



Barriers Analysis and Knowledge, Attitudes and Practices Assessment on Sexual and Reproductive Health and Rights and Gender-Based Violence in the West Bank

Implemented by:
Juzoor for Health and Social Development

In partnership with CARE Palestine

2026

Table of Contents

List of Abbreviations	5
Chapter 1. Introduction.....	6
Chapter 2. Methodology	8
2.1. Study Design.....	8
2.2. Study Setting	8
2.3. Study Population and Sampling	9
2.4. Social Roles of participants	10
2.5. Notes on Representation	11
2.6. Ethical Considerations.....	11
2.7. Methodological Limitations	11
Chapter 3. Contextual Background	13
3.1. Norms, Demographics, and Structural Constraints	13
3.2. Political and Humanitarian Context	13
3.3. Health System	15
3.4. Legal System.....	16
3.5. Gaps in Sexual and Reproductive Health and Rights (SRHR)	17
3.5.1. Demographic Context and Youth SRHR Needs	17
3.5.2. Availability and Accessibility of SRHR Services	18
3.5.3. Structural and Institutional Barriers	19
3.5.4. Socio-Cultural and Economic Barriers.....	21
3.5.5. Trust, Confidentiality, and Youth-Specific Barriers.....	22
3.5.6. Disability and Intersectional Exclusion.....	22
3.6. Contextual Implications for the Study	23
Chapter 4. Findings: Gendered Knowledge, Attitudes, Practices, and Barriers.....	25
4.1. Learning the Body: Knowledge, Silence, and Gendered Socialization.....	25
4.1.1. Adolescents: Between Curiosity, Silence, and Informal Learning.....	25
4.1.2. Young Women: Bodily Autonomy, Fertility, and Social Pressure	29
4.1.3. Reproductive Decision-Making and Family Authority	31

4.1.4. Young Men: Masculinity, Anxiety, and Private Knowledge	33
4.1.5. Adult Women and Mothers: Endurance, Protection, and Intergenerational Change	36
4.1.6. Institutional Perspectives: Awareness Efforts and Institutional Hesitation	37
4.2. Marriage, Fertility, and the Social Regulation of Reproductive Life	39
4.2.1. Adolescents: Preparing for Marriage and Adult Roles	40
4.2.2. Young Women: Fertility, Timing, and Social Legitimacy	41
4.2.3. Young Men: Marriage, Provision, and Reproductive Anxiety	43
4.2.4. Adult Women and Mothers: Marriage, Endurance, and Reproductive Expectation ..	44
4.2.5. Institutional Perspectives: Marriage, Fertility, and Structural Contradictions	46
4.3. Gendered Power, Violence, and Everyday Control	47
4.3.1. Adolescents: Protection, Restriction, and the Normalization of Control	47
4.3.2. Young Women: Reproductive Pressure and Negotiating Authority	51
4.3.3. Young Men: Masculinity, Emotional Pressure, and Authority	54
4.3.4. Adult Women and Mothers: Endurance, Silence, and Social Obligation	57
4.3.5. Institutional Perspectives: Violence, Protection, and Unequal Systems of Authority	59
4.4. Access to SRHR and GBV Services	60
4.4.1. Adolescents: Confidentiality, Mobility, and Access to Support	61
4.4.2. Young Women: Confidentiality, Referral Pathway, and Access to Services	63
4.4.3. Young Men: Privacy, Help-Seeking, and Limited Emotional Support	67
4.4.4. Adult Women and Mothers: Trust, Confidentiality, and Access to Care	69
4.4.5. Institutional Perspectives: Access, Provider Capacity, and Continuity of Services	72
Chapter 5. From Awareness Gaps to the Social Regulation of Bodily Life	76
5.1. Fragmentation as a Structuring Condition	76
5.2. Knowledge, Silence, and the Social Regulation of Bodily Life	77
5.3. Gender, Reproductive Labor, and the Uneven Distribution of Responsibility	80
5.3.1. Reproductive Labor and the Feminization of Care	80
5.3.2. Reproductive Authority and Negotiated Autonomy	82
5.3.3. Masculinity, Provision, and Reproductive Anxiety	85
5.3.4. Reproductive Control and the Continuum of Violence	86

5.4. Conditional Access, Uneven Geography, and the Political Organization of Care.....	87
5.5. Digital Mediation and the Reconfiguration of Authority	90
5.6. Implications for SRHR and GBV Programming	91
Chapter 6. Recommendations	95
6.1. Conclusion	95
6.2. Recommendations	96

List of Abbreviations

Abbreviation	Full Term
AI	Artificial Intelligence
Area C	Areas under full Israeli civil and military control in the West Bank under the Oslo framework
CARE	CARE International
CBO	Community-Based Organization
CSE	Comprehensive Sexuality Education
FGD	Focus Group Discussion
FP	Family Planning
GBV	Gender-Based Violence
IDI	Individual Interview
KAP	Knowledge, Attitudes, and Practices
KII	Key Informant Interview
MHPSS	Mental Health and Psychosocial Support
MISP	Minimum Initial Service Package
MoE	Ministry of Education
MoH	Ministry of Health
MoSD	Ministry of Social Development
NGO	Non-Governmental Organization
NRS	National Referral System
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
OPD	Organization of Persons with Disabilities
PbW	Powered by Women
PCBS	Palestinian Central Bureau of Statistics
PoDs	Persons with Disabilities
PSEA	Protection from Sexual Exploitation and Abuse
PSS	Psychosocial Support
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infection
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNRWA	United Nations Relief and Works Agency for Palestine Refugees in the Near East
WHO	World Health Organization

Chapter 1. Introduction

Access to sexual and reproductive health and rights (SRHR) and protection from gender-based violence (GBV) in the West Bank (WB) takes shape within a setting defined by layered forms of constraint. These include social expectations around gender and family, institutional practices that regulate care, and a broader political environment marked by movement restrictions, economic pressure, and fragmented governance. These conditions do not operate separately. They intersect in ways that structure how people learn about their bodies, how they make decisions, and whether they are able to seek care.

Discussions of SRHR often begin from the assumption that access depends on awareness or service availability. Fieldwork for this study points to a different starting point. Information about the body, sexuality, and reproduction circulates unevenly. It is shaped by what can be spoken within families, what is permitted in schools, and what is considered acceptable in public space. Silence, avoidance, and partial knowledge are part of how this field is organized. Adolescents and young people, in particular, navigate these gaps through informal channels, including peers and digital media including Artificial Intelligence (AI), with varying levels of trust in what they find.

Access to services is shaped by conditions that extend beyond the health system. Reaching a clinic may require time, money, and the ability to move across space that is not always accessible. Seeking care may involve exposure to judgment from providers or visibility within the community. Decisions are rarely individual. They are negotiated within households and influenced by expectations around marriage, fertility, and gender roles. For women and girls, these expectations often define both responsibility for reproductive health and limits on autonomy.

The relationship between SRHR and GBV emerges within this same field. Control over mobility, information, and reproductive decisions is closely tied to broader forms of gendered power. Experiences of violence are not always named directly, but they shape how individuals assess risk, what they avoid, and where they turn for support. Reporting remains limited, and formal systems are not consistently seen as accessible or protective.

The study is situated within the *Powered by Women (PbW)* project, implemented by Juzoor for Health and Social Development in partnership with CARE International. It responds to a need to understand how these dynamics operate across different locations and population groups. The focus is on adolescents, youth, adult women, and men, including those living in rural areas, camps, and localities affected by movement restrictions. Particular attention is given to People with Disabilities (PoDs), whose experiences highlight additional layers of dependency, exclusion, and risk.

The analysis is organized across three levels as presented in Illustration 1. The first concerns everyday interactions: how knowledge is shared or withheld, how norms are enforced, and how individuals navigate expectations. The second looks at institutions, including health services and community-based

structures, and the ways in which they enable or limit access. The third situates these dynamics within a broader context shaped by occupation, economic conditions, and uneven development across regions.

The study draws on focus group discussions, key informant interviews, individual interviews, and a KAP survey. The qualitative material provides detail on how people describe their experiences and decisions, while the survey captures patterns across a larger group of respondents. Together, these sources allow for an examination of how barriers are experienced, how they differ across contexts, and how they are sometimes negotiated or challenged.

This report presents the findings of that process. It follows how knowledge, access, and decision-making are shaped across different settings, and where gaps persist between formal rights and everyday practice.

Navigating Knowledge and Access Challenges



Illustration 1. Navigation knowledge and Access Challenges



Chapter 2. Methodology

2.1. Study Design

This study combined qualitative and quantitative methods in order to examine how SRHR and GBV are understood, negotiated, and lived across different social and geographic settings in the WB. Rather than treating knowledge, attitudes, practices, and barriers as separate domains, the study approached them as interconnected processes shaped through family relations, institutional encounters, mobility, gendered authority, and access to resources.

The quantitative component consisted of a cross-sectional KAP survey used to identify broader patterns related to information access, reproductive decision-making, service use, perceptions of violence, and barriers to care and protection. The qualitative component included focus group discussions (FGDs), key informant interviews (KIIs), and individual interviews (IDIs), allowing the study to move beyond frequencies and categories into the social conditions through which these patterns take shape.

The study moved between aggregated patterns and everyday experience. Survey findings provided a wider view of recurring trends across groups and locations, while qualitative material made it possible to examine hesitation, contradiction, silence, negotiation, and unequal access as they emerged within lived social relations

2.2. Study Setting

Fieldwork was conducted across several locations in the WB, including northern governorates (Jenin and Tubas), central areas (Ramallah and surrounding localities), southern governorates (Hebron and Bethlehem), and the Jordan Valley. These locations were selected not simply as geographic units, but as sites shaped differently by mobility restrictions, institutional access, economic conditions, and social visibility.

Attention was given to villages, camps, urban areas, Area C communities, and localities affected by road closures and checkpoint systems. These differences shaped not only access to services, but also the circulation of information, forms of social control, and the conditions under which SRHR and GBV could be discussed publicly or privately.

The quantitative component extended beyond the primary qualitative field sites. Survey participants were drawn from multiple governorates, including East Jerusalem and additional localities not included in qualitative fieldwork. Participants came from villages, urban areas, camps, and Bedouin communities, allowing comparison across different social and spatial conditions

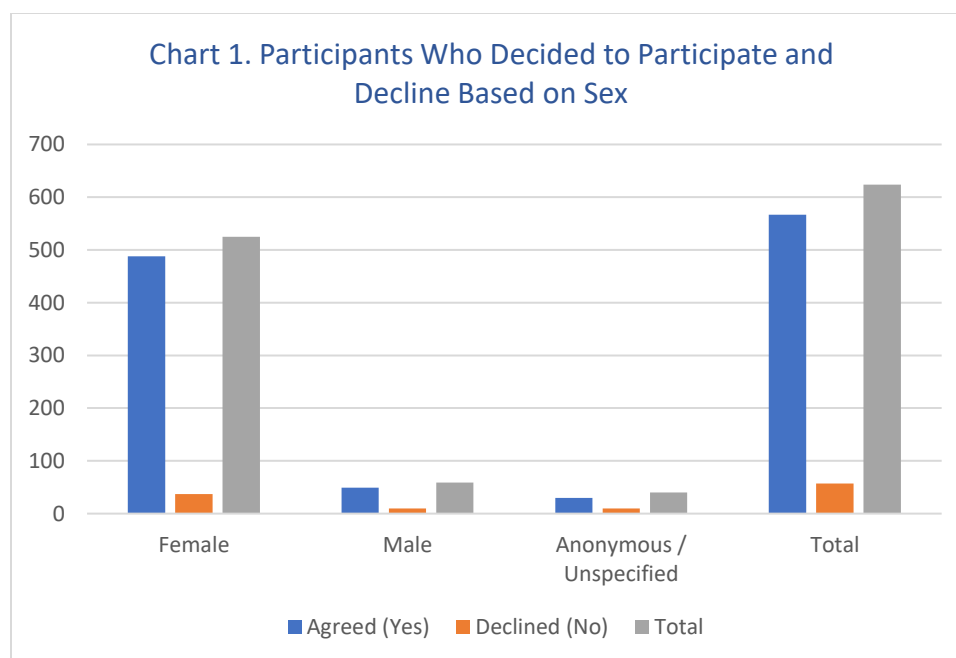
2.3. Study Population and Sampling

The study included participants across different age groups, sex, and social positions, including adolescent girls and boys (15–17 years), young women and men (18–29 years), adult women (30 years and above), service providers and institutional actors, and PoDs.

The qualitative component used purposive sampling to include participants occupying different positions within households, institutions, and community life. Participants were recruited through local organizations, community networks, and field facilitators familiar with the local social context.

The quantitative component used a non-probability sampling approach. Survey participants were recruited through community outreach and organizational networks across multiple governorates. The survey was not intended to produce statistically representative findings at the population level. Rather, it was designed to identify recurring patterns across different social groups and geographic locations.

A total of 624 individuals were approached for participation in the survey component. Of these, 567 agreed to participate and 57 declined. Female participants constituted the majority of those who agreed to participate, with 488 female participants compared to 49 male participants and 30 anonymous or unspecified respondents. Chart 1 presents participation and decline by sex.



The distribution of participation reflects broader gendered dynamics surrounding SRHR and GBV discussions. Women were considerably more represented among respondents who agreed to participate, which mirrors the qualitative fieldwork where women and girls were generally more

willing to engage in discussions related to reproductive health, family relations, and access to services. Lower male participation reflects wider social patterns in which SRHR continues to be positioned primarily as a women’s issue, while reproductive health and help-seeking remain less openly discussed among men and boys.

The inclusion of anonymous or unspecified respondents is also significant given the sensitivity of SRHR and GBV topics. Some participants may have preferred not to disclose sex because of privacy concerns or discomfort related to the subject matter itself.

The qualitative component included a total of 109 participants engaged through FGDs, KIIs, and IDIs. The distribution of participants across methods, sex, and geographic areas is presented in Table 1.

Table 1. Distribution of Participants by Method, Sex, and Geographic Area

Method	Group	Female	Male	Total	South	North	Center	Geographically Anonymous	National
FGDs	Adolescents (15–18)	37	8	45	17	19	9	-	-
FGDs	Youth (18–29)	24	0	24	8	10	6	-	-
FGDs	Adult Women (30+)	18	0	18	3	5	10	-	-
KIIs	Stakeholders	11	4	15	5	3	1	-	6
IDIs	Individuals	1	6	7	3	1	2	-	1
KAP Survey	Population (15+)	525	89	624	210	189	166	2	-
TOTAL (Qualitative)	-	91	18	109	36	38	28	-	7
Grand Total		616	107	733	246	227	194	2	7

2.4. Social Roles of participants

Participants include individuals occupying different roles within their communities. These include adolescents navigating school and family expectations, young people making decisions related to relationships and work, adult women managing household and caregiving responsibilities, and men engaged as community members or service users.

The qualitative sample also includes stakeholders from health institutions, civil society organizations, and community leadership. These participants provide insight into how services are delivered, how decisions are made within institutions, and how policies are interpreted at the local level.

Three individual interviews were conducted with PoDs, including two young women and one young man. These interviews highlight how access to information and services is shaped by

dependency, mobility constraints, and social perceptions of disability, particularly in relation to gender.

2.5. Notes on Representation

The composition of the sample reflects both the design of the study and the conditions under which data was collected. The predominance of female participants provides depth in understanding the experiences of women and girls, who are directly affected by many SRHR and GBV-related issues. Yet, male perspectives are more limited, particularly in group discussions. This reflects broader patterns in which SRHR is not commonly discussed among men in structured settings.

The survey provides wider coverage, though it remains skewed toward female respondents. This should be considered when interpreting patterns related to knowledge, attitudes, and practices.

2.6. Ethical Considerations

Given the sensitivity of SRHR and GBV topics, particular attention was given to privacy, voluntary participation, and participant safety throughout the research process.

Participation was voluntary, and informed consent was obtained prior to all interviews and survey participation. Participants were informed of their right to decline participation or withdraw at any stage of the process.

Discussions and interviews were conducted in settings intended to reduce exposure and maintain confidentiality. Data was anonymized during analysis and reporting.

Facilitators conducting discussions related to violence and sensitive experiences were trained to:

- Avoid pressure for disclosure,
- Respond appropriately to participant distress, and
- Provide information on available support services when needed.

These considerations were particularly important when working with adolescents and PoDs, whose participation may involve additional forms of vulnerability, dependency, or exposure.

2.7. Methodological Limitations

Several limitations should be considered when interpreting the findings. For instance, the survey was not designed to produce statistically representative findings at the population level. Rather, it aimed to capture variation across groups and locations in the WB.

Female participants were overrepresented, particularly within qualitative discussions. This provided substantial depth regarding women's and girls' experiences while limiting the range of perspectives captured from adolescent boys and young men. Lower male participation also

reflects broader patterns in which SRHR remains less openly discussed among men in formal research settings.

The sensitivity of SRHR and GBV topics likely shaped disclosure, particularly in relation to sexuality, violence, coercion, and family conflict. Concerns related to social visibility and confidentiality may also have influenced participant responses in smaller communities.

The number of participants with disabilities was limited and cannot fully represent the diversity of disability-related experiences across locations and age groups.

Movement restrictions and logistical constraints affected access to some communities and may have limited participation from populations living in highly restricted areas.

Meanwhile, the use of multiple methods and participant groups allowed for triangulation across different forms of evidence, strengthening the study's ability to identify recurring patterns across social and geographic contexts.

Chapter 3. Contextual Background

3.1. Norms, Demographics, and Structural Constraints

The State of Palestine has a predominantly young population, with PCBS estimating the population in the West Bank and Gaza Strip at 5.61 million in mid-2025, including approximately 3.41 million in the West Bank and 2.20 million in the Gaza Strip¹. Children under 18 represent 43% of the population overall, rising to 47% in Gaza, while older persons aged 65 and above constitute a small share of the population. This demographic profile underscores the importance of adolescent- and youth-responsive SRHR and protection programming².

In the West Bank, population growth has remained more stable, yet demographic trends should be read alongside structural constraints that shape everyday life and service access. Governorates such as Hebron continue to experience population pressure alongside economic strain, while Jerusalem's figures do not fully capture pressures linked to displacement risk, settlement expansion, residency insecurity, and restricted urban access. Northern governorates such as Jenin, Tubas, and Nablus are affected by repeated insecurity, movement restrictions, and localized disruption, while lower-density areas such as Jericho and Tubas continue to face chronic underinvestment and limited infrastructure³.

Data from the Palestinian Central Bureau of Statistics (PCBS) indicate persistent gender disparities in labour market participation in the West Bank. In the fourth quarter of 2025, labour force participation among males reached 71.5%, compared with only 18.6% among females. Although unemployment rates among labour force participants were relatively similar between men (27.6%) and women (26.9%), unemployment among young female graduates aged 19-29 remained substantially higher at 44.5%, compared with 28.3% among males⁴.

3.2. Political and Humanitarian Context

The West Bank is governed through a fragmented territorial and administrative system rooted in the Oslo framework. Under the Oslo II arrangements, the West Bank was divided into Areas A, B, and C. Area A, comprising around 18% of the West Bank, falls under Palestinian civil and security administration; Area B, around 22%, is under Palestinian civil administration and Israeli security

¹ Palestinian Central Bureau of Statistics (PCBS) Presents the Conditions of the Palestinian Population on the Occasion of The World Population Day, 11/07/2025. Available at: <https://www.pcbs.gov.ps/>

² Palestinian Central Bureau of Statistics (PCBS). Percentage Distribution of Individuals (15 years and above) in Palestine by Sex, Educational Attainment and Governorate, 2023. Available at: https://pcbs.gov.ps/site/lang_en/708/default.aspx?lang=en&utm_source

³ International Peace and Cooperation Center (IPCC). (2024). Population dynamics in the West Bank 2023–2025. Jerusalem: IPCC. Available at: <https://www.ipcc-jerusalem.org/en/1/12?utm>

⁴ Palestinian Central Bureau of Statistics (PCBS). Press Release on the Results of the Labour Force Survey, West Bank, Fourth Quarter (October–December 2025). Ramallah: PCBS, February 15, 2026.

control; and Area C, around 60%, remains under full Israeli civil and security control, including planning, zoning, land registration, and infrastructure development⁵.

This territorial fragmentation has direct implications for access to health, protection, and social services. Area C communities face particularly severe constraints because restrictions on planning, infrastructure, movement, and development limit the availability and continuity of services⁶. Across the West Bank, checkpoints, road closures, iron gates, demolitions, settler violence, and economic hardship affect mobility and service access, with disproportionate consequences for women, adolescents, PoDs, and communities in rural, Bedouin, and marginalized areas⁷. Daily commutes between villages and urban centers often exceed four hours, limiting access to education, healthcare, and livelihoods. Emergency services, particularly for women and girls, face significant delays. These constraints disproportionately affect women, especially those in rural or marginalized areas like Tubas, Area C, and refugee camps⁸.

The humanitarian protection environment has deteriorated further in recent years. According to the United Nations Office for the Coordination of Humanitarian Affairs (OCHA), between 5 and 11 May 2026, approximately 90% of the 45 Palestinian-owned structures demolished in the West Bank were related to agricultural livelihoods, water infrastructure, sanitation, or other income-generating activities, exacerbating the vulnerability of already at-risk communities. The same reporting period documented a substantial escalation in settler-related violence in the Jordan Valley, where the monthly average of incidents resulting in casualties or property damage increased fourteen-fold compared with 2020 levels⁹. Protection risks remain particularly acute in Area C, where humanitarian access constraints, weak service coverage, and coercive practices continue to undermine civilian resilience. According to the Protection Cluster (PC), approximately 35% of protection interventions in the West Bank are concentrated in Area C, with a particular focus on GBV prevention and response, legal aid, and psychosocial support services¹⁰. Nevertheless, protection coverage remains fragmented and insufficient, particularly in remote

⁵ United Nations, Israeli-Palestinian Interim Agreement on the West Bank and the Gaza Strip (Oslo II Accord) (Washington, DC, September 28, 1995), accessed April 22, 2026, <https://www.un.org/unispal/document/auto-insert-185434/>

⁶ Protection Cluster (2025). Occupied Palestinian Territory. West Bank protection analysis update. Available at: https://globalprotectioncluster.org/sites/default/files/2025-03/occupied_palestinian_territory_-_west_bank_-_protection_analysis_update_march_2025.pdf

⁷ War Child. (2025). Understanding the effects of the Israeli occupation on the mental health and wellbeing of children and caregivers in East Jerusalem and the West Bank. Available at: https://www.warchild.net/documents/345/Effects_of_Israeli_Occupation_on_Mental_Health_Wellbeing_in_East_Jerusalem_West_Bank.pdf?utm_source=chatgpt.com

⁸ UNICEF Humanitarian Situation Report No. 39. 31 May 2025. Available at: <https://www.unicef.org/media/>

⁹ United Nations Office for the Coordination of Humanitarian Affairs (OCHA). Humanitarian Situation Report. May 15, 2026. Accessed May 22, 2026. <https://www.ochaopt.org/content/humanitarian-situation-report-15-may-2026>

¹⁰ UNFPA. (2024). Lifelines in crisis: Mobile healthcare teams in the West Bank provide essential services. <https://palestine.unfpa.org/en/news/lifelines-crisis-mobile-healthcare-teams-west-bank>

and herding communities, where mobile clinics and outreach teams frequently constitute the only available point of access to essential services.

3.3. Health System

The Palestinian Public Health Law No. 20 of 2004 mandates the Ministry of Health (MoH) to provide comprehensive preventive, curative, rehabilitative, and emergency health services. National policy frameworks, including the National Health Strategy 2021–2027 and the Child and Adolescent Health Strategy 2020–2027, emphasize gender equity and align with international human rights instruments, including the Convention on the Rights of the Child (CRC) and the International Covenant on Economic, Social and Cultural Rights (CESCR).

Despite these commitments, implementation remains inconsistent, particularly in marginalized and geographically isolated areas. Although Palestine ratified the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) in 2014 and subsequently developed the *National Health Strategy 2021–2023*, substantial disparities persist in the accessibility and quality of health services¹¹. More than 180 communities across the West Bank, particularly in Area C, reportedly lack adequate access to primary healthcare services¹².

Although reproductive health is formally integrated into national health priorities, critical gaps remain in access to contraceptive services, maternal healthcare, sexually transmitted infection (STI) treatment, and comprehensive sexual health education¹³. The absence of a comprehensive domestic violence law further weakens survivor protection frameworks and limits access to justice and accountability mechanisms for GBV survivors¹⁴. Early marriage and honor-based norms continue to restrict bodily autonomy, particularly among adolescent girls and unmarried women¹⁵. For PoDs, overlapping vulnerabilities such as inaccessible infrastructure, social stigma, and exclusion from decision-making, create heightened barriers to care¹⁶.

The health system in the West Bank continues to face severe operational and access-related constraints amid escalating violence, movement restrictions, and fiscal instability. According to

¹¹ Euromed Rights. (2023). *Situation report on discriminations against women in Palestine*. https://euromedrights.org/wp-content/uploads/2023/05/facsheet-PALESTINE_EN.pdf

¹² World Health Organization. (2024). *Overcoming barriers to health care access in the West Bank with mobile clinics*. WHO Eastern Mediterranean Regional Office. <https://www.emro.who.int/opt/news/overcoming-barriers-to-health-care-access-in-the-west-bank-with-mobile-clinics.html>

¹³ UNFPA. (2025, July–August). *Palestine situation report #19: July–August 2025*. United Nations Population Fund. <https://palestine.unfpa.org/en/publications/palestine-situation-report-19-july-august-2025>

¹⁴ Euromed Rights. (2023). *Situation report on discriminations against women in Palestine*. https://euromedrights.org/wp-content/uploads/2023/05/facsheet-PALESTINE_EN.pdf

¹⁵ UNICEF Data. (2024). Child marriage country profile: State of Palestine. UNICEF. <https://childmarriedata.org/country-profiles/state-of-palestine>

¹⁶ UNFPA. (2025). GBV service access for women with disabilities in the West Bank. United Nations Population Fund. <https://palestine.unfpa.org/sites/>

the World Health Organization (WHO) *Health Emergency Appeal 2026*, violence, including settler attacks, demolitions, evictions, and militarized operations, has intensified across the West Bank, particularly in northern governorates. Between October 2023 and December 2025, more than 1,100 Palestinians were killed and over 920 attacks on healthcare were recorded. Increasing movement restrictions continue to fragment Palestinian territory and obstruct the movement of patients, ambulances, and healthcare workers¹⁷.

WHO further reported that one in five households indicated that their children had been unable to access needed healthcare or medicines at least once since October 2023. The prolonged fiscal crisis affecting the Palestinian Authority (PA) has also disrupted health service delivery, including interruptions in health worker salaries, shortages of essential medicines, and reduced operational capacity of primary healthcare centers, outpatient specialty clinics, and hospitals. As of 2026, only 63% of primary healthcare centres in the West Bank were partially functional, operating on average one day per week compared with six days per week prior to 2023. Mental health and psychosocial needs remain acute, particularly among children and youth¹⁸.

3.4. Legal System

There is currently no comprehensive legal framework specifically safeguarding the SRHR of women and youth in Palestine. While certain provisions within the Palestinian Basic Law, Personal Status Law, and applicable criminal legislation address aspects of women's and children's rights, the existing legal framework remains fragmented and inadequately protective.

In the West Bank, the applicable criminal legislation remains largely derived from the Jordanian Penal Code No. 16 of 1960, while in the Gaza Strip the British Mandate Penal Code No. 74 of 1936 continues to apply in certain areas. These legal systems have been widely criticized for containing discriminatory provisions that inadequately protect women and reinforce gender inequality. Although Article 308 of the Jordanian Penal Code, which previously allowed perpetrators of rape to evade prosecution by marrying the victim, was repealed in the West Bank through Law No. 5 of 2018, the legal framework does not criminalize domestic violence or sexual harassment¹⁹.

Furthermore, the legal definition of rape under the Jordanian Penal Code No. 16 of 1960 remains gender-restrictive, recognizing women and girls exclusively as victims of rape. Sexual assault against males is categorized separately as "defilement", carrying lesser legal penalties²⁰. Abortion remains criminalized under existing legislation, including in cases involving rape. Although incest

¹⁷ World Health Organization (WHO). WHO's Health Emergency Appeal 2026: Occupied Palestinian Territory. Geneva: World Health Organization, 2026.

¹⁸ Ibid (WHO, 2026).

¹⁹ UNFPA (2018). State of Palestine. Gender Justice Assessment of laws affecting gender equality and protection against gender-based violence. Available at: <https://palestine.unfpa.org/sites/default/files/pub-pdf/Gender%20Justice%20and%20The%20Law.pdf>

²⁰ MIFTAH 2019. Factsheets on sexual violence in the Palestinian context

is criminalized under Jordanian law, prosecution procedures remain restrictive, as complaints may only be initiated by a relative of the perpetrator. In addition, while certain legal reforms addressing so-called “honor crimes” have been introduced in the West Bank, including the repeal of Article 340, mitigating provisions that reduce penalties for crimes committed in the name of “honor” reportedly continue to be applied in the Gaza Strip²¹.

Over the past five years, several legislative and policy efforts have also sought to strengthen protection against gender-based violence. These include amendments to Labour Law No. (7) of 2000 to explicitly prohibit sexual harassment in the workplace; Decree No. (21) of 2019, which set the legal age of marriage at 18 years while leaving exceptions that continue to require reform; and the drafting of anti-human trafficking legislation aimed at criminalizing sexual exploitation in all its forms. Although Article 308 of the Jordanian Penal Code, which previously allowed perpetrators of rape to evade prosecution by marrying the victim, was repealed in the West Bank through Law No. 5 of 2018, the legal framework does not criminalize domestic violence or sexual harassment²². Moreover, major gaps remain, particularly the absence of a comprehensive domestic violence law and the continued fragmentation of applicable legal frameworks between the West Bank and Gaza Strip.

3.5. Gaps in Sexual and Reproductive Health and Rights (SRHR)

3.5.1. Demographic Context and Youth SRHR Needs

Palestinian society remains predominantly young. According to the Palestinian Central Bureau of Statistics (PCBS), youth aged 18–29 numbered approximately 1.2 million people by mid-2025, representing 21% of the total Palestinian population, including 22% in the West Bank²³. This demographic profile highlights the importance of youth-responsive SRHR services, particularly in light of worsening humanitarian, economic, and protection conditions.

Adolescents and young women face particular SRHR barriers. The Palestinian Multiple Indicator Cluster Survey 2019–2020, implemented by PCBS with UNICEF and the Ministry of Health, remains the most recent comprehensive household source on reproductive health indicators. It shows that family planning use remains lower among younger married women, while adolescent girls and young women face higher risks linked to early marriage, limited contraceptive access,

²¹ UNDP, UN Women, UNFPA, ESCWA (2018). Palestine: Gender, Justice, and the Law; Assessment of laws affecting gender equality and protection against gender-based violence

²² UNFPA (2018). State of Palestine. Gender Justice Assessment of laws affecting gender equality and protection against gender-based violence. Available at:

<https://palestine.unfpa.org/sites/default/files/pub-pdf/Gender%20Justice%20and%20The%20Law.pdf>

²³ Abu-Hamad, B., Hamad, B., Jones, N., & Gercama, I. (2021). Adolescent access to health services in fragile and conflict-affected contexts: The case of the Gaza Strip. Published in: Conflict and Health. Available at: https://pmc.ncbi.nlm.nih.gov/articles/PMC8139118/?utm_source=chatgpt.com

and inadequate reproductive health information²⁴. UNFPA has also documented that social norms continue to restrict young people’s access to SRHR information, education, and services, while many adolescents rely on informal or digital sources that may provide incomplete or inaccurate information²⁵.

Widespread knowledge gaps persist regarding contraception, menstrual hygiene, sexually transmitted infections (STIs), and available protection services, particularly among adolescents, unmarried women, persons with disabilities, and communities in rural and Area C locations²⁶. Misinformation rooted in social stigma, patriarchal norms, religious taboos, and unverified online content continues to undermine bodily autonomy and reinforce harmful beliefs surrounding contraception, GBV reporting, and sexual health. In the absence of trusted and accurate information, many individuals continue to rely on peers, relatives, or social media platforms, which may further perpetuate stigma and misinformation²⁷.

Comprehensive sexuality education remains limited and unevenly institutionalized. While UNFPA has supported culturally adapted comprehensive life education and out-of-school sexuality education initiatives in Palestine, including the “Majd” virtual ambassador model for adolescents aged 12–18, these interventions do not yet amount to systematic, universal, age-appropriate SRHR education across all schools and communities²⁸.

3.5.2. Availability and Accessibility of SRHR Services

Although family planning and reproductive health services are formally available through the public health system, their utilization remains uneven, particularly among vulnerable women, adolescents, and marginalized communities. According to the Palestinian Ministry of Health and UNFPA, the West Bank has 590 primary healthcare centers operated by the Ministry of Health, UNRWA, NGOs, and Palestinian Medical Military Services. Among these, the Ministry of Health provides family planning services in 270 centers and high-risk pregnancy services in 77 clinics. Despite this infrastructure, access remains constrained by mobility barriers, attacks on healthcare, shortages, and uneven service distribution²⁹.

²⁴ Nutrition Cluster Palestine, UNICEF, and World Health Organization (WHO). *Nutrition Vulnerability and Situation Analysis in the Occupied Palestinian Territory*. Jerusalem: Nutrition Cluster Palestine, 2023

²⁵ Sarra, A., and Sharek Youth Forum. *Social Norms and Sexual and Reproductive Health among Youth in Palestine*. (UNFPA 2020).

²⁶ Palestinian Central Bureau of Statistics (PCBS), United Nations Children’s Fund (UNICEF), and Palestinian Ministry of Health. *Palestinian Multiple Indicator Cluster Survey 2019–2020: Survey Findings Report*. Ramallah: PCBS and UNICEF, 2021.

²⁷ Ibid (UNFPA 2020).

²⁸ United Nations Population Fund (UNFPA), *Country Case Studies on UNFPA’s Global Programme on Out-of-School Comprehensive Sexuality Education: Palestine* (New York: UNFPA, 2023).

²⁹ Ibid (UNFPA, 2025).

WHO's Health Emergency Appeal 2026 confirms that the West Bank health system is operating under severe pressure. Between October 2023 and December 2025, more than 920 attacks on healthcare were recorded in the West Bank, while movement restrictions continued to fragment Palestinian territory and obstruct the movement of patients and ambulances. WHO further reported that 63% of primary healthcare centers in the West Bank were only partially functional, opening on average one day per week, compared with six days per week before 2023³⁰.

In addition, WHO reported that 35 humanitarian health partners currently support service delivery in the West Bank, including 11 partners operating mobile clinics reaching approximately 140,000 people across 221 locations affected by severe access restrictions³¹. In many remote and access-restricted communities, mobile clinics, outreach teams, and midwives remain the primary, and in some cases the sole, providers of SRHR, maternal health, primary healthcare, mental health, and protection-related services. Nevertheless, these modalities remain vulnerable to funding shortages, insecurity, movement restrictions, and administrative constraints, resulting in inconsistent service continuity³².

3.5.3. Structural and Institutional Barriers

While family planning services are widely offered by public health system, their full utilization is limited, especially for vulnerable women in marginalized communities because of hindrance to physical access and lack of awareness and socio-economic conditions, and many gaps are still found which the public health care system does not cover. For example, a comprehensive and age-appropriate education on SRHRs is not provided in schools although there were manuals developed for training teachers on SRHR and information on family planning methods is not consistently provided to women before or after they undergo an abortion. There is limited participation of women, youth and vulnerable groups living in the Area C, Jerusalem and Gaza Strip in public life and decision-making, and limited accountability when it comes to women issues including SRHR³³.

Although educational manuals and teacher-training materials on SRHR have been developed, comprehensive and age-appropriate sexuality education remains inconsistently institutionalized within formal school systems. UNFPA's Palestine case study on out-of-school comprehensive sexuality education notes that initiatives such as the "Majd" model provide culturally sensitive SRHR information for adolescents, but these remain targeted interventions rather than universal

³⁰ World Health Organization (WHO). WHO's Health Emergency Appeal 2026: Occupied Palestinian Territory. Geneva: WHO, 2026.

³¹ World Health Organization (WHO). Health Conditions in the Occupied Palestinian Territory, Including East Jerusalem, and in the Occupied Syrian Golan. Executive Board, 158th Session, EB158/25.

³² Ibid (UNFPA 2020).

³³ MIFTAH, UNFPA (2015). Country Assessment towards Monitoring and Reporting Sexual and Reproductive Health and Rights (SRHR) in Palestine.

school-based provision³⁴. Information on family planning and reproductive health options, including post-abortion family planning counselling, has also been identified as inconsistently provided in earlier Palestinian SRHR monitoring assessments³⁵. Furthermore, women, youth, persons with disabilities, and marginalized communities continue to face barriers to meaningful participation in SRHR and protection-related decision-making, while disability-inclusive and survivor-centered GBV/SRHR services remain insufficiently institutionalized³⁶.

The National Referral System (NRS) for Women Victims of Violence was established to strengthen coordination between health, social, legal, and protection actors. However, implementation remains inconsistent across governorates due to weak dissemination, limited inter-sectoral coordination, insufficient provider training, and low survivor awareness of available services. Although some NGOs and community-based organizations have established localized referral mechanisms, these systems often remain project-based and financially unsustainable³⁷.

In 2024 and early 2025, the NRS and broader GBV referral architecture underwent important updates. The GBV Area of Responsibility, led by UNFPA under the Protection Cluster, continued to strengthen coordination across health, social, legal, and protection actors³⁸. In late 2024 and March 2025, GBV partners developed, validated, finalized, and disseminated updated Standard Operating Procedures (SOPs) for GBV case management in crisis settings to improve consistency and quality of service provision³⁹. OCHA also reported that GBV referral pathways were updated in March 2025 to reflect changes in the availability of service providers amid rapidly deteriorating humanitarian conditions⁴⁰.

While SRHR and protection services formally exist in the West Bank, access remains fragmented and unequal. Service gaps are driven by movement restrictions, attacks on healthcare, partial functionality of facilities, weak referral systems, social stigma, and the continued dependence of remote communities on intermittent humanitarian and mobile service delivery mechanisms.

³⁴ United Nations Population Fund (UNFPA). *Country Case Studies on UNFPA's Global Programme on Out-of-School Comprehensive Sexuality Education: Palestine*. New York: UNFPA, 2023

³⁵ Ibid (Miftah, 2015).

³⁶ United Nations Population Fund (UNFPA) and Women Enabled International. *Women and Young Persons with Disabilities: Guidelines for Providing Rights-Based and Gender-Responsive Services to Address Gender-Based Violence and Sexual and Reproductive Health and Rights*. New York: UNFPA, 2018.

³⁷ National Referral System for Victims of Gender-Based Violence, State of Palestine. (2023). *National referral system for victims of gender-based violence in the State of Palestine (2013–ongoing)*. SDG16. Available at: <https://www.sdg16.plus/policies/national-referral-system-for-victims-of-gender-based-violence-state-of-palestine>

³⁸ United Nations Population Fund (UNFPA), Palestine Situation Report No. 13, December 2024 (New York: UNFPA, 2024)

³⁹ World Health Organization (WHO), WHO Response in oPt: April–December 2024 (Cairo: WHO Regional Office for the Eastern Mediterranean, 2024)

⁴⁰ United Nations Office for the Coordination of Humanitarian Affairs (OCHA), Gaza Humanitarian Response Update, 16–29 March 2025 (Jerusalem: OCHA oPt, 2025)

3.5.4. Socio-Cultural and Economic Barriers

Socio-cultural norms and economic vulnerabilities continue to shape access to SRHR services and information in the West Bank. UNFPA research on social norms and SRHR among Palestinian youth found that stigma, restrictive gender norms, and conservative social attitudes continue to limit young people's ability to access SRHR education, reproductive healthcare, and protection services. These barriers disproportionately affect adolescent girls, unmarried women, women with disabilities, and women living in marginalized communities⁴¹.

Economic inequalities further compound SRHR vulnerabilities. According to PCBS labour force data for the first quarter of 2026, labour force participation in the West Bank reached 70.1% among males compared with only 17.5% among females. Among youth aged 15–29, only 18% of young women participated in the labour force compared with 60.2% of young men, while unemployment among young women reached 44.2%, compared with 37.1% among young men⁴². Existing literature and UNFPA analyses suggest that economic dependency and restrictive gender norms can negatively affect women's autonomy in health-related and reproductive decision-making, including access to contraception, SRHR services, legal assistance, and protection support⁴³.

Social norms remain deeply intertwined with communication and help-seeking behaviors related to SRHR and GBV. Concepts associated with honour, shame, modesty, and family reputation strongly influence whether individuals seek information, disclose violence, or access SRHR services. These norms often determine who is permitted to discuss SRHR issues, who may access contraception or GBV services, and which topics remain socially taboo, particularly those related to sexuality, rape, sexually transmitted infections, and reproductive autonomy⁴⁴.

Oxfam's 2021 analysis further highlighted persistent gaps in youth wellbeing, including limited access to nutrition, psychosocial support, SRHR information, and youth-friendly services, particularly among adolescent girls. Stress, anxiety, economic insecurity, and prolonged exposure to occupation-related violence and instability continue to negatively affect young people's wellbeing and future opportunities⁴⁵.

⁴¹ Ibid (UNFPA 2020).

⁴² Palestinian Central Bureau of Statistics (PCBS). Labour Force Survey in the West Bank: January–March 2026. Ramallah: PCBS, 2026

⁴³ Ibid (UNFPA, 2020).

⁴⁴ UNFPA, UNICEF, & World Health Organization. (2021). *KAP study on sexual and reproductive health and rights in the occupied Palestinian territory*. https://palestine.unfpa.org/sites/default/files/pub-pdf/kap_study_long_report.pdf

⁴⁵ Oxfam. (2021). *Youth Wellbeing in the Occupied Palestinian Territory: An In-Depth, Multi-Level and Interdisciplinary Study into Wellbeing and Gender Equality among Palestinian Youth*. Oxfam International. Available at: <https://policy-practice.oxfam.org/resources/>

3.5.5. Trust, Confidentiality, and Youth-Specific Barriers

Low levels of trust in formal institutions represent an additional barrier to SRHR and GBV service utilization. Women and youth frequently express concerns regarding confidentiality, provider attitudes, discrimination, and the safety of service environments⁴⁶. Fear of being recognized at healthcare facilities or social service offices often discourages service-seeking behavior, particularly in conservative or close-knit communities. The presence of male staff, inadequate privacy measures, and insufficient safeguarding mechanisms may further deter women and adolescents from accessing care⁴⁷.

Survivors of violence may also avoid seeking support due to fears of blame, disbelief, social repercussions, or re-traumatization. Many therefore rely on informal support networks, including family members, peers, community elders, teachers, or digital communication platforms. While these informal networks may provide immediate emotional support, they frequently lack professional referral pathways, survivor-centered approaches, and confidentiality safeguards⁴⁸.

Adolescents and youth face additional barriers related to social stigma and limited confidentiality⁴⁹. Concerns about parental discovery or community judgment discourage many adolescents, particularly girls, from seeking SRHR services or information. In the absence of trusted formal systems, communities rely on informal networks including social media, midwives, elders, teachers, or WhatsApp groups⁵⁰. While useful, these can reinforce misinformation and lack proper referral pathways⁵¹.

3.5.6. Disability and Intersectional Exclusion

Women and girls with disabilities experience heightened exclusion due to intersecting forms of discrimination related to gender, disability, poverty, and displacement. Research conducted by UNFPA Palestine found that women with disabilities frequently encounter barriers in accessing health, protection, and GBV services due to physical inaccessibility of facilities, lack of adapted communication materials, limited provider preparedness, and weak inclusion in service planning and decision-making processes. The study further highlighted that stigma, social isolation,

⁴⁶UNFPA (2024). Lifelines in Crisis: Mobile Healthcare Teams in the West Bank Provide Essential Services. <https://palestine.unfpa.org/en/news/lifelines-crisis-mobile-healthcare-teams-west-bank>

⁴⁷OCHA (2023). Humanitarian needs overview 2023: Occupied Palestinian Territory. United Nations Office for the Coordination of Humanitarian Affairs. https://www.ochaopt.org/sites/default/files/HNO_2023.pdf

⁴⁸ United Nations Population Fund (UNFPA). (2025, December). *Palestine situation report #13: December 2024*. UNFPA. <https://www.unfpa.org/resources/palestine-situation-report-13-december-2024>

⁴⁹ United Nations Population Fund (UNFPA). (2025). *Technical guidance: Comprehensive life education (CLE) for adolescents and youth*. UNFPA. <https://palestine.unfpa.org/sites/default/files/pub-pdf/2025-04/AY-CLE-Technical-Guidance-English.pdf>

⁵⁰UNFPA, UNICEF, & World Health Organization. (2021). Knowledge, attitudes and practices (KAP) on sexual and reproductive health and rights (SRHR) in the occupied Palestinian territory. UNFPA Palestine.

https://palestine.unfpa.org/sites/default/files/pub-pdf/kap_study_long_report.pdf

⁵¹Ibid (UNFPA, UNICEF, World Health Organization, 2021)

dependency on caregivers, and restricted mobility increase women's vulnerability to violence while simultaneously limiting their ability to seek support and access SRHR service⁵².

Recent human rights analyses have similarly emphasized that women and girls with disabilities in Palestine continue to face structural exclusion from healthcare and public life, particularly in marginalized and access-restricted communities. Communication barriers, inadequate accessibility standards, discriminatory social attitudes, and limited disability-sensitive services further undermine their access to SRHR information, reproductive healthcare, psychosocial support, and protection services⁵³. These vulnerabilities are compounded for individuals living in poverty, displaced households, and communities exposed to recurrent violence, militarized operations, and movement restrictions in the West Bank⁵⁴.

3.6. Contextual Implications for the Study

The contextual conditions outlined above are central to how this study understands SRHR and GBV in the West Bank. Territorial fragmentation, restricted mobility, uneven institutional development, economic precarity, and humanitarian deterioration shape the everyday terrain through which people learn, move, seek care, and make decisions. These conditions structure the availability of services, the reliability of referral pathways, the circulation of information, and the risks attached to asking for support.

The study therefore approaches SRHR and GBV as experiences produced through the interaction of gender norms, family authority, institutional trust, political restriction, and unequal access to resources. Decisions related to contraception, fertility, marriage, reporting violence, or seeking care are made within households, communities, clinics, schools, checkpoints, and digital spaces. They are shaped by what can be said, where one can go, who may know, and what consequences may follow.

This context also explains the study's comparative focus across geography, age, gender, and disability. Adolescents, women, persons with disabilities, and residents of marginalized or access-restricted communities face compounded barriers related to mobility, confidentiality, social visibility, and service continuity. Their experiences reveal how structural constraints enter intimate life, bodily knowledge, reproductive decision-making, and protection-seeking.

For this reason, the fieldwork examined trust in services, informal learning, digital information-seeking, movement restrictions, reproductive authority, and fragmented access pathways. These were not treated as separate themes. They were understood as interconnected dimensions of

⁵² United Nations Population Fund (UNFPA). *Women and Girls with Disabilities: Needs of Survivors of Gender-Based Violence and Services Offered to Them*. Jerusalem: UNFPA Palestine, 2018.

⁵³ Ibid (UNFPA, 2018).

⁵⁴ OCHA. (2023). *Humanitarian needs overview 2023: Occupied Palestinian Territory*. United Nations Office for the Coordination of Humanitarian Affairs. https://www.ochaopt.org/sites/default/files/HNO_2023.pdf

how SRHR and GBV are lived under conditions of occupation, social regulation, and uneven institutional reach.

Chapter 4. Findings: Gendered Knowledge, Attitudes, Practices, and Barriers

The findings presented in this chapter examine how SRHR and GBV are experienced and negotiated across different social positions, age groups, and geographic settings in the WB. Rather than treating knowledge, access, violence, or reproductive decision-making as separate issues, the analysis focuses on how these experiences are shaped through everyday family relations, gender expectations, institutional encounters, mobility restrictions, and unequal social conditions. The findings draw comparatively on FGDs, IDIs, and KIs with adolescents, young women and men, adult women, PoDs, and institutional actors across urban areas, camps, rural communities, and marginalized localities.

Survey findings are presented at different analytical levels depending on the relevance of each question to the participant group being discussed. Some charts present overall population patterns across sex, age, and geography, while others focus specifically on adolescents, young women, adult women, men, or persons with disabilities where subgroup analysis was analytically more meaningful. The presentation therefore follows the thematic structure of the findings rather than applying a single uniform charting format across all sections.

4.1. Learning the Body: Knowledge, Silence, and Gendered Socialization

This section presents findings on how participants learn about the body, sexuality, puberty, menstruation, contraception, reproductive health, and relationships. It focuses on sources of information, gaps in knowledge, attitudes toward discussing SRHR, and barriers that limit access to accurate and trusted information.

Across age groups and locations, participants described SRHR knowledge as uneven. Some participants had clear awareness of bodily changes, reproductive health, and rights, while others reported limited knowledge, embarrassment, or uncertainty. Family communication, school-based education, peer networks, digital platforms, and NGO awareness sessions all played a role in shaping knowledge. However, participants repeatedly indicated that information was often partial, delayed, or difficult to discuss openly.

Silence around sexuality and reproductive health was especially visible among adolescents and young people. Many participants described relying on peers, social media, search engines, or AI-based tools when they could not ask parents, teachers, or service providers directly. These patterns suggest that access to SRHR information is shaped by trust, privacy, gender expectations, family communication, and the social conditions under which questions can be asked safely.

4.1.1. Adolescents: Between Curiosity, Silence, and Informal Learning

Adolescents across different geographic areas described puberty, bodily change, and sexuality as topics that remain difficult to discuss openly within families and schools. Participants frequently

reported receiving fragmented or incomplete information related to menstruation, bodily development, relationships, and reproductive health, particularly during early adolescence. Discussions revealed differences in levels of awareness, confidence, and communication across gender and geographic settings.

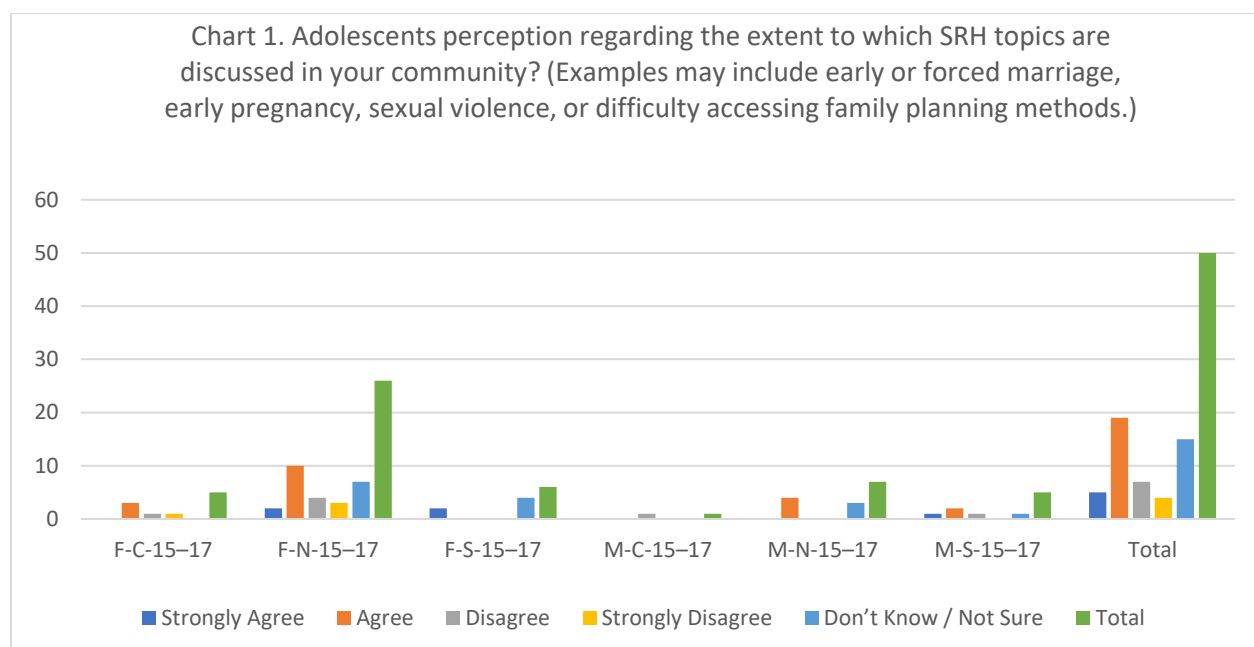
Adolescent girls generally demonstrated greater willingness to discuss bodily changes and reproductive health concerns than boys. Participants from Jenin and Tubas emphasized the importance of understanding menstruation, puberty, hygiene, and emotional changes at an early stage. Several girls described SRHR information as important for reducing fear, confusion, and embarrassment associated with bodily development. One participant explained that girls need to understand that bodily changes “are natural and more than normal,” particularly during adolescence when many experience uncertainty and fear.

Participants also emphasized the importance of trusted communication within families. Adolescent girls repeatedly described the need for safe spaces where they could ask questions openly without shame or judgment. One participant explained: *“It is my right in reproductive health that my mother herself is understanding and aware of these things so that when I ask her she is my reference and I do not go ask someone else like friends or internet sites”*.

Many adolescents reported that communication related to sexuality and reproductive health remains limited within households. Participants from Ramallah and surrounding urban areas described generational discomfort surrounding discussions of sexuality, relationships, and bodily autonomy. In these settings, adolescents frequently reported turning to online platforms, social media, Google, TikTok, and ChatGPT to obtain information privately.

In rural and socially conservative areas such as Yatta and Beit Fajjar, discussions reflected greater sensitivity surrounding sexuality-related topics in both schools and family settings. Adolescents described schools as cautious environments where discussions often remain limited to hygiene and basic biological information. Several participants explained that students avoid asking questions publicly because of embarrassment or fear of judgment from peers and teachers, making online searching an alternative source of information for many adolescents seeking privacy and anonymity.

Survey findings also reflected adolescents’ perceptions regarding community openness to discussing sensitive SRHR and GBV-related issues, including early marriage, forced marriage, early pregnancy, sexual violence, and barriers related to contraception and reproductive decision-making. Chart 1 presents responses by sex and geographic cluster.



Overall, 48.0% of adolescent respondents either agreed or strongly agreed that issues affecting sexual and reproductive health and rights are discussed within their communities. By comparison, 22.0% disagreed or strongly disagreed, while 30.0% reported uncertainty.

Perceptions varied across gender and geographic areas. Female adolescents, particularly in southern communities, reflected higher levels of uncertainty regarding whether SRHR- and GBV-related issues are openly discussed within their communities. Male adolescents generally perceived somewhat greater openness toward discussing these issues, although uncertainty remained present across groups.

These findings closely reflected the qualitative discussions with adolescents, particularly girls, who repeatedly described selective openness surrounding SRHR issues. Topics such as puberty, hygiene, and menstruation were viewed as more acceptable for discussion, while issues related to sexual relationships, violence, bodily autonomy, contraception, and coercion remained significantly more sensitive.

Boys in the FGDs discussed SRHR somewhat differently. Male participants frequently associated sexuality-related discussions with embarrassment, discomfort, and fear of negative judgment, particularly in relation to fathers or older male authority figures. Several participants explained that boys rely primarily on peers, online searching, or informal conversations rather than family communication. One participant stated: *“In our society, we were raised to see these topics as shameful”*.

Chart 2 presents responses across all participant groups regarding self-reported SRHR knowledge and ability to discuss SRHR issues with peers or others. Within this broader pattern, adolescent

responses show uneven confidence. Among adolescent girls aged 15–17 in northern areas, 42% described themselves as having good or moderate SRHR knowledge, while 23% reported insufficient knowledge and 23% expressed uncertainty. Similar patterns appeared among adolescent girls in southern areas, suggesting that younger participants continue to face hesitation, incomplete communication, and uneven exposure to SRHR information.

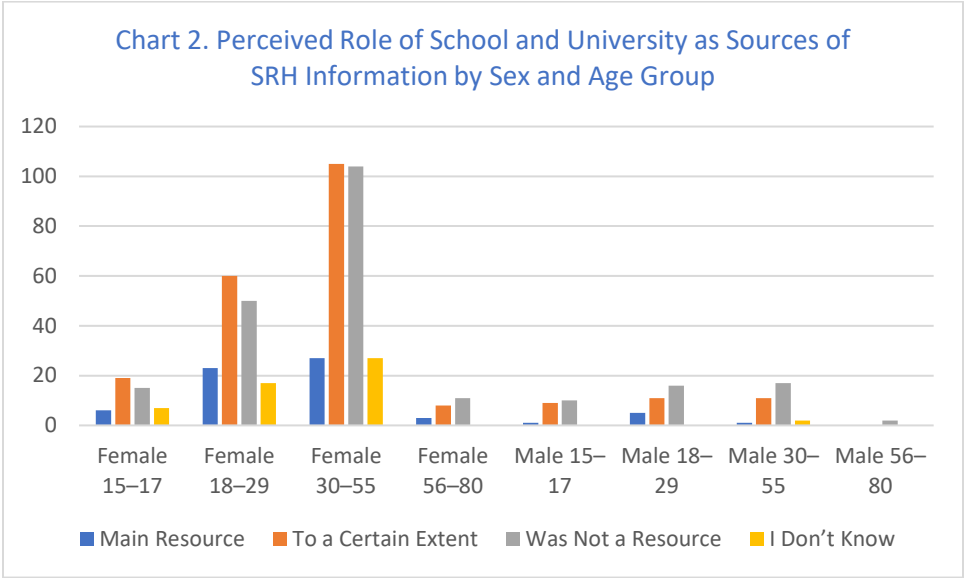
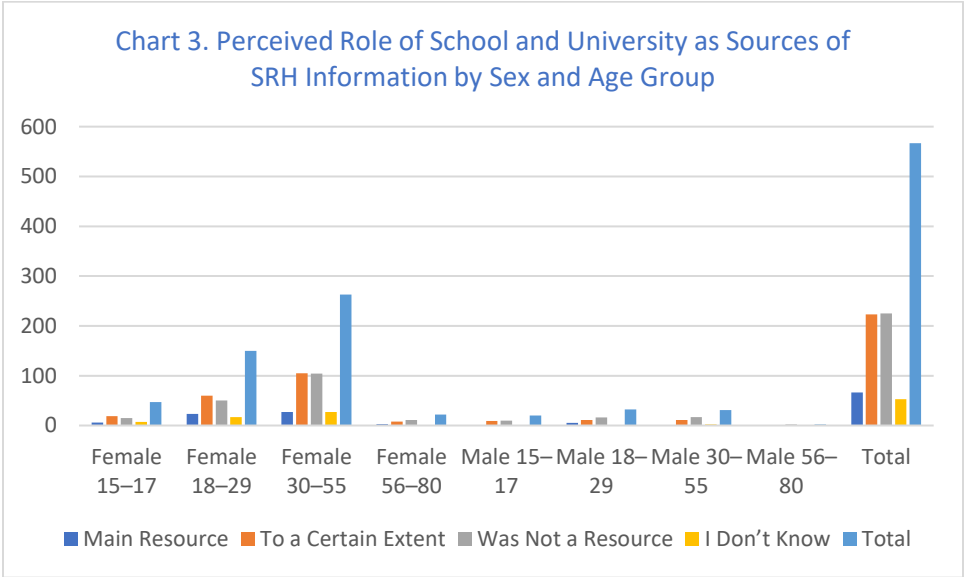


Chart 3 presents responses regarding schools and universities as sources of SRHR information.



Within the adolescent group, schools and universities were widely perceived as partial or insufficient sources of SRHR information. Female respondents more frequently described schools as providing limited information, while male adolescents more often reported that schools were not meaningful sources of SRHR knowledge at all. These findings closely reflected qualitative

discussions in which adolescents repeatedly described school-based education as cautious, incomplete, and largely restricted to hygiene and biological information.

Across discussions, adolescents repeatedly identified several barriers affecting access to SRHR information and support, including:

- embarrassment discussing sexuality and bodily changes,
- limited family communication,
- weak school-based SRHR education,
- fear of judgment or blame,
- reliance on unreliable online sources,
- social stigma surrounding SRHR discussions,
- and lack of confidential spaces for asking questions safely.

At the same time, adolescents consistently emphasized the importance of trusted communication, school-based awareness, safe dialogue spaces, and accurate information delivered in age-appropriate ways. Many participants also linked SRHR knowledge with self-confidence, bodily awareness, emotional wellbeing, and protection from harassment, coercion, and unsafe relationships.

Across discussions, adolescents described SRHR learning as fragmented and unevenly distributed across families, schools, peer networks, online platforms, and awareness initiatives. Access to trusted information depends heavily on sex, geography, privacy, and the availability of emotionally safe spaces for discussion. While many adolescents demonstrated increasing awareness regarding bodily health and reproductive issues, participants repeatedly emphasized that embarrassment, silence, and fear of judgment continue to shape how knowledge is sought, shared, and trusted.

4.1.2. Young Women: Bodily Autonomy, Fertility, and Social Pressure

Young women discussed SRHR through bodily autonomy, reproductive awareness, emotional wellbeing, and access to trusted information. Across discussions, participants described increasing awareness of reproductive health, family planning, contraception, and mental health compared to previous generations. At the same time, they described continuing social pressure surrounding marriage, fertility, and women's reproductive roles.

Participants in Ramallah and surrounding urban areas more frequently framed SRHR through the language of wellbeing, informed choice, and personal autonomy. Several women emphasized that reproductive health includes emotional, psychological, and physical wellbeing and should not be limited to childbirth alone. One participant explained: *"The woman must have the right to choose whether she wants to give birth now or not and how many children she wants to have and*

when she wants to give birth". Several women emphasized the importance of family planning, reproductive preparedness, and informed decision-making before pregnancy and marriage.

Despite this growing awareness, discussions repeatedly highlighted the extent of social pressure surrounding fertility and reproductive timing. Several participants explained that delayed pregnancy often becomes subject to questioning, interference, and community commentary.

One participant from Ramallah described her experience after delaying pregnancy in order to complete university studies: *"People started talking and interfering, telling me to go to the doctor... Even when you are confident in your decision, people's comments still affects you psychologically"*.

Participants also described emotional and physical exhaustion associated with pregnancy, childbirth, and caregiving responsibilities. One participant stated: *"After giving birth, even now, I still feel exhausted physically and mentally. No one checks on you or offers help; they only care that you have children and increase the family size"*.

Geographic differences were visible across discussions. Women from Ramallah and central urban areas generally described greater exposure to universities, NGO activities, online educational content, and awareness initiatives related to SRHR. Participants from peripheral communities such as Al-Jiftlik and Fasayil described stronger pressure surrounding marriage timing, fertility, and women's expected roles within family structures.

In the Jordan Valley, several participants explained that marriage and childbearing continue to be closely linked to feminine respectability and family reputation. Delayed pregnancy was frequently associated with gossip, assumptions about infertility, or family interference. At the same time, participants acknowledged gradual changes related to girls' education, women's employment, and broader awareness regarding reproductive health.

PoD participants resisted being understood exclusively through disability itself. One woman explained: *"I have a phobia of gas, not because of my disability. I am a normal human being just like normal person who has phobia of gas"*. The statement challenged assumptions that every emotional or bodily experience should be interpreted through disability alone. Fear and anxiety were described instead as part of living within broader conditions of war, insecurity, and instability.

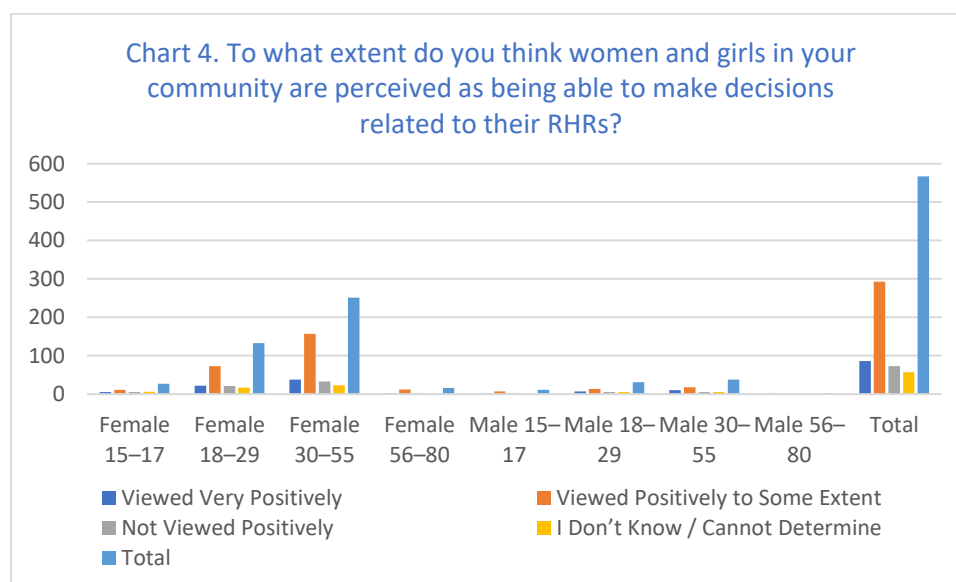
Women with disabilities also reflected on how shame and embarrassment shape bodily experience from adolescence onward. One participant recalled her first menstruation while studying at a boarding school for girls with visual impairments and described how embarrassment and silence initially shaped her understanding of menstruation before later receiving reassurance and support from the social worker.

Across discussions, young women linked SRHR knowledge with confidence, preparedness, and the ability to negotiate pressure surrounding marriage, fertility, and reproductive expectations. At the same time, participants repeatedly described reproductive knowledge as socially mediated through family influence, community scrutiny, unequal gender expectations, and uneven access to trusted communication spaces. These patterns appeared more strongly in rural and marginalized communities, where reproductive life remained closely tied to family reputation and social visibility.

4.1.3. Reproductive Decision-Making and Family Authority

Discussions of women’s reproductive autonomy consistently highlighted the role of husbands, parents, extended family members, and broader community expectations in shaping reproductive health decisions. Both qualitative and survey findings indicated that decisions related to contraception, healthcare access, marriage timing, and fertility remain embedded within family structures and social norms across many communities.

Survey findings, as presented in Chart 4, reflected broad support for women’s participation in reproductive decision-making, although perceptions varied by age, gender, disability status, and geographic location. Overall, 67% of respondents viewed women’s participation in reproductive decision-making either very positively or somewhat positively. Support was strongest among women aged 18–29 and 30–55 years. Female respondents more frequently identified marriage decisions, timing of marriage, family planning, maternal healthcare, and access to SRHR services as areas in which women should actively participate.



At the same time, qualitative discussions revealed that women’s reproductive autonomy is often negotiated within wider familial and social relations. Participants repeatedly described

reproductive decisions as shaped by husbands, mothers-in-law, relatives, and community expectations, particularly in rural and socially interconnected settings.

Survey findings reinforced these patterns. Across demographic groups, respondents frequently identified husbands and family members as influential actors in decisions related to contraception and women's access to reproductive healthcare.

The clearest pattern concerned husbands' involvement in decisions related to contraceptive use. Across most geographic clusters and age groups, respondents most frequently reported that husbands' involvement applies "to a large extent" within their communities. This perception appeared especially pronounced among women aged 30–55 years in northern and southern areas.

Perceptions regarding parental involvement in married daughters' contraceptive decisions were more varied. Respondents more commonly selected "applies to some extent" or "applies to a limited extent," suggesting that parental influence remains socially present, although less consistently perceived than husbands' involvement.

Responses regarding parental involvement in married daughters' visits to healthcare providers also varied across locations and demographic groups. Compared with contraceptive decision-making, healthcare visits were more often understood as areas of shared family involvement rather than direct control. Respondents from central areas, particularly women aged 18–29 and 30–55 years, more frequently reported that such involvement "does not apply".

The survey examined three dimensions of reproductive decision-making: husbands' involvement in contraceptive decisions, parental involvement in married daughters' contraceptive decisions, and parental involvement in married daughters' healthcare visits. Geographic variation appeared across all three indicators. Respondents from northern and southern areas generally perceived stronger family involvement in reproductive decision-making than respondents from central areas. These differences reflected variations in social norms, family structures, educational exposure, and community expectations across locations.

Age and disability status also shaped responses. Younger respondents aged 15–17 years more frequently selected "I don't know" or "applies to some extent", reflecting greater uncertainty regarding reproductive decision-making processes. Respondents with disabilities similarly expressed higher levels of uncertainty across several indicators, potentially linked to lower participation in SRHR discussions and reduced access to reproductive health information and services.

Overall, the findings indicate that reproductive decision-making continues to be widely understood as a relational process shaped by husbands, family members, and community norms, particularly in matters related to contraception and reproductive choices within marriage.

4.1.4. Young Men: Masculinity, Anxiety, and Private Knowledge

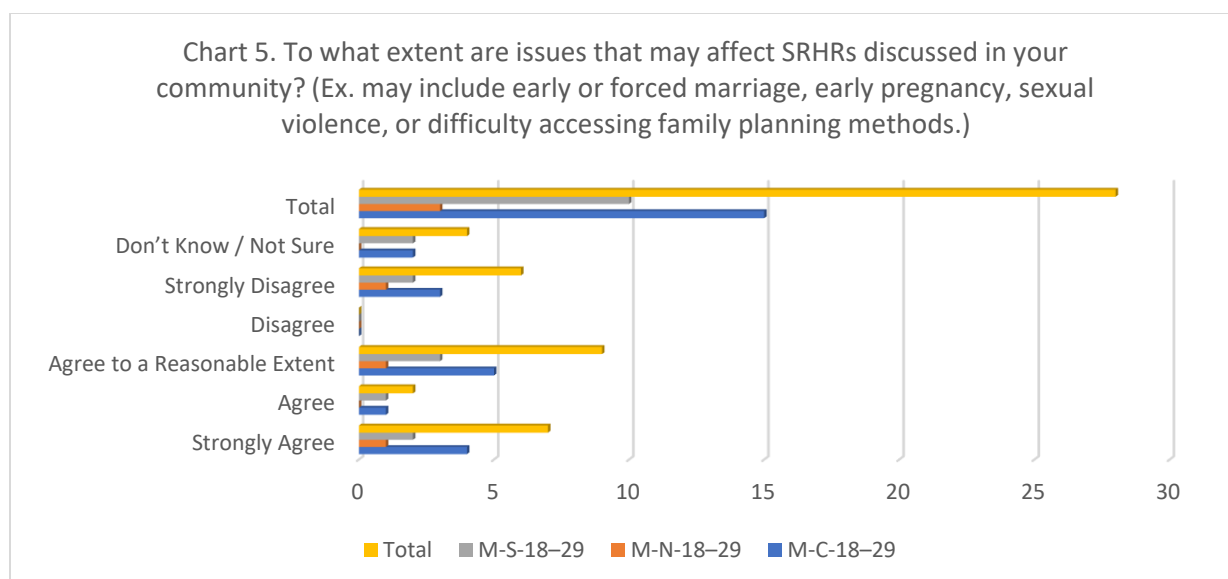
The interviews with young men revealed a relationship to SRHR shaped by secrecy, economic pressure, bodily anxiety, and uncertainty surrounding masculine adulthood. Discussions of sexuality and reproductive health rarely appeared as medical or educational questions alone. They were tied to social reputation, marriageability, provision, emotional restraint, and the pressure to appear capable in contexts marked by unemployment, political instability, and limited institutional trust.

Participants described sexuality and reproductive health as socially sensitive subjects associated with embarrassment and fear of judgment. In Beit Fajjar, Biddu, Ramallah, and Nablus, such discussions remained largely confined to trusted friendships and private conversations. Public discussion carried the risk of ridicule, moral judgment, or exposure. One participant explained: “In our society, we were raised to see these topics as shameful.”

This silence shaped how young men accessed knowledge. Schools were described as offering fragmented biological information while avoiding relationships, sexual wellbeing, emotional intimacy, contraception, and fertility. Several participants recalled teachers skipping lessons on the reproductive system or discussing them with visible discomfort. One participant explained: “When we reach lessons about the reproductive system in school, teachers provide only minimal explanations, which forces us to seek knowledge outside the school environment.”

In the absence of trusted institutional spaces, young men relied on internet searches, social media, artificial intelligence, peers, and informal networks. Digital platforms became private routes for asking questions that could not easily be raised within families, schools, clinics, or community settings. Participants also expressed concern about misinformation, fragmented knowledge, and the lack of reliable guidance. AI-based tools were trusted partly because they allowed anonymity and reduced the risk of social exposure.

Survey data complicates the picture of silence. Among male respondents aged 18–29, 64.3% agreed to varying degrees that SRHR- and GBV-related issues, including early marriage, early pregnancy, sexual violence, contraception, and reproductive decision-making, are discussed within their communities (Chart 5). Yet this reported openness was uneven: 21.4% strongly disagreed, while 14.3% were uncertain.



Men from central areas expressed the strongest sense of openness, with 66.7% agreeing to some degree that these issues are discussed. In southern areas, 60% expressed agreement, while the remaining respondents were evenly divided between strong disagreement and uncertainty. This ambivalence corresponds with interviews from Yatta and Beit Fajjar, where sexuality, intimate relationships, and reproductive health were described as socially sensitive and difficult to name publicly.

Northern responses were more divided, although the sample was small: one-third strongly agreed, one-third agreed to a reasonable extent, and one-third strongly disagreed. These differences suggest that openness around SRHR is unevenly distributed across social settings.

The interviews clarify what this “openness” often means in practice. Young men described conversations that occur privately among trusted friends, in cafés, online, or through anonymous searches. They rarely described open discussion within families, schools, clinics, or formal community settings. Public speech remained risky because it could invite judgment, ridicule, or reputational harm. SRHR may therefore be discussed in communities while remaining socially contained, gendered, and carefully managed.

The interviews also revealed anxiety surrounding masculinity itself. Marriage remained strongly tied to provision, authority, and economic capability, while worsening economic conditions increasingly undermined young men’s ability to meet these expectations. Participants linked masculine adulthood to employment, housing, and financial independence under conditions of unemployment, rising costs, and shrinking opportunities after October 2023. One participant described how “the role of men has been reduced to that of a financial provider, like a bank card.”

Several participants reflected critically on older forms of masculinity centered on authority and control. Young men questioned expectations that men should remain emotionally distant, sexually dominant, or solely responsible for financial provision while offering little caregiving or emotional support within households. One participant described seeing women carry newborn children alone after childbirth while husbands stood nearby without helping, calling this “a regression in roles.”

Masculinity appeared increasingly fragile under economic and political pressure. Young men connected unemployment, dependency, and delayed marriage to inadequacy, frustration, and loss of social standing. Changing gender roles also surfaced in discussions of women’s employment and financial contribution to households, especially where masculine authority still depends on economic provision.

Fertility emerged as another sensitive source of masculine anxiety. Young men linked reproductive ability to marriageability, masculine reputation, and future family life. Fertility testing, sexual performance, and delayed pregnancy remained difficult to discuss openly, even among married men. Participants described reluctance among men to seek reproductive healthcare or acknowledge possible health concerns because illness may be experienced as weakness or social failure.

Political violence entered these discussions directly. One participant described anxiety about his reproductive health following imprisonment and physical assault by Israeli forces targeting young men’s “sensitive/private areas.” After his release, he sought fertility testing because he feared “wronging a future wife.” Reproductive anxiety was therefore tied to the bodily effects of detention, political violence, and chronic insecurity.

Despite these pressures, several participants described growing interest among younger men in reproductive awareness, emotional compatibility, and shared responsibility within marriage. Some questioned assumptions surrounding large family size, repeated childbirth, and women’s unequal caregiving burdens under worsening economic conditions. Others emphasized mutual respect, emotional support, and reproductive knowledge as necessary for building stable households.

Young men’s overall perceptions revealed masculinity as negotiated between authority and vulnerability, silence and curiosity, provision and incapacity, social expectation and economic reality. Sexuality and reproductive health remained difficult to discuss publicly, yet they occupied a central place in how young men imagined adulthood, marriage, bodily integrity, and future family life.

4.1.5. Adult Women and Mothers: Endurance, Protection, and Intergenerational Change

Adult women and mothers discussed SRHR primarily through communication, caregiving, family guidance, and responsibility toward younger generations. Their discussions reflected changing perceptions regarding girls' education, reproductive health awareness, and parent-child communication, while also revealing continuing discomfort surrounding sexuality and reproductive issues within families and communities.

Women from northern areas such as Zababdeh and Ya'bad more frequently described gradual shifts in awareness compared with previous generations. Participants explained that girls today have greater exposure to education, social media, universities, and awareness initiatives than their mothers did. However, many mothers acknowledged that communication within families remains limited, particularly regarding sexuality, intimate relationships, and contraception.

One participant explained: *"The biggest problem is that the mother herself does not know anything. It might be different if she had received training"*.

Women repeatedly described uncertainty regarding how and when to discuss sexuality and reproductive health with adolescents. Many participants supported age-appropriate guidance while expressing concern about exposing girls to information "too early." Discussions reflected tension between the desire to protect adolescents and recognition that young people increasingly access information independently through social media and online platforms. One woman stated: *"Our daughters know everything from the internet; they do not need to go ask their parents"*.

Participants from both northern areas and the Jordan Valley emphasized that mothers are often expected to carry primary responsibility for discussing puberty, menstruation, bodily changes, marriage, and reproductive health with daughters. Fathers were generally described as less involved in these conversations. One participant explained: *"Honestly, since the father is a partner in raising the children, he should have a role. But unfortunately, the father's role is absent, and everything falls on the mother to handle"*.

Women also discussed the role of schools in SRHR education. Across locations, participants described school-based information as limited and largely restricted to hygiene, puberty, and basic biological information. Discussions related to sexuality, relationships, consent, and family planning were described as minimal or avoided altogether.

Participants from Al-Jiftlik and surrounding areas described increasing exposure to NGO-led awareness activities and women's groups, particularly through organizations working on reproductive health and community education. Women from northern areas also emphasized the importance of trusted awareness spaces outside formal school settings, especially where mothers themselves feel uncomfortable discussing sexuality directly.

At the same time, participants repeatedly highlighted concern regarding misinformation online and the absence of trusted sources of guidance for adolescents. Women explained that girls and boys increasingly rely on social media, internet searches, and peers because families and schools do not consistently provide sufficient information.

Several mothers also linked SRHR awareness to protection from harassment, coercion, and unsafe relationships. Participants emphasized the importance of teaching girls bodily boundaries, self-confidence, and when to seek help or guidance.

Across discussions, adult women and mothers occupied a complex position within the KAP landscape. Many supported greater awareness, later marriage, improved communication, and stronger guidance for younger generations. However, participants also reflected continuing discomfort surrounding sexuality, limited confidence discussing intimate topics, and broader social norms that continue shaping communication within households and communities.

4.1.6. Institutional Perspectives: Awareness Efforts and Institutional Hesitation

Institutional actors described SRHR as a field shaped by silence, caution, and uneven legitimacy within community life. Educators, healthcare providers, and community organizations spoke of persistent difficulty addressing sexuality, reproductive health, and intimate relations openly, particularly in rural areas and socially conservative settings. These difficulties formed part of a broader moral landscape in which sexuality remains closely tied to family reputation, social surveillance, and respectability.

Schools emerged repeatedly as sites of partial knowledge. Formal education largely confines SRHR discussions to hygiene and basic biology, while questions related to sexuality, consent, emotional wellbeing, contraception, and bodily autonomy remain marginal, uncomfortable, or avoided. One provider remarked: “What we observed is that schools only teach personal hygiene.” Another recalled that teachers often “skip them or talk about them with embarrassment.”

These accounts echoed discussions with adolescents and mothers, who described school-based education as insufficient for navigating the social and emotional realities surrounding puberty, relationships, and reproductive health. Knowledge appeared unevenly distributed across formal instruction, family silence, peer exchange, and digital spaces.

Institutional actors repeatedly referred to a “culture of shame” surrounding SRHR communication. Parents were often described as uncertain or uncomfortable discussing sexuality with adolescents, particularly daughters. In this context, silence operated as a social practice tied to protection, modesty, and fear of reputational harm. One participant explained: “There is a

need to increase health awareness so that people can better understand these issues and move away from the perception that they are shameful.”

Geography shaped these dynamics. Participants working in Hebron, East Yatta, refugee camps, and remote southern communities described stronger social conservatism alongside limited institutional presence and mobility restrictions. In these settings, access to SRHR information and psychosocial support depended heavily on irregular outreach efforts and personal networks. One provider working in remote areas explained: “They say there is no one to guide them.”

Institutional actors from the Jordan Valley and northern areas, including Tubas and Jenin, similarly described uneven access to awareness initiatives. NGO programs and women’s groups sometimes created spaces for discussion, although these interventions often relied on temporary funding cycles, volunteers, and inconsistent institutional continuity.

Questions of trust and confidentiality appeared throughout the interviews. In smaller communities, institutional spaces remain deeply entangled with local social relations. Clinics, schools, and service centers were often perceived as socially exposed spaces where private matters could quickly circulate through networks of kinship and familiarity. One provider explained: “Women do not feel safe going to government or UNRWA clinics because if a woman shares her issue, it may become public knowledge.”

Providers also reflected critically on institutional limitations. Several participants acknowledged that healthcare workers, counselors, and educators frequently lack training in adolescent-friendly communication, gender-sensitive approaches, disability inclusion, and GBV response. Institutional hesitation around sexuality often mirrored broader social discomfort.

At the same time, many providers observed that adolescents increasingly seek information through social media, internet searches, AI-based platforms, and peer networks because formal institutions are rarely experienced as trusted spaces for asking intimate questions. Digital platforms therefore emerged as alternative sources of knowledge shaped by misinformation, uncertainty, and uneven reliability.

Across interviews, institutional actors described SRHR awareness as constrained by social stigma, weak educational frameworks, concerns over exposure and confidentiality, mobility restrictions, and inconsistent institutional outreach. Participants also pointed to gradual shifts in community attitudes, particularly through women’s groups, local awareness initiatives, and sustained engagement with community organizations.

Social change around SRHR appeared uneven, negotiated, and highly dependent on trust. Community-based outreach worked to create socially legitimate spaces where discussions of sexuality, reproductive health, and bodily wellbeing could occur with reduced fear of shame or

exposure. To that end, service providers proposed directions to improve SRHR awareness and access as shown in Diagram 2.

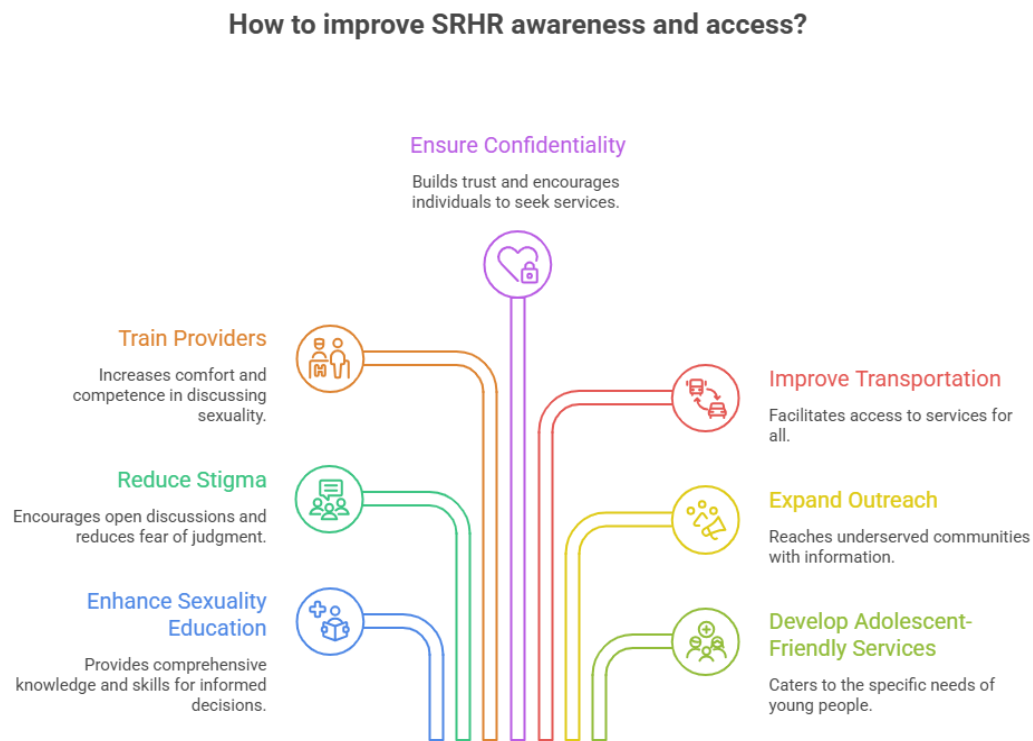


Diagram 2. Service Providers Perceptions on How to Improve SRHR Awareness and Access.

4.2. Marriage, Fertility, and the Social Regulation of Reproductive Life

This section examines how marriage, fertility, and reproductive decision-making are experienced across generations, genders, and geographic settings in the West Bank. Discussions consistently situated marriage and childbearing within wider social expectations related to adulthood, family continuity, gendered responsibility, and economic survival. Family influence, educational opportunities, financial conditions, and community norms all shaped how participants understood marriage, fertility, and reproductive life.

Experiences varied significantly across locations and social contexts. Participants from Ramallah and other urban areas more frequently emphasized delayed marriage, higher education, emotional readiness, and reproductive planning. Discussions from the Jordan Valley, rural southern communities, and economically marginalized areas reflected stronger pressure surrounding early marriage, fertility, and women's caregiving roles.

Young men often approached marriage through the language of economic obligation and social responsibility, particularly the expectation to secure employment and provide financially for a

future household. Women's discussions centered more heavily on pregnancy, childbirth, caregiving, and the physical and emotional demands associated with family life.

4.2.1. Adolescents: Preparing for Marriage and Adult Roles

Adolescents across different geographic areas described marriage as closely tied to education, maturity, responsibility, and future stability. Expectations surrounding marriage and adulthood emerged early in both girls' and boys' narratives, although these expectations remained strongly shaped by gender and location.

Adolescent girls frequently associated marriage with caregiving, childbirth, and domestic responsibility. Across discussions in Bethlehem, Tubas, and the Jordan Valley, girls repeatedly emphasized the importance of completing education and reaching emotional and physical maturity before marriage. Early marriage was widely described as harmful to girls' wellbeing, education, and future opportunities. One participant asked: *"How can someone raise children when she still needs raising herself?"*

Girls from Bethlehem and northern areas more openly rejected marriage before the age of 18 and often linked marriage to university completion, independence, and personal readiness. Several participants described girls marrying at 15 or 16 as unprepared for pregnancy, caregiving responsibilities, and married life. One participant explained: *"The body is not complete enough to carry pregnancy"*.

Discussions from Yatta and some rural southern communities reflected stronger social acceptance of early marriage, although many adolescent girls themselves expressed clear opposition to the practice. Participants explained that some families continue to view marriage as a form of protection for girls or as a response to economic hardship and social pressure.

In the Jordan Valley and Fasayil, adolescents more frequently described interrupted education and pressure to marry at younger ages, particularly among girls from economically marginalized households. Marriage appeared closely connected to economic precarity, limited educational access, and restricted future opportunities.

Boys discussed marriage through somewhat different concerns. Male adolescents repeatedly linked marriage to employment, financial capability, and the ability to support a future family. Several participants explained that young men are expected to complete their education, secure stable work, and achieve financial independence before marriage becomes socially possible. One participant stated: *"Now nobody can get married because there is no money"*.

Boys from Tubas and northern areas also described marriage as requiring maturity, discipline, and preparedness for family responsibility rather than simply reaching a particular age. Several

participants explained that young men who marry early are often viewed as incapable of sustaining a household or fulfilling expected social roles.

Across discussions, marriage emerged less as an individual decision than as a social transition shaped by family expectations, economic conditions, educational trajectories, and gendered norms surrounding adulthood and responsibility. Although awareness of the social and health consequences associated with early marriage appeared stronger among many adolescents than among previous generations, girls in rural and marginalized communities continued to describe stronger pressure surrounding marriage timing and family expectations.

4.2.2. Young Women: Fertility, Timing, and Social Legitimacy

Young women spoke about marriage and reproduction through the pressures that gather around fertility, pregnancy timing, family intervention, and the social value of motherhood. Their accounts showed a generational shift in reproductive awareness, especially among women with access to universities, urban networks, NGO programs, and health information. Yet reproductive decisions remained embedded in family expectations and community judgment.

In Ramallah and surrounding urban areas, women more often described marriage and childbirth through planning, emotional readiness, partner communication, and personal choice. Reproductive health was understood as bodily autonomy, mental wellbeing, and the ability to decide when pregnancy becomes possible or desirable. As one participant explained: “A woman should know her rights and decide herself when she is ready to have children and whether her body is prepared.”

Several women in Ramallah described delaying pregnancy after marriage to complete university, build financial stability, or prepare emotionally for parenthood. Childbirth was framed as a major physical and psychological responsibility that requires readiness, support, and care.

In Jenin and Tubas, reproductive awareness was closely tied to women’s health, pregnancy spacing, and the ability to answer family pressure. Young women challenged expectations of repeated childbirth and son preference. One participant explained: “Society implants ideas that children are support... and if she has three girls they say may God give her a boy.”

Women in northern areas described growing familiarity with family planning among educated women and those exposed to universities, NGOs, and awareness sessions. This awareness gave women language to name pressure, negotiate pregnancy spacing, and question inherited expectations. It rarely freed them from the social demand to prove fertility after marriage.

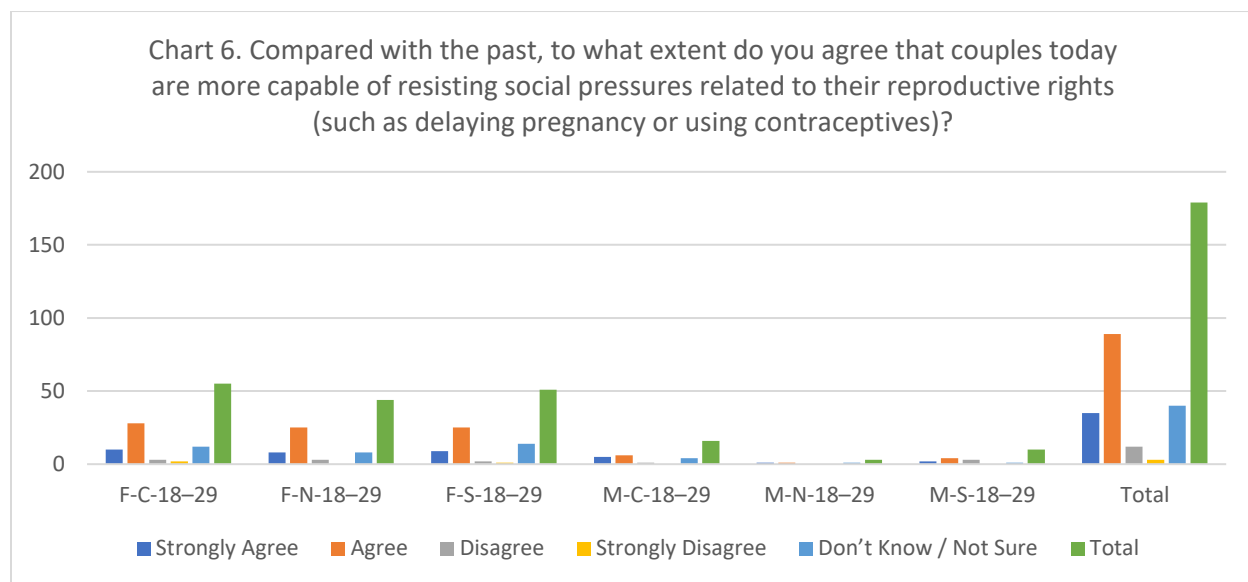
In the Jordan Valley and marginalized rural communities, childbirth soon after marriage carried stronger social weight. Women from Fasayil, Al-Jiftlik, and surrounding areas linked motherhood to respectability, family continuity, and social stability. Delayed pregnancy invited gossip,

suspicion, and family interference. As one participant stated: “If pregnancy is delayed, people assume the woman has a deficiency.”

Reproductive pressure also entered women’s emotional lives. Participants described anxiety, exhaustion, self-doubt, and psychological strain produced by family intervention, childcare demands, and the absence of practical support. One woman explained: “After giving birth, even now, I still feel exhausted physically and mentally. No one checks on you or offers help; they only care that you have children and increase the family size.”

Decision-making followed the same social geography. Women in Ramallah and some northern areas more often imagined reproductive decisions as shared between partners. In rural and marginalized communities, mothers-in-law, relatives, and extended family networks remained more present in decisions around pregnancy, contraception, and childbirth.

The survey data points to the same uneven transition. Among respondents aged 18–29, 69.3% agreed or strongly agreed that couples today are more able than previous generations to resist social pressure around delayed pregnancy and contraception. Only 8.4% disagreed or strongly disagreed, while 22.3% were uncertain (Chart 6).



Women in the north expressed the strongest sense of change, with 76.9% agreeing or strongly agreeing that couples today have greater ability to resist reproductive pressure. In central areas, the figure was 69.1%. In southern areas, 66.7% agreed or strongly agreed, although uncertainty was highest there, with 27.5% selecting “don’t know/not sure.” These differences suggest that reproductive autonomy is expanding unevenly, shaped by location, education, family structure, and access to supportive networks.

Men also recognized some change, especially in central areas, though responses from southern communities were more mixed. Their answers suggest that shifts in reproductive decision-making are visible beyond women's narratives, while remaining contested in places where family authority and social scrutiny remain stronger.

Young women's accounts show fertility as a social relation rather than a private biological event. Pregnancy timing, contraception, and childbirth are shaped by marriage expectations, kinship authority, economic uncertainty, son preference, and the uneven distribution of caregiving. Younger women increasingly speak the language of planning, spacing, rights, and readiness, yet motherhood remains a primary measure through which women's social legitimacy after marriage is judged.

4.2.3. Young Men: Marriage, Provision, and Reproductive Anxiety

Young men described marriage as an increasingly difficult social threshold shaped by economic instability, political uncertainty, and changing expectations surrounding masculine responsibility. Marriage remained closely associated with adulthood, provision, and social legitimacy, yet many participants described feeling unable to meet the conditions required to establish a household or sustain family life.

Participants from Beit Fajjar, Bethlehem, Biddu, Ramallah, and Nablus repeatedly described delayed marriage as a growing reality among younger generations. Unemployment, rising living costs, housing insecurity, and restricted economic opportunity after October 2023 shaped how participants imagined marriage and future family formation. One participant explained: *"A young man at the beginning of his life wants to achieve financial stability. However, unemployment is high, talents are often neglected, and economic pressures are significant"*.

In southern communities especially, marriage was understood less through age than through economic capability. Young men described strong social pressure to secure employment, complete education, obtain housing, and demonstrate financial stability before marriage becomes socially acceptable. Economic incapacity therefore delayed not only marriage itself, but also recognition as a socially competent adult man.

Participants also reflected on the emotional consequences of prolonged economic insecurity. Several described frustration, anxiety, and diminished self-worth linked to unemployment and dependency. Economic pressure appeared closely tied to masculine identity, particularly where men continued to carry primary responsibility for provision despite shrinking opportunities for stable work.

At the same time, some participants questioned inherited expectations surrounding family size and reproductive responsibility. Discussions from Ramallah and Nablus more frequently

emphasized emotional readiness, reproductive planning, and the ability to provide care rather than simply produce children. One participant explained: *“One must ask whether they are capable of providing care and emotional support to their children”*.

Several young men also reflected critically on the physical and emotional burden carried by women within marriage. Participants questioned assumptions that women should continue repeated childbirth regardless of exhaustion, economic hardship, or bodily strain. Some described awareness of how pregnancy and caregiving responsibilities affect women’s physical and psychological wellbeing, particularly in contexts where support remains limited.

Fertility itself carried significant emotional weight. Young men described anxiety surrounding reproductive ability, delayed fertility, and sexual performance, particularly within communities where masculinity remains closely tied to virility, marriage, and fatherhood. Reproductive concerns often remained hidden because acknowledging sexual or fertility problems risked social embarrassment and damage to masculine reputation. Several participants explained that men frequently avoid medical consultation unless problems become unavoidable.

Participants also described widespread confusion and limited preparation for intimate relationships and marital life. Several explained that young men often enter marriage with fragmented or inaccurate knowledge shaped by rumor, pornography, peer discussion, or internet sources rather than meaningful education or open communication. One participant described how many young people *“were later surprised that reality was different, which led to confusion and psychological distress”*.

Marriage therefore appeared simultaneously as aspiration, obligation, and source of anxiety. Young men continued to measure adulthood through marriage, provision, and fatherhood, while economic collapse, political instability, and changing gender relations increasingly complicated their ability to fulfill these expectations. Their accounts revealed marriage as deeply entangled with masculinity, bodily confidence, economic survival, and the uncertain possibility of building stable family life under prolonged conditions of insecurity.

4.2.4. Adult Women and Mothers: Marriage, Endurance, and Reproductive Expectation

Adult women and mothers spoke about marriage and fertility through lived experiences of childbirth, caregiving, exhaustion, and long-term family responsibility. Their discussions centered on the practical and emotional realities of marriage, repeated childbirth, and women’s expected roles within households and extended family structures.

Women from northern areas such as Zababdeh described gradual shifts in attitudes toward girls’ education and marriage timing. Participants explained that early marriage has become less common in some communities, particularly among families with stronger educational

backgrounds. One participant explained: *“In Zababdeh, early marriage has decreased. It is prohibited according to the legal age”*. In these discussions, marriage was increasingly associated with university education, emotional maturity, and financial preparedness rather than age alone. Women described marriage as requiring readiness for responsibility, caregiving, and family life.

In Fasayil and marginalized areas of the Jordan Valley, participants described stronger pressure surrounding marriage timing and childbirth. Early marriage was closely linked to economic hardship, educational inequality, family reputation, and concerns surrounding girls’ future security. One participant recalled the words of a girl who married at 15: *“If I could go back in time, I would not get married, and I would not marry my daughter at a young age. Girls need to decide their path once they grow up and become more aware of life”*.

Women from the Jordan Valley also described stronger pressure surrounding childbirth immediately after marriage. Delayed pregnancy frequently generated gossip, assumptions of infertility, and family intervention, particularly within tightly interconnected rural communities.

Participants repeatedly returned to the physical and emotional burden associated with repeated childbirth and caregiving. Several mothers linked large family size to exhaustion, financial strain, and reduced ability to support children emotionally and educationally. One participant stated: *“Marriage should take place at age 20 or older. A woman should not continuously have children one after another just to ‘get it over with’”*.

Women also described unequal power within reproductive decision-making. Several participants explained that women may possess knowledge about contraception and pregnancy spacing while remaining unable to negotiate fertility decisions freely because of pressure from husbands, mothers-in-law, or extended family members.

Participants additionally reflected on the consequences of entering marriage without preparation or prior discussion of sexuality and intimate relationships. Women described newly married girls experiencing fear, confusion, and coercion because sexuality had remained socially silenced before marriage. One participant explained: “The problem is a lack of awareness. No one provided her with information, which is why she was afraid.”

Compared with younger women, mothers spoke about family planning through accumulated experience rather than rights-based language. Discussions focused on women’s health, caregiving capacity, emotional exhaustion, and the demands of raising children under economic and social pressure.

Marriage and reproduction emerged as deeply shaped by family expectations, economic precarity, unequal caregiving burdens, and persistent social pressure surrounding fertility and motherhood. Many participants supported later marriage, education, and pregnancy spacing,

while continuing to navigate social environments in which fertility and caregiving remain central to feminine responsibility and family reputation.

4.2.5. Institutional Perspectives: Marriage, Fertility, and Structural Contradictions

Institutional actors described marriage and reproductive life through the contradictions between legal reform, social practice, economic precarity, and uneven access to services. Interviews with healthcare providers, women's organizations, religious actors, and SRHR programmes repeatedly returned to the distance between formal policy and everyday reproductive realities, particularly in rural and marginalized communities.

Early marriage emerged as one of the clearest expressions of this gap. Participants explained that although the legal age of marriage has been raised to 18, exceptions, informal religious arrangements, and weak enforcement continue to permit marriage below the legal age in practice. One participant explained: *"The legal age of marriage was set at 18, but exceptions allow marriage under 18. In practice, many girls still marry under 18"*.

These accounts closely reflected discussions from the Jordan Valley and marginalized southern communities, where adolescents and mothers described continuing cases of marriage among girls aged 15–17 years. Institutional actors working in Fasayil, Al-Auja, East Yatta, and surrounding areas linked early marriage to educational inequality, poverty, family pressure, and anxieties surrounding girls' security and social reputation.

Providers also described major gaps in premarital preparation and reproductive awareness. Many girls were described as entering marriage with limited understanding of pregnancy, contraception, bodily autonomy, or intimate relationships. One participant explained: *"The issue is not only fear, the problem is a lack of awareness. No one provided her with information"*.

Reproductive expectations remained strongly gendered throughout these discussions. Institutional actors described continued pressure on women to prove fertility shortly after marriage and to continue childbearing regardless of economic hardship, emotional exhaustion, or physical strain. Delayed pregnancy frequently generated stigma, family intervention, and assumptions of infertility.

Interviews with women's organizations and health programmes also reflected the unequal reproductive burden placed on women. Providers explained that women are far more likely than men to seek reproductive healthcare, request contraception, or participate in family planning programmes, while men often remain peripheral to reproductive care and decision-making.

Geographic inequality shaped access to marriage-related and reproductive health services. Participants working in Ramallah and other urban centers described relatively greater availability of awareness programmes, women's groups, and specialized services. Providers working in East

Yatta, the Jordan Valley, refugee camps, and remote villages described transportation barriers, movement restrictions, weak infrastructure, and inconsistent service provision. One participant stated:

“In remote areas, they say there is no one to guide them. We work hard to reach out to all groups especially adolescents and young women and men. But movement restrictions as a result of the occupation measurements hinder us in hard to reach areas”.

Movement restrictions and economic instability repeatedly appeared as central obstacles affecting continuity of reproductive healthcare. Participants described women delaying medical visits, avoiding follow-up care, or relying on emergency and mobile services because of checkpoints, transportation costs, and the absence of nearby facilities.

Several institutional actors also highlighted the limited availability of adolescent-friendly and disability-inclusive services. These gaps affected access to premarital counselling, family planning, confidential support, and reproductive healthcare for adolescents, unmarried women, and women with disabilities.

Interviews further reflected ongoing tension surrounding the public framing of SRHR. Some institutional actors emphasized rights-based approaches, while others relied on religious or culturally acceptable language in order to secure community legitimacy and reduce resistance. Approaches to awareness and service delivery therefore varied considerably across locations depending on local conservatism, institutional trust, and community relationships.

Institutional actors ultimately described marriage and reproductive life as shaped by overlapping structural pressures: weak implementation of legal protections, economic insecurity, movement restrictions, gendered expectations, unequal educational access, and fragmented service systems. These conditions appeared repeatedly across the accounts of adolescents, young women, young men, and mothers, particularly in discussions surrounding early marriage, reproductive pressure, unequal caregiving burdens, and constrained reproductive autonomy.

4.3. Gendered Power, Violence, and Everyday Control

This section examines how gendered power operates through everyday forms of regulation, emotional pressure, unequal authority, and social surveillance. Violence rarely appeared only through direct physical harm. Participants more often described ordinary practices that shape how women and girls move, speak, seek support, access information, and negotiate bodily autonomy within family and community life.

4.3.1. Adolescents: Protection, Restriction, and the Normalization of Control

Discussions with adolescents revealed how gendered control becomes embedded in everyday life through restrictions on movement, communication, clothing, friendships, and social behavior.

Expectations surrounding adolescence differed sharply by gender and location, particularly in relation to girls' visibility, mobility, and reputation.

Girls more frequently described restrictions framed through protection, family honor, and fear of social judgment. Participants from Yatta, Fasayil, and other rural or socially conservative communities explained that girls' movement becomes more closely monitored after puberty. Mobility restrictions were often linked to fears surrounding relationships with boys, harassment, and community gossip. One participant explained: "Parents marry girls early because they believe her protection is in her husband's house."

In Bethlehem and some northern areas, girls expressed stronger opposition to early marriage and greater support for education and personal autonomy. Yet even in urban settings, participants described adolescence as a stage marked by increased monitoring of girls' behavior, clothing, friendships, and movement outside the home. Respectability remained closely tied to modesty, caution, and family reputation.

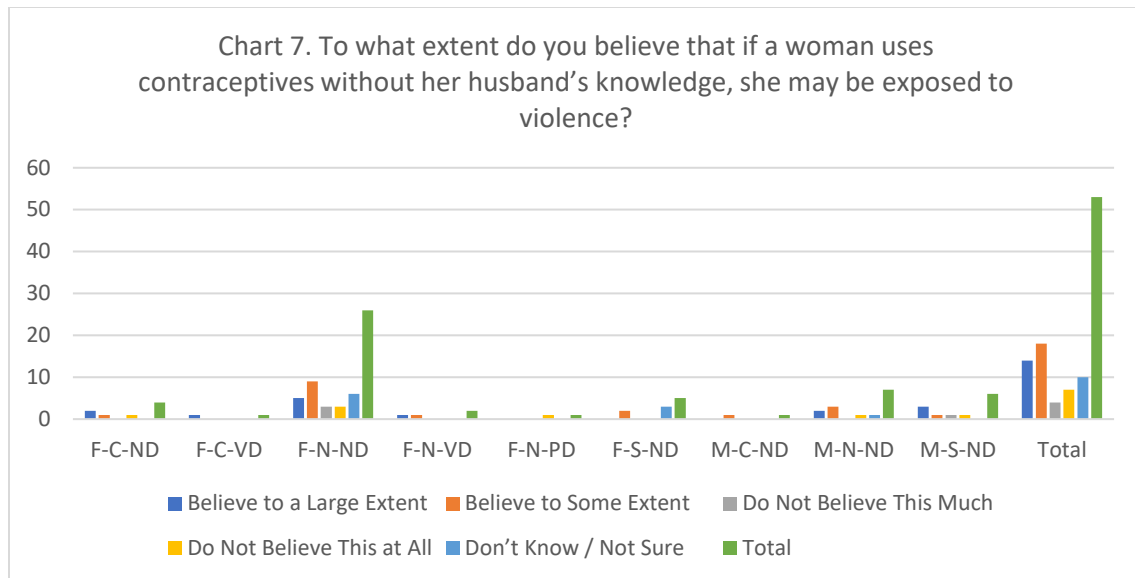
Participants also connected silence surrounding sexuality, bodily boundaries, and relationships to vulnerability and emotional pressure. Several girls emphasized the importance of understanding consent, bodily autonomy, and self-protection, particularly in contexts where adolescents often rely on social media or peers rather than trusted adults for information. One participant stated: "We need to know how to defend ourselves and what to do if we are exposed to harassment."

Discussions from the Jordan Valley and southern communities reflected stronger anxiety surrounding harassment, gossip, and social exposure. Several participants explained that girls avoid discussing personal concerns because they fear blame, misunderstanding, or punishment from adults. One participant explained: "Girls are afraid people will ask why they are asking these questions."

Boys described gendered expectations differently. Male adolescents spoke more often about emotional restraint, pressure to appear strong, and expectations surrounding responsibility and adulthood. Several explained that boys are expected to manage emotional concerns privately and avoid showing vulnerability.

Participants from Tubas and northern areas also described unequal freedom of movement between girls and boys. Several girls explicitly referred to differences in education, mobility, and independence. One participant explained: "The boy can study outside and live in university housing, but the girl is often not allowed."

Survey findings reflected similar perceptions regarding gendered control and unequal authority within reproductive decision-making. Adolescents were asked whether women may face violence if they use contraceptives without their husbands' knowledge (Chart 7).

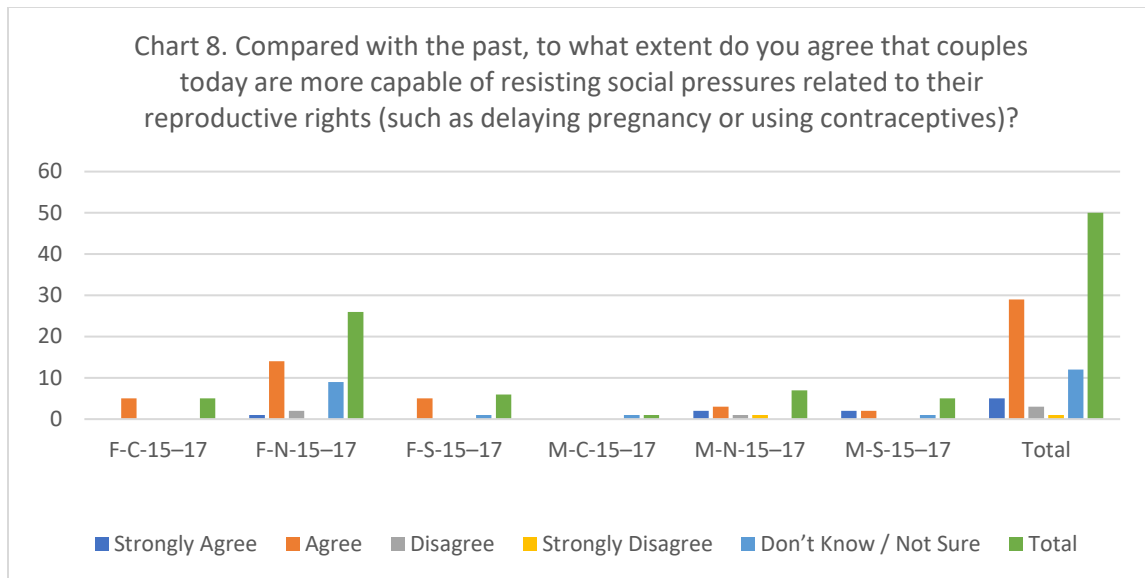


Among adolescent respondents, 60.4% believed to varying degrees that women may be exposed to violence under such circumstances. By comparison, 20.8% rejected the statement either partially or completely, while 18.9% expressed uncertainty.

Recognition of potential violence appeared strongest among male respondents from northern areas without disabilities, where 71.5% believed women may face violence if contraceptives are used without husbands' knowledge. Female adolescents from northern areas also reflected strong recognition of this possibility, although responses within this group showed greater uncertainty and variation.

Geographic differences were also visible. Adolescents from northern and southern areas more frequently perceived violence linked to women's reproductive decision-making than respondents from central areas. Southern male respondents reflected sharper polarization, with some describing violence as highly likely while others rejected the statement or expressed uncertainty.

Adolescents also reflected changing perceptions surrounding reproductive pressure within marriage. Among respondents aged 15–17 years, 68% agreed or strongly agreed that couples today are more capable of resisting pressure related to delayed pregnancy and contraception compared with previous generations. Only 8% disagreed, while nearly one-quarter expressed uncertainty (Chart 8).



Girls from northern and southern areas generally perceived greater reproductive autonomy among younger couples, although uncertainty remained high, particularly among respondents from the North. Among girls from the North cluster aged 15–17 years, 61.5% either agreed or strongly agreed that couples today have greater ability to resist pressure surrounding reproductive decisions, while 34.6% reported uncertainty. Female respondents from southern areas demonstrated even stronger agreement, with 83.3% agreeing that couples today are more able to resist reproductive pressure compared with the past.

Male adolescents similarly described gradual social change, especially regarding couples' ability to negotiate reproductive decisions more independently than previous generations. Male adolescents also reflected strong perceptions of gradual social change. Among northern male respondents aged 15–17 years, 71.5% either agreed or strongly agreed with the statement, while 80.0% of southern male respondents expressed agreement or strong agreement.

These shifts, however, coexisted with continuing forms of everyday control. Adolescents repeatedly connected safety and confidence to supportive family relationships, trusted communication, and emotionally responsive adults. Girls in particular emphasized the importance of spaces where questions related to sexuality, bodily changes, relationships, and harassment could be discussed without shame or punishment.

SRH and GBV-related Barriers identified by adolescents included:

- fear of judgment or blame,
- embarrassment discussing sexuality and bodily changes,
- unequal restrictions on girls' mobility,

- weak communication with adults,
- lack of confidential support spaces,
- limited school-based discussion of relationships and consent,
- and social pressure surrounding reputation and gender roles.

Gendered power therefore appeared less through isolated incidents of violence than through ordinary forms of regulation shaping mobility, emotional expression, bodily autonomy, and access to knowledge. These pressures were strongest in rural and marginalized communities, although girls from urban areas also described continuing surveillance surrounding reputation, modesty, and socially acceptable behavior.

4.3.2. Young Women: Reproductive Pressure and Negotiating Authority

Among young women, gendered power appeared most clearly through unequal authority within intimate relationships, pressure surrounding feminine respectability, and the expectation that women absorb emotional strain quietly in order to preserve family stability. Participants described reproductive life as deeply exposed to scrutiny from relatives, neighbors, in-laws, and wider social networks, even in contexts where women were educated, employed, or involved in decision-making.

Women from Ramallah and surrounding urban areas spoke more openly about the psychological weight of social interference in intimate and reproductive decisions. Participants described exhaustion produced by constant monitoring, questioning, and commentary surrounding pregnancy, family life, and women's responsibilities within marriage. Greater education or financial independence did not necessarily reduce this pressure. Instead, many women described navigating expanding personal aspirations alongside persistent expectations surrounding motherhood, caregiving, and social conformity.

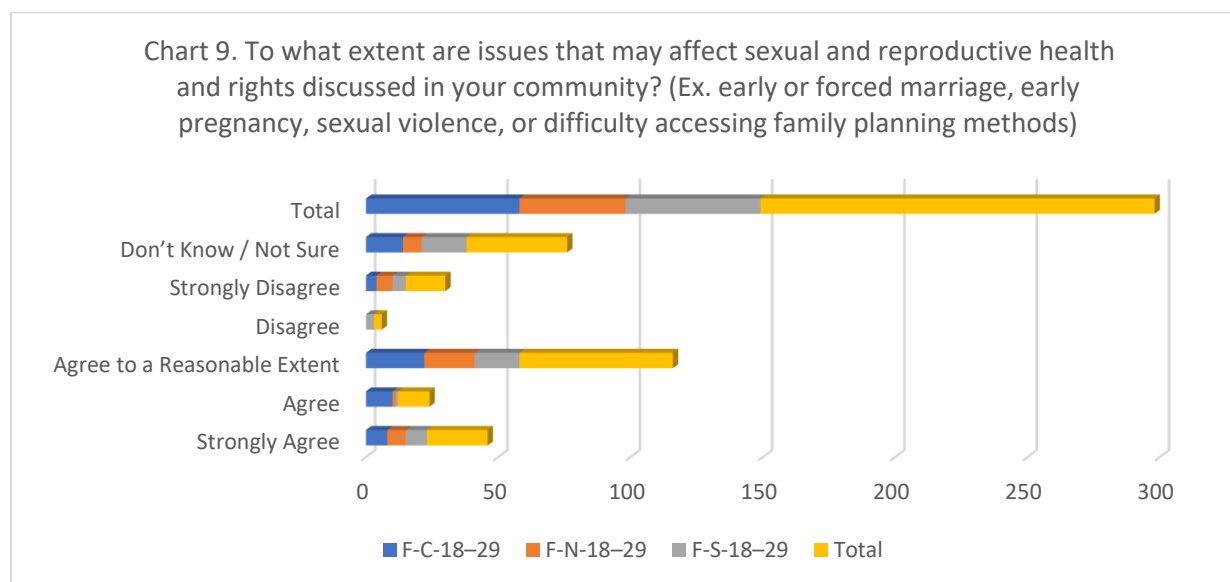
In Jenin and Tubas, discussions focused more directly on unequal emotional and reproductive labor within marriage. Participants described women as carrying primary responsibility for maintaining family cohesion, adapting to husbands' families, managing childcare, and accommodating reproductive expectations. Emotional endurance appeared normalized within everyday married life. Several participants explained that women are expected to tolerate interference, pressure, and exhaustion quietly in order to avoid conflict or social judgment.

Discussions from Yatta, Beit Fajjar, and conservative southern communities reflected stronger restrictions surrounding women's ability to discuss sexuality, intimate relationships, and reproductive concerns openly. Participants repeatedly referred to shame, social stigma, and fear of exposure, particularly for unmarried women or women experiencing reproductive difficulties. One participant explained: "They consider that if a woman is married, it is normal for her to talk and attend such discussions, but if she is not married it is forbidden and shameful."

Young women also described unequal standards surrounding fertility and reproductive responsibility. Delayed pregnancy, infertility, or reproductive complications were described as burdens that fall disproportionately on women regardless of male reproductive health. One participant explained: “If she does not have children, they say she has a defect and is not useful and tell him to divorce her.”

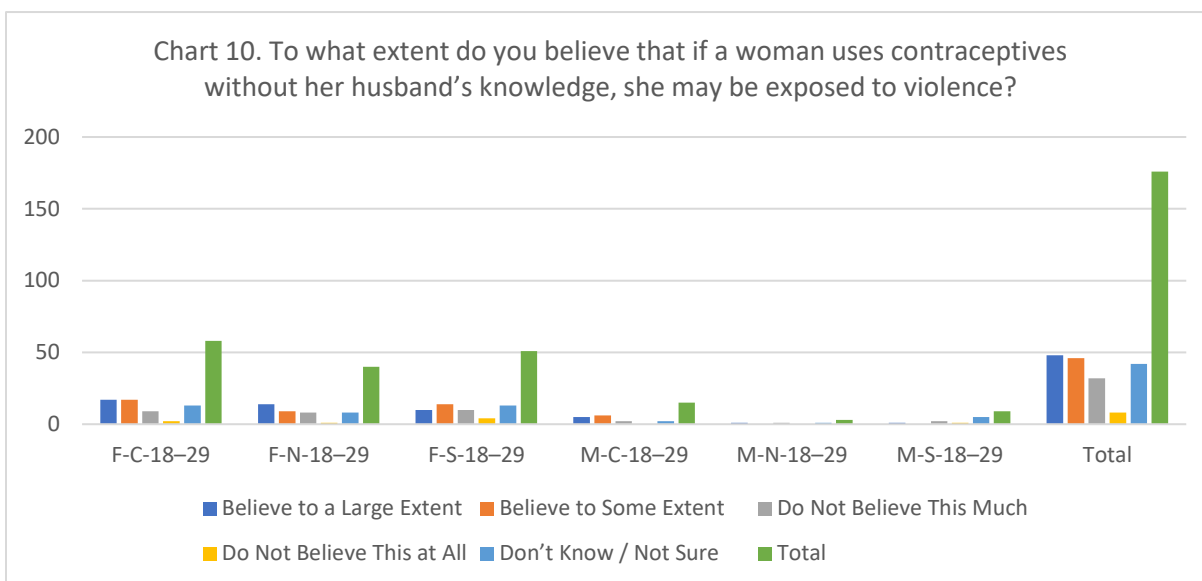
Participants repeatedly described silence as part of women’s social role within marriage. Marital dissatisfaction, emotional distress, sexual relationships, and reproductive concerns were treated as private matters that should remain contained within the household. Several women explained that speaking openly risks blame, exposure, or accusations of threatening family stability. Reputation and confidentiality shaped whether women felt able to seek support or discuss intimate concerns openly.

Survey findings reflected similar tensions surrounding public discussion of SRHR- and GBV-related issues. Among women aged 18–29 years, 62.4% agreed to varying degrees that issues such as early marriage, forced marriage, early pregnancy, sexual violence, contraception, and reproductive decision-making are discussed within their communities. Yet 25.5% expressed uncertainty, while 12.1% disagreed or strongly disagreed, reflecting continuing discomfort and uneven openness (Chart 9).



Women from central areas described the greatest sense of openness, with 69% agreeing to some degree that these issues are discussed within their communities. At the same time, nearly one-quarter still expressed uncertainty, suggesting that discussion remains cautious and socially bounded even in relatively urban settings.

Responses from northern areas reflected a more polarized pattern. Although 67.5% agreed to varying degrees that these issues are discussed, 15% strongly disagreed and 17.5% remained uncertain. In southern communities, openness appeared more limited. Among women aged 18–29 years from southern areas, 51% agreed to some degree that these issues are discussed publicly, while one-third selected “don’t know/not sure”. These findings closely reflected discussions from Yatta, Beit Fajjar, and surrounding communities, where sexuality and reproductive rights remained highly sensitive topics (Chart 10).



Survey findings also reflected widespread recognition of unequal authority over women’s reproductive decisions. Among respondents aged 18–29 years, 53.4% believed to varying degrees that women may face violence if they use contraception without their husbands’ knowledge. Another 23.9% expressed uncertainty.

Women themselves demonstrated the strongest recognition of this possibility. Among female respondents from central areas, 58.6% believed women may face violence under such circumstances. Similar perceptions appeared among women from northern areas. Responses from southern communities showed greater variation, with higher levels of uncertainty and partial rejection alongside continued recognition of possible violence.

Men also acknowledged the possibility of violence linked to women’s independent contraceptive decisions, although levels of recognition varied geographically and were lower in some southern areas.

Participants from both urban and rural settings further described contraception and reproductive healthcare as responsibilities carried primarily by women. Men were often perceived as socially distant from reproductive care, contraception, and everyday reproductive management. As one

participant stated: *“We are a patriarchal society that places responsibility on the woman, and the solution must always be with her”*.

Women from villages, refugee camps, and areas affected by checkpoints additionally described how transportation barriers, movement restrictions, financial strain, and fear of social exposure shape access to reproductive healthcare and support. Several participants explained that women may avoid seeking services or discussing sensitive concerns because they fear being recognized, judged, or misunderstood within tightly interconnected communities.

Young women rarely framed these experiences directly through the language of violence. Instead, they spoke through the language of pressure, endurance, shame, silence, emotional exhaustion, and unequal responsibility. Gendered control appeared embedded within ordinary family relations, social expectations, and intimate life, where coercion often becomes normalized through everyday practices of care, protection, and moral regulation.

4.3.3. Young Men: Masculinity, Emotional Pressure, and Authority

The interviews with young men showed that gendered power also operates through the demands placed on men themselves. Participants described masculinity as a socially regulated role organized around authority, emotional control, provision, and sexual competence. Young men were expected to appear confident, knowledgeable, and economically capable even under conditions marked by unemployment, political violence, uncertainty, and emotional strain.

Across interviews, emotional restraint appeared central to masculine identity. Participants from Beit Fajjar, Biddu, Ramallah, and Nablus repeatedly explained that men are expected to manage fear, insecurity, and personal distress privately. Emotional disclosure, reproductive anxiety, or sexual difficulty could easily be interpreted as weakness or diminished masculinity. One participant explained that many young men avoid attending sessions labeled “sexual education” because of embarrassment and fear of social judgment.

Several participants described growing up within what they called a “culture of shame,” where sexuality and reproductive health were treated as socially dangerous subjects. Silence surrounding these issues shaped how young men learned about relationships, sexual health, and marriage. Participants explained that boys are often expected to already possess this knowledge while simultaneously being denied safe or legitimate spaces to ask questions. As a result, many relied on fragmented information circulating through peers, pornography, social media, or anonymous online searching.

The interviews also revealed how masculine authority remains closely tied to economic provision despite worsening economic conditions. Participants repeatedly linked adulthood and marriage to employment, housing, and financial stability. Economic insecurity after October 2023

intensified feelings of inadequacy and uncertainty surrounding masculine roles within family life. One participant described how “the role of men has been reduced to that of a financial provider, like a bank card,” while another reflected on the tension created when wives become primary providers within households.

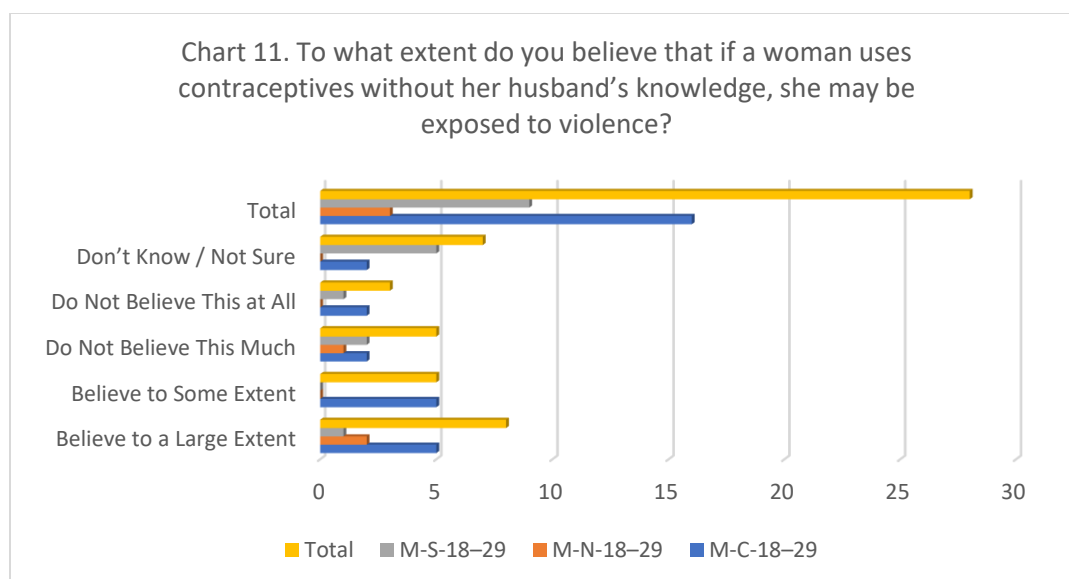
Participants also spoke critically about inherited forms of masculinity centered on control and entitlement. Several questioned assumptions that men should remain emotionally distant while women absorb the physical and emotional burdens of childbirth, caregiving, and household management. One participant recalled witnessing women carrying newborns alone after childbirth while husbands stood nearby without helping, describing this as “a regression in roles.”

Fertility and sexual performance emerged as particularly sensitive sites of masculine anxiety. Participants linked reproductive ability directly to marriageability, masculine reputation, and social worth. Delayed fertility, erectile dysfunction, or sexual difficulty were rarely discussed openly because reproductive incapacity carried the possibility of humiliation and social exposure. One participant described how men often refuse fertility testing because they fear their masculinity will be questioned. Others explained that many young men avoid acknowledging illness altogether.

Political violence entered these discussions in deeply intimate ways. One participant described anxiety following imprisonment and physical assault targeting young men’s reproductive organs. After his release, he sought fertility testing because he feared “wronging a future wife”. Reproductive anxiety therefore emerged through the bodily effects of detention, violence, and prolonged insecurity, where masculinity itself becomes experienced as vulnerable and exposed.

The interviews also reflected broader uncertainty surrounding intimacy and marital relationships. Several participants explained that young men often enter marriage with limited preparation for emotional intimacy, sexual relationships, or shared reproductive responsibility. Knowledge surrounding sexuality circulated informally and unevenly, while schools, families, and institutions remained largely silent. One participant explained that many young men later discover that “reality was different”, producing confusion and psychological distress within marriage.

Survey findings reflected uneven recognition among young men regarding violence linked to women’s reproductive autonomy. Among male respondents aged 18–29 years, 46.4% believed to varying degrees that women may face violence if they use contraception without their husbands’ knowledge. Another 28.6% rejected the statement, while 25% expressed uncertainty (Chart 11).



Recognition of possible violence was strongest among men from central areas, where 62.5% believed women may face violence under such circumstances. Responses from southern areas reflected greater uncertainty and lower recognition overall. Although the northern sample was limited, respondents from northern communities also acknowledged that reproductive decision-making may expose women to conflict within marriage.

Compared with adolescents and young women discussed earlier, young men demonstrated lower recognition of reproductive coercion and violence linked to contraceptive decision-making. Their responses reflected broader masculine norms surrounding privacy, authority, and family control, where reproductive conflict may remain normalized or difficult to name directly.

At the same time, several participants questioned assumptions that women alone should carry responsibility for contraception, fertility management, caregiving, and emotional labor within households. Some described reproductive knowledge and emotional awareness as necessary parts of responsible masculinity and stable family life. Others emphasized that men should provide emotional support and participate more actively in caregiving and reproductive decision-making.

Young men's accounts ultimately revealed masculinity as sustained through emotional suppression, pressure to perform competence, fear of judgment, and limited opportunities for vulnerability or support. Authority remained central to masculine identity, yet many participants also described uncertainty about how to inhabit these expectations under conditions shaped by economic instability, social surveillance, and political violence.

4.3.4. Adult Women and Mothers: Endurance, Silence, and Social Obligation

Discussions with adult women and mothers revealed how gendered control becomes woven into ordinary family life through endurance, silence, unequal responsibility, and social obligation. Participants rarely described violence only through physical harm. More often, they spoke about pressure, emotional exhaustion, restricted autonomy, and the expectation that women preserve family stability regardless of personal cost.

Women from the Jordan Valley, Fasayil, Al-Jiftlik, and surrounding rural communities repeatedly linked marriage, childbirth, and caregiving to broader systems of kinship obligation and social surveillance. Marriage was often described as a transition into intensified responsibility, where women are expected to adapt to husbands' families, tolerate interference, and carry the emotional burden of maintaining cohesion within the household. Participants explained that endurance itself becomes part of socially accepted femininity.

Several women connected early marriage directly to dependency and unequal authority. Girls who marry young often enter marriage with limited education, financial independence, or emotional preparation, increasing vulnerability within both marital and extended family structures. One participant recalled a girl married at 15 who later said: "If I could go back in time, I would not get married." Another woman repeated a phrase she heard during an awareness session: "A child raising a child".

Participants also described how silence surrounding sexuality and intimate relationships leaves many women entering marriage without preparation or understanding. Women spoke about fear, confusion, and emotional distress surrounding marital intimacy, particularly among younger brides. One participant described a 15-year-old girl who spent forty days refusing physical intimacy after marriage because she was frightened and unprepared. Another woman described hearing a mother advise her son to "tie her to the bed and take what you want", referring to his newly married wife. Participants explicitly identified such practices as violence, while also emphasizing that many women remain silent because of shame, fear, and social pressure.

The interviews repeatedly returned to women's emotional isolation within marriage. Marital relationships, sexuality, contraception, and reproductive difficulties remained difficult to discuss openly even among women themselves. Participants explained that women fear exposure, gossip, and reputational harm if intimate concerns become public. In tightly interconnected communities, confidentiality is fragile, and personal matters easily circulate through kinship and neighborhood networks. Silence therefore operates as a form of social protection while simultaneously deepening women's isolation.

Women also described persistent pressure surrounding fertility and childbirth. Delayed pregnancy frequently generated suspicion, unsolicited advice, and family intervention.

Participants spoke about women being blamed for infertility regardless of male reproductive health, while expectations surrounding motherhood remained closely tied to feminine worth and social legitimacy. One participant described how her daughter delayed pregnancy while attending university, only to face growing pressure from relatives and her mother-in-law to have another child.

Caregiving itself emerged as a source of exhaustion and unequal responsibility. Women described waking before dawn to complete domestic labor, agricultural work, childcare, and paid employment while remaining primarily responsible for the emotional wellbeing of the household. Participants repeatedly emphasized that women's labor has expanded rather than diminished over time, particularly under worsening economic conditions. Education and NGO involvement created greater mobility and awareness for some women, especially in Al-Jiftlik and nearby areas, yet caregiving and domestic responsibility remained overwhelmingly feminized.

Discussions also revealed generational shifts in attitudes toward family planning and reproductive decision-making. Younger women increasingly questioned repeated childbirth, large family size, and the assumption that women should sacrifice their health for reproduction. Several participants described daughters openly rejecting the reproductive paths followed by their mothers. One woman explained that her daughter told her: "I don't want to be like you; I don't want nine children".

At the same time, participants described how older social expectations continue to regulate women's choices. Some women explained that husbands still oppose contraception or frame family planning as morally unacceptable. Others described pressure from mothers-in-law and relatives who continue to view repeated childbirth as necessary for family continuity and social respectability.

Access to reproductive healthcare was also shaped by geography, poverty, checkpoints, transportation barriers, and fear of exposure. Women from Al-Jiftlik and surrounding areas described long travel times, expensive transportation, weak clinic infrastructure, and concern that visits to reproductive health clinics would become publicly known within the community. Several participants explained that women prefer seeking support from trusted individuals, community guides, or outsiders rather than local providers because confidentiality cannot be guaranteed.

Adult women's accounts revealed gendered power less through isolated incidents than through accumulated forms of obligation, emotional pressure, silence, and normalized inequality. Marriage, caregiving, sexuality, and reproduction remained structured by expectations that women absorb strain quietly while protecting family reputation, maintaining social cohesion, and carrying responsibility for the emotional and reproductive labor of everyday life.

4.3.5. Institutional Perspectives: Violence, Protection, and Unequal Systems of Authority

Institutional actors described violence as sustained through family authority, social exposure, economic dependency, and weak protection systems. Across interviews, violence was discussed less as isolated physical assault and more as part of everyday social relations shaping women's movement, reproductive decisions, emotional expression, and access to support.

Many participants explained that women avoid reporting violence because disclosure itself can place them at risk. In small towns, villages, and camps, clinics, police stations, and Family Protection Units are socially visible spaces. A woman entering one of these institutions may immediately become the subject of gossip, suspicion, or family intervention. Several providers explained that women often prefer seeking help outside their own communities because confidentiality cannot be separated from local kinship relations.

Silence therefore appeared as part of women's survival strategies. Participants described women remaining silent about marital violence, sexual coercion, reproductive pressure, or harassment because speaking openly may threaten family stability, expose them to blame, or escalate violence within the household. One provider explained that even approaching services may carry the risk of "honor"-based retaliation.

Institutional actors also connected violence to the absence of reproductive and sexual knowledge. Several participants described girls entering marriage without preparation for sexual relationships, bodily changes, contraception, or reproductive decision-making. In these discussions, lack of information was not treated as an educational gap alone, but as a condition that increases vulnerability within marriage and reinforces women's dependence on family authority.

Early marriage emerged repeatedly within these accounts. Participants from Al-Auja, Fasayil, Tubas, Hebron, and surrounding areas described continuing practices of unregistered or informal marriage below the legal age despite official restrictions. Institutional actors linked these marriages to poverty, weak educational access, fear surrounding girls' reputation, and the belief that marriage provides protection.

Several interviews showed how political fragmentation and economic crisis intensify pressure within households. Checkpoints, unemployment, displacement, settler violence, and movement restrictions were described as conditions that increase dependency and emotional strain while reducing access to healthcare and protection services. Service providers working with displaced families described overcrowded living conditions, absence of privacy, and growing psychological distress among adolescents and women.

Participants working with persons with disabilities described violence through dependency and social isolation. Girls and women with disabilities were described as particularly exposed to harassment and exploitation while remaining excluded from confidential support systems and accessible healthcare. Several participants referred to cases where families concealed abuse or avoided reporting violence because of stigma and fear of exposure.

Institutional actors also spoke about mistrust toward protection and referral systems themselves. Although referral structures formally exist, participants repeatedly described weak follow-up, fragmented coordination, shortage of trained personnel, and lack of adolescent-friendly or disability-inclusive services. Several providers explained that women often trust individual community workers, volunteers, or outside organizations more than formal institutions.

Questions of legitimacy shaped how SRHR and violence could be discussed publicly. Some organizations used rights-based language, while others approached these issues through religion, family wellbeing, or health in order to avoid resistance in conservative communities. Participants repeatedly described schools as one of the clearest institutional gaps. Sexuality, bodily autonomy, and intimate relationships remain largely absent from formal education, while teachers and counselors often avoid these topics because of embarrassment or fear of backlash.

At the same time, several providers described gradual shifts in community engagement. Women's groups, awareness sessions, youth initiatives, and intergenerational dialogue created spaces where participants began discussing subjects previously treated as shameful or forbidden. Many participants explained that once trust is established, women and adolescents often express strong interest in continuing these conversations.

The interviews located violence within ordinary structures of family life, social control, institutional weakness, and political insecurity. Gendered power operated through silence, dependency, restricted mobility, reproductive pressure, and unequal access to protection. In many cases, women's safety depended less on formal rights than on their ability to navigate family authority, social reputation, and community surveillance.

4.4. Access to SRHR and GBV Services

This section examines how adolescents, women, men, and marginalized groups navigate systems of knowledge, care, and support related to SRHR and GBV. Across discussions, access to information and services depended not only on physical availability, but also on trust, confidentiality, emotional safety, institutional reputation, and the ability to seek support without social exposure.

4.4.1. Adolescents: Confidentiality, Mobility, and Access to Support

Adolescents described access to SRHR and GBV-related support as shaped by trust, confidentiality, family response, gender expectations, and geographic access. Across groups, adolescents did not frame service access only as a question of whether clinics, schools, or organizations exist. They focused more on whether they could ask safely, whether adults would respond without blame, and whether services could be reached without exposure, cost, or fear.

Girls across the South and North most often identified mothers as the first and safest source of support when they had questions about their bodies or health. In the southern girls' group, participants said a girl would usually speak with "her mother, because she is the closest person to her," while others mentioned sisters, close friends, aunts, grandmothers, or teachers if the mother was absent or unavailable. Northern girls similarly emphasized mothers, older sisters, school counsellors, and teachers, particularly when family conditions were difficult. Girls repeatedly agreed that mothers were preferable to friends, although friends remained important when girls felt embarrassed to approach parents.

Adolescent boys in the northern group described a somewhat different pattern. Boys said they may speak with mothers, fathers, or both parents, and some mentioned the clinic as an option. This contrasted with girls' accounts, where mothers and female relatives were more central. In the southern girls' discussion, participants explained that boys usually speak with fathers or older brothers, although they acknowledged that some boys may turn to mothers if they are especially close to them. This suggests that help-seeking remains strongly gendered: girls are expected to seek support through female family members, while boys are expected to rely on male relatives or manage concerns more privately.

Geographic differences were visible in how adolescents described knowledge of services. In northern girls' groups, participants more frequently identified multiple possible sources, including school counsellors, teachers, Juzoor, health services, pharmacies, and awareness sessions. Some girls said that "most girls know where to go," although others emphasized that not all girls know because families, schools, and institutions do not consistently guide them. In the South, girls also identified clinics, pharmacies, and online sources, but the discussion reflected more uncertainty around whether information was safe, age-appropriate, or reliable.

Girls in Fasayil and Al-Auja described more concrete geographic access barriers. They mentioned local clinics, but also noted distance within the locality and the need to go to hospitals for more serious conditions. This points to a distinction between basic service presence and meaningful access. A clinic may exist, but distance, limited services, or the need for referral can still restrict access.

Across locations, adolescents described schools as inconsistent entry points for SRHR information and referral. Some southern girls reported receiving information from religious education, science teachers, or NGO sessions, while others said school information was limited and treated mainly as material for exams. Northern girls were more critical, explaining that schools often reduce or skip sensitive topics because of shortened school days, strikes, or discomfort among teachers and counsellors. Boys in the northern group also stated directly that schools do not provide enough information.

When discussing barriers to asking for help, girls across regions emphasized family response, embarrassment, and fear of judgment. Southern girls said difficulty depends on whether parents are able to “contain” and accept their children’s questions. They also noted that some mothers are too burdened to respond, pushing girls toward friends. Northern girls more directly described fear of blame, fear that adults would be angry, shame, psychological weakness, and the feeling that “they will not understand us.” Fasayil girls added that some topics cannot be discussed before marriage and that girls may turn to the internet when embarrassment prevents them from asking someone directly.

Safety in clinics also differed by gender and geography. Southern girls expressed more confidence in visiting doctors, although they raised financial costs and family attitudes as barriers. Some said that medical costs, such as a 70-shekel visit, may make a girl hesitate before seeking care. Others described how family reputation can discourage girls from talking about illness, with one participant recalling that her grandmother said it was not good for a girl to gain a reputation for being sick. Northern boys, by contrast, agreed that they do not feel safe discussing personal health issues with doctors. Fasayil girls also said they do not always feel safe, especially if alone with a male provider, and emphasized the need for someone trusted to accompany them.

The main barriers for adolescent girls were therefore not limited to service availability. They included embarrassment, family reaction, cost, distance, lack of trusted information, fear of being misunderstood, and concern about reputation. For boys, barriers appeared more strongly linked to privacy, masculinity, and discomfort discussing personal health issues with providers. Across both sexes, adolescents emphasized that services become safer when confidentiality is guaranteed, providers are trusted, and information is delivered seriously and respectfully.

Adolescents’ recommendations were consistent across regions. Girls called for school-based sessions, trained counsellors, anonymous question boxes, trusted online options, parental awareness, and safe spaces where girls can ask questions without fear. Boys emphasized confidentiality, doctors who do not disclose information, and lower medication costs. Southern girls also stressed confidence, self-protection, harassment response, and the right to say “no,” while Fasayil girls emphasized practical needs, including hygiene supplies, awareness sessions in local areas, and parental guidance.

Overall, adolescents' access to SRHR and GBV-related support is shaped by a gap between need and safe use. Many adolescents can name potential sources of support, but access depends on whether those sources are trusted, confidential, affordable, geographically reachable, and socially acceptable. Girls face stronger barriers related to reputation, family control, and safety, while boys face barriers linked to privacy and masculinity. Rural and marginalized areas face additional constraints related to distance, limited services, and weaker institutional outreach.

4.4.2. Young Women: Confidentiality, Referral Pathway, and Access to Services

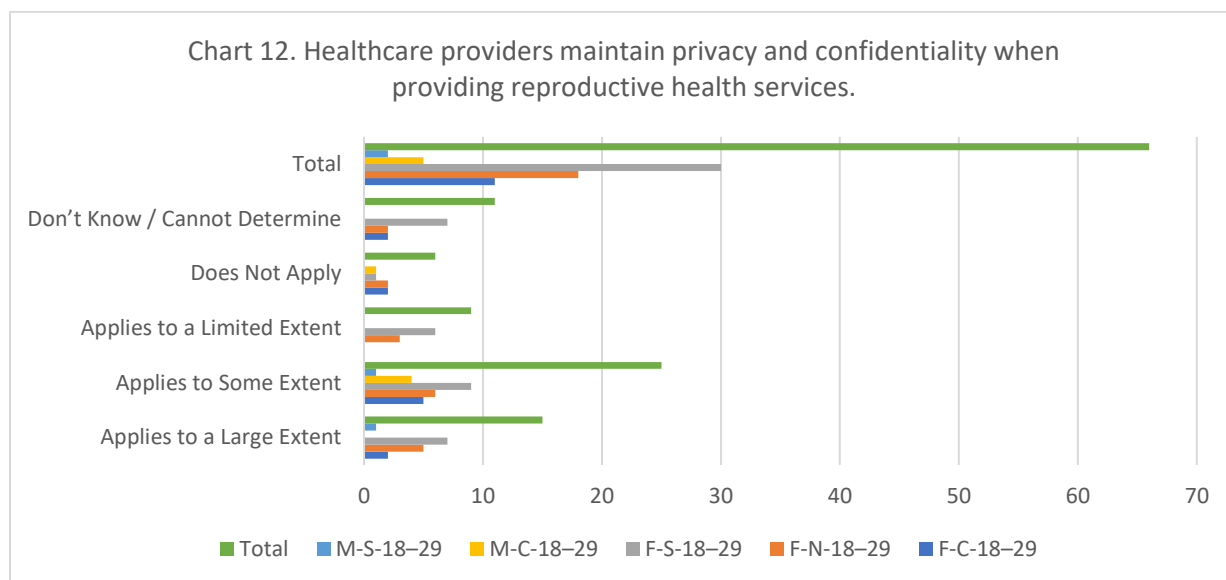
Young women across different geographic areas described access to SRHR and GBV-related services as shaped by confidentiality, family response, provider trust, mobility restrictions, and uneven awareness of available support systems. Although participants generally knew that clinics, hospitals, NGOs, and some institutional services exist, many explained that practical access depends on whether women feel safe seeking help without judgment, exposure, or social consequences.

Participants from Tubas, Jenin, and surrounding northern areas demonstrated greater awareness of formal referral pathways related to violence, protection, and SRHR support. Young women referred to doctors, clinics, the Family Protection system, governorate gender units, and security agencies as possible sources of support in cases involving assault, blackmail, or reproductive health concerns. However, discussions repeatedly emphasized that family reaction often determines whether girls seek help at all. Several participants explained that some families respond through blame, anger, or silencing rather than support. One participant explained: *"If the girl feels that she was wronged in something and wants her right, they silence her and tell her: do you want to bring us shame?"*.

Northern participants also described strong concern regarding trust and confidentiality. Several women explained that girls may avoid seeking support if they fear gossip, harsh reactions, or loss of trust within the family. Participants repeatedly emphasized that violence and reproductive concerns remain difficult to discuss openly, particularly where girls are expected to protect family reputation.

Survey findings among young women aged 18–29 years also reflected mixed perceptions regarding confidentiality within reproductive health services. A total of 66 young women respondents answered the question on whether healthcare providers maintain privacy and confidentiality when providing reproductive health services. Overall, 60.6% believed that confidentiality applies either "to a large extent" or "to some extent", while 22.7% expressed uncertainty and another 22.7% believed confidentiality applies only to a limited extent or does not apply at all. Young women from southern areas reflected the highest levels of uncertainty regarding provider confidentiality (Chart 12). These findings closely reflected the qualitative

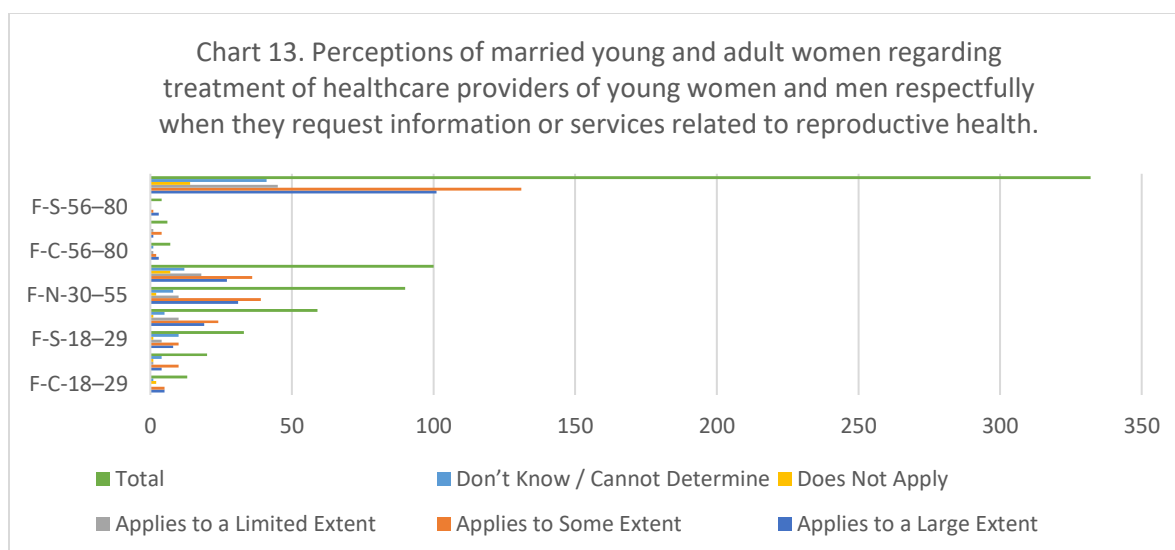
discussions in which participants repeatedly linked help-seeking to trust, privacy, and fear of social exposure, particularly within smaller and socially interconnected communities.



At the same time, young women from northern areas showed stronger awareness regarding women’s rights, referral systems, and gender-based violence structures compared with other locations. Several participants referred directly to awareness sessions, gender trainings, women’s organizations, and advocacy initiatives that had influenced their understanding of reproductive rights and protection mechanisms.

By contrast, participants from Ramallah and surrounding central areas focused more heavily on institutional visibility, provider behavior, and quality of care. Although clinics and hospitals were more available geographically, several women explained that many young people still do not know where to seek confidential SRHR support or reliable information. One participant stated: *“If I knew there was an institution where we could go and ask, yes, I would go”*.

Survey findings also reflected generally positive but uneven perceptions regarding whether healthcare providers treat young women and men respectfully when they request reproductive health information or services. A total of 332 married young and adult women respondents answered this question. Overall, 69.9% believed that respectful treatment applies either “to a large extent” or “to some extent,” while 17.8% believed it applies only to a limited extent or does not apply at all. Another 12.3% reported uncertainty (Chart 13).



Perceptions varied across geographic areas and age groups. Among women aged 30–55 years, respondents from northern areas reflected the strongest confidence in respectful treatment, with 84.3% believing respectful treatment applies either to a large or some extent. Women from southern areas aged 30–55 years also reflected relatively positive perceptions, although concerns remained more visible regarding limited respectful treatment.

Younger women aged 18–29 years demonstrated somewhat lower confidence overall. Respondents from southern areas reflected the greatest concern regarding respectful treatment, with a larger proportion believing respectful treatment applies only to a limited extent or expressing uncertainty.

These findings closely reflected the qualitative discussions in which women repeatedly emphasized that provider attitudes, respectful communication, confidentiality, and non-judgmental treatment strongly shape whether young women feel safe seeking SRHR services or asking sensitive questions. Participants explained that respectful treatment is particularly important for unmarried women, younger women, and women seeking information related to sexuality, contraception, or reproductive concerns.

Women from Ramallah also discussed mistrust toward some public health services, particularly regarding confidentiality, poor treatment, and provider attitudes. Participants described overcrowded hospitals, long waiting times, and experiences in which healthcare workers appeared dismissive or insensitive toward patients.

At the same time, young women from central areas appeared somewhat more open discussing sexuality, sexually transmitted infections, and reproductive concerns conceptually, particularly within awareness sessions or peer discussions. However, they also emphasized that many young people continue seeking information privately through online medical applications, internet

searching, or anonymous consultation platforms because direct questioning remains socially uncomfortable.

Participants from Bethlehem and Hebron reflected somewhat different concerns. Young women from southern communities emphasized embarrassment, lack of specialized services, and the absence of clear spaces where unmarried women or young men can seek SRHR support safely. Discussions suggested that available services are still strongly associated with marriage, pregnancy, and contraception rather than broader reproductive health counseling or preventive support. One participant explained: *“We do not have centers specifically for these topics”*.

Southern participants also repeatedly linked limited-service use to social stigma and lack of accurate information. Several women explained that girls often enter marriage without sufficient understanding of sexual relationships or reproductive health because these issues remain minimally addressed in schools and difficult to discuss within families.

Across all geographic areas, participants described service use as largely reactive rather than preventive. Young women explained that girls and women usually seek care only after experiencing illness, pregnancy concerns, delayed fertility, or serious emotional distress rather than for routine SRHR counseling or preventive guidance. One participant explained: *“Girls request services but only when SRHR problems happen to them... but for knowledge and awareness no”*.

Young women across locations also described important gender differences in help-seeking. Participants repeatedly explained that women are expected to manage contraception, fertility concerns, reproductive consultations, and family planning, while young men often avoid seeking services because of shame, embarrassment, or fear that reproductive problems may affect perceptions of masculinity. One participant explained: *“The young man considers that if he asks, it reduces his masculinity”*.

Political and geographic conditions further shaped access. Participants from Jenin, villages around Ramallah, Bethlehem, and marginalized rural communities repeatedly referred to checkpoints, closures, displacement, transportation costs, and long distances to hospitals as barriers affecting access to care. Several explained that nearby clinics often provide only limited services, while hospitals and specialized care remain difficult to reach during military closures or periods of insecurity. One participant described a woman who: *“gave birth at the checkpoint because they did not let her pass”*.

Displacement and economic hardship were also described as affecting women’s ability to access menstrual supplies, contraception, transportation, and private spaces for care. Participants explained that women living under unstable conditions may delay treatment, reduce attention to their health, or lose continuity of care altogether.

Young women with disabilities described additional barriers affecting access to SRHR and GBV-related support, particularly regarding privacy, mobility, adapted communication, and social recognition of their emotional and reproductive lives. Participants explained that women with disabilities are often perceived as dependent or asexual, making it more difficult for them to seek information, discuss intimate concerns, or access services openly. One participant explained: *“People are surprised that I can cross the street, get married, or have children”*. Participants emphasized that women with disabilities are not unwilling to discuss SRHR issues. Rather, access depends heavily on trust, confidentiality, emotionally safe environments, and providers capable of communicating respectfully and appropriately. On the other hand, participants described how inaccessible shelters, overcrowded environments, and interrupted mobility undermine bodily privacy and everyday care. One young woman with disability described displacement centers as *“a very bad experience, especially when bathrooms have stairs, particularly for PoDs when their families are not with them”*.

Women from urban areas described somewhat greater access to disability-focused organizations and advocacy spaces, while participants from rural communities and camps described stronger social surveillance and fewer opportunities for independent participation and confidential help-seeking. Across discussions, women with disabilities emphasized the importance of being recognized as socially complete persons whose emotional, sexual, and reproductive lives cannot be reduced to dependency or medical need alone.

Across locations, young women consistently emphasized the need for confidential and youth-friendly services, mobile outreach, awareness activities in schools and universities, trained specialists, and safe spaces where young people can ask questions without fear of judgment or exposure. Participants repeatedly stressed that access depends not only on the existence of services, but also on trust, privacy, respectful treatment, affordability, and social acceptance of help-seeking itself.

4.4.3. Young Men: Privacy, Help-Seeking, and Limited Emotional Support

Young men described access to SRHR-related services as shaped by privacy concerns, fear of judgment, masculinity norms, and limited availability of trusted or specialized services. Across interviews, participants repeatedly emphasized that young men are less likely than women to seek reproductive or sexual health services directly, particularly for concerns related to fertility, sexual relationships, or sexually transmitted infections.

Participants from Beit Fajjar, Biddu, Ramallah, and Nablus explained that young men often avoid clinics unless problems become severe or directly affect marriage or fertility. Several participants stated that reproductive healthcare for men is largely associated with infertility testing before or after marriage rather than preventive care, counseling, or routine consultation. One participant

explained: *“To my knowledge, it is mainly addressed before marriage for medical examinations. Beyond that, not really”*.

Young men repeatedly linked low service use to embarrassment and fear of exposure. Participants explained that many men avoid asking questions related to sexual health because these issues are treated as shameful or because reproductive problems are associated with weakness or reduced masculinity. One participant explained: *“Fertility has been linked to masculinity, so he is afraid that his masculinity will be questioned”*.

Geographic differences also shaped service access. Participants from villages and conservative communities such as Beit Fajjar described stronger social pressure and greater concern regarding privacy compared with participants from Ramallah or Surda. Several young men explained that they prefer seeking care outside their own towns because local doctors, pharmacists, or clinic staff may know their families personally. One participant explained: *“Young people in my community prefer to go to Bethlehem rather than Beit Fajjar, because they want to avoid being seen by relatives”*.

Participants from Ramallah and more urban areas described somewhat easier physical access to clinics and specialists, although they still emphasized stigma surrounding SRHR-related help-seeking. Several young men explained that even when services are available, many young men prefer online searching, artificial intelligence tools, or private conversations rather than formal consultations.

Discussions also reflected differences between services available for women and those available for men. Participants repeatedly noted that women have more visible reproductive health entry points through gynecology clinics, maternal care, and family planning services, while young men lack equivalent spaces for confidential consultation. One participant stated: *“We have gynecology clinics, but for male-related health issues, we have to go to Bethlehem”*.

Young men additionally described distrust toward the confidentiality of services in smaller communities. Participants explained that fear of gossip, exposure, or social judgment discourages many young men from seeking SRHR-related support locally. One participant explained: *“Most young people feel embarrassed, and fear of exposure or scandal is a major issue for them”*.

Political and economic conditions further affected access. Participants from Nablus, Beit Fajjar, and villages surrounding Jerusalem described checkpoint delays, closures, transportation costs, and uneven distribution of healthcare services across urban and rural areas. Several explained that hospitals and specialized care are concentrated in major cities, while villages often lack nearby services. One participant described how: *“villages in the eastern and southern parts of Nablus lack government health services altogether”*.

Participants also emphasized that financial hardship affects help-seeking, particularly under conditions of unemployment, salary reductions, and economic instability. Several explained that private consultations, transportation, and diagnostic testing are financially difficult for many young men.

Young men further described service systems as fragmented and weakly connected to youth needs. Participants repeatedly stated that there are few youth-friendly services, few trusted awareness spaces, and limited outreach specifically targeting young men. One participant explained: *“There are no centers specifically focused on sexual education or on marital and sexual relationship issues”*.

At the same time, some participants referred to possible alternatives that could improve access, including mobile clinics, confidential hotlines, awareness sessions, trained specialists, school-based education, and community outreach through trusted organizations.

Across discussions, young men described SRHR service access as constrained less by complete absence of services than by shame, fear of exposure, masculinity norms, weak confidentiality, and lack of specialized youth-friendly support. While some participants appeared increasingly open to seeking medical advice or information, most described SRHR concerns as issues managed privately rather than through accessible and trusted institutional system.

4.4.4. Adult Women and Mothers: Trust, Confidentiality, and Access to Care

Adult women and mothers described access to SRHR and GBV-related services through experiences of trust, privacy, transportation, provider behavior, and long-standing gaps in awareness and community support. Across discussions, women emphasized that access is shaped not only by whether clinics or health centers exist, but also by whether women feel safe using them without exposure, judgment, or financial burden.

Women from northern areas such as Zababdeh and Ya’bad focused primarily on gaps in communication, limited SRHR education, and the narrow scope of available services. Participants explained that healthcare support remains concentrated around pregnancy, childbirth, and contraception, while broader discussions related to sexuality, marital relationships, sexually transmitted infections, or emotional wellbeing remain limited both in clinics and in community life.

Several women explained that health services generally provide basic maternal care and simple guidance but rarely address deeper SRHR concerns before marriage or during adolescence. One participant stated that services focus “mostly on pregnancy and contraception”, while another explained that clinics provide “simple instructions” without discussing sexuality or reproductive relationships in depth.

Women from northern areas also linked weak service engagement to broader discomfort discussing SRHR openly within families and institutions. Participants repeatedly explained that many mothers themselves lack confidence discussing these issues, while fathers are often absent from conversations related to reproductive health and bodily awareness. In this context, girls frequently rely on friends, internet searching, or fragmented information rather than structured support systems.

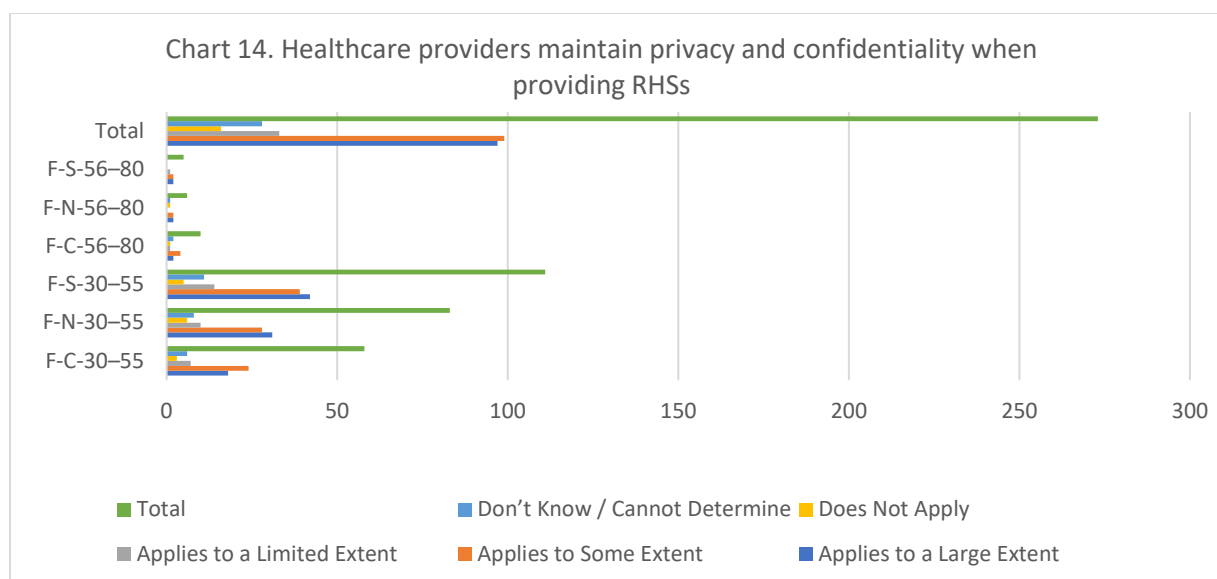
At the same time, northern participants reflected somewhat greater confidence in schools and formal institutions compared with women from more marginalized communities. Several women emphasized that schools should provide scientifically grounded SRHR information because online sources cannot always be trusted. However, they also described school-based education as limited, cautious, and largely restricted to hygiene and biological topics.

Discussions from the Jordan Valley and Jericho reflected a more structurally constrained experience of access. Women from Al-Jiftlik, Fasayil, and Al-Auja focused heavily on transportation barriers, clinic shortages, financial hardship, checkpoint restrictions, and fear of social exposure within tightly connected communities. Unlike northern participants, who emphasized communication gaps and weak awareness, women from the Jordan Valley repeatedly described the physical difficulty of reaching services themselves. One participant explained: *“You may wait two hours for a car, which causes you to miss awareness sessions”*.

Women described clinics as geographically distant, inconsistently available, or lacking medications and specialized care. Transportation costs were also repeatedly identified as major barriers, particularly under current economic conditions. Participants explained that even when women know where services exist, transportation expenses and checkpoint restrictions may prevent them from attending appointments or awareness activities regularly.

Confidentiality emerged much more strongly in the Jordan Valley discussions than in the northern group. Women repeatedly expressed fear that seeking SRHR or GBV-related services could expose them to gossip, reputational harm, or community scrutiny. Several participants explained that women avoid discussing sensitive issues in government or public clinics because personal information may spread within the community.

Survey findings among adult women also reflected mixed but generally more positive perceptions regarding confidentiality within reproductive health services. A total of 273 adult women respondents aged 30 years and above answered the question on whether healthcare providers maintain privacy and confidentiality when providing reproductive health services. Overall, 71.8% believed that confidentiality applies either “to a large extent” or “to some extent”, while 12.1% believed confidentiality applies only to a limited extent or does not apply at all. Another 10.3% reported uncertainty (Chart 14).



Perceptions varied somewhat across geographic areas. Women from southern areas aged 30–55 years reflected the strongest confidence in provider confidentiality, with 73.0% believing confidentiality applies either to a large or some extent. Similar patterns appeared among women from northern areas, where 71.1% expressed confidence in confidentiality practices. Respondents from central areas reflected slightly lower confidence and somewhat higher uncertainty.

Compared with young women, adult women appeared somewhat more trusting of healthcare providers and reproductive health services overall. This may reflect greater familiarity with maternal healthcare systems, longer-term engagement with clinics and midwives, and stronger reliance on reproductive health services throughout marriage and childbirth. At the same time, the findings also suggest that concerns regarding privacy, exposure, and inconsistent provider behavior remain present across all geographic areas, as one participant from the Jordan Valley explained: *“Women do not feel safe going to government or UNRWA clinics because if a woman shares her issue, it may become public knowledge”*.

Women from Al-Jiftlik and surrounding communities described relying instead on trusted local female guides, nurses, or specific providers known for respecting confidentiality. In these discussions, trust in the individual provider often mattered more than trust in the institution itself.

Differences also appeared in perceptions of provider behavior. Women from the Jordan Valley described mixed experiences with healthcare workers. Some participants emphasized that doctors, nurses, and midwives remain trusted sources of advice, especially for newly married women seeking family planning information. Others explained that provider behavior varies greatly and that some professionals fail to ensure privacy or respectful treatment.

Despite these differences, women across both geographic areas described SRHR services as largely reactive rather than preventive. Participants explained that women usually seek care during pregnancy, fertility problems, childbirth complications, or urgent reproductive concerns rather than for preventive counseling, emotional support, or routine SRHR education.

Women from both northern areas and the Jordan Valley also emphasized that men and boys remain largely absent from SRHR-related services. Participants explained that reproductive healthcare is still treated socially as a women's responsibility, while men seek support only in cases of severe fertility problems or medical complications.

Across discussions, adult women repeatedly emphasized the need for trusted awareness spaces, confidential services, trained specialists, and stronger outreach to marginalized communities. Women from northern areas emphasized improving communication and school-based awareness, while women from the Jordan Valley stressed transportation support, mobile services, privacy protection, and locally trusted providers.

Overall, the discussions reflected significant geographic inequality in women's access to SRHR and GBV-related support. In northern areas, barriers centered more heavily around communication, limited awareness, and institutional hesitation surrounding sensitive topics. In the Jordan Valley and marginalized rural communities, women faced additional structural barriers related to mobility, poverty, checkpoint restrictions, weak healthcare infrastructure, and fear of community exposure. Across both settings, women consistently described trust, confidentiality, and respectful treatment as central conditions for safe access to services.

4.4.5. Institutional Perspectives: Access, Provider Capacity, and Continuity of Services

Institutional actors described access to SRHR and GBV services as shaped by overlapping structural, institutional, and social barriers. Across KIs, service providers emphasized that services formally exist, but their accessibility, continuity, confidentiality, and responsiveness vary significantly across geographic areas and population groups, particularly under conditions of political instability and economic crisis.

A recurring concern across interviews was the gap between policy commitments and actual service delivery. While national protocols and strategies recognize SRHR and GBV-related needs, providers explained that implementation remains uneven in practice. Several participants noted that adolescents, unmarried women, and persons with disabilities may formally have the right to access services, yet often face hesitation, exclusion, or differential treatment, particularly within public sector settings. These gaps were described as especially visible in relation to confidential counseling, STI-related care, hormonal treatment, and services for unmarried women and girls.

Adolescents were repeatedly identified as one of the most underserved groups. Institutional actors explained that adolescent-friendly services remain limited and that many providers lack training in communicating with young people about sensitive SRHR and GBV issues in safe and age-appropriate ways. One respondent described adolescents as “nationally marginalized,” emphasizing that services are still not adequately designed around their needs.

Geographic fragmentation emerged as one of the strongest barriers affecting continuity of care. Providers working in Jenin, Tubas, Hebron, East Yatta, the Jordan Valley, and remote rural communities described how checkpoints, road closures, transportation costs, displacement, and insecurity disrupt access to hospitals, clinics, awareness sessions, and referral pathways. These barriers affect the wider population, but institutional actors emphasized that their impact is significantly greater for women, girls, persons with disabilities, Bedouin communities, and residents of remote and Area C localities.

Participants repeatedly explained that access barriers intensified following escalation of military incursions and displacement. Several providers described cases in which women could not reach hospitals during labor because of movement restrictions, resulting in deliveries at checkpoints, in ambulances, or in non-specialized facilities. In response, organizations and health actors introduced emergency obstetric centers, safe delivery kits, mobile clinics, and outreach services to maintain minimum continuity of care. Although these interventions were described as essential, providers stressed that they cannot replace stable and comprehensive public health systems.

Mobile clinics were repeatedly identified as important mechanisms for reaching marginalized populations, particularly in remote and underserved communities. However, institutional actors also questioned their sustainability, continuity, and coverage. Several respondents explained that mobile services originally intended for Area C and isolated communities are now compensating for wider gaps in fixed public services because government clinics are understaffed, inconsistently available, or unable to maintain regular operations during emergencies.

Provider preparedness emerged as another major institutional challenge. KIIs repeatedly highlighted gaps in technical knowledge, adolescent-friendly communication, disability inclusion, confidentiality practices, and survivor-centered GBV response. Several institutional actors explained that some providers continue approaching SRHR primarily as a medical issue without adequately addressing psychosocial needs, stigma, family pressure, violence, or protection concerns. One participant summarized this gap directly: *“If the centers are prepared, doctors are not prepared”*.

Participants also emphasized that service quality often depends heavily on the attitudes and interpersonal skills of individual providers rather than on institutional systems themselves.

Confidentiality, empathy, respectful treatment, and the ability to build trust were repeatedly described as essential conditions for safe access to services.

Referral systems were described as formally present but operationally inconsistent. Institutional actors explained that referrals may function effectively when focal points are trained and engaged, yet continuity of care remains weakened by poor follow-up systems, fragmented coordination, and inconsistent communication between health, psychosocial, legal, and protection sectors. Several respondents stressed the need for stronger case-tracking mechanisms to ensure that referrals continue beyond the initial point of contact.

Confidentiality and fear of exposure emerged as major barriers across all regions. Providers repeatedly explained that women, adolescents, and survivors of violence may avoid services because they fear being identified, judged, or socially exposed within their communities. These concerns were described as especially significant in smaller and tightly interconnected communities where service providers, beneficiaries, and families often know one another personally.

Disability inclusion was described as partial and uneven across institutional systems. Participants from Qader and other organizations working with persons with disabilities explained that many facilities remain physically inaccessible and lack reasonable accommodation measures, adapted communication tools, and staff trained to work respectfully with girls and women with disabilities. Several respondents emphasized that disability-related exclusion becomes more severe during emergencies and displacement, when mobility restrictions, overcrowding, and lack of privacy intensify existing vulnerabilities.

Institutional actors also highlighted the heightened protection risks faced by girls and women with disabilities under crisis conditions. Participants described cases in which families struggled to secure basic menstrual and care supplies during displacement, increasing dependency and social pressure on girls. One provider explained: *“As a result of difficulty in obtaining basic materials such as Always and Pampers, the girl became an additional burden on the family, so marriage became the solution”*.

Participants additionally described how access for girls and women with disabilities often depends on negotiating transportation, accompaniment, family permission, and privacy simultaneously. In rural and marginalized areas, these barriers were described as particularly severe because of weak infrastructure and limited specialized services.

Important geographic differences also appeared across institutional responses. Providers working in East Yatta, Masafer Yatta, the Jordan Valley, Bedouin communities, and remote northern villages described barriers that were primarily structural, including distance, weak infrastructure, transportation shortages, and limited local services. By contrast, providers in urban areas

described relatively greater service availability but continuing barriers related to confidentiality, provider attitudes, social stigma, and financial cost.

Coordination between institutions was described as necessary but insufficient. Several respondents explained that organizations sometimes duplicate services, compete for funding, or rely on short-term project cycles rather than sustained programming. Institutional actors repeatedly emphasized the importance of stronger coordination between health, psychosocial, educational, legal, and protection sectors, particularly during emergencies and displacement.

Across KIIs, institutional actors consistently emphasized that access to SRHR and GBV services depends on more than physical service availability. Access is shaped by trust, confidentiality, provider preparedness, mobility, affordability, disability inclusion, and social acceptance of help-seeking itself. These barriers become more severe for adolescents, unmarried women, persons with disabilities, displaced populations, and residents of marginalized communities. The findings suggest that improving access requires both strengthening institutional systems and addressing the broader social and structural conditions that continue to limit safe and equitable use of services.

Chapter 5. From Awareness Gaps to the Social Regulation of Bodily Life

This discussion brings the findings into conversation with existing SRHR, GBV, gender, disability, and humanitarian literature. It examines how bodily life is socially organized under conditions of political fragmentation, economic pressure, gendered authority, and uneven institutional reach. The chapter first discusses what the findings reveal, then identifies where previous programming approaches have remained limited, and finally considers the implications for future intervention.

5.1. Fragmentation as a Structuring Condition

Fragmentation organizes bodily life in the West Bank. It shapes how people move, seek care, learn about their bodies, assess risk, and decide what can be spoken openly. SRHR is encountered through scattered sites: schools, clinics, NGOs, mobile teams, family networks, peers, social media, AI platforms, and temporary project interventions. These sites rarely form a continuous system. People assemble knowledge and care across partial, unstable, and unevenly trusted spaces.

This fragmentation reflects the political geography of the West Bank. Territorial segmentation, checkpoints, military closures, settler violence, transportation costs, and uneven institutional development shape who can reach services and under what conditions. The desk review shows that Area C communities, camps, villages, and remote rural areas face weaker service continuity and greater dependence on mobile clinics and outreach teams. These forms of care are essential, yet remain vulnerable to funding cycles, insecurity, and interrupted access.

The fieldwork shows how this political geography enters intimate life. Women delay healthcare visits when transportation becomes unaffordable or movement through checkpoints becomes uncertain. Adolescents search privately online because families and schools remain uncomfortable spaces for discussing sexuality and bodily change. Young men turn to AI and anonymous digital searches because public discussion risks embarrassment and judgment. Service providers describe weak referral pathways, inconsistent coordination, and gaps between awareness, protection, and care.

Fragmentation is also institutional and social. Schools provide partial biological information while avoiding sexuality, consent, and intimate relationships. Clinics may offer treatment without privacy or emotional safety. NGOs create temporary spaces for awareness that often disappear when projects end. Families provide care while also regulating speech, mobility, sexuality, and reproductive decisions. Information circulates widely, yet rarely settles into trusted systems.

The findings challenge approaches that treat SRHR mainly as an awareness deficit. Adolescents and young people are already searching, comparing, and exchanging information through peers, workshops, internet searches, pornography, social media, AI tools, and informal conversations.

The problem lies in the unstable and socially risky conditions through which knowledge is accessed, interpreted, and trusted.

This instability shapes bodily life. Access to care depends on movement, confidentiality, family approval, economic capacity, and social visibility. Asking questions may expose adolescents to shame. Seeking reproductive healthcare may expose women to gossip. Reporting violence may threaten family relations or personal safety. People learn to move carefully between institutions, households, digital spaces, and informal networks.

Fragmentation therefore structures care, authority, knowledge, and protection. SRHR is negotiated through unstable relations between households, institutions, digital platforms, humanitarian interventions, and political restrictions. The result is a field of care where responsibility shifts onto individuals, families, and local intermediaries, while public systems remain uneven, interrupted, and socially mistrusted.

5.2. Knowledge, Silence, and the Social Regulation of Bodily Life

The findings show that knowledge about the body, sexuality, and reproduction is regulated socially before it is institutionalized educationally or medically. Information moves through moral boundaries that shape who may speak, what can be discussed openly, and when certain forms of knowledge become socially acceptable. Sexuality remained closely tied to family reputation, modesty, and social visibility across generations and geographic settings.

Silence therefore operates as a form of social regulation rather than simple absence of information. Discussions of sexuality are delayed, softened, redirected into biological language, or displaced into private spaces. Marriage continues to mark the point at which sexuality and reproduction become socially discussable, particularly for women. Before marriage, questions surrounding bodily change, relationships, contraception, or desire remain socially sensitive and often difficult to articulate openly.

The desk review reflects similar patterns across previous SRHR research in Palestine, where reproductive knowledge remains embedded within family authority, moral regulation, and social expectations surrounding gender and respectability. Yet the fieldwork complicates portrayals of Palestinian society as socially fixed or uniformly conservative. The findings instead point to uneven social transitions shaped by geography, education, economic conditions, and political fragmentation.

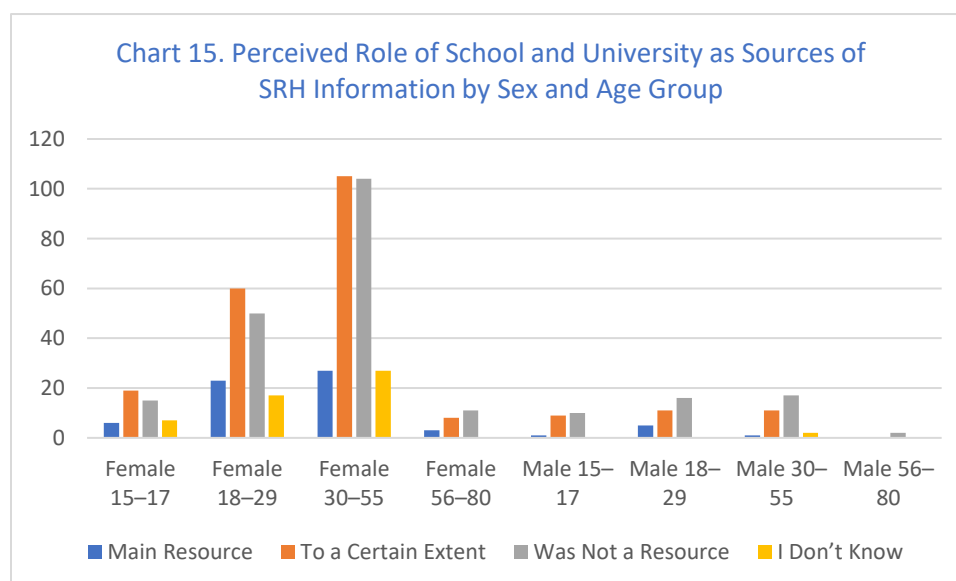
These shifts appeared most clearly among young women in Ramallah and some urban centers, where participants increasingly framed SRHR through emotional wellbeing, bodily autonomy, reproductive planning, and psychological health. University education, NGO engagement, and digital exposure contributed to changing forms of bodily awareness and reproductive negotiation.

Women spoke more openly about contraception, delayed pregnancy, emotional exhaustion, and unequal reproductive pressure than older generations often considered socially possible.

At the same time, these transformations remained uneven and socially fragile. In camps, villages, and economically marginalized areas such as parts of the Jordan Valley and southern localities, reproductive life remained more tightly regulated through kinship visibility, gossip, and family authority. Questions surrounding marriage, sexuality, and fertility circulated through collective family relations rather than individual choice alone.

Schools reflected these contradictions clearly. Educational institutions formally address puberty and biology while avoiding sexuality, consent, emotional intimacy, and bodily autonomy. Teachers and counselors frequently skip or minimize these subjects because of embarrassment, institutional caution, or fear of community reaction. Adolescents therefore move elsewhere in search of information.

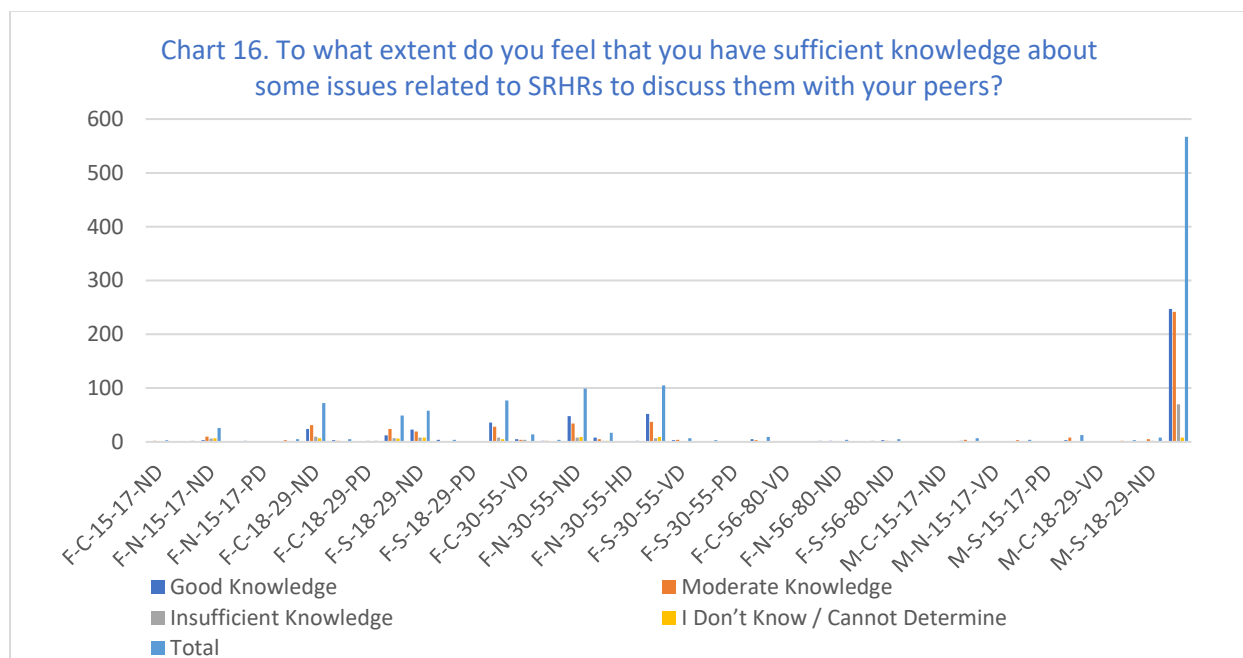
The survey findings reinforce this institutional gap. Among adolescent girls aged 15–17, 40% described schools and universities as providing SRHR information only “to a certain extent,” while 32% described them as “not a resource.” Among adolescent boys, 50% described schools as “not a resource,” while only 5% identified educational institutions as a main source of SRHR knowledge. Similar patterns appeared across older age groups, where schools and universities were more frequently viewed as partial or insufficient sources rather than trusted spaces for reproductive knowledge (Chart 15).



These patterns help explain the growing role of digital mediation. Adolescents and young adults were already searching, comparing, and exchanging information through peers, social media, pornography, AI platforms, workshops, and informal conversations. Digital searching often

functioned as a socially safer alternative in contexts where asking questions publicly risks embarrassment, judgment, or exposure. In camps and tightly interconnected rural communities especially, participants described carefully managing what could be spoken openly because personal matters circulate quickly through kinship and neighborhood networks.

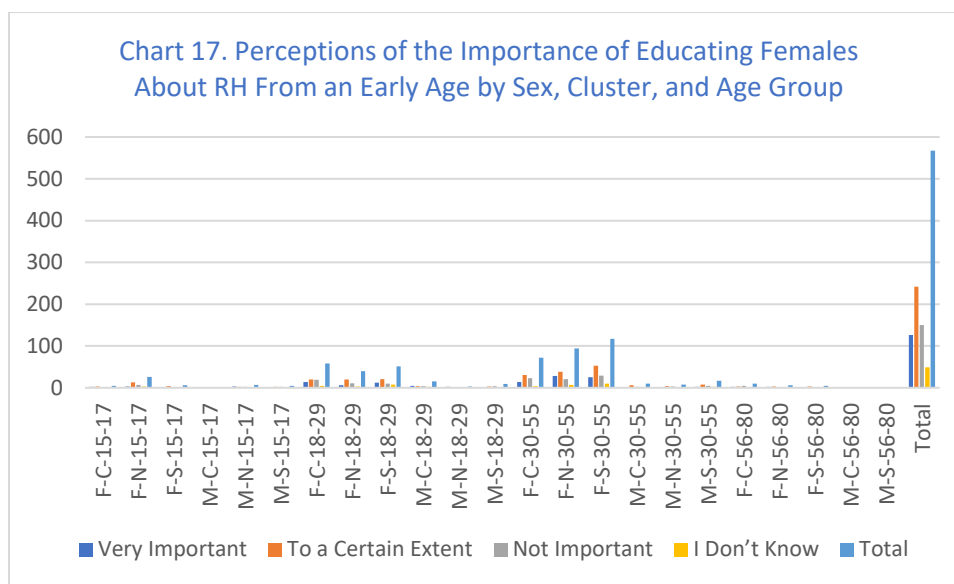
The survey findings also reflected uneven confidence discussing SRHR issues. Adult women generally expressed greater confidence, particularly those exposed to universities, reproductive health programmes, or NGO initiatives. Among women aged 30–55 without disabilities, 83% in northern areas and 85% in southern areas described themselves as having either good or moderate SRHR knowledge. By contrast, adolescent girls reflected greater uncertainty. Among girls aged 15–17 in northern areas, only 42% described themselves as having good or moderate SRHR knowledge, while 23% reported insufficient knowledge and another 23% expressed uncertainty. Young men similarly reflected uneven confidence and limited discussion, particularly in northern and southern areas (Chart 16).



Disability shaped these experiences unevenly as well. Participants with disabilities repeatedly emphasized the importance of trusted communication, adapted information, and gradual relationship-building in enabling discussion of SRHR concerns. The fieldwork showed that access to knowledge depends heavily on emotional safety, social trust, and the possibility of asking questions without humiliation or exposure.

The findings also reveal changing attitudes toward reproductive education for girls. Across the full sample, 65% of respondents viewed early reproductive health education for girls as either very important or important to some extent. Support was strongest among women aged 18–29 and

30–55 across different geographic areas. Yet 26% still did not consider early reproductive education important, while 9% expressed uncertainty. Male respondents, particularly in conservative areas and older age groups, expressed lower and less consistent support (Chart 17).



These tensions show that reproductive knowledge for girls is increasingly recognized as socially necessary, especially in relation to health, marriage preparation, and protection from harm. At the same time, bodily knowledge remains morally regulated through family authority, gender expectations, and community surveillance.

The findings therefore challenge intervention models that treat SRHR primarily as information delivery. Knowledge does not circulate independently from trust, gendered authority, emotional safety, and social legitimacy. Information becomes meaningful through the conditions under which people are able to ask questions, interpret experience, disclose concerns, and negotiate bodily life without fear of shame, punishment, or exposure.

5.3. Gender, Reproductive Labor, and the Uneven Distribution of Responsibility

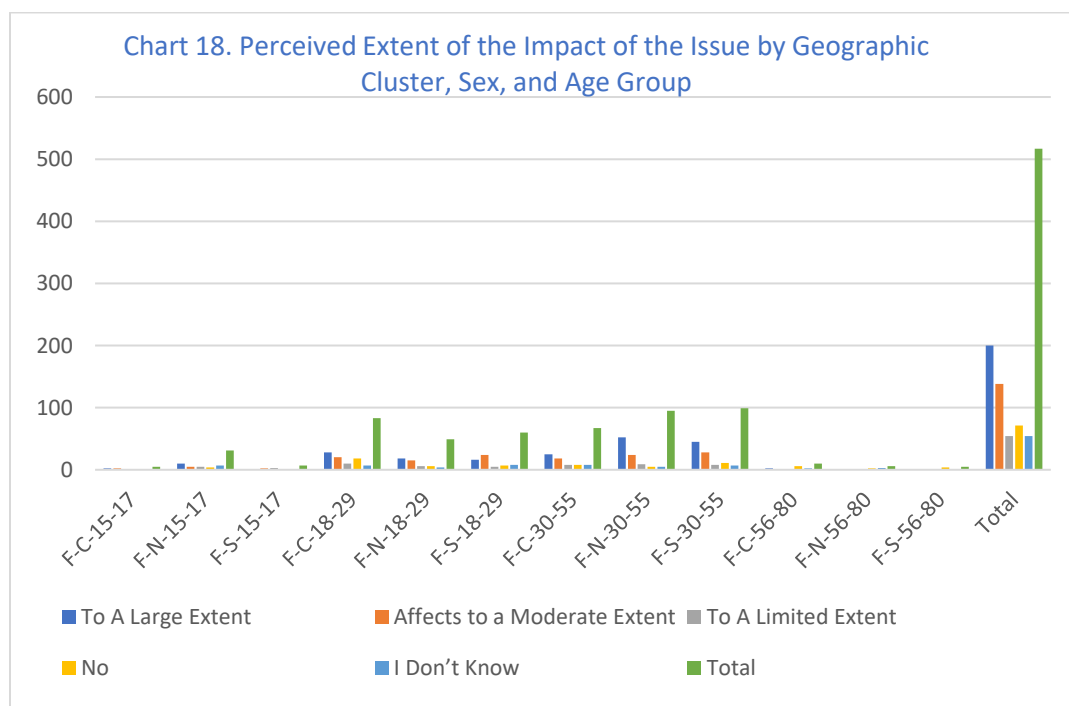
5.3.1. Reproductive Labor and the Feminization of Care

The findings show that reproductive life remains organized through unequal distributions of labor, responsibility, and emotional strain. Women carry contraception, pregnancy, childbirth, caregiving, family mediation, and the practical management of reproductive health while simultaneously absorbing the social consequences attached to fertility, marriage, and family stability. Reproductive labor therefore extends far beyond biological reproduction itself. It includes emotional regulation, negotiation within extended family structures, management of social expectations, and the continuous work of preserving household cohesion.

Across the fieldwork, fertility appeared less as a private reproductive choice than as a socially monitored dimension of marriage and feminine legitimacy. Pregnancy confirmed social belonging within marriage, while delayed childbirth exposed women to scrutiny from relatives, neighbors, and in-laws. Questions surrounding contraception, pregnancy spacing, or reproductive timing rarely remained confined to couples themselves. Decisions circulated through wider kinship structures where husbands, mothers-in-law, and extended family members often retained influence over reproductive life.

The findings suggest that reproductive pressure operates through ordinary social relations rather than through explicit coercion alone. Women repeatedly described emotional exhaustion, interference, and unequal responsibility as expected dimensions of marriage. Childcare, emotional support, family planning, and reproductive healthcare remained heavily feminized responsibilities even among women engaged in paid work, university education, or community activity.

The survey findings reinforce this pattern. Across the full sample, 65% of female respondents believed that limited SRHR awareness affects marital relationships either to a large extent or to a moderate extent. Recognition of this relationship was strongest among women aged 30–55, particularly in northern and southern areas, where large majorities connected reproductive knowledge directly to marital stability, communication, and emotional wellbeing (Chart 18).



These perceptions reflect how reproductive life is experienced relationally rather than individually. Across the FGDs and IDIs, women repeatedly linked limited communication

surrounding sexuality, fertility, contraception, and emotional wellbeing to misunderstanding, pressure, emotional isolation, and unequal expectations within intimate relationships. Reproductive knowledge therefore carried implications for emotional life, family relations, and women's everyday capacity to negotiate authority within marriage.

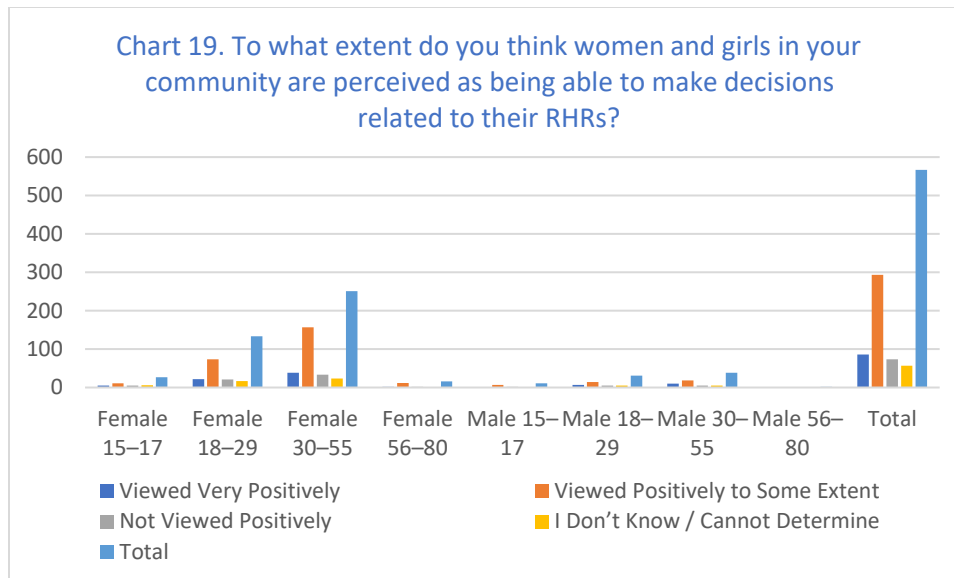
The desk review similarly points to the persistence of unequal gendered labor within Palestinian households, particularly under conditions of economic precarity, restricted mobility, and weak institutional support. The fieldwork extends this literature by showing how reproductive labor becomes intensified under fragmentation and crisis. Women described balancing caregiving, paid work, transportation burdens, emotional mediation, and reproductive expectations within conditions shaped by checkpoint systems, unstable incomes, weak healthcare continuity, and declining institutional trust.

At the same time, the findings reveal important generational shifts. Younger women increasingly questioned repeated childbirth, unequal caregiving burdens, and assumptions that women should absorb reproductive pressure silently. Women spoke more openly about emotional exhaustion, pregnancy spacing, bodily strain, and the need for shared responsibility within marriage. Yet these shifts remained uneven and socially negotiated rather than fully normalized.

5.3.2. Reproductive Authority and Negotiated Autonomy

The findings show that reproductive decision-making remains embedded within unequal systems of family authority, social monitoring, and gendered expectation. Support for women's participation in reproductive decisions appeared relatively widespread at the level of formal attitudes. In practice, however, reproductive autonomy remained conditional, negotiated, and unevenly distributed across geography, age, disability, and family structure.

Survey findings reflected broad support for women's participation in reproductive decision-making. Across the sample, 67% of respondents viewed women's participation either very positively or somewhat positively. Support appeared strongest among women aged 18–29 and 30–55, particularly in relation to marriage decisions, maternal healthcare, family planning, and access to reproductive health services (Chart 19).



Yet the qualitative material complicates these formal expressions of support. Reproductive decisions rarely appeared as fully individual decisions. Contraception, pregnancy timing, healthcare access, and fertility remained negotiated within wider family structures where husbands, mothers-in-law, parents, and relatives continued to exercise influence. Women frequently described reproductive autonomy as something managed within relationships rather than exercised independently from them.

The findings also suggest that some forms of women's decision-making are more socially acceptable than others. Maternal healthcare and marriage-related decisions were more widely recognized as legitimate domains of women's participation than contraception or reproductive control. Family planning remained more contested because it directly intersects with authority over fertility, sexuality, and family continuity.

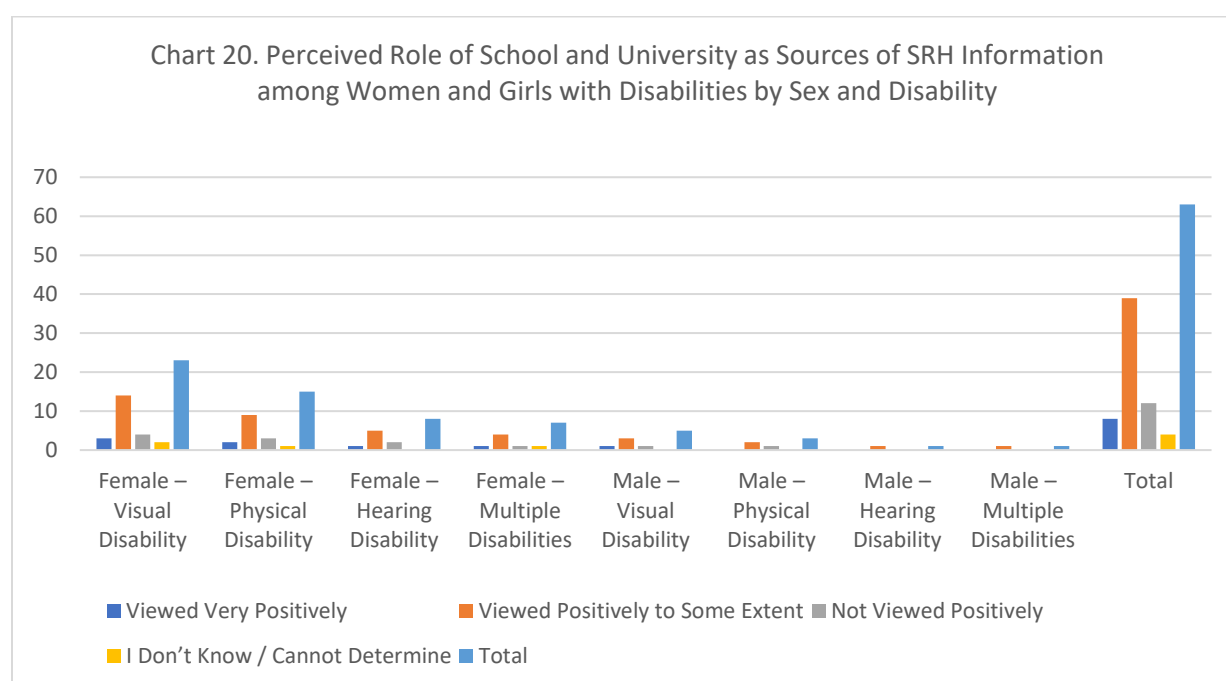
Geographic differences reflected these uneven negotiations. Respondents from Ramallah, Bethlehem, and Tubas expressed broader recognition of women's reproductive participation across multiple domains. In parts of Hebron, Jenin, and more socially conservative rural areas, support appeared narrower and more conditional, particularly regarding contraception and access to SRHR services. These differences reflected broader variations in educational access, institutional exposure, mobility, and kinship structures across locations.

The fieldwork further revealed how age shapes reproductive authority. Older women often possessed greater practical authority within reproductive decision-making because of lived experience related to marriage, childbirth, and healthcare navigation. Adolescents, by contrast, reflected narrower understandings of reproductive rights and greater uncertainty regarding women's autonomy. Younger girls frequently understood reproductive decisions primarily

through marriage and maternal care rather than through broader questions of bodily autonomy or reproductive choice.

The findings from participants with disabilities add another dimension to these negotiations. Women with disabilities repeatedly described their adulthood, sexuality, and reproductive capacity as questioned or socially managed within families and institutions. Reproductive autonomy was frequently shaped through dependency, protection narratives, and assumptions surrounding vulnerability. The issue was therefore not only access to services, but recognition as socially legitimate reproductive subjects.

Women with disabilities reflected additional layers of negotiation around reproductive authority. The survey showed strong formal support among women with disabilities: 74% of women with visual disabilities and 73% of women with physical disabilities viewed women’s and girls’ reproductive decision-making either very positively or positively to some extent. Similar support appeared among women with hearing and multiple disabilities, although with some uncertainty and uneven acceptance (Chart 20).



The qualitative material, however, showed that autonomy remains closely managed within family environments. Participants described having their adulthood, sexuality, and reproductive legitimacy questioned through protection, dependency, and supervision.

Male respondents with disabilities also expressed generally supportive attitudes. Among men with visual disabilities, 80% viewed women’s reproductive decision-making positively or somewhat positively, although the small sample limits broader interpretation. The stronger

analytical point is that disability reshapes how authority, dependency, and bodily legitimacy are negotiated within households and institutions.

The findings ultimately point to a distinction between formal support for women's reproductive participation and the everyday conditions through which decisions are actually made. Reproductive authority remains relational, negotiated, and socially monitored rather than fully individualized.

5.3.3. Masculinity, Provision, and Reproductive Anxiety

The findings complicate portrayals of men as detached from reproductive life. Young men repeatedly described fertility, marriage, provision, and sexual performance as major sources of anxiety, pressure, and uncertainty. Masculinity appeared less as stable authority than as a demanding social role shaped by economic instability, emotional restraint, delayed marriage, and political insecurity.

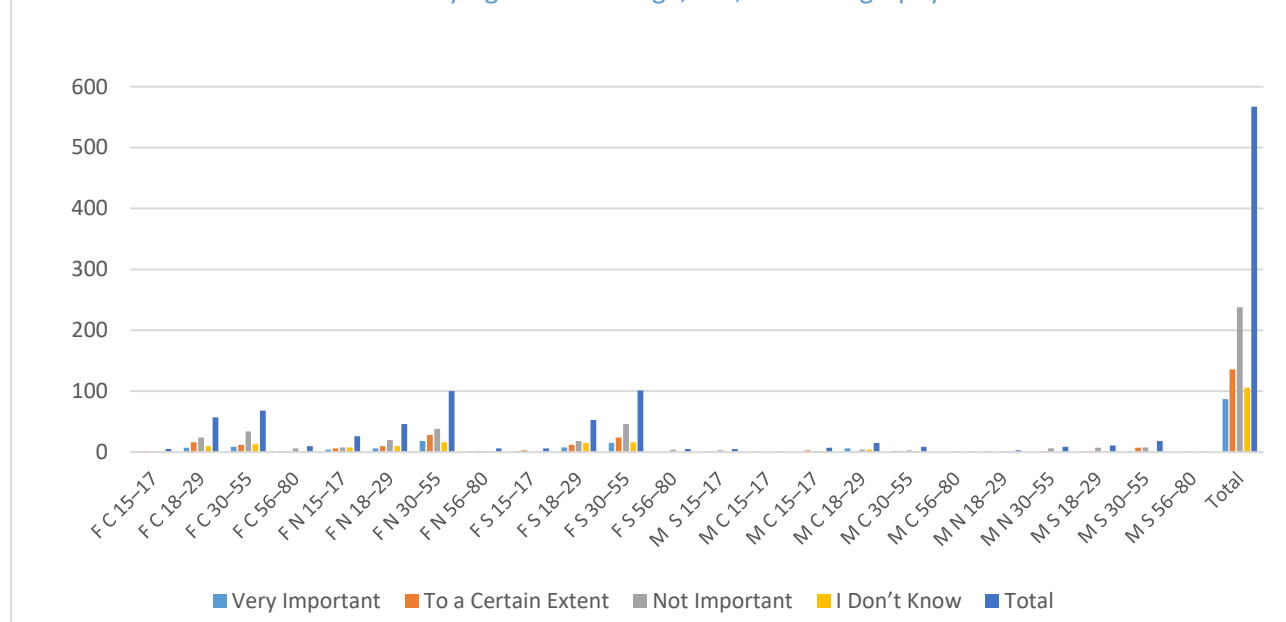
Marriage remained closely tied to employment, housing, and financial capability. Young men described feeling responsible for achieving forms of adulthood that increasingly appear economically unreachable. Unemployment, declining incomes, and movement restrictions intensified pressure surrounding masculine provision, particularly after October 2023. Under these conditions, delayed marriage became both an economic condition and a source of social inadequacy.

Reproductive anxiety also emerged through fears surrounding fertility and sexual capability. Fertility testing, delayed pregnancy, and sexual performance carried significant social weight because reproductive capacity remained tied to masculine reputation and marriageability. Men frequently avoided discussing reproductive concerns publicly because illness or sexual difficulty could be interpreted as weakness or diminished masculinity.

The fieldwork also revealed how political violence enters masculine bodily life directly. Detention, physical assault, unemployment, and prolonged insecurity produced anxiety surrounding bodily integrity, reproductive ability, and future family formation. Young men linked these experiences to emotional pressure while simultaneously describing the absence of socially legitimate spaces for vulnerability or discussion.

Survey findings reflected the continuing social positioning of SRHR as primarily a women's issue. Support for early SRHR education for boys remained inconsistent across regions and age groups. Across the full sample, only 15% viewed early SRHR education for boys as very important, while 42% did not consider it important. Male respondents in northern and southern areas expressed particularly low support overall (Chart 21).

Chart 21. Perceptions of the Importance of Educating Boys and Men on SRHR from an Early Age Based on Age, Sex, and Geography



These findings correspond closely with the qualitative material. Young men repeatedly described embarrassment surrounding sexuality, limited communication with fathers, and lack of trusted spaces for discussing reproductive concerns openly. Knowledge circulated privately through peers, internet searching, AI platforms, and informal networks rather than through stable institutional systems.

At the same time, several participants questioned inherited models of masculinity centered on emotional distance and unilateral authority. Some young men emphasized emotional support, shared caregiving, reproductive awareness, and mutual respect as necessary components of marriage and family life. These perspectives suggest emerging shifts in masculine expectations, although such shifts remain uneven and constrained by broader economic and political pressures.

The findings therefore suggest that SRHR programming cannot continue treating reproductive health solely as a women's issue. Male silence, reproductive anxiety, and emotional restriction remain structurally produced through dominant expectations surrounding masculinity, provision, and authority.

5.3.4. Reproductive Control and the Continuum of Violence

The findings show that SRHR and GBV are experienced through the same structures of authority, regulation, and unequal control. Violence rarely appeared only through explicit physical assault. More often, participants described pressure, monitoring, reproductive coercion, emotional

exhaustion, restricted mobility, and fear of exposure as ordinary dimensions of intimate and family life.

Women frequently spoke about contraception, fertility, and reproductive healthcare through the language of endurance, silence, and negotiation rather than direct coercion. Decisions surrounding pregnancy or contraception often unfolded within unequal relations where women anticipated conflict, blame, or interference if reproductive choices challenged family expectations.

Survey findings reflected widespread recognition that women may face violence related to independent reproductive decision-making. Large proportions of adolescents, young women, and men acknowledged that contraceptive use without a husband's knowledge could expose women to violence or conflict within marriage. These responses suggest that reproductive control remains socially recognizable even where it is not always named directly as violence.

The findings also show how violence becomes normalized through everyday family structures. Restricted movement, emotional pressure, reproductive monitoring, and unequal caregiving burdens often appeared socially ordinary rather than exceptional. Participants described women remaining silent about reproductive pressure, marital dissatisfaction, or sexual coercion because disclosure itself may threaten family cohesion or expose them to shame and social retaliation.

The desk review similarly points to the limitations of frameworks that separate GBV from SRHR institutionally and analytically. The fieldwork extends this argument by showing how bodily regulation operates through ordinary kinship relations, moral expectations, and unequal authority long before violence appears in legally recognizable form.

These dynamics were intensified under conditions of fragmentation, displacement, and economic insecurity. Checkpoints, overcrowding, weak institutional protection, and unstable livelihoods increased dependency while limiting women's mobility, confidentiality, and access to support. Violence therefore cannot be separated from the broader political organization of care, movement, and social survival in the West Bank.

The findings ultimately suggest that reproductive control operates through a continuum of social regulation extending across households, institutions, communities, and political structures. SRHR and GBV are therefore inseparable fields of lived experience rather than distinct domains of intervention.

5.4. Conditional Access, Uneven Geography, and the Political Organization of Care

The findings show that access to SRHR depends on far more than the formal existence of services. Care becomes possible only when mobility, affordability, confidentiality, institutional trust, and social legitimacy align at the same moment. These conditions are unevenly distributed across the

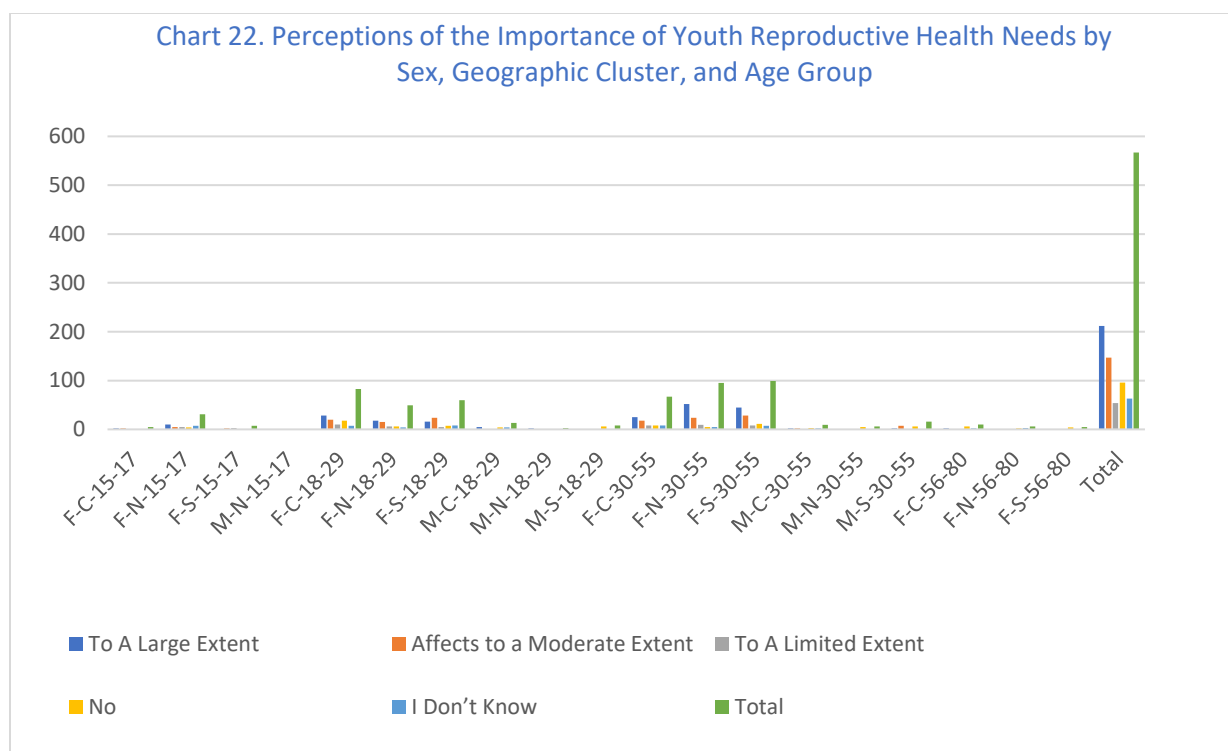
West Bank and remain unstable under conditions of territorial fragmentation, economic crisis, and weak institutional continuity.

Participants described access as a process of constant negotiation. Women, adolescents, and young men repeatedly assessed whether movement was possible, whether transportation costs could be managed, whether a clinic was socially safe, and whether confidentiality could realistically be protected. Seeking care often required navigating checkpoints, unstable transportation, family approval, and fear of exposure simultaneously. Under these conditions, postponing care, relying on informal advice, or avoiding services altogether became common strategies rather than exceptional responses.

The desk review reflects the same structural unevenness. Area C communities, camps, villages, and remote rural areas continue to experience weaker institutional presence, interrupted service continuity, and heavier dependence on mobile clinics and humanitarian outreach. The fieldwork showed how these broader conditions enter everyday reproductive life. Participants from Al-Jiftlik, Fasayil, East Yatta, Masafer Yatta, and surrounding areas repeatedly described healthcare access through the language of waiting, checkpoints, transportation costs, and uncertainty surrounding movement itself.

Geography shaped access unevenly. Participants from Ramallah and some urban centers described greater exposure to universities, NGOs, private clinics, and specialized services. In camps, villages, and marginalized rural communities, institutional absence was far more visible. Participants described health centers operating intermittently, shortages of providers and medications, and dependence on temporary outreach interventions that fluctuate according to donor funding, emergency conditions, and political restrictions.

Survey findings reflected this uneven recognition of youth SRHR needs. Among women aged 30–55, recognition was strongest in northern and southern areas, where approximately 80% and 74% respectively viewed youth reproductive health needs as important to a large or moderate extent. Among adolescent girls, recognition was more ambivalent: 48% of girls aged 15–17 in northern areas viewed these needs as important, while 23% rejected their importance and 23% expressed uncertainty. Male respondents showed weaker recognition overall. Among men aged 18–29, 75% in southern areas and 67% in northern areas either viewed youth reproductive health needs as unimportant or expressed uncertainty (Chart 22).



These patterns suggest that youth SRHR continues to occupy an uncertain social position. Reproductive and sexual health concerns are more easily recognized once connected to marriage, pregnancy, or motherhood than during adolescence itself. Adolescents therefore remain suspended between biological transition and social silence, where bodily change becomes visible while discussion remains restricted.

The findings also show that institutional access cannot be separated from social exposure. In camps and tightly interconnected rural communities, women repeatedly described avoiding local clinics because personal matters quickly circulate through family and neighborhood networks. Confidentiality remained one of the central conditions shaping whether services could actually be used. Women often preferred traveling outside their communities or relying on trusted intermediaries because local visibility itself carried risk.

The fieldwork further complicates approaches that treat accessibility primarily through infrastructure. Participants with disabilities described barriers extending beyond physical access into communication, privacy, transportation, caregiver dependence, and institutional attitudes. Women with disabilities repeatedly described struggling for recognition as persons with sexual, emotional, and reproductive lives rather than as dependents requiring supervision or protection. Under these conditions, access becomes shaped through dependency relations as much as through physical infrastructure.

Political violence and economic instability deepened these inequalities further. Displacement, checkpoint closures, declining incomes, overcrowded living conditions, and interruptions in public services intensified dependency within households while weakening institutional continuity. Bodily privacy itself became unstable under conditions where movement, healthcare, shelter, and personal safety could no longer be assumed.

The findings therefore suggest that mobility must be understood as part of reproductive infrastructure. Under conditions of political fragmentation, the ability to move safely across space becomes inseparable from the ability to seek care, disclose violence, access knowledge, maintain privacy, and negotiate bodily autonomy. Care remains unevenly distributed across geography because movement itself remains politically organized.

5.5. Digital Mediation and the Reconfiguration of Authority

The findings show that authority over bodily knowledge is no longer concentrated within families, schools, clinics, or religious institutions. Adolescents and young adults increasingly move between peers, social media, AI platforms, online searching, workshops, and informal digital networks in order to understand sexuality, relationships, bodily change, and reproductive health. Knowledge is assembled across overlapping and competing sources rather than received through singular trusted structures.

Digital platforms functioned as socially safer spaces for asking questions that remain difficult to raise publicly. Adolescents, young women, and young men repeatedly described turning to Google, TikTok, ChatGPT, online doctors, and anonymous searches because face-to-face discussion carries the risk of embarrassment, exposure, ridicule, or moral judgment. In camps, rural communities, and socially conservative areas such as Yatta and parts of the Jordan Valley, digital searching often became one of the few available spaces where sensitive questions could be explored privately.

The findings suggest that digital mediation reflects a broader crisis of institutional trust surrounding SRHR communication. Families, schools, and clinics continue to hold formal authority, yet many young people experience these spaces as cautious, emotionally uncomfortable, morally restrictive, or socially unsafe. Adolescents repeatedly described schools as partial sources of biological information that avoid sexuality, consent, emotional intimacy, and reproductive relationships. Parents similarly remained important figures within family life while often lacking the language, confidence, or willingness to discuss sexuality openly.

Survey findings reflected this shift clearly. Among adolescent girls aged 15–17 in northern areas, 69% identified internet and social media as sources of SRHR information, compared to 58% who identified friends and 46% who identified family members. Similar patterns appeared among young women aged 18–29 across geographic areas, where digital platforms consistently ranked

among the most frequently identified sources of SRHR knowledge. Young men similarly relied heavily on peers, internet searching, AI tools, and informal digital spaces, while schools and universities appeared far less consistently as trusted sources overall.

Generational differences were also visible. Older respondents relied more heavily on family-based learning, clinics, and healthcare providers, while younger participants increasingly navigated SRHR through layered combinations of peers, social media, anonymous searching, and informal digital engagement. Religious institutions and NGOs appeared less consistently across all groups as central sources of authority.

At the same time, digital mediation produced new forms of uncertainty. Participants repeatedly expressed concern regarding misinformation, exploitative online content, unrealistic expectations surrounding sexuality and relationships, and the absence of reliable guidance for interpreting what young people encounter online. The fieldwork showed that access to digital knowledge remains uneven because it depends on literacy, internet availability, digital confidence, and the ability to evaluate information critically.

Participants with disabilities described additional forms of exclusion. Access to online information depended heavily on whether platforms, communication tools, and awareness materials were adapted for visual, hearing, or intellectual accessibility. Digital searching expanded access for some participants while reproducing exclusion for others.

The findings therefore suggest that digital platforms do not replace family or institutional authority entirely. Authority itself becomes dispersed across overlapping systems of information, trust, and social influence. Adolescents and young adults increasingly navigate bodily life through fragmented combinations of peers, influencers, AI tools, clinics, family advice, workshops, and online searching, often without stable frameworks for evaluating or reconciling competing forms of knowledge.

This shift reflects broader transformations in trust, privacy, and intergenerational authority under conditions where young people increasingly manage sexuality, bodily knowledge, and emotional life across fragmented institutional and digital environments.

5.6. Implications for SRHR and GBV Programming

The findings suggest that many existing SRHR and GBV interventions remain narrower than the social realities they seek to address. Programming often treats access as a technical problem of awareness, referral, or service availability, while the fieldwork shows that bodily life is negotiated through family authority, social exposure, emotional safety, economic dependency, political fragmentation, and uneven institutional trust. The central issue is therefore not simply whether

services or information exist, but under what social conditions people are able to ask questions, seek care, disclose violence, move safely, or negotiate reproductive decisions.

The study also shows the limits of awareness-delivery models that assume information alone produces behavioral change. Participants across generations were already exposed to large amounts of information through social media, peers, AI platforms, workshops, internet searching, and informal networks. Yet knowledge remained fragmented, emotionally unstable, and socially risky to use. Many participants described becoming able to discuss sexuality, violence, or reproductive pressure only after trust developed gradually over time. Short-term workshops and isolated campaigns rarely created the continuity necessary for sustained communication, emotional safety, or long-term support.

Programming therefore needs to shift from information transfer toward relationship-building infrastructures. Trust emerged throughout the fieldwork as one of the central conditions shaping whether adolescents, women, men, and persons with disabilities felt able to ask questions, seek support, or disclose concerns. Participants repeatedly distinguished between services that formally exist and services that feel socially usable. Confidentiality, emotional safety, provider sensitivity, and social legitimacy often mattered as much as technical availability.

The findings further suggest that SRHR and GBV programming cannot continue treating households only as sites of resistance or culture. Families simultaneously function as spaces of care, regulation, protection, dependency, negotiation, and silence. Mothers often carried the responsibility for reproductive communication while lacking support themselves. Fathers remained socially influential while frequently absent from communication around bodily life, emotional wellbeing, and reproductive health. Programmes targeting adolescents without engaging wider family relations therefore risk reproducing the same silences they attempt to address.

At the same time, the study shows that gender transformation cannot rely exclusively on empowering women while leaving masculine pressures unaddressed. Young men repeatedly described anxiety surrounding provision, fertility, emotional control, delayed marriage, and bodily adequacy under conditions of economic collapse and political violence. SRHR continues to be socially positioned as a women's issue, leaving male emotional life, reproductive anxiety, and relational responsibility largely outside existing programming frameworks. This absence reinforces silence among men while concentrating reproductive and emotional labor further onto women.

The findings also challenge approaches that separate SRHR from GBV institutionally and analytically. Women rarely described violence only through direct physical assault. More often, they spoke through the language of pressure, endurance, monitoring, emotional exhaustion,

restricted movement, reproductive coercion, and unequal authority within everyday family life. Programmes that isolate GBV from reproductive life risk overlooking how bodily regulation operates through ordinary social relations long before violence appears in legally recognizable form.

Political fragmentation also reshapes the meaning of care itself. Checkpoints, transportation costs, military closures, displacement, weak infrastructure, and interrupted public services all structure who can reach support safely and consistently. Mobility emerged throughout the study as part of reproductive infrastructure rather than simply a logistical issue. Under these conditions, continuity of care cannot depend exclusively on fixed-site service models. Community-based outreach, mobile approaches, decentralized support structures, and locally embedded networks remain essential, particularly in camps, Area C communities, villages, and marginalized rural areas.

The findings additionally point to the growing importance of digital mediation. Adolescents and young adults increasingly navigate sexuality, bodily change, and emotional life through AI tools, anonymous searches, social media, and online networks because institutional communication remains emotionally restricted and socially cautious. Digital spaces therefore function as informal infrastructures of care, learning, and privacy. Yet these same spaces also produce misinformation, uneven access, exploitation risks, and new forms of exclusion, particularly for persons with disabilities and populations with limited digital literacy. Programmes can no longer treat digital engagement as secondary to formal service delivery. It has already become central to how young people navigate bodily knowledge and emotional support.

The fieldwork also reveals the importance of moving beyond narrowly biomedical understandings of reproductive health. Participants repeatedly connected SRHR to emotional wellbeing, fear, shame, social legitimacy, marriageability, exhaustion, and the ability to sustain relationships under pressure. Reproductive life was experienced socially, emotionally, economically, and politically at the same time. Programmes focused exclusively on contraception, maternal care, or awareness indicators risk missing how reproductive pressure is actually lived within households and intimate relationships.

The experiences of persons with disabilities further demonstrate the limitations of approaches centered only on physical accessibility. Participants described exclusion through communication barriers, dependency relations, institutional discomfort, social isolation, and denial of sexual and reproductive legitimacy. Inclusion therefore requires more than ramps or transportation. It requires recognition of persons with disabilities as full social and reproductive subjects capable of intimacy, desire, decision-making, and independent participation in care.

Finally, the findings suggest that fragmentation itself has become normalized within programming environments. Communities move between temporary projects, interrupted funding cycles, mobile clinics, emergency interventions, awareness campaigns, and inconsistent institutional support. Participants repeatedly described the exhaustion of navigating unstable systems that appear briefly and disappear again. Sustainable intervention therefore depends less on expanding isolated projects than on strengthening continuity, local trust, intergenerational communication, institutional accountability, and socially usable forms of care.

The broader implication of the study is that SRHR and GBV programming in the West Bank cannot be approached solely through service expansion or awareness provision. Bodily life is shaped through overlapping relations of political violence, social regulation, kinship authority, emotional survival, and uneven institutional legitimacy. Effective interventions will depend on whether programmes are able to work within these lived social realities rather than around them.

Chapter 6. Recommendations

The questions raised throughout this study move beyond access to services alone. They touch the conditions through which people learn to speak about their bodies, negotiate care, endure pressure, seek protection, maintain dignity, and imagine future family life under prolonged uncertainty. The following sections bring these realities together in order to reflect on what meaningful, socially grounded, and sustainable responses to SRHR and GBV might require in the West Bank today.

6.1. Conclusion

This study began from questions about access to SRHR and GBV services in the West Bank. The findings ultimately point to a broader reality: bodily life itself is organized through fragmentation, unequal authority, social surveillance, and unstable systems of care. SRHR is not experienced only through clinics, awareness sessions, or reproductive health programmes. It is lived through households, checkpoints, schools, overcrowded communities, digital spaces, economic pressure, and everyday negotiations over mobility, reputation, silence, and survival.

The study shows that young people are not disconnected from knowledge. Adolescents and youth actively search, compare, interpret, and negotiate information through peers, social media, AI platforms, workshops, and informal networks. Yet knowledge remains uneven, emotionally risky, and socially regulated. Questions surrounding sexuality, bodily autonomy, contraception, emotional wellbeing, and violence continue to move through systems of caution, shame, and moral supervision. Silence remains socially productive. It regulates what can be spoken, who may ask, and when bodily knowledge becomes socially legitimate.

At the same time, the findings reveal significant social shifts. Young women increasingly speak through the language of emotional wellbeing, reproductive planning, bodily autonomy, and shared responsibility within marriage. Young men question older forms of masculinity centered solely on provision and authority while also describing profound pressure surrounding employment, fertility, emotional restraint, and delayed adulthood. Mothers increasingly recognize the limits of silence and the need for communication with younger generations, even while navigating discomfort inherited across generations. These shifts are uneven, fragile, and geographically differentiated, yet they reflect changing social imaginations surrounding intimacy, care, and reproductive life.

The study also demonstrates that reproductive life remains deeply collective. Decisions related to fertility, marriage, contraception, pregnancy, and healthcare are rarely experienced as fully individual choices. They unfold within relations of kinship, dependency, obligation, and family visibility. Women continue to carry the practical and emotional labor of reproduction while also absorbing the consequences of social monitoring, reproductive pressure, and unequal caregiving

expectations. Violence similarly appears through ordinary forms of regulation: silence, reproductive coercion, restricted movement, emotional exhaustion, and unequal authority within everyday family life.

Political conditions intensify these dynamics continuously. Territorial fragmentation, checkpoints, displacement, transportation barriers, economic collapse, and interrupted institutional systems shape who can seek care, move safely, maintain privacy, or access protection. Mobility itself becomes part of reproductive infrastructure. Under these conditions, access to care depends as much on geography, trust, and social exposure as on formal service availability.

The experiences of persons with disabilities reveal these inequalities sharply. Participants described exclusion through dependency, inaccessible communication, institutional discomfort, weak confidentiality, and denial of sexual and reproductive legitimacy. Their experiences demonstrate that inclusion cannot be reduced to physical accessibility alone. It requires recognition of persons with disabilities as full social and reproductive subjects.

The findings also point to an important transformation in authority itself. Families, schools, clinics, NGOs, and religious institutions remain influential, yet they no longer operate as singular centers of trusted knowledge. Young people increasingly navigate overlapping systems of information where digital platforms, AI tools, peers, and informal searching coexist with formal institutions. Authority over bodily life has become fragmented, negotiated, and unstable.

The study therefore suggests that SRHR and GBV in the West Bank cannot be understood through narrow frameworks of awareness deficits or service gaps alone. They must be understood through the broader social organization of bodily life under conditions of political fragmentation, economic precarity, uneven institutional legitimacy, and gendered authority. The central issue is not simply whether information or services exist, but whether people are able to ask, move, trust, disclose, negotiate, and seek support safely within the worlds they inhabit.

6.2. Recommendations

The recommendations below focus on strengthening continuity, trust, accessibility, and social legitimacy within SRHR and GBV programming. They address the conditions shaping how people seek care, communicate about bodily life, navigate institutions, manage social pressure, and access protection under fragmentation, economic insecurity, and uneven systems of support. The recommendations also emphasize the importance of locally grounded, relational, and long-term approaches capable of responding to the lived realities reflected throughout the study.

1. Build Long-Term, Relational Approaches Rather than Short-Term Awareness Campaigns

The findings show that information alone does not produce trust, confidence, or sustained change. Adolescents, women, and young men repeatedly described becoming able to discuss

sexuality, reproductive pressure, emotional wellbeing, or violence only after relationships of trust developed gradually over time. Short-term awareness campaigns may temporarily expose participants to information, yet they rarely create stable environments where difficult questions can continue to be negotiated safely.

Future programming should therefore move away from isolated awareness sessions toward long-term relational approaches rooted in continuity and trust-building. This requires repeated engagement with the same communities, facilitators, schools, youth groups, women's centers, and local institutions over extended periods. Small-group work, peer dialogue, intergenerational communication models, and sustained community presence are likely to be more effective than one-time campaigns or short project cycles.

Programmes should also recognize that trust itself functions as infrastructure. In many communities, participants evaluated services according to confidentiality, emotional safety, social legitimacy, and provider attitudes before deciding whether care could actually be used.

2. Strengthen Integrated and Decentralized SRHR–GBV Systems

The study shows that women and adolescents continue to navigate SRHR and GBV through fragmented institutional pathways. Health services, psychosocial support, legal assistance, protection mechanisms, and referral systems often operate separately, forcing individuals to move repeatedly between disconnected institutions while managing stigma, transportation barriers, and fear of exposure.

Strengthening service integration therefore requires more than expanding individual programmes. Referral pathways between SRHR, GBV, psychosocial support, and legal services should become operationally coordinated, confidential, and locally accessible. The National Referral System requires stronger implementation, provider preparation, and continuity across governorates and sectors.

The findings also demonstrate that centralized service models remain insufficient under conditions of territorial fragmentation and movement restriction. Camps, Area C communities, villages, Bedouin localities, and remote rural regions require decentralized and community-based approaches capable of functioning under unstable mobility conditions.

Mobile clinics, outreach teams, and local community health structures should therefore be treated as permanent components of care infrastructure rather than temporary emergency responses. Programmes should strengthen continuity between mobile and fixed services so that care does not disappear once humanitarian projects conclude.

3. Reposition Confidentiality and Emotional Safety as Central Conditions of Access

Participants consistently described confidentiality and fear of exposure as central barriers shaping help-seeking behavior. In tightly interconnected communities, visiting a clinic, police station, or Family Protection Unit may itself expose women and adolescents to gossip, family intervention, or reputational harm.

Programmes should therefore treat privacy and emotional safety as central dimensions of service quality rather than secondary ethical considerations. Confidential spaces, discreet referral mechanisms, low-visibility entry points, and provider sensitivity directly shape whether individuals feel able to seek support.

This requires training providers in trauma-informed, adolescent-friendly, disability-inclusive, and non-judgmental communication. It also requires institutional cultures that understand SRHR and GBV not only as medical issues, but as emotionally and socially sensitive fields shaped by fear, shame, and unequal authority.

In some communities, participants expressed greater trust in outside providers than local actors because anonymity itself created safety. Service models should therefore remain flexible enough to respond to local dynamics surrounding visibility and trust.

4. Integrate Emotional Wellbeing into SRHR Programming

The findings repeatedly connected reproductive life to emotional exhaustion, anxiety, fear, shame, marital tension, and psychological pressure. Participants rarely experienced SRHR as purely biomedical. Pregnancy, fertility, contraception, sexuality, and marriage were discussed through emotional survival, family negotiation, and social legitimacy.

Programmes should therefore integrate mental health and psychosocial support more directly into SRHR interventions. Emotional wellbeing cannot remain secondary to reproductive healthcare because participants themselves experience these dimensions together.

This includes:

- Integrating psychosocial support into reproductive health services;
- Strengthening counseling and safe dialogue spaces;
- Addressing emotional pressure within marriage and caregiving; and,
- Recognizing reproductive exhaustion as a social and psychological issue as much as a health issue.

The findings also suggest that women often carry emotional mediation within households while lacking spaces for their own support. Programmes targeting women should therefore move beyond reproductive education alone toward broader support for emotional wellbeing and relational negotiation.

5. Engage Men through Care, Emotional Life, and Reproductive Responsibility

The study complicates approaches that frame men primarily as barriers to women's health. Young men repeatedly described anxiety surrounding fertility, marriage, provision, emotional restraint, unemployment, and bodily adequacy under conditions of economic collapse and political insecurity.

Male silence around SRHR often reflected fear of humiliation, weakness, or social failure rather than lack of concern. At the same time, many young men questioned older models of masculinity centered solely on authority and provision.

Programmes should therefore engage men through frameworks of care, emotional wellbeing, shared reproductive responsibility, and relational communication rather than only through behavior-change messaging. Discussions of masculinity should address:

- Reproductive anxiety,
- Emotional suppression,
- Fertility concerns,
- Caregiving responsibilities, and,
- The pressures attached to masculine adulthood.

Creating socially legitimate spaces where men can discuss these issues safely may reduce stigma while also redistributing emotional and reproductive labor more equitably within households.

6. Expand Comprehensive and Age-Appropriate SRHR Education

Schools emerged throughout the study as partial and cautious spaces that largely avoid sexuality, consent, relationships, emotional intimacy, and bodily autonomy. Adolescents therefore increasingly rely on fragmented digital and informal sources of knowledge.

The findings suggest the need for comprehensive, age-appropriate SRHR education integrated gradually across developmental stages rather than delivered only through isolated biological lessons or emergency awareness sessions.

Educational approaches should:

- Address puberty, consent, relationships, contraception, bodily autonomy, digital safety, and emotional wellbeing;
- Prepare teachers and counselors to discuss these issues confidently and sensitively; and,
- Involve parents in ways that reduce resistance while strengthening communication within households.

The findings also suggest that programmes should avoid framing sexuality education solely through fear, danger, or moral panic. Adolescents repeatedly linked reproductive knowledge with self-confidence, bodily awareness, and protection from coercion and exploitation.

7. Recognize Digital Spaces as Central SRHR Environments

Digital platforms now function as major infrastructures of learning, privacy, and emotional navigation for adolescents and youth. Young people increasingly turn to AI tools, anonymous searches, TikTok, Google, peer networks, and online medical content because institutional communication remains socially restricted and emotionally uncomfortable.

Programmes should therefore engage digital realities directly rather than treating online spaces as secondary to formal service delivery. Youth-friendly Arabic digital platforms, verified information channels, anonymous support systems, and digital referral pathways should become integrated components of SRHR programming.

At the same time, programmes should address the risks participants repeatedly identified:

- Misinformation,
- Exploitative content,
- Unrealistic sexual expectations, and,
- Lack of critical evaluation skills.

Digital literacy should therefore become part of SRHR education itself.

Accessibility also remains critical. Persons with disabilities repeatedly described exclusion from online information because materials and platforms are not adapted appropriately. Disability-inclusive digital engagement should therefore become a standard component of programme design.

8. Move Beyond Physical Accessibility toward Full Inclusion of Persons with Disabilities

The findings demonstrate that disability exclusion extends far beyond infrastructure. Women and girls with disabilities described dependency, communication barriers, institutional discomfort, family supervision, and denial of sexual and reproductive legitimacy.

Inclusion therefore requires recognizing persons with disabilities as full social and reproductive subjects rather than only service recipients. Programmes should strengthen:

- Disability-sensitive communication systems;
- Adapted educational materials;
- Confidential reporting pathways;
- Provider training on respectful engagement; and,

- Direct participation of persons with disabilities in programme design and evaluation.

Family engagement also remains essential because many barriers emerge within systems of protection, dependency, and social control inside households themselves.

9. Address Geographic Inequality as a Structural Condition

The study shows that geography shapes bodily life directly. Camps, villages, Bedouin communities, Area C localities, and remote rural regions continue to face weaker service continuity, transportation barriers, unstable mobility, and limited institutional presence.

Programming should therefore approach geographic inequality as a structural condition rather than a logistical challenge alone. Service continuity in marginalized areas requires:

1. Decentralized delivery models,
2. Transportation support,
3. Local partnerships,
4. Community health points,
5. Satellite outreach structures (small local units, outreach hubs, women's centers, community rooms, municipal spaces, school-based support points, village focal points, mobile-team follow-up locations), and,
6. Flexible service schedules adapted to movement restrictions and emergency conditions.

Mobility itself should be treated as part of reproductive infrastructure because the ability to move safely remains inseparable from access to care, protection, and information.

10. Shift from Project Logic toward Institutional Continuity

Participants repeatedly described exhaustion from fragmented interventions that appear briefly and disappear again. Communities move continuously between workshops, mobile clinics, awareness campaigns, emergency responses, and interrupted referral systems without experiencing stable institutional continuity.

The findings therefore point to the need for longer-term institutional investment rather than short funding cycles focused on outputs alone. Sustainable programming requires multi-year partnerships; stable local presence; coordinated referral systems; institutional accountability; and continuity between humanitarian and developmental approaches.

Programmes should strengthen local systems capable of remaining socially trusted beyond temporary project cycles. The central challenge identified by the study is not simply expanding services or increasing awareness. It is building forms of care that remain emotionally usable, socially legitimate, politically realistic, and institutionally continuous under conditions of fragmentation and prolonged instability.

Annexes