 (n=21)	Ø 2.7 (n=385)	Ø 2.7 (n=207)	Ø 2.4 (n=248)	Ø 2.8 (n=369)	Ø 2.5 (n=490)

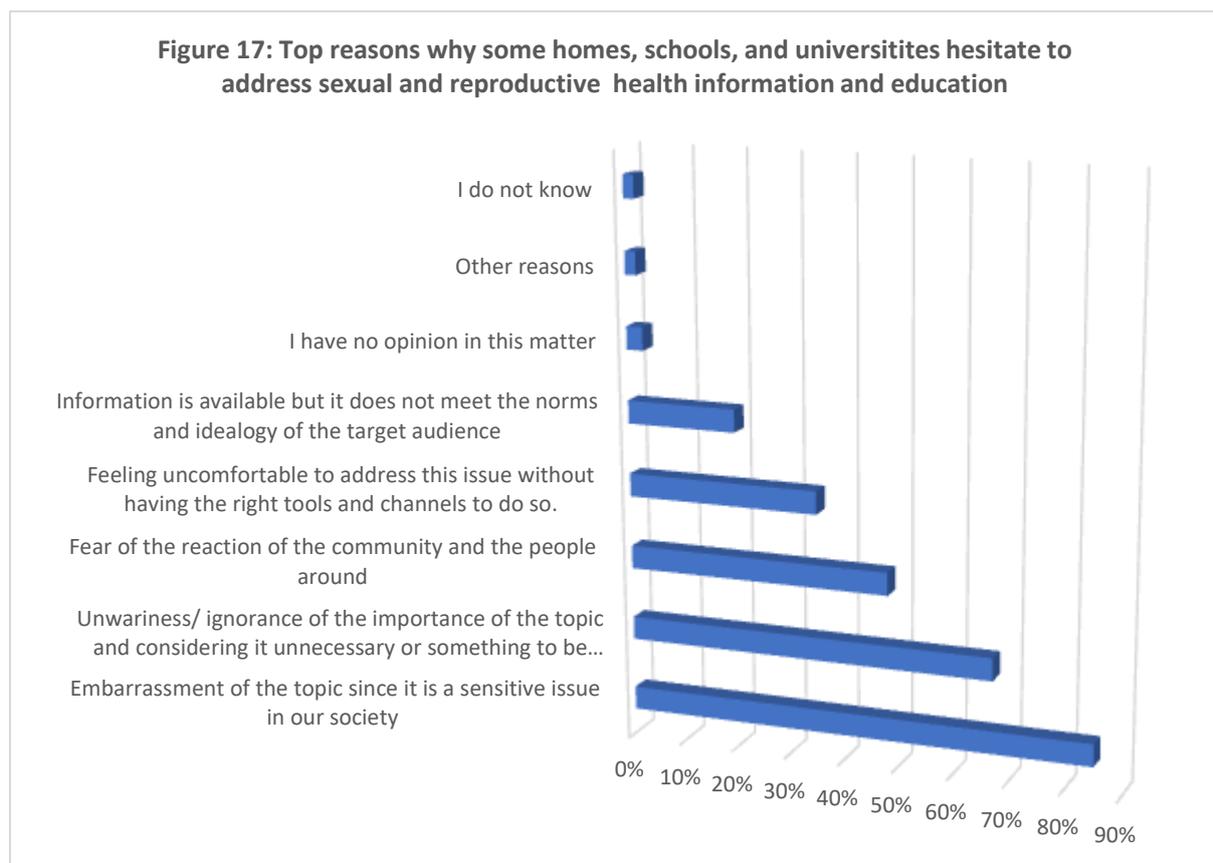
“As soon as a child starts walking, we need to start to educate them about their bodies, who is allowed to touch them and who not, teaching them that their bodies are theirs and not for anyone to touch and kiss whenever they please”.

When respondents were asked to choose the top three reasons why they think schools and parents do not openly talk about sexual and reproductive health, most respondents ranked “Embarrassment and feelings of shame, considering this a sensitive topic and *Eib* (shameful) to talk about as the

number one reason. Feeling of shame and embarrassment was followed by “Ignorance and unawareness of the importance of this topic in all stages of life and considering it (meaning SRH information) a must-have when getting married only”. The third most important reason is “Fear of the negative reaction of surrounding society”.

In the validation discussions, participants were in favour of including SRH information in school curricula. For example, the Ramallah female group all agreed to include sexual and reproductive health education at an early age, giving gradual information, that are comprehensible and appropriate per age group, and building on the info as one grows older. One participant illustrated saying: “As soon as a child starts walking, we need to start to educate them about their bodies, who is allowed to touch them and who not, teaching them that their bodies are theirs and not for anyone to touch and kiss whenever they please”.

Another respondent added: “it’s not only about school curricula, we need to have a comprehensive approach and start with the home as well. We have village councils and municipalities who have access to their communities. If we gather women who have children in a certain age group in the village, we can engage to understand what information they need, and do they know how to bring it over to their children. If a mother herself doesn’t know, how can she educate her child?”



Several survey respondents followed up by adding further notes to this question further elaborating on why schools or parents at home are too careful with such topics. One respondent summed it by saying that society equates sexual and reproductive health information with sexual intercourse only.

“لأن باعتقاد المجتمع بأن المقصود من الصحة الإنجابية هي العلاقة الجنسية فقط.”

“Because in the eyes of society, what is meant by reproductive health is sexual intercourse only”
The frequently used argument put forward by participants is the belief of parents and/educators that addressing this topic with young people “opens their eyes”, meaning that young people will be exposed to new knowledge that would encourage them to be sexually active at a younger age. One respondent said that this is often a struggle faced by some educators who are afraid that parents will disapprove of covering this material at school and are keen on choosing schools where this curriculum is not offered. Other reasons given were that educators do not have the right knowledge and skills to address these topics, so they avoid opening the topic; and that SRH education is not part of our tradition or way of doing things; as well as unawareness about the importance of addressing this topic. Religion was considered a limitation by some respondents, and an opportunity by others.

Reasons given by respondents are clearly related to what is called Injunctive norms, also often called moral norms. These do not refer to what one feels and does, but rather to what one thinks others think and feel or expect about one’s behaviour. “It’s a taboo topic and those who initiate talking about it are perceived as guilty (immoral), said one respondent *تابو اجتماعي يلصق التهم بالمبادرين*. Another said: “Sexual education is perceived as a disgraceful topic that detracts/derails the individual from his or her religious path, but we all know this is not true”.

“النظر للثقافة الجنسية على أنها فعل مشين ينقص من الفرد أو أنه غير ملتزم دينياً عند تفكيره في هذه الأمور لكن هذا أمر غير صحيح”

Another respondent said: “They think that talking about these topics encourages young people (from both sexes) to have extra-marital affairs. This is something we often hear in society even though it is wrong (in colloquial language they would say: We don’t want to open their eyes”.

“ظناً منهم ان الحديث عن هذه المواضيع قد يجعل الشباب (من كلا الجنسين) الى التوجه لاقامة علاقات جنسية خارج اطار الزواج ، وهو رأي نسمعه دائماً في المجتمع رغم انه للأسف خاطئ (بالعامية يقولون: ما بدنا نفتح عيونهم)“.

Very few respondents felt apprehensive about addressing such topics at an early age. In the words of one female respondent, many people fear that sexual and reproductive health education may lead to “moral decline”, and added that she herself believes this, and thinks that such information should be provided through pre-marital counselling: *I am in favour of having a premarital workshop addressing relationships, communication and mutual respect for engaged couples for a period of at least 6 months. This is, in my opinion, the ideal solution to overcome ignorance/naivety between couples”.*

“الخوف من النحادر الأخلاقي للبعض وانا من المتخوفين أيضا ، لآكن اوايد عمل دورة تدريبية في العلاقات والتفاهم والتفاعل والاحترام بين الزوجين في فترة الخطوبة للزوجين لا تقل عن ستة أشهر وبرأيي هذا الحل الامثل للتخلص من الجهل بالعلاقات بين الزوجين”.

This question opened a lot of discussion, stories and anecdotes in the FGD sessions. Some FGD respondents made comments that parents gave them “The headlines” only at home and did not deep dive into topics. At times parents use cryptic language and jokes to tease their children. “You are now a man” when the mother discovers dirty underwear of her child after having his first wet dream. Teasing about entering puberty but at the same time not explaining the changes that take place created a feeling of embarrassment, inappropriateness and generally feeling different or abnormal to some respondents.

Respondents said that adults assume that their children know. One female participant from Ramallah shared how a year after she got her period, her mother found by accident that she was using pads in the wrong way. A whole year has passed before she finally was instructed how to use a pad.

Even simple and self-evident information is sometimes overlooked by parents and caregivers according to discussions that took place during the FGDs. Sometimes the information that a young person needs is not complicated. For example, several FGD participants mentioned the Islamic Washing *غسيل الجنابة* as an example. How to clean yourself up in accordance with the Islamic laws, for

“When you are still a boy sitting with your mom and aunts, you hear them talking about women stuff, and suddenly they discover you’re in the room and kick you out, you have no idea why but you start associating these topics of things you should not know or hear...”

example after finishing off the monthly cycle for girls, is an example of a piece of information that youth reported having missed from their parents during puberty.

The vagueness, secrecy and discomfort are felt by youth at an early age, says one participant: “When you are still a boy sitting with your mom and aunts, you hear them talking about women stuff, and suddenly they discover you’re in the room and kick you out, you have no idea why but you start associating these topics of things you should not know or hear”. He added “Or when you are watching a movie with your father and a kissing scene comes, you feel so uncomfortable as if you are the one doing the kissing, these are situations where you start feeling guilty because they make you feel out of place”, explained one FGD male participant from Gaza.

One FGD respondent from Ramallah, shared a story of how in a mixed school, the boys and the girls were in shock for a whole week after the teacher has taken them through the biology lesson. “We all felt exposed, we could not speak to the other sex for a whole week, we were in shock”.

The previous example illustrates how students might come from a background that limits their exposure to the opposite sex at home and in schools. Some pupils attend girls-only or boys-only schools during the primary educational phase (grades 1-6). During the preparatory, and secondary (high school grades 7-12), they transfer to mixed schools, especially if the number of students is too low to keep sex segregated schools. This could be a giant leap for some students who are not socialized to mix with the other sex and find it difficult to related and be in the company of the other sex. Add to that a reproductive health biology lesson which might make youngsters feel uncomfortable with each other. It is therefore important that sexual and reproductive health education is phased and is incremental and gradual, building on the basic concepts of family and relations during young age and moving gradually to handle more physical and emotional elements of SRH.

A similar scenario was described in an interview with Mrs. Amal Awadallah Masri of the PFPPA whose organisation conducts CSE trainings with youth. Gender balance is maintained in all trainings.

“On day one of the training, you will find the boys sitting on one side, and the girls sitting on the other. By the end of the training, you take pictures and see they mixed up.”

Many young people expressed confusion and distress at the way social norms around them changed – seemingly inexplicably – as they hit puberty. It left them confused and sometimes even angry. One respondent shared a story of how she saved all her pocket money for months to be able to buy a bicycle. She played for hours with her pink bicycle. She bitterly recalls: “a day after I got my period, my mother took my bicycle and gifted it to my male cousin. The next time I saw him playing with the bike it was painted green”. Once young people reached puberty, they saw their lives and relations changing, along with a change in gendered expectations, often times without a clear explanation.

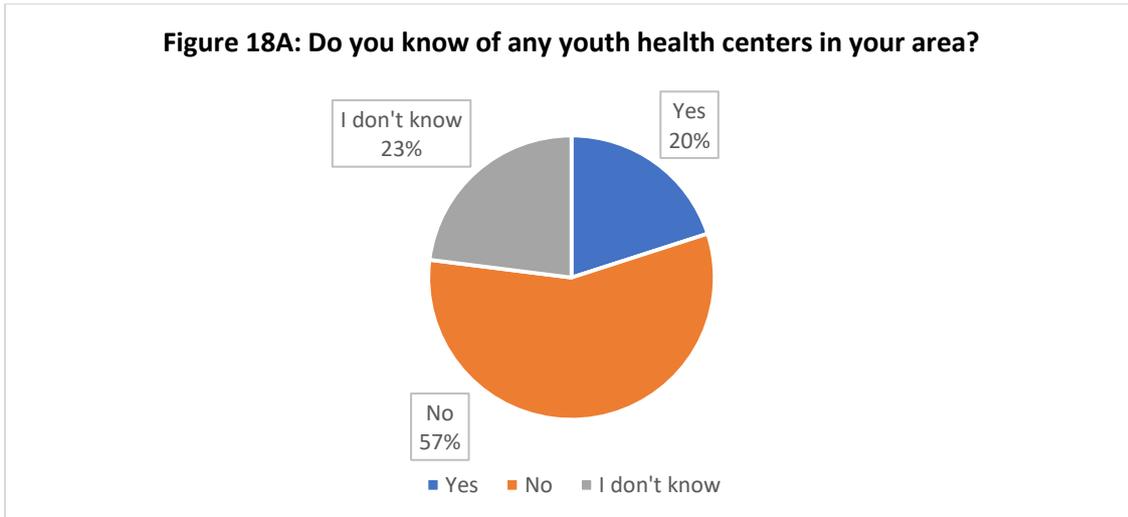
Social norms around SRH are reinforced sometimes in the smallest things. For example, during the FGD in Ramallah some girls shared how in some shops in the villages you would find the monthly pads stuck in a dark corner of the shop, with a set of black plastic bags hanging next to them. “When monthly pads become so secretive, you grow up thinking this is a secret, and something to be ashamed of that you must hide it from others” said one female participant.

“You grow up hearing the words Haram and Eib over and over again, but when you get married, you are expected to suddenly know everything”.

As soon as they got their periods, the lives of many girls changed. Suddenly they were no longer allowed to ride bicycles, dance Dabkeh with their male peers, participate in the Scouting *Kashaaf*, sleep over at friends or family outside the house. They had to give up some of their favourite hobbies simply because they now have their periods. Girls become ashamed if they buy monthly pads. Their surroundings gradually socialize them to become ashamed of the most natural changes in their lives. Yet much is expected of these females when they enter adulthood and get married. As one participant put it: “You grow up hearing the words *Haram* and *Eib* over and over again, but when you get married, you are expected to suddenly know everything”.

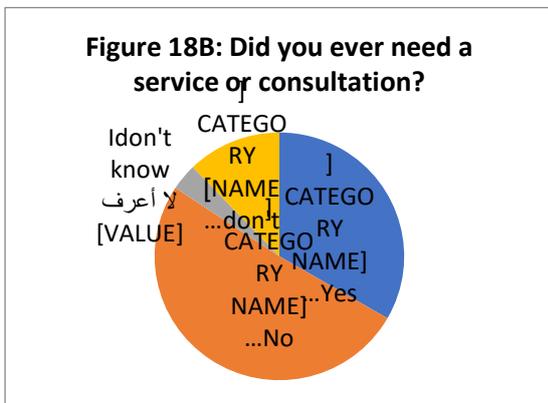
3.9 Awareness and Availability of Services

Figure 18A: Do you know of any youth health centers in your area?



Only 20% (n=171) of all respondents of the survey know of a youth medical centre in their areas as shown in the figure below. More than half of the respondents of the online survey was unaware of any youth centres that they can consult or obtain services at. When asked if they ever needed a reproductive health-related medical service or consultation, 33% (n=287) of respondents said yes. FGD respondents were also not aware of special services or youth centres available for youth only. If a service or consultation is needed, girls reported that they would first ask a trusted person in their direct surroundings or ask their mothers to go to the doctor for cases like irregular periods.

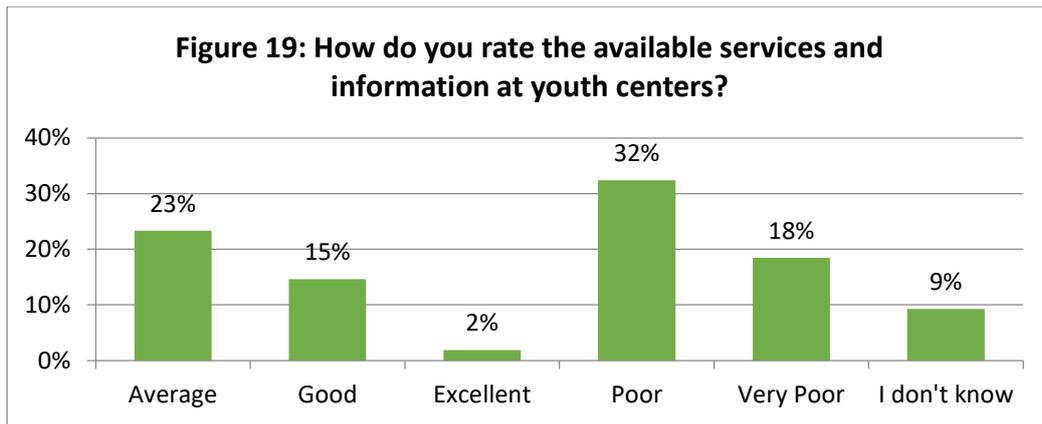
Figure 18B: Did you ever need a service or consultation?



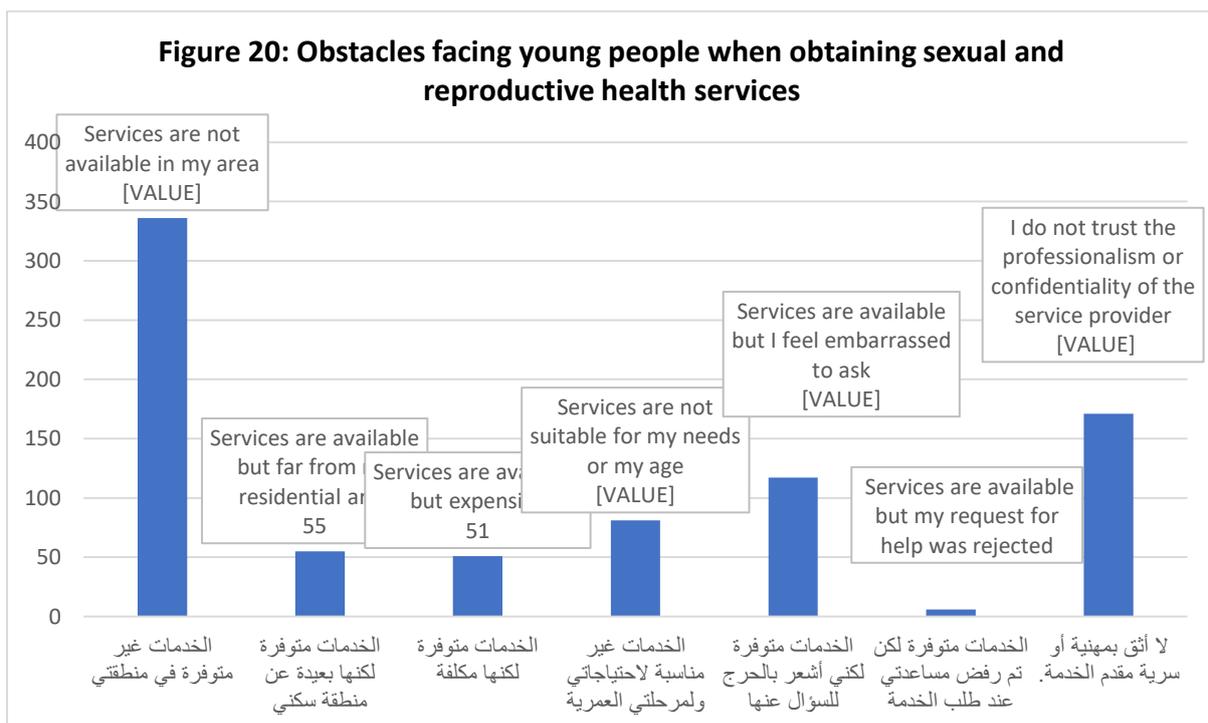
The nature of consultations sought by respondents were very diverse covering all core SRH topics and questions regarding sexual relations and practices. The following topics were listed by respondents as areas where they needed consultation and visited a health centre for: *Early or late menstruation; sex and disability; birth control; virginity and sexual pleasure; STIs; family planning; infertility treatment; body image and concerns about penis size; ovulation; healthy sexual relationships; puberty;*

sexual intercourse for the first time; wedding night; sexual relations during the engagement period; sexual positions; masturbation sexual diversity; pregnancy and prenatal care; miscarriage; life after divorce; communication between couples”.

How did respondents rate the quality of the services obtained, in the case that they have sought a service? Survey analysis shows that 50% of all respondents who answered this question rated the available services as poor or very poor, while only 17% rated them as good to excellent. 23% gave an “average” or acceptable rating, while 9% said they do not know.



The following chart (Figure 20) illustrates the top obstacles respondents ranked highest when asked about the main challenges when accessing SRH services. The highest percentage was given to option “because the service is not available in my area”, followed by the challenge “I do not trust the professionalism and confidentiality of the service provider”, the third most named challenge was “service is available, but I feel ashamed asking for it”.



The most chosen challenge is the unavailability of the youth centres in all parts of Palestinian territories. This was a common remark given in FGDs especially in that of the Gaza Strip, noting that services do not reach all areas of the Strip. Also, male participants in the FGDs in Gaza preferred not to visit a youth centre if needing a consultation for fear of stigma if a friend or an acquaintance sees them in the centre. A similar suggestion was made by several survey respondents who recommended that youth health centres be staffed by professionals who do not live in the area. This is in order to safeguard their privacy when they visit. Some participants recommended that the personnel of the centre are “strangers” to the area. This relates to the second main challenge

indicated in the survey on privacy issues: (I do not trust the professionalism or confidentiality of the service provider), and indicates that youth would be concerned about what others think about them if they are seen obtaining a sexual reproductive health service of any sort.

There were only very few comments around service provision for unmarried youth, except for a few comments made regarding the services available for unmarried sexually active youth. One respondent said:

“I am in a sexual relationship with my partner and I want to go to check on my health and reproductive system, but I am not able to take these tests because they are not available for us as unmarried. I also have questions regarding my sexual relationship, but I cannot ask any doctor about this because I am not married (problems like pain during sex, or vaginal dryness).

انا على علاقة جنسية مع شريكي ودائماً ما اريد التوجه لاجراء فحوصات للطمأننة على صحتي وصحة جهازي التناسلي ولكنني لا استطيع اجراء اي من الفحوص لأنها غير متوفرة لنا كشباب غير متزوجين. كما واحيانا ما واجه بعض الامور المتعلقة بعلاقتنا الجنسية ولكن لا استطيع السؤال عنها اي طبيب مختص لانني غير متزوجة ايضاً (مثل الم معين او جفاف المهبل)

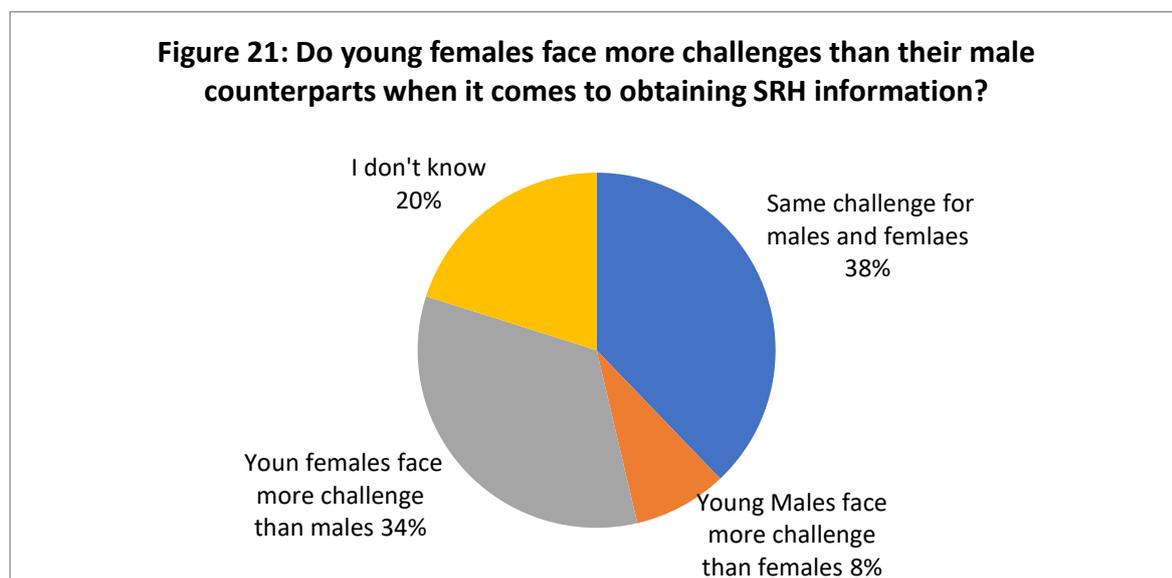
Another respondent suggested that youth centres should not only be specialized in SRH services as this might be a reason for young people not to visit it. Mainstreaming SRH information and services as part of an overall health package of young people is a better strategy according to the participant as it will reduce the potential stigma or shame of visiting an SRH service point.

“This unit or health centre must be youth-friendly, not only limited to sexual and reproductive health services, because this may prevent many from going there to it for fear of social stigma. Also, the staff must be reliable and preferably not from the same city or place of residence, because this makes youth more comfortable to go without feeling embarrassed that the workers know them or know someone from their family. This health centre should cover any sorts of tests for youth regardless.

يجب ان تكون هذه الوحدة او المركز الصحي صديق الشباب ليس مقتصرًا فقط على خدمات الصحة الانجابية والجنسية، لان هذا قد يمنع الكثيرين من التوجه له خوفاً من الوصمة المجتمعية. كما ويجب ان يكون العاملين فيه موثوقين ويفضل ان لا يكونوا من نفس المدينة او مكان السكن، لان هذا يجعل الشباب مطمئنين اكثر للذهاب دون الشعور بالحرج ان يكون العاملين يعرفونهم او يعرفون شخصاً من عائلاتهم. فقد يشمل هذا المركز اي فحوصات لاي شاب/شابة بجميع المجالات

The study also included a question on whether or not young women face more challenges in obtaining sexual and reproductive health information and services, than their male counterparts. There were different answers given by male FGDs. Some males who participated in the FGD said that girls usually have more information and face less challenges in obtaining this information. “They have their mothers whom they are closer to than boys in general”, said one participant. Most males had an assumption that female’s body changes start earlier during puberty (with menstruation) and therefore they obtain information on sexual and reproductive health **earlier** than boys. This assumption is true to a certain extent as girls usually reach puberty earlier than boys. Another participant said that because females marry earlier, they usually have more information and need reproductive health services earlier than males. In addition, health centres focus more on women and mother’s health than on males as indicated by several respondents in the Gaza Strip who gave examples of women’s centres in the strip. However, a few FGD male participants said that females have a restricted space to obtain this information and cannot freely join educational activities and

clubs as males do. Also, that there are heavier social norms that restrict girls' access to this information, and that it is not easy for a girl to seek medical consultation on these issues compared to males.



A closer look at the perception that males and females have regarding challenges to access information for males and females, shows that most males and females agree that they either have the same challenges; or that females in general have more challenge. A fewer number (11% of males, and 7% of females think that young males have more challenges in obtaining

Table 6: Do young females face more challenges than their male counterparts when it comes to obtaining SRH information?

Value	All cases	Males	Females
Same challenges males and females	38 % (326)	41 % (153)	35 % (172)
Young males face more challenges	8 % (73)	11 % (39)	7 % (34)
Young females face more challenges	34 % (289)	34 % (126)	33 % (163)
I don't know	20 % (173)	14 % (51)	25 % (121)
Total	Ø 2.4 (n=861)	Ø 2.2 (n=369)	Ø 2.5 (n=490)

3.10 Solutions and Way Forward

When it comes to improving SRH information and services, participants of the survey as well as the FGDs had a lot to say. More than half of the respondents answered this open, optional question. In total 490 out of 861 total respondents answered. The following is a summary of the main points and frequently mentioned suggestions given. The suggestions are categorized in: Informational Needs, and Infrastructural Needs.

Table 7: A summary of respondent's suggestions for improving SRH in Palestine

Informational Needs	
	Include reproductive health in school curricula in order to allow for equal and wide access to the information by all.
	Delegate a social worker or teacher, a consultation hour and a safe place for students, especially teenage girls to ask and speak freely with the teacher on these topics.
	Work through mainstream media to address SRH topics
	Organize regular seminars for youth to attend
	Raise awareness about the availability of youth services and map their locations for youth.
	Paid (with symbolic fees) seminars for students especially high school and university ages on SRH topics.
	Create awareness video series on social media and deliver this information from a scientific point of view by experts and doctors.
	Create a reproductive health curriculum (not one lesson or chapter only) but more of a weekly curriculum like math and English, has its own time and gradually introduces youth to the topic.
	Create a premarital curriculum for couples and making it a requirement before marriage.
	Create an App where youth can find information and where to obtain the services they need.
	Information and Education material (brochures, leaflets) should be available to youth
	Host experts in schools who come in and educate young people from time to time.
	Organize large scale awareness campaigns in the media and on social media networks to raise awareness of certain youth SRH topics.
	Address the feeling of shame and embarrassment that youth have when obtaining this information and give them the right tools and information to do so.
	Engage society at large in this issue by organizing inclusive seminars and addressing the SRH from a wider perspective.
	Make premarital testing and education a prerequisite for all
	Information is not enough. SRH is ongoing issue that you address since early age. The problem will not be fixed simply by providing the information and service now. A long-term investment is needed.
	Find ways to debunk stigma and embarrassment of addressing these issues among youth and in our society
	Organize sex-separated seminars for young men and women both married and unmarried.
	Create a compulsory curriculum for university students (not only for schools)
	Hold marital counselling sessions for newlyweds so they learn how to understand and communicate better with each other and with the children.
	Survey youth needs when it comes to reproductive and sexual health and provide the necessary means to address these needs.
	Create an online awareness and education platform and ensure that information is credible and presented by professional medical staff.
	Create a hotline for youth to be able to get advice and consultation via the phone.
	Establish guidelines and laws that require schools to address SRH topics with their students.
	Offer a specialized workshop for pregnant women of childbearing in preparation for birth and delivery.
	Engage religious leaders and educate them on their role to address these topics with their communities.
Infrastructural Needs	
	Creating special knowledge centres that make information and services available to youth
	Train service providers and social workers how to deliver these services to youth and

	answer their questions to meet their needs.
	Establishing SRHR units in all provinces of Palestine.
	Deliver information and services through peer educators
	Work through the UNRWA clinics and delegate a special time and space for youth and reproductive health
	Sensitize service providers, especially in the public sector to the basics of a professional, discrete, and humane interaction with service seekers.
	Create a space for unmarried to get these services because only married people and targeted.
	Create a private online platform with reliable information.
	Create a special platform for parents to have the tools on how to educate their children
	Invest in educating medical staff on reproductive health issues and increasing their expertise and knowledge on the matter.
	Establish family counselling clinics where both males and females can get these services and information.
	Provide discrete services including a laboratory for testing.
	Establishing an +18 Youth initiative/organisation مبادرة الشباب to have meaningful youth participation in SRH topics and needs
	Provide private and confidential one-on-one counselling service online
	Too few youth centres; with sometimes limited programs, there is a need to have more of them and widen the services available to young people.

The previous list summarized the suggestions given by youth on what can be done to improve SRH education. This was followed by a second open question to ask about *HOW*, allowing respondents to give their suggestions on how sexual reproductive health education can be introduced and advocated for in Palestinian society. Almost two thirds of all respondents (n=551) answered this open question. Several respondents placed the first step with parents and specifically the mother as the primary source of information for young people. "By educating the mother so she in turn transfers the information smoothly to her children, as well as through improving school curricula if possible".

"من خلال تثقيف الامهات و التي بدورها تنقل المعلومة بسلاسة الى الابناء ، و محاولة تحسين المواد المدرسية ان امكن"

Many respondents saw that the primary role of reproductive and sexual health education is with parents first. Followed by gradual introduction of reproductive health topics in schools. One respondent said, "It's important to gradually and strategically introduce these topics at school, in order to avoid clash with society, and in order to avoid creating a big gap between they societal norms on one hand, and between what they hear at school on the other".

"ادخالها بالمناهج المدرسية ولكن بشكل تدريجي وحذر ومدروس وذلك لتتال تقبل من المجتمع وكذلك لتجنب تعرض الاطفال لفجوة بين الثقافة المجتمعية التي يعيشون بها وبين ما يتلقوه بالمدارس".

Other suggestions made included: working through television programs, and targeting young children at an earlier age; producing detailed booklets using storytelling such as that of the adventures of "Majd"¹⁶; establishing a national youth forum to work on awareness building, using media and billboards; working through existing initiatives such as Sharek Youth Forum; offering

¹⁶ Majd is an application with videos and educational games targeting adolescents.

<https://palestine.unfpa.org/en/video/meet-majd-and-majd-palestine>

information discretely through the internet and social media platforms; strengthening youth networks in Palestine and offering workshops outside the main cities; banning websites that give wrong information; increasing services in non-urban areas; using interactive theatre; using cartoon characters as illustrations of various topics are direct examples of the ideas mentioned by survey respondents. It is worth noting here that some of the participants who took part in this research are familiar with the work with YPeer network and other programs run through the Sharek Youth Forum.

Another respondent suggested making SRH a compulsory course at universities:

من قبل الاهل في سن الطفولة بشكل يناسب اعمارهم وفي المدارس حيث يتجنب المعلمون شرح مادة العلوم المتعلقة بالصحة الانجابية وفي سن المراهقة يلجى الشباب الى المواقع الاباحية حيث المفاهيم الخاطئة عن الجنس ويكون هنالك دور للجامعات في الزام الطلبة وتثقيفهم في موضوع الصحة الجنسية عبر طرح مساق اجباري في الخطة الاكاديمية حول موضوع الصحة الجنسية.

Several respondents addressed the need to first work on establishing a space to address these topics. There are limited circles and persons who talk about the need for comprehensive sexual and reproductive health and education in the Palestinian society. Before deep diving into solving the need, we must first create a safe space and address the restrictiveness of our society that does not provide entry points to talk about.

"الانفتاح لطرح الثقافة الجنسية بدون خجل ولا تشدد فكري لنشر الوعي للان الثقافة الجنسية تضع حد للشهوه وتتحكم بها بما يجعل الانسان متزن فكريا واخلاقيا سواء للذكر او الانثي وذلك بيني علاقة زوجية واعيه وراشدة ...".

"Openness to introduce sexual education without shame and conservatism in order to spread awareness. Sexual awareness and education put an end to lust and controls it. This make a person intellectually and morally more balanced, both males and females. They are then able to build a mature and conscious marital relationship ...".

ازالة مفهوم العيب قدر الإمكان في تخيلات المراهقين واذهانهم واخذ الامور بسلاسة مع اهمية توفير خبراء اصحاب شخصيات "قوية وجذابة"

"Eliminate the concept of *Eib* (Shame) as much as possible from the minds and imaginations of adolescents, taking gradual and smooth steps to introduce topics with the help of strong and influential experts".

4. Conclusion

"Eliminate the concept of Eib (Shame) as much as possible from the minds and imaginations of adolescents, taking gradual and smooth steps to introduce topics with the help of strong and influential experts".

The above quotation from one of the survey respondents captures well the status of social norms and youth in Palestine in as far as seen in this study. Restrictive social norms and lack of dialogue and space to address SRH issues have held youth in this survey "captive" and unable to have agency over their own sexual and reproductive education and information. They are

dependent on parents, schools and educators' openness and willingness to address these topics. Social norms that are blocking or hindering sexual and reproductive health education do not reflect the personal convictions of youth who responded to the survey but rather what these youth think society at large, and their direct social and familial circle in particular, expects them to think and behave.

A majority of 90% of FGD participants and survey respondents (total of more than 900 persons) who participated in this survey were open to including SRH topics in schools and universities and did not perceive this knowledge and an intrusion on Palestinian society and culture. This is a positive indication of the support and dire need youth see in obtaining further information on their SRH. There was a clear preference that this information should start first at the homes and with parents, with a clear preference for obtaining scientific and reliable information from medical experts. If it was up to most youth responding to this survey, they would not hesitate about introducing a robust curriculum on reproductive and sexual health and schools.

The number of enthusiastic responses, comments and meaningful opinions and participation of the survey respondents as well as the FGDs indicated a need for young people to obtain further information and to engage with society at large on SRH issues. The high level of engagement especially from the Gaza Strip, as well as by female respondents, in general, indicates an eagerness to address these topics. Respondents, as well as participants, did not shy away from sharing their ideas and speaking about the topic. They were willing to engage with other entities to raise awareness and improved the quality of services and information offered now. This is a hopeful sign that young people are receptive and are looking for ways to improve access to information and services for themselves and their peers.

The current information and resources available in schools do not meet the expectations and needs of young people when it comes to sexual and reproductive health. Addressing basic information on the reproductive system and personal hygiene is not enough. A careful look at school curricula of grade 10 (see Annex 3) shows a very technical lesson on reproductive systems of males and females, highlights about puberty but no attention given to the personal and emotional growth, what it means to go through this stage in one's life, or what services are available. The little available curricula seem detached from the emotional and psychological needs of young people. Sexual and reproductive health education is presented in the curricula as an academic exercise and is detached from the personal experience and needs of young people who are going through stages of puberty or adolescence in their lives.

Several FGD participants mentioned a more progressive curriculum (Grade 7 Health and Environment) which contained detailed information on puberty. Unfortunately, this curriculum has been cancelled since 2018 and some chapters have been absorbed in a new curriculum on social sciences.

There are positive initiatives by several organisations and networks such as Juzoor, Sawa, Ypeer to name a few. However, these initiatives are not large scale. SRH civil society organisations are dependent on schools, parents and ministries to have access to youth, but this access seems the exception rather than the rule and is sometimes dependent on personal connections and networks.

Young people reported using a variety of different sources of information to fill the informational gaps they have (see Annex 4 List of online sources). Males reported using peers who have sexual relations as reference points for their own knowledge. Females navigated their way to find the information they needed either by consulting close and trusted sources like mothers, aunts, close friends and older siblings. Who to ask and when, are important for females, in order to avoid being seen by her surrounding environment as “rude”, or “too outgoing” or simply “immoral”.

Young people, in general, rely on a diverse offering of information, mostly originating from outside the Palestinian context. Not all named sources are suitable for the Palestinian context. For example, a Facebook page of a YouTube channel of a religious leader in the Gulf is not fitting with the needs or social norms of the Palestinian context. It is recommended that organisations or coalitions such as the Adolescent Coalition provides and promotes a list of reliable sources that young people can consult.

For both males and female’s privacy and confidentiality is an important aspect of the service provision. Revoking the feeling of shame and embarrassment *Eib* associated with these topics was frequently mentioned. This is clearly a blocker preventing many young people from speaking up and seeking information and services.

5. Recommendations

There is the urgent need to address youth sexual and reproductive health needs, incrementally and systematically, involving all stakeholders such as parents and caregivers, duty bearers, and involving youth themselves. In addition, several short and long terms solutions or recommendations can be addressed. Some of these are complex while others are lesser complex interventions that can already create a difference for many.

1. Create an intergenerational dialogue between students, parents and educators to have an open and honest conversation on addressing SRH issues of young people. Young people who responded to the questionnaire indicated that parents and educators make assumptions that addressing these issues with young people lead to “losing one’s path” or de-railing from the faith. There is a perception that educators and parents are blockers and bottlenecks, and there is a lack of trust in young people to be able to use this information wisely and how it affects them. Such dialogue will also lead to more insights into why teachers and duty bearers might be hesitant about addressing the reproductive and sexual health of young people in their schools and universities.
2. Young people as stakeholders in future and interventions and not be merely considered as beneficiaries of programs and interventions that service them. Initiatives such as Y-peer networks have shown to be efficient and effective in reaching young people and giving them agency and responsibility to bring information and raise awareness of their peers. Y-peer network in Palestine has been able to access to several schools, including UNRWA schools with facilitation from UNFPA, and address pupils directly, and is seen by some of the survey respondents and FGD as a more reliable source of reaching young people. But Y-peer network remains an informal channel of reaching youth by youth, lacking the systemization needed to work at scale. The recommendation here is to further spread the Ypeer network and advocate for the network to access all schools.
3. While interventions to address SRH designed for youth are needed, these are not enough. Similar interventions and programs should be devised for parents and caregivers in order to better equip them on how to address these topics at home. One recommendation is to seize opportunities that health providers are in contact with parents at regular health and medical centres. These points of contacts can be also used to deliver extra information on how to address reproductive health with their children. Utilize existing contact points to raise awareness on reproductive health issues will be more of a natural and seamless way to pass this information to parents without putting pressure on them or confront them with their shortcomings and challenge of their religious and cultural beliefs that may have hindered their communication with their children on SRH matters.
4. The current SRH programs and curricula address, if any, the very basics of reproductive health. Young people indicated a need for more in-depth and follow up informational point where they can find reliable and medical information. They also expressed the need to speak to a professional outside the limited time of school curricula or peer sessions. Its recommended to invest in either a platform, discussion board or a way for young people to have free access to professional help.

5. Creating space for dialogue on SRH issues and normalizing these topics as part of a normal discourse. It is also important to take into consideration the social norms that have prevented and restricted reproductive health information for generations. Communication, intergenerational dialogue, and dialogue between men and women on SRH are important elements to create a new space where SRH issues can be addressed. Respondents in this survey chose the topic of relational and communication skills as one of the top issues where they needed more information. These skills are needed to break the silence and alleviate the barriers of shame and embarrassment youth felt. Program managers should also take into consideration interventions that create a healthy and open discussion on SRH. One example is to start with “low hanging fruit” such as premarital counselling session, or courses for newlyweds.
6. Engage teachers and school principles to understand what challenges they face and how they can be supported. A few peer educations during the focus group session mentioned that school principals and teachers are sometimes blocking Y-peer education sessions in schools, even if the session is not about sexual reproductive health (an awareness session on breast cancer was given as an example). In another interview, the Executive Director of a service provider organization said that her team’s access to schools depended on personal connections with the administration and staff. It is recommended to engage with educators and understand their needs and fears of addressing SRH of young people and how these fears can be eliminated.
7. Youth are seeking diverse informational sources online and filling gaps in their information from reliable but also from suspicious or inappropriate points of information. While you cannot prevent youth from googling their problems, it is recommended that CSOs and educators working on this topic can produce a list of trusted sources that they know and approve of and disseminate it among their students for further information.
8. Ministries of health and education and organisations such as the UNRWA can provide schools and medical centres with communication and education material on reproductive health and rights. In addition to brochures on reproductive health topics, it is recommended that brochures containing a service mapping of the available services for youth are made available, including services such as: suicide hotline, GBV support groups, what to do in case of sexual assault incidents, honour crimes, etc. Communication and Information material should be available at health centres, hospitals and private practices.
9. There is a lack of public figures, experts, influencers and advocates for SRH in Palestinian society who are visible online and offline. CSOs can invest in using social influences, YouTubers and vloggers that young people follow and respect in order to spread knowledge and awareness on SRHR topics, including issues such as GBV, sexual harassment, early marriage.
10. Service providers and medical staff are considered a trusted source of information for youth. Not all medical staff are trained in handling SRH issues. Some staff are also not prepared or trained to address these topics with their patients. A recommendation here is to work with

medical staff to increase their knowledge on SRH needs of youth and how to handle these topics with their patients.

11. Quality of service: issues around value clarification of service providers, confidentiality and privacy of youth visiting youth centres were often discussed in both the survey and the FGDs. It's important to ensure that service providers are aware of this issue and are well trained to safeguard the privacy of their patients and observe all standards and procedures in each visit they receive. Service providers should communicate and emphasize youth-friendly and privacy standards to young people who might be seeking their help.

12. Activate the role of local media especially television and radio in addressing sexual reproductive health in the public sphere. Many parents and housewives consume local radio and tv programs. In fact, in many homes, tv or radio is playing almost non-stop. Such channels can dedicate airtime to address these topics by hosting experts and medical doctors who can raise awareness of parents in order to increase their knowledge and equip them with the right approach on how to raise their children with correct information and attitudes.

6. List of Annexes

- Annex 1 – Online Survey (English Translation)
- Annex 2 - List of Statements from the Survey
- Annex 3 - Life Sciences PNA curricula of grade 10.
- Annex 4 – List of online resources and influencers
- Annex 5 – Focus Group Discussion Guides

About the research team:

This research has been conducted by Sharek Youth Platform, with supervision, guidance, and final reporting by SRHR consultant Abir Sarras. The Sharek team included: Bader Zamareh - Executive Director; Laila Qawas-MEAL officer / FDGs facilitator and study focal point at Sharek; Adel Saabaneh- Operational manager / FDGs facilitator; Mohammed Abu Rjeleh- Project Coordinator, Gaza / FDGs facilitator; Rawan Majdalawe- Volunteer, Gaza/ FDGs facilitator; Hanin Kuttob - FDGs facilitator Jerusalem; Abrar AlHamouri - FDGs facilitator Jerusalem.