Gender and Health
in the occupied Palestinian territory

2023

World Health Organization
occupied Palestinian territory

HEALTH CLUSTER
OCCUPIED PALESTINIAN TERRITORY

Gender and Health
in the occupied Palestinian territory

2023

World Health Organization
occupied Palestinian territory

HEALTH CLUSTER
OCCUPIED PALESTINIAN TERRITORY

CONTENTS

World Health Organization
occupied Palestinian territory

HEALTH CLUSTER
OCCUPIED PALESTINIAN TERRITORY

Executive Summary

Gender disparities in the health system of the occupied Palestinian territory (oPt) are exacerbated by social norms, gender discrimination, and gender roles, especially during humanitarian and health crises, such as the COVID-19 pandemic or escalations.

Although efforts have been made to integrate gender analysis into humanitarian response, the focus has largely remained on traditionally perceived "women's issues" such as sexual reproductive health rights (SRHR) and gender-based violence (GBV). Challenging gender norms, promoting gender equality, and creating an inclusive health environment that specifically addresses the health needs of women, men, girls, and boys in all their diversity is critical to achieving sustainable progress.

Sociocultural norms in oPt may contribute to health disparities. For example, men are more likely to smoke due to societal norms and expectations, while women and girls may face mobility restrictions, which promotes a sedentary lifestyle and associated health problems. Health inequities are exacerbated by the ongoing Israeli occupation, Palestinian political fragmentation, the blockade of Gaza, restrictions on movement, and the implementation of the permit regime. The lack of basic necessities such as quality water and electricity in some areas further impacts people in precarious situations. However, gender roles can become fluid due to poverty and unemployment, which often increases the burden on women as they navigate patriarchal structures while taking on dual roles as providers and breadwinners for the family.

Examining the role of Health Cluster partners in delivering gender-responsive care reveals both challenges and opportunities. While gender policies exist, gaps remain in their implementation. Organizations often reduce the concept of gender to women's issues and neglect its relevance to men and broader social constructs. Given the needs on the ground, gender equality principles are put into practice only sporadically and inconsistently.

The limited participation of women in policymaking needs to be addressed, with efforts to review policies, eliminate discriminatory laws, and strengthen accountability. The Palestinian Ministry of Health (MoH) has demonstrated welcome commitment, but comprehensive integration of gender analysis across all health sectors has yet to realised.

Women are the majority in the nursing sector, but decision-making functions are predominantly performed by men. Disaggregating data by gender, age, and disability is critical to developing effective health programs.

Gender equity significantly influences health care service accessibility and quality. Discriminatory practices, high costs, and long waiting times often impede access to health care, especially for women affected by lower insurance rates and poverty. Mechanisms are in place to address violence against women and sexual harassment, but awareness among health care providers and those who use services remains limited. Integrating gender sensitivity into health care delivery, improving monitoring systems, and enhancing project funding are critical. Prioritisation of short-term humanitarian interventions also affects the scope and volume of activities.

Women's right to accessible, nondiscriminatory, and quality sexual and reproductive health (SRH) care is often violated due to cultural norms and patriarchal authority, leading to problems such as early marriage, recurrent pregnancies, and blame for infertility. The decline in maternal mortality rates, high fertility rates, and the culture of shame surrounding sexual issues due to stigma are of concern. Access to family planning services is lower than the regional average due to supply constraints, inadequate resources, and financial constraints.

SRH projects should address women's health needs beyond reproductive age and address the specific needs of single and postmenopausal women. It is critical to promote gender equality

in contraceptive practices and raise awareness of SRH among male community members.

GBV significantly impacts health and well-being, a situation that was exacerbated by the COVID -19 pandemic. While the National Referral System and the Ministry of Health have made progress in providing specialised GBV services, problems such as stigma and discrimination, lack of consistent policy implementation, and limited clinical management for rape protocols persist. This underscores the urgent need for collaborative training of social and health care providers and improved infrastructure.

Stigma often discourages people with symptoms of mental disorders from seeking help. Men who seek help for mental health problems may be seen as less "manly" or less able to cope with stress and adversity. In many cases, women are seen as weak or unstable when they seek mental health services, which can have negative social consequences. Therefore, there is an urgent need to further reform the mental health care system, invest in resources and knowledge, and integrate mental health services into existing health facilities.

Emergencies disproportionately affect women and girls, exacerbating their mental and physical health problems and caregiving responsibilities. At such times, essential services such as obstetric care are often neglected. Cultural beliefs and social norms, such as the requirement for companions during medical visits, mobility restrictions, and the stigmatisation of certain diseases, further limit access to health care.

In summary, the interplay of gender, cultural norms, economic hardship, and emergency situations creates multiple barriers to health care in the oPt. Prioritizing gender, promoting mental health awareness, reducing stigma, and ensuring accessible services are urgently needed to improve health outcomes. To enhancing access to health care in oPt, a comprehensive approach is needed that challenges discriminatory practices, promotes gender equality, raises awareness of the importance of timely health care, and trains health care providers on inclusivity and sensitivity. Further legislative reforms, increased funding for gender-specific projects, improved SRH services, and increased awareness of mental health and related services are needed.

INTRODUCTION

Barriers, including gender barriers, to accessing health care are exacerbated during humanitarian emergencies, while increased health needs arise from higher levels of exposure to gender-based violence, particularly for women and girls.[1] The protracted protection crisis in the occupied Palestinian territory (oPt) unequally affects women, men, girls, and boys. Gender discrimination, gender roles, gender norms and gender relations create particular risks and vulnerabilities. For example, the COVID-19 pandemic has disproportionately affected women, who have taken on increased unpaid caregiving responsibilities and faced additional burdens to maintain household cleanliness. Lockdown measures may have further reinforced the confinement of women indoors for their safety, both within the household and at the community level[2]. As primary domestic caregivers, women may have shouldered the responsibility of managing household tasks, including maintaining the house, managing finances, purchasing groceries, and prioritising unpaid care work for their families. These added responsibilities often come at the expense of women's own health and well-being and must be juggled together with their formal and informal work commitments.

The 2021 Joint Care International and OCHA Palestine Rapid Gender Analysis[3] (RGA) reported that the clusters had made progress in utilising and integrating the gender analysis into the humanitarian response planning process but that more could still be done, specifically by improving

1) O'Neill, M. (2022, May 5). Listening to female voices can stop humanitarian crises harming women's and girls' health. World Economic Forum. https://www.weforum.org/agenda/2022/05/listening-to-female-voices-can-stop-humanitarian-crises-harming-women-s-and-girls-health/

2) OCHA. (2020). How COVID-19 measures affect women, girls, men and boys differently. United Nations Office for the Coordination of Humanitarian Affairs - Occupied Palestinian Territory. http://www.ochaopt.org/content/how-covid-19-measures-affect-women-girls-men-and-boys-differently

3) OCHA & CARE International. (2021). Rapid gender analysis to inform the 2021 humanitarian programme cycle in the OPT. https://www.un.org/unispal/document/rapid-gender-analysis-to-inform-the-2021-humanitarian-programme-cycle-in-the-opt-ocha-care/

the sector-specific gender analysis and its application to specific sectoral interventions. The RGA also noted that further cross-cutting work could be done across all sectors since, overwhelmingly, most of the gender analysis focused on areas traditionally associated with "women's issues" such as gender-based violence (GBV), sexual and reproductive health (SRH), and maternal health.

Equity in health refers to the absence of avoidable and unfair differences among different groups of people, whether defined socially, economically, demographically, or geographically. Health inequities go beyond measurable differences and encompass unnecessary, avoidable, unfair, and unjust disparities in health. These inequities are closely tied to broader issues of fairness and justice, and potential discrimination associated with such factors as ethnicity, race, sex, language, religion, disability, and more. Reducing health inequities is crucial for strengthening health systems, universal health coverage, the realization of the right to health, and sustainable social development.

Gender-specific medicine is an area of medicine that has been largely overlooked. Cardiovascular diseases, despite being the leading cause of death and disability in women, have predominantly been studied in men, resulting in a lack of understanding of gender differences in risk factors, disease manifestations, and treatment effects[4] There are notable variances between sexes in the pharmacokinetics and pharmacodynamics of certain drugs, as well as in the occurrence, severity, and prognosis of specific cancers[5]. Similarly, there are gender disparities in the prevalence, incidence, and presentation of mental health issues. For instance, studies have shown that women, compared to men, are twice as likely to experience depression and anxiety disorders[6]; women are more prone to experiencing sexual and physical violence, which has been associated with symptoms of both physical and mental ill-health[7]. Additionally, gender-based disparities in stress and coping mechanisms, influenced by societal expectations of gender roles and norms, significantly impact mental health outcomes.[8]

Gender equality is a crucial aspect of human rights, recognising that individuals are entitled to equal rights and freedoms regardless of the socially ascribed roles for 'women' and 'men.' Gender discrimination intersects with other forms of discrimination, creating complex systems of inequality called intersectionality. It is important to distinguish between gender and sex, as gender refers to social roles and identities while sex pertains to biological characteristics. Barriers to health care access for women and girls include restrictions, limited decision-making power, lower literacy rates, discriminatory attitudes, and inadequate training and awareness among health care providers. Consequently, woman and girls face higher risks of sexually transmitted infections, malnutrition, respiratory infections, elder abuse, and violence rooted in gender inequality[9]. Harmful gender norms also affect the health and well-being of boys, men, and individuals with diverse gender identities, impacting their behaviours, substance misuse, and mental health.

To address these disparities, it is essential to challenge rigid gender norms, promote gender equality, and establish inclusive healthcare environments that support individuals of all genders. Recognising and addressing intersecting factors contributing to gender inequality can lead to improved health outcomes and overall well-being for everyone.

4) Baggio, G., Corsini, A., Floreani, A., Giannini, S. & Zagonel, V. (2013). Gender medicine: a task for the third millennium. Clinical Chemistry and Laboratory Medicine (CCLM), 51(4), 713-727. https://doi.org/10.1515/cclm-2012-0849
5) Chiang, C.-K., & Kuo, F.-C. (2012). Clinical applications of gender differences in laboratory medicine. Clinical Chemistry and Laboratory Medicine (CCLM), 50(11), 1901–1914. https://doi.org/10.1515/cclm-2012-0849
6) Remes, O., Brayne, C., van der Linde, R., & Lafortune, L. (2016). A systematic review of reviews on the prevalence of anxiety disorders in adult populations. Brain and Behaviour, 6(7). https://doi.org/10.1002/brb3.497
7) Garcia-Moreno, C., Jansen, H. A., Ellsberg, M., Heise, L., & Watts, C. H. (2015). Prevalence of intimate partner violence: findings from the WHO multi-country study on women's health and domestic violence. The Lancet, 368(9543), 1260-1269.
8) Addis, M. E., & Mahalik, J. R. (2003). Men, masculinity, and the contexts of help seeking. American Psychologist, 58(1), 5-14.
9) WHO. (n.d.-a). Gender and health. Retrieved April 4, 2023, from https://www.who.int/health-topics/gender

ABOUT THIS GENDER ANALYSIS

The Health Cluster in the occupied Palestinian territory (oPt) is a coordination mechanism led by the World Health Organization (WHO) and co-coordinated by the Palestinian Ministry of Health (MoH). It brings together various partners, including UN agencies, NGOs, and donors, to provide a coordinated response to the health needs of Palestinians affected by the ongoing violence and humanitarian crisis. The Health Cluster ensures that partners work together in a coordinated manner to maximize the impact of the response and avoid duplication of efforts. It also integrates cross-cutting issues such as gender, age, protection, disability, and more into the humanitarian response. By recognising and addressing these issues, the Health Cluster aims to make the response more effective, inclusive, and equitable.

This gender analysis supports the Health Cluster's efforts to integrate the gender analysis more effectively in the response planning process for the occupied Palestinian territory (oPt). It summarizes key gender information from recent reports to enhance the understanding of gender dynamics and sectoral needs. Additionally, it offers specific recommendations for the Health Cluster to consider in the humanitarian programme cycle, enabling the integration of gender issues into projects implemented by partners. The report aims to complement existing gender data, analysis, and actions outlined in the Humanitarian Needs Overview (HNO) and Humanitarian Response Plan (HRP).

This gender analysis employs mixed methods, including a literature review, quantitative assessment, and qualitative interviews and focus groups. Relevant local and international studies and reports were gathered for the literature review, while the quantitative assessment involved a survey of the Health Cluster partners to gather information about their capacity to integrate gender in their work. The qualitative component included semi-structured interviews with key stakeholders and focus groups, with service providers, and beneficiaries in different areas of the oPt. This entailed a total of 28 semi-structured interviews with key stakeholders from 25 organisations and eight focus groups in the West Bank and Gaza Strip. The interviews included UN agencies, government officials, and civil society organisations, with tailored questions about service delivery and health policy. Focus groups involved rights-holders (six groups: three for men, three for women) and health workers (two groups). The right-holders focus groups had 66 participants in total, while the health worker groups had 17 participants. Complete question sets are available in the Methodology Appendix. For more information on the purpose and methodology of this analysis, see Annexes I & II.

The findings and recommendations of the gender analysis were discussed and validated in workshops with the Health Cluster partners, allowing for feedback and comments from stakeholders. Key counterparts of the Health Cluster, such as the women's health unit of the MoH and UN agencies, provided input and ensured the accuracy, relevance, and acceptability of the final product.

Overall, the gender analysis aims to generate insights and recommendations that will help in addressing gendered health needs and access barriers. By integrating gender equality considerations into the work of the Health Cluster partners, the analysis seeks to promote more inclusive and equitable health services in the oPt.

CONTEXT

The protracted crisis, coupled with the Israeli occupation's policies, including settlements and the presence of security checkpoints, both fixed and temporary, create significant obstacles for the health system to function properly and for individuals to access health care in a timely manner. This is especially challenging in the Gaza Strip and areas in areas of the West Bank, including east Jerusalem, affected by the separation wall, settlement infrastructure, and Israeli restrictions on movement, building and development – including Area C, H2 of Hebron, and the Seam Zone between the separation barrier and the 1949 Armistice Line. People often have to endure precarious access long delays at checkpoints, where they may be arbitrarily denied passage. Patients, their companions and health workers require permits to move between different parts of the oPt.

839

Gaza **patients passed away** while awaiting permit response between 2008-2021

In the Gaza Strip between 2008 and 2021, 839 patients passed away while awaiting permit response.[10] Health service providers face additional difficulties reaching their work centers due to delays and restrictions at checkpoints. Ambulances and health care staff are often arbitrarily detained, causing further obstacles for health care providers. The arbitrary arrest of health care workers also poses a significant hindrance to health care provision throughout the oPt.[11] In addition, the continued attacks on the Palestinian people, especially in the Gaza Strip but also increasingly across the West Bank, have devastating effects such as the destruction of infrastructure, attacks on health care[12], increased injuries, and physical disabilities, not to mention the psychological damage, especially among children.[13]

Culture, society, and environment shape one's mental and physical well-being. For example, in the oPt, 54.4% of men reported that they are smokers, compared to 7.7% of women[14]. Studies show that smoking is often viewed as a symbol of manhood and power[15], which could contribute to the higher rates of smoking among men in many cultures, including the oPt. In contrast, women who smoke may be stigmatised[16]. The high prevalence of smoking among men in the oPt may be attributed to cultural expectations and traditional gender roles that tend to prioritse masculinity. Additionally, factors such as peer pressure, advertising, and social norms can also influence men's smoking behaviour[17]. The gender gap in smoking rates could be contributing to differences in health outcomes between men and women.

10) WHO and Health Cluster (2022). 15 of health and blockade in Gaza. https://www.emro.who.int/images/stories/palestine/documents/15_years_of_blockade_and_health_in-gaza.pdf?ua=1
11) WHO (2023). Increasing attacks on health care & health worker testimony. World Health Organization - Regional Office for the Eastern Mediterranean. Retrieved April 4, 2023, from http://www.emro.who.int/opt/news/increasing-attacks-on-health-care-a-health-worker-testimony.html
12) WHO and Health Cluster (2022). 15 of health and blockade in Gaza. https://www.emro.who.int/images/stories/palestine/documents/15_years_of_blockade_and_health_in-gaza.pdf?ua=1
13) Ministry of Health Palestine (2022) Health Annual Report 2021. https://site.moh.ps/Content/Books/Hqgu4D5vfT6bDhDUtl36GHhx9oYlCS9JplXYDfOMKrnDt6YoDPkPdl_I6mhnD3xb5MaPpX1mx6k6J4WowTnGUc1135KRHMmuMwEi1Zh1QUmFY.pdf
14) PCBS (2022). Smoking and Tobacco Consumption Survey, 2021. Retrieved from https://www.pcbs.gov.ps/site/512/default.aspx?lang=en&ItemID=4246
15) Greaves, L., & Jategaonkar, N. (2006). Understanding the gendered aspects of smoking patterns among Canadian immigrant and refugee men: A qualitative study. Social Science & Medicine, 62(4), 1024-1036.
16) Courtenay, W. H. (2000). Constructions of masculinity and their influence on men's well-being: A theory of gender and health. Social Science & Medicine, 50(10), 1385-1401.
17) Chisholm, J. F., Goldstein, G. P., & Stober, J. (2000). Cultural factors and smoking behavior among Asian and Pacific Islander American women: A social learning theory approach. Health Education & Behavior, 27(6), 751-764.

Households reported girls being at risk of **verbal harassment**

14.1%

West Bank

14.2%

Gaza Strip

Households reported girls being at risk of **sexual harassment or sexual violence**

6.1%

West Bank

6.5%

Gaza Strip

Source: 2022 multi-sectoral needs assessment (MSNA)

Women and girls also face security concerns and limited access to safe public spaces. In the 2022 multi-sectoral needs assessment (MSNA) when asked about specific security concerns for girls, 14.1% of households (HH) in West Bank and 14.2% in Gaza, reported girls being at risk of verbal harassment and, 6.1% in West Bank and 6.5% in Gaza, reported girls being at risk of sexual harassment or sexual violence. Due to deep rooted social norms that limit the movement of girls outside the house, most adolescent girls in Gaza lead a much more sedentary life, spending much of their time at home watching TV; 7.4% of youth between the ages of 15 and 29 reported their membership in a sports club, revealing a notable gender disparity. The percentage stood at 13.8% among boys, while only 0.8% of girls reported being part of a sports club[18], which has a negative health impact as reflected by the fact that more than half of the adolescent girls in Gaza are either overweight or obese[19].

The blockade on the Gaza Strip severely affects access to specialized medical services, such as chemotherapy. Referrals and permits are required for patients to receive treatments outside Gaza, and men are more likely to have their permits rejected based on gendered notions that they are more threatening and dangerous than women or children[20]. Men between the ages of 18 and 40 years old generally have the lowest approval rates, standing at 79%, compared to 87-88% for other age and gender groups. There are also variations in approval rates depending on district and sub-district, with Jenin recording the highest denial rate of 19%, whereas Jericho has the lowest at 10%. In Gaza, from 2019 to 2021, the approval rate was lowest for men aged 18 to 45 years at 47%, while women over 60 years had the highest rate at 80%. Trends in the age and gender distribution of companion permit applications have shifted since 2012. There was a notable increase in 2018 with more applications from older females. Between 2019 and 2021, 65% of these applications were for female companions. The largest demographic of companions was women aged 41 to 60 years, comprising 36% of applications in 2021. However, this proportion has seen a decrease over the past four years, down from 42% in 2018[21].

18) Abu Hamad, B., Jones , N., & Gercama, I. (2021). Adolescent access to health services in fragile and conflict-affected contexts: The case of the Gaza Strip. Conflict and Health. https://doi.org/10.1186/s13031-021-00379-0
19) Ibid
20) UN Women. (2022). After the May 2021 Escalation: A Multi-Sectoral Gender Needs Assessment in the Gaza Strip. https://palestine.unwomen.org/sites/default/files/2022-05/D6_A%20Multi-Sectoral%20Gender%20Needs%20Assessment%20in%20the%20Gaza%20Strip_110522.pdf
21) WHO (2023). Right to Health: Barriers to health and attacks on health care in the occupied Palestinian territory, 2019 to 2021. ISBN 978-92-9274-087-0 . https://applications.emro.who.int/docs/9789292740887-eng.pdf

Water and electricity shortages due to the occupation strongly affect daily care tasks to meet household needs. This situation is exacerbated in remote areas, where access to infrastructure and basic services is already limited, leading to further marginalisation and vulnerability. Housing conditions are severely impacted by the occupation, with demolitions and escalations of violence causing many people to live in overcrowded and inadequate shelters. Additionally, the protection of civilians remains a significant concern, with ongoing violence and military operations resulting in deaths, injuries, and displacement. These challenges have a significant impact on the health and wellbeing of people, as well as their ability to access basic human rights and essential services, including health care. The situation highlights the urgent need for sustained humanitarian assistance and efforts to address the root causes of the conflict and support durable solutions for all people in the oPt.

In Area C, a total of 92,810 individuals have the opportunity to access health services through mobile clinics, which are provided by the Ministry of Health (MoH) and their partners[22]. These mobile clinics play a crucial role in providing healthcare services to various segments of the population. It is notable that there is a higher utilization of these clinics by women, the elderly, and children. To ensure accessibility for women, many of the doctors working in these clinics are women themselves. However, it is important to acknowledge that men may face lower access to these clinics. This is primarily due to the operating hours of the clinics, which often coincide with typical working hours for men.

In contexts of poverty and unemployment, gender roles can become more fluid as individuals negotiate new roles to ensure their survival. In many cases, women are forced to assume multiple roles, including that of primary breadwinner and caretaker of the family. For example, in the Gaza Strip, where

22) May 2023_Mobile Clinics Coverage 4Ws.xlsx. (n.d.). Google Docs. Retrieved May 31, 2023, from https://docs.google.com/spreadsheets/d/1GNDIKuLXYiWOfGeZQU4l6IEw5w44b8A4/edit#gid=942592086

the number of people with disabilities has grown in the aftermath of the Great March of Return, and other factors such as drug addiction, migration, and the ongoing violence have further exacerbated this situation[23].Women's increased role as primary breadwinners has highlighted the gendered impact of the conflict and the importance of addressing gender inequalities as part of any efforts to promote economic growth and development. However, this situation also places an additional burden on women, who must often navigate patriarchal social structures that restrict their mobility and limit their access to resources.

Women's caregiving responsibilities are often overlooked, undervalued, and uncompensated. On average, women do seven times more unpaid care work than men[24]. The average woman in the oPt spends 3 hours 42 minutes a day doing household work (cooking, cleaning, etc.), while men dedicate 1 hour 17 minutes for the same; women spend 2 hours 15 minutes taking care of children, the elderly or disabled family members in comparison to 57 minutes among men[25]. Men do not always provide the needed support in caregiving duties, these responsibilities take a toll on women, leading to physical and emotional exhaustion, and economic (since this care work is unpaid work) and social burdens[26].

3 Hours
42 minutes

Time spent
on **household**
chores/day

1 Hours
17 minutes

2 Hours
15 minutes

Time spent **taking care**
of children, the elderly or
disabled family members

57 Minutes

23) Gender Analysis Validation Workshop. Ramallah (2023/02/21) & Gaza (2023/03/07).
24) UN Women. (2020). The care economy in Palestine: Towards recognizing, reducing, and redistributing unpaid care work (Policy Brief No. 4). https://arabstates.unwomen.org/sites/default/files/Field%20Office%20Arab%20States/Attachments/Publications/2020/12/English_PolicyBrief_Palestine.pdf
25) PCBS. (2015). ***Average Time Spent on Various Activity for Persons Aged 10 Years and Above by Sex in Palestine for Selected Years.*** https://www.pcbs.gov.ps/Portals/_Rainbow/Documents/time%20use4.htm
26) Caputo, J., Pavalko, E. K., & Hardy, M. A. (2016). The Long-Term Effects of Caregiving on Women's Health and Mortality. Journal of marriage and the family, 78(5), 1382–1398. https://doi.org/10.1111/jomf.12332

The family is a fundamental source of support in Palestinian life. Its strength, based on cohesiveness and harmony, is crucial for Palestinians to endure the discriminatory measures imposed by the occupation, which contribute to economic hardship. The family, while providing support, also perpetuates conflicting and cooperative elements in gender relations. Family solidarity may not necessarily translate into more equitable gender relations, as conflicts and inequalities persist alongside cooperation. Factors such as economic situation and education level influence the extent of these dynamics. [27].

Addressing these challenges requires sustained humanitarian assistance, efforts to address the root causes of the conflict, and support for durable solutions. Promoting gender equality and challenging patriarchal norms are crucial aspects of achieving better health outcomes and overall well-being in the oPt.

Gender in Laws and Policies in the oPt

The Palestinian people living in the West Bank and Gaza Strip are protected under the international humanitarian law. This protection is established through the application of international humanitarian law, specifically the Fourth Geneva Convention, which safeguards the rights and well-being of individuals residing in territories under foreign military control. As an occupied population, Palestinians are entitled to the full protection of their fundamental rights and freedoms, including access to essential services, adequate health care, and a dignified standard of living. It is the responsibility of the occupying power to ensure the welfare and safety of the occupied population, addressing both their physical and mental well-being. Recognising and upholding the protected status of Palestinians under the international humanitarian law is essential for promoting their rights, safeguarding their lives, and working towards a just and sustainable resolution to the protracted crisis.

However, the Palestinian population faces numerous challenges because of the occupation. Counter-terrorism laws further restrict the activities of NGOs and INGOs, impacting their ability to provide essential health care services. The internal political fragmentation within the oPt further complicates the exercise of Palestinian rights. Moreover, the disruption of the Legislative Council has hindered the adoption of legal measures against discrimination, and the frequent use of Decree-Laws without transparency or consultations has faced criticism[28]. Women and girls in the Gaza Strip and the West Bank face multiple sets of laws, with varying levels of protection, perpetuating discriminatory practices in matters such as marriage, divorce, child custody, and inheritance. Different legal frameworks inherited from the British Mandate, Jordanian, and Egyptian laws are applied, with patriarchal customs sometimes taking precedence.

The National Policy Agenda in Palestine (2017-2022) demonstrates the government's commitment to gender equality, eliminating discrimination against women and girls, and integrating gender considerations into policies and planning. Women's civil society organisations, along with international partners, have supported these efforts to enhance gender equality and address gender-based violence. Proposed reforms to labour, family protection, and local election laws aim to align with international standards and ensure equal opportunities for women. However, some proposals have faced obstacles or fall short of global norms. The Committee on the Elimination of Discrimination Against Women (CEDAW) has identified deficiencies in Palestinian laws and called for consistency with human

27) Institute of Women's Studies - Birzeit University, UN Women and PROmundo-US. (2017). ***Understanding masculinities: Results for the international men and gender equality survey (IMAGES): Egypt, Lebanon, Morocco, and Palestine***. https://imagesmena.org/wp-content/uploads/2018/03/Understanding-Masculinities-in-Palestine-English.pdf
28) Ibid

rights treaties[29]. CSOs have highlighted that gender issues have been deprioritised by the government, leading to inadequate enforcement of protective measures and a failure to safeguard women activists[30].

Progress has been made in addressing violence against women and girls, as critical articles in the penal code applicable in the West Bank have been amended or abolished. For example, the repeal of Article 340 removed exceptions that could mitigate punishments for the so-called honour killings, and Article 99 was amended to exclude crimes against women and children from mitigation measures. Article 308, which allowed rapists to escape prosecution by marrying the victim, has been abolished. Efforts led by the Ministry of Justice, in collaboration with the Ministry of Women's Affairs and others, aim to improve the Legal Aid Law to better respond to the needs of women victims of violence. Despite these efforts, there has been no progress in the draft legal aid law, and specific laws criminalising domestic violence or providing protection have not been endorsed yet, despite advocacy from women's civil society organizations[31].

Existing legislative frameworks still contain discriminatory elements affecting women and girls, despite the prohibition of discrimination under the Amended Basic Law[32]. The Public Health Law of 2004 focuses on married mothers and child health, neglecting unmarried women, those suffering from infertility, post-menopausal women, and adolescent girls. Reproductive and sexual health issues are not comprehensively

29) UNCT in the Occupied Palestinian Territory. (2022). Common Country Analysis. https://palestine.un.org/sites/default/files/2022-09/United%20Nations%20Common%20Country%20Analysis%20for%20the%20Occupied%20Palestinian%20Territory_16_August_2022.pdf
30) WCLAC, & AL-Muntada. (2022). Joint submission report on the state of Palestine by the women's center for legal aid and counselling (WCLAC), and the Palestinian non-governmental organizations forum to combat violence against women (Al Muntada)1 , to the 85th pre-sessional working group of the CEDAW committee. https://www.wclac.org/files/library/22/11/cve0jmifw0axaakmwcslq7.pdf
31) UNCT in the Occupied Palestinian Territory. (2022). Common Country Analysis. https://palestine.un.org/sites/default/files/2022-09/United%20Nations%20Common%20Country%20Analysis%20for%20the%20Occupied%20Palestinian%20Territory_16_August_2022.pdf
32) Basic law of the Palestinian national authority. (2005). https://www.venice.coe.int/webforms/documents/default.aspx?pdffile=CDL(2009)008-e

addressed, and gender-based violence remains unaddressed. Women have the right to access health care, including family planning services, without needing permission from a legal guardian or spouse. The law grants all individuals, including women, access to essential, primary, and emergency care, with treatment plans clearly explained and patients having the right to consent or refuse care. Throughout these provisions, the patients' specific circumstances, dignity, and religious and cultural beliefs are respected.

The Palestinian Labour Law of 2000 prohibits gender discrimination in employment but lacks provisions to protect women from workplace violence, such as assaults and sexual harassment[33]. Domestic workers are not covered under the law, but some level of protection has been established through a Council of Minister's decision. However, informal workers, including domestic service and immediate family members of employers, lack legal guarantees and access to social insurance[34][35].

The retirement law of 2005 contains discriminatory provisions against women, limiting pension benefits only to their spouses under strict conditions. Men, on the other hand, have broader eligibility for pension benefits. Amendments to the law in 2022 did not address this discrimination, negatively impacting women working in the health sector and their financial security.

Pregnancy termination in Palestine is heavily restricted, with the procedure prohibited except in cases where a woman's life is at risk. The Penal Codes in the West Bank and Gaza criminalise abortion, with penalties ranging from imprisonment for women who undergo the procedure to those who assist them. Approval from the pregnant woman, her husband or guardian, and records of the procedure must be provided. Rare exceptions for abortion may be granted by the mufti in cases of rape or incest, but specific cases like raped women with mental disabilities or young girls are not addressed. The doctor cannot be forced to perform the procedure even in cases where it is allowed[36].

There is a lack of comprehensive legal protection for survivors of gender-based violence (GBV) in oPt. There is a need to introduce comprehensive laws to criminalise all forms of violence against women and provide effective remedies for survivors[37]. The stalled progression and gap left by the legislative holdup of the Family Protection Bill underlines how, in the absence of a robust legal mechanism to defend their rights, women and girls subjected to GBV may encounter scarce access to legal remedies and support services. The Family Protection Bill is key in galvanising a collective response to violence, safeguarding women, children, and families, empowering survivors, and ensuring accountability for perpetrators.

LGBT+ individuals face significant challenges and discrimination in the oPt. Same-sex relations are not criminalised in the West Bank, but they are not widely accepted religiously and socially. In Gaza, same-sex relations are punishable by up to 10 years of imprisonment[38]. LGBT+ individuals face high levels of persecution[39], with limited legal protection or social acceptance, which contributes to their limited visibility within the broader community[40].

33) ESCWA, UNFPA, UN Women, UNDP. (2019). Gender justice & the law – State of Palestine. https://www.undp.org/sites/g/files/zskgke326/files/migration/arabstates/Palestine.Summary.19.Eng.pdf
34) WCLAC, NGO Forum to Combat Violence Against Women (Al-Muntada), General Union of Palestinian Women, & AMAL Coalition to Combat Violence Against Women in the Gaza Strip. (2021). NGO Parallel Report to the Initial Report of the State of Palestine Submitted to the Committee on Economic, Social and Cultural Rights (p.13). https://www.wclac.org/files/library/21/08/r2npecpzdqt3i2rgqtdm3m.pdf
35) Report on the Status of Women and Girls in Palestine (2018) Submitted to the Committee on the Elimination of All Forms of Discrimination against Women. https://www.un.org/unispal/document/women-convention-state-of-palestine-initial-periodic-report-to-cedaw/
36) Committee on the Elimination of Discrimination against Women. (2018). Concluding observations on the initial report of the State of Palestine (CEDAW/C/PSE/CO/1). https://documents-dds-ny.un.org/doc/UNDOC/GEN/N18/238/06/PDF/N1823806.pdf?OpenElement
37) ESCWA, UNFPA, UN Women, UNDP. (2019). Gender justice & the law – State of Palestine. https://www.undp.org/sites/g/files/zskgke326/files/migration/arabstates/Palestine.Summary.19.Eng.pdf
38) *In* the West Bank, same-sex acts were decriminalized under the Jordanian Penal Code of 1951 still in force. In Gaza, however, still follows the British Mandate Criminal Code Ordinance, No. 74 of 1936
39) Amnesty International. (2022). Human rights in Palestine (State of). https://www.amnesty.org/en/location/middle-east-and-north-africa/palestine-state-of/report-palestine-state-of/
40) UNCT in the Occupied Palestinian Territory. (2022). Common Country Analysis. https://palestine.un.org/sites/default/files/2022-09/United%20Nations%20Common%20Country%20Analysis%20for%20the%20Occupied%20Palestinian%20Territory_16_August_2022.pdf

Efforts have been made to adopt a comprehensive and fair health insurance system for people with disabilities and their families in Palestine. However, accurate statistics on disabilities, including disabled women, are lacking due to the absence of a registration and documentation system. Services provided to people with disabilities are scattered, highlighting the need for better coordination between relevant government bodies to address the specific needs of disabled individuals.[41]

FINDINGS

Roles and capacities of health cluster partners to support gender responsive care provision

In general, there is a lack of clarity regarding the definition and concept of gender equality and women's empowerment. The terms "gender", "LGBT+" and "GBV" are often used interchangeably by non-experts. There is no common definition or agreement on the term "gender" and a tendency for subjective bias. The terminology itself is challenged. In addition, translations of gender terminology such as "sex" and "gender", "الجنس" and "النوع الاجتماعي or الجندر" are complicated. Many dictionaries use "الجنس", which is not widely accepted in the development and humanitarian sectors because it translates as "sex" rather than "gender"[42]. As mentioned earlier, even the definition of "discrimination" is a legislative challenge[43]. Because "gender" is understood as an issue related to women rather than a social construct that determines perceptions of masculinity and femininity, the focus of work and discussions is often exclusively on women's issues.This analysis asserts that systems and practies often discriminate against

41) Palestinian Centre for Human Rights (PCHR). (2022). On Their International Day: Persons with Disabilities in Palestine Struggle Towards Realizing All Their Rights. https://pchrgaza.org/en/on-their-international-day-persons-with-disabilities-in-palestine-struggle-towards-realizing-all-their-rights/

42) Buchhave, C.O. (2021) Translating "gender" into Arabic: "jins " , "jinsayn " , "naw'" or "jindar "? - A study of the translation of the concept "gender" in single- and multi-word expressions in feminist knowledge building. [Lund University]: https://lup.lub.lu.se/luur/download?func=downloadFile&recordOId=9068463&fileOId=9068466

43) UNCT in the Occupied Palestinian Territory. (2022). Common Country Analysis https://palestine.un.org/sites/default/files/2022-09/United%20Nations%20Common%20Country%20Analysis%20for%20the%20Occupied%20Palestinian%20Territory_16_August_2022.pdf

women and perpetuate inequality, but also that harmful stereotypes and norms affect men's behaviours in seekinghealth care. For example, young men's permits for health service referrals are the least likely to be accepted. They also face stigma when seeking mental health support services due to traditional gender roles that prescribe stoicism and emotional restraint as desirable masculine traits[44].

Different institutions have different methodologies and approaches to implement and measure gender mainstreaming[45], and this is particularly evident in the development and humanitarian aid sectors (for example, Inter Agency Standing Committee Gender and Age Marker, OECD Gender marker, ECHO gender and age marker). It is important to note that while these tools have similar objectives, their methodologies and approaches can vary significantly. Moreover, gender mainstreaming approaches can also vary between different organisations, and different people within the same organisation may have different levels of knowledge and practical understanding about how to mainstream gender.

The interviews and focus group discussions mostly agreed that gender policies exist in a theoretical framework, and there are gaps at the level of implementation. It will take time, training, follow-up, and a change in the attitudes and ideas of decision-makers and health service providers to address these gaps. Moreover, the potential to implement gender mainstreaming and gender equality policies requires gender-sensitive and responsive planning and budgeting. According to the preliminary survey, over half (52.38%) of respondents reported having a dedicated gender focal point or unit, although there were significant variations among different types of organisations. All UN agencies and the Ministry of Health reported having a dedicated person or unit, compared to only 40% of INGOs and 33.33% of national organisations. The lack of specialised staff is identified as one of the challenges to implementing cross-cutting issues and mainstreaming gender equality, particularly for national partners and INGOs. This suggests that more efforts need to be made to build the capacity of organisations at the local and national levels to effectively address gender issues in their programmes and policies.

52.48%

Respondents reported having a dedicated gender focal point of unit

Nearly all organisations state that they work on the basis of equality and non-discrimination, but few mention the use of an analysis indicating the different resources and needs of women, men, girls, and boys and those in situations of vulnerability. Out of the 40 projects submitted under the Health Cluster for the HRP 2023, 11 projects from eight organisations mentioned having used a gender analysis to frame their projects, while 17 projects considered some aspects as part of their needs analysis. Hence, equity its true sense, that is taking into account the needs of different groups in the provision of services, is not always standard practice.

In general, since there isn't a comprehensive understanding of gender mainstreaming, there is also low awareness about the usefulness and benefits of including a gender analysis for framing projects. Some NGOs noted that they

44) UN Women. (2022). After the May 2021 Escalation: A Multi-Sectoral Gender Needs Assessment in the Gaza Strip https://palestine.unwomen.org/sites/default/files/2022-05/D6_A%20Multi-Sectoral%20Gender%20Needs%20Assessment%20in%20the%20Gaza%20Strip_110522.pdf

45) Milward, K., Mukhopadhyay , M., & Wong, F. F. (2015). Gender Mainstreaming Critiques: Signposts or Dead Ends? [Institute of Development Studies Bulletin] https://opendocs.ids.ac.uk/opendocs/bitstream/handle/20.500.12413/7732/IDSB_46_4_10.1111-1759-5436.12160.pdf?sequence=1

try to at least include both men and women in all assessments and needs analysis, while some organisations carry out gender analysis since it is a part of their mandate or required by the donor. Having the funding and capacity to cover this research is also a major issue.

Most new services developed as part of certain programmes are supported by donor projects, which undermines their chance of sustainability after the cessation of support.[46] The short time frames for such projects allow for change in knowledge, but not for attitudes and practices. NGOs interviewed reported that they put in place some policies related to gender mainstreaming to receive funding from certain donors. However, the NGO landscape in the health sector is uneven. Some organisations have strong expertise in gender mainstreaming at the national level, while others specialise in service delivery, but in general there is a lack of capacity and expertise in technical areas such as gender mainstreaming and also in the overall management and funding of humanitarian projects.

Some cluster partners noted that the reliance of the cluster system on the expertise of Women Led Organisations (WLOs) in mainstreaming gender into humanitarian response can sometimes become a burden, as in most cases, this support is provided on voluntary basis[47].

The healthcare system is not always equipped to provide comprehensive services that focus on prevention, and often has a strong emphasis on curative measures. This means that there may not be enough emphasis placed on educating women about the importance of preventive measures, such as regular breast cancer screenings, proper pregnancy spacing, and safe delivery preparations. This lack of education and emphasis on prevention can lead to women not taking the necessary steps in maintaining their health and well-being, which can negatively impact the overall health outcomes.

According to this analysis there is a lack of real and effective participation of women in policy formulation. Structural inequality persists. Gender policies are often limited to a quantitative perspective such as quotas. While these kinds of measures can be useful, it is not enough. Gender policies must address social practices and norms that perpetuate patriarchal domination and inequality. Such policies will have a more long-term and influential impact on the status of women. Therefore, it is essential to address these gaps through initiatives aimed at eliminating discriminatory laws and legislation, as well as reviewing, monitoring policies, and ensuring accountability during implementation and impact.[48]

The MoH in Palestine has committed to promoting gender equality and integrating gender into its plans and actions. Its current plan includes several interventions that consider gender and age, such as establishing special departments for elderly and adolescent health, expanding early care for children, and prioritising disability and sexual and reproductive health issues. The MoH is also adopting a family approach in primary health care and improving response for and integrating services for women survivors of gender-based violence. The Ministry is working to improve the integration of gender in its work and sensitise its staff, with partners, noting that the latest strategic plan is more gender sensitive[49]. The rights-holders interviewed in focus groups (both health workers and service users) pointed out

> “There is no comprehensive integration process yet, there are only attempts to take gender into account and implement policies and action plans, but not in all health sectors.”[50]

46) Mentioned in 20% of the KIIs and validated in both validation workshops
47) Gender Analysis Validation Workshop. Gaza (2023/03/07)
48) ESCWA, UNFPA, UN Women, UNDP. (2019). Gender justice & the law – State of Palestine https://www.undp.org/sites/g/files/zskgke326/files/migration/arabstates/Palestine.Summary.19.Eng.pdf
49) Though, there is not enough information about the achievements related to these plans as the last implementation cycle ended recently (2017-2022).
50) 3 of the focus group discussions (Gaza and WB)

70%

Of the health work force in the oPt are women

- 2020

As of 2020, women represented nearly 60 per cent of workers in the care sector in the oPt and 70 per cent of frontline health workers (12,558 nurses and medics in the West Bank and Gaza Strip) [51]; yet, men enjoy much higher levels of political and community participation and engagement in the health system. A significant percentage of medical practitioners, dentists, nurses, and pharmacists are women, with 20.4%, 35.9%, 56.9%, and 63.6% representation, respectively. However, men have higher levels of political and community engagement within the health system. Women occupy two out of 14 general directorate positions (14.3%), and 6 units (30%) are led by women. Additionally, only 23.5% of senior positions at the Ministry of Health are led by women, excluding the minister (female) and the deputy and assistant deputy ministers (all male)[52]. It should be noted that not all women leading general directorates hold an official grade A4 or higher, and some are only acting directors.

23.5%

Of senior positions at the Ministry of Health are led by women

Regarding sex, Age, and Diversity Disaggregated Data (SADD) in West Bank and Gaza, the results of the preliminary survey showed that 33.32% of the partners stated that they did not face any barriers to obtaining SADD. However, others noted that the unavailability of such data at healthcare providers' level, the lack of commitment (14.28%), and the lack of a comprehensive health information system that can collect such data concisely (23.8%) posed significant barriers. The survey also found that 52.38% of organisations only sometimes analyse gender disparities in service utilisation.

The survey revealed that collecting SADD poses a variety of barriers for health cluster partners. The lack of priority given to collecting and analysing such data is a significant obstacle, and some organisations may not have consolidated disaggregated data. Limited funding can also be a significant barrier, as some organizations may lack the resources needed to generate disaggregated data. Partners and stakeholders may not always be committed to sharing disaggregated data, and inconsistent, duplicate, or irregular data can further complicate the collection process. Limited staff, incomplete or late data from health providers, and technical issues related to health information systems can also create challenges. Addressing these barriers is critical to ensure that organisations have the necessary data to design effective health programmes and policies that meet the diverse needs of all members of the community.

Gender roles and attitudes that may affect the provision of health services

The organisation and delivery of healthcare services can also have a significant impact on gender equity in health care. For instance, if health care services are not affordable or accessible, certain groups may be excluded from receiving necessary care. Additionally, if healthcare providers are not trained to recognise and address gender-based health disparities, patients may not receive the care and support they need. To ensure that all individuals have

51) UN Women (2020). COVID-19: Gendered Impacts of the Pandemic in Palestine and Implications for Policy and Programming. https://arabstates.unwomen.org/sites/default/files/Field%20Office%20Palestine/Attachments/Publications/2020/4/COVID%2019%20-%20UN%20Women%20Rapid%20Gender%20Analysis.pdf

52) Consultation with MoH (April 2023)

access to high-quality healthcare services, it is important to recognise and address the ways in which gender influences health outcomes and access to care. This requires a commitment to providing equitable, culturally sensitive, and gender-responsive health care services that are accessible to all, regardless of their gender or other demographic factors.

Most of the literature, focus groups, and participant interviews, expressed concerns regarding the coverage of the public health insurance and its services. In general, there was consensus that it is not sufficiently able to cover the needs of patients. The quality of noncommunicable diseases (NCDs) services provided through the public sector, the chronic shortage of certain medicines, the long waiting times to receive services, and the methodology of patient care, especially how health care providers interact with patients were mentioned by participants. There is a need to provide support for strengthening the supervisory and regulatory role of the Ministry of Health by enhancing accountability mechanisms, follow-up, evaluation and application of laws, legislations, health systems and health plans. According to the interviews, there is a gap between planning, implementation, and accountability.

Many people prefer private health care services, but high costs make them unaffordable, especially for those experiencing unemployment and poverty. Women are disproportionately affected due to their lower insurance rates and increased risk of poverty, which is known as the "feminisation of poverty." This economic disadvantage limits women's access to resources such as capital and collateral, leading to negative psychosocial outcomes and perpetuating the cycle of poverty[53] [54].

Particularly relevant to this analysis was the number of patients who indicated that they prefer private health care services because of the attention, care, professional treatment, and respect they receive. There are important structural reasons that affect perceptions of services including, overcrowding, heavy workload of health workers and the long waiting lists, but also the lack of awareness of service providers regarding the importance of non-discrimination, its repercussions on improving overall health and achieving justice, and

53) Christensen, MacKenzie A. (2019), "Feminization of Poverty: Causes and Implications", Gender Equality, Encyclopaedia of the UN Sustainable Development Goals, (pp. 1–10), doi:10.1007/978-3-319-70060-1_6-1, ISBN 978-3-319-70060-1
54) UN Women. (2019). Needs of women, girls, boys, and men in humanitarian action in Palestine (p. 8). https://palestine.unwomen.org/sites/default/files/Field%20Office%20Palestine/Attachments/Publications/2019/9/UNWPALCOGenderAlert2019.pdf

knowledge of the rights and needs of the most excluded groups.[55] Some participants in the focus groups highlighted situations involving shouting and cursing at women during childbirth, which in extreme cases may also lead to beating. Females in two women's focus groups stated a preference for private health care services to gain agency over child delivery and avoid the risk of obstetric violence[56].

Another example of discrimination and preferential treatment is how some service providers may give attention and distinction to relatives, friends, "well-known families" and those of high status in society[57]. Women's participation in public life and the labour market is weaker, so their network of relationships and acquaintances is affected and limited compared to men, hence, they may not find a way to speed up their access to health services like men[58]. This kind of treatment and cycle also puts women at risk of sexual harassment and abuse.

The discussion groups pointed out that the attitudes of health service providers vary according to the geographical area, their degree of awareness and social status.

> "Sometimes doctors deal with patients as slaves, and there is a kind of superiority in their behaviour. There are few who deal with patients of both sexes appropriately" [59]

A group attributed the mishandling of patients to the enormous pressure on government hospitals, saying:

> "In government hospitals doctors have good medical competencies, but there are not enough resources to meet their needs - neither space nor the equipment. The pressure on doctors is high, which often results in unacceptable behaviours with patients and families, while the private sector is a commercial sector." [60]

It has been identified that there may be areas of improvement in certain aspects of the commitment to uphold professional ethics. These ethics may underscore the importance of treating all individuals with utmost respect, preserving their dignity and privacy, and providing them with comprehensive information to ensure the provision of high-quality and culturally sensitive services. It is worth noting that some service providers may require further support in fully appreciating the significance of equality and the consideration of gender-related factors in health care delivery. Addressing any instances of mistreatment or disparities experienced by

55) Interview UN staff on 26/10/2022
56) Report of the Special Rapporteur on violence against women, its causes and consequences on a human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence (2019) A/74/137. https://digitallibrary.un.org/record/3823698?ln=en
57) Jebril, M., & Deakin, S. (2022). The political economy of health in the Gaza strip: Reversing de-development. Journal of global health, 12, 03014. https://doi.org/10.7189/jogh.12.03014
58) Buttorff, G., & Welborne, B. (2015). Working those connections: Exploring Arab women's differential access to opportunity in the Middle East and North Africa (Issue brief no. 07.17.15). Rice University's Baker Institute for Public Policy. https://www.bakerinstitute.org/research/women-and-wasta-clout-mideast
59) Male focus group – Jabalia, Northern Gaza
60) Female Focus Group - Hebron

both female and male patients can contribute to fostering an environment conducive to trust and the continuation of care.[61] Participants in the discussion groups complained about poor treatment and control by the reception staff, and their lack of sensitivity in key departments such as gynecology or the emergency departments, where asking about someone's marital status is routine practice. They also pointed out how some prioritise men for fear of their aggressiveness and to avoid any confrontation, resulting in men being treated to before women[62,63].

In light of the societal norms and cultural context in Palestine, it may be deemed more culturally sensitive to inquire about a woman's marital status rather than her sexual activity or pregnancy status. Asking a woman if she is married respects her privacy and aligns with local cultural sensibilities, potentially preventing any discomfort or offense that may be caused by more direct inquiries about personal matters. It's important to note that this practice can present its own barriers. Specifically, for younger or unmarried women, having to disclose their marital status can become an obstacle to accessing important services such as sexual and reproductive health care (SRH). It's a fine balance that needs to be struck between cultural sensitivity and ensuring equal access to critical health services for all women, regardless of their marital status.

Many participants also pointed out attitudes of superiority from some medical staff. According to the perceptions of the interviewees of both the focus group discussions and KII with health cluster partners, there is low implementation of guidelines regarding respect for dignity, non-discrimination and privacy in government hospitals and centers, though in UNRWA clinics these principles are stricter and there are more guidance and policies than in the government sector.[64]

The Ministry of Health has a code of conduct for public officials, but there isn't always training on it or signature by workers in the Ministry. They are still under the civil servant law, but training and follow-up especially among managers is encouraged[65]. The Health Strategy for the Southern Governorates states implementing the code of conduct as one of its objectives for 2021-2025. Even among Health Cluster partners, some stated they are not aware of the existence of the codes of conduct in public hospitals, only in some private clinics[66]. UNRWA has a code of conduct. The Agency strives to embody gender equality and provide services without discrimination. However, the impact of this policy and the extent to which it integrates gender, and its results need an in-depth study.

61) Interview NGO service provider 26/10/2022
62) Male Focus group - Old City –Hebron 16/11/202
63) Focus group in Tulkarem
64) Gaza Focus Group Discussions 22/11/2022
65) OECD (2016), The Implementation of the Palestinian Code of Conduct: Strengthening Ethics and Contributing to Institution-Building, OECD Public Governance Reviews, OECD Publishing, Paris, https://doi.org/10.1787/9789264256934-en.
66) NGO service provider 01/12/2022

There is room for improvement regarding the involvement of the Ministry in policies related to addressing and preventing sexual harassment, implementing reporting mechanisms, and providing protection to victims of harassment in both the West Bank and Gaza.

It is important to note that all organisations within the Health Cluster are required to adhere to internal and humanitarian community standards on preventing sexual exploitation, abuse, and harassment (PSEAH). Additionally, a toll-free helpline called SAWA is available to all humanitarian staff and individuals affected by violence, including women, men, and children, offering a secure and efficient channel for reporting incidents GBV, including, sexual exploitation and abuse (SEA) perpetrated by humanitarian actors.

> "There are cases of exploitation and abuse, regardless of its nature, and they are not addressed by official mechanisms. Rather, the discussion takes place in informal frameworks and is not officially monitored through reports. Women do not file complaints because society is closed and there is discretion, which puts them in more trouble" [67]

Regarding accountability to the people, the MoH does have a complaints department and, for example, in Gaza all level four primary health care (PHC) facilities have a focal point[68].

> "There is a complaints department in the Ministry of Health that receives complaints from male and female citizens, but the extent of citizens' knowledge about it is limited. Women are also reluctant to submit complaints to it, specifically regarding such issues as extortion or sexual harassment, for fear of scandal and lack of confidence their privacy being respected" [69].

The limited follow-up, accountability, control, and the weak existence of protection policies in health facilities, affect the performance and behaviour of health personnel[70]. This also breaches the enjoyment of health rights with dignity. There needs to be more awareness about the importance of maintaining safety, security, and confidentiality, so people can report without fear and be provided with needed protection.

The majority of those interviewed confirmed that a significant barrier is the behaviour of the health staff who are not sensitised and do not consider gender and GBV issues a priority[71]. One interviewee pointed out the dearth of knowledge about gender policies and gender equality in the health system:

> "...these issues are not familiar to us, and I do not know if there are policies; they may be generalized in some hospitals, but from my experience, these policies are not generalized at all." [72]

Another example is the lack of knowledge about the existence of referral mechanisms and institutions that care for GBV survivors and provide services to them. The MoH has worked towards the implementation of GBV referrals since 2016. Recently they have prepared a booklet with a mapping of GBV focal points, and the training of trainers is improving acceptance in clinics. Not all staff are aware of the system, but the numbers are increasing. The problem is not only the issue of trusting the health staff and their attitudes, but also the referral to other institutions, such as the police, and lack of trust in them[73].

There is a challenge associated with monitoring, accountability, follow-up of implementation and lessons learned. There is very low belief and ownership regarding gender issues, and

67) UN staff, interview on 20/10/2022
68) Gender Analysis Validation Workshop – Gaza 7/03/2023
69) NGO worker, on 03/11/2022
70) AMAN Transparency Palestine. (2022). The national health strategy and its response to combating corruption in general and gender-based corruption (No. 239). https://www.aman-palestine.org/en/reports-and-studies/18881.html
71) Reported in 13 KII, 4 focus groups and the validation workshops. It is notable that all the female focus groups mentioned this, plus the focus groups of male rights-holders in Gaza.
72) Interview NGO service provider WB 7/11/2022
73) Gender Analysis Validation Workshop – Ramallah 21/02/2023

they are considered costly compared to other health issues. There are still gaps in the provision of appropriate health services for some of the most vulnerable people, such as people living with disabilities. Gender integration and the modification of ideas and concepts needs time. There has been a considerable interruption of funding in the last two years due to the Palestinian and the Middle East and North Africa (MENA) regional context. This affects the implementation of projects, many of which are humanitarian rather than developmental. This affords them a short life span, affecting the volume and scope of activities. The problem is also related to the sensitivity of decision-makers and service providers. Training is required to increase the sensitivity of health workers.

THE IMPACT OF GENDER NORMS, ROLES AND RELATIONSHIPS ON HEALTH NEEDS

Sexual and reproductive health and rights (SRHR)

Under the international human rights law, women are entitled to reproductive health care services and goods, and faci lities that are available in adequate numbers, accessible physically and economically, accessible without discrimination, and of good quality[74]. Despite these obligations, violations of women's sexual and reproductive health care rights are frequent worldwide. These violations take many forms, including denial of access to services only needed by women, poor quality of services, making women's access to services subject to third-party authorisation, and undertaking actions related to women's sexual and reproductive health without their consent. This includes forced sterilisation, forced virginity testing, and forced abortion.[75] Early marriage and early pregnancy, or recurrent pregnancies at very close intervals have a devastating impact on women's health with sometimes fatal consequences. Women are also often blamed for infertility, ostracised, and subjected to various human rights violations as a result.[76]

74) Office of the United Nations High Commissioner for Human Rights. (n.d.). Sexual and Reproductive Health and Rights. Retrieved May 8, 2023, from https://www.ohchr.org/en/women/sexual-and-reproductive-health-and-rights
75) UN Committee on the Elimination of Discrimination Against Women (CEDAW). (1999). CEDAW General Recommendation No. 24: Article 12 of the Convention (Women and Health). A/54/38/Rev.1, chap. I. Retrieved from https://www.refworld.org/docid/453882a73.html
76) UNFPA. (2017). World's Apart: Reproductive health and rights in an age of inequality (The State of World Population). https://reliefweb.int/report/world/state-world-population-2017-worlds-apart-reproductive-health-and-rights-age-inequality

Those interviewed, whether from health institutions or from focus groups with rights-holders, mentioned the impact of culture and society that perpetuates patriarchal authority over the rights and entitlements of women, inhibits the decision-making power and health-seeking behaviour among women's care utilization. For example, during the validation workshop in Gaza, it was reported that contraceptive use needs to be a shared agreement with the husband, in some cases, the husband has to be present when providing contraceptives to the woman.

Family planning services are available to clients at MoH facilities regardless of whether they have medical insurance or not, with a minimal co-payment charge. UNRWA centres in the West Bank and Gaza provide free family planning services. However, despite the availability of these services, the usage of modern contraception methods remains lower than in other countries in the region, with 59.4% of married women in reproductive age using some form of contraception as of 2020. Of this group, 16.6% use traditional methods and 42.8% use modern methods[77].

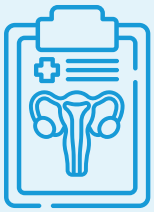
> Family planning is often initiated late, only after the fourth or fifth child and after having a satisfactory number of children/boys[78].

The unmet need for family planning increased from 10.9% in 2014 to 12.9% in 2019. Comprehensive and readily available SRH services remain a challenge, and the supply chain and commodity security have weaknesses, leading to frequent stockouts at MoH stores[79]. Additionally, there are insufficient financial and human resources for family planning services. Two out of the five essential family planning supplies, namely progesterone only pills and male condoms, were not available in stock at MoH and UNRWA clinics in Gaza for much of 2019[80]. After the GMR (Great March of Return) protests in Gaza in 2018, condoms were blacklisted by Israel and unavailable in the Gaza Strip for around 2 years[81]. This shortage of family planning supplies and contraceptive methods, along with other factors such as the unmet need for family planning, limited access to comprehensive SRH services, and insufficient financial and human resources for family planning services, compromised maternal and child health outcomes in the Gaza Strip. The protracted crisis has also impacted SRH services, including maternal health services in the oPt, resulting in a range of challenges from duplication of services to shortage of equipment and supplies and restricted mobility.

Despite the progress made in reducing maternal mortality since the early 1990s, there has been a recent decline. Following the record low in 2017 at 5.9 deaths per 100,000 live births, there has been a gradual escalation in the maternal mortality ratio. This includes a substantial surge of 67 per cent from 2020 to 2021, elevating from 28.5 to 47.7 per 100,000 live births, an increase partly associated with the effects of COVID-19. Roughly 78 per cent of maternal fatalities in 2020 were deemed avoidable, given the presence of prompt standardised obstetric care and appropriate interventions during the preconception, antenatal, and postnatal stages. Even though more than 99 per cent of women give birth in a health care facility under the supervision of trained medical professionals, there are approximately 94,000 Palestinian women of childbearing age living in extremely marginalized areas who continue to be neglected, facing a

77) PCBS. (2020). Selected Mother and Child Health Indicators. https://www.pcbs.gov.ps/Portals/_Rainbow/Documents/mother-child2000-2020-03E.htm
78) UNFPA (2019). Assessment of the Family Planning Situation in Palestine. Retrieved from https://palestine.unfpa.org/sites/default/files/pub-pdf/FP-Study-Final-Ver-Sept19.pdf
79) UNFPA (2022). State of Palestine: Country Programme Document 2022-2026. Retrieved from https://palestine.unfpa.org/sites/default/files/pub-pdf/dp.fpa_.cpd_.pse_.7_-_palestine_cpd_-_final_-_5dec22.pdf
80) UN OCHA. (2019). Mothers at risk: Limited access to medicine and family planning services compromises maternal and child health. OCHA oPt. https://www.ochaopt.org/content/mothers-risk-limited-access-medicine-and-family-planning-services-compromises-maternal» \l «ftn3» \t «_blank
81) The Jerusalem Post . (2020). Gaza terror: How condoms became a weapon against Israel. https://www.jpost.com/arab-israeli-conflict/incendiary-balloons-launched-from-gaza-are-often-condoms-616619

dearth of access to sexual and reproductive health services. Persistent apprehensions remain regarding the standard of care, particularly emergency obstetrics, coupled with inadequate compliance with service standards and hospital protocols within health care establishments. This is partly attributed to ineffective regulation[82].



94 000

Palestinian women of childbearing age living in extremely marginalized areas face a dearth of access to sexual and reproductive health services

High fertility rates could be related to many factors, including culture, the socio-economic situation, education, politics, and religion. However, patriarchal notions of women's roles within the family mean that women are often valued based on their reproductive ability, encouraging fertility, and having many children, especially in the most traditional and religious contexts[83]. While the total fertility rate continues to decline, at 3.8 children per woman in 2019, compared to six in 1997, it is still one of the highest in the region.

There is a culture of shame about raising sexual issues that may prevent adolescent girls and boys from accessing services. In addition, there is also a lack of health facilities catering to them and young people in general. Youth-friendly centers are still limited and not generalised, and some have pointed to the stigma when visiting reproductive and sexual health services, specifically in rural or more isolated areas.[84] Young people receive little or no information at school regarding bodily and psychological changes that they experience during puberty, however, there are efforts under the MoH Adolescent Strategy to include this in school curricula.[85]

Customs, norms, and traditions tend to rule over access to SRHR. Ignorance and lack of awareness of SRHR issues is an obstacle to the request and access to services. Sexually transmitted infections (STIs) remain mostly unreported either because of stigma or because of the lack of a comprehensive and age appropriate SRHR education. Some tests are hardly ever available, such as HPV or gonorrhoea[86]. Moreover, there is no accurate reporting and data. For example, the annual report used a syndromic approach to cover this issue i.e., vaginal discharge might be counted as a sexually transmitted infection (STI). Under the MoH SRHR strategy for 2018-2022, there are plans to work on improving STI screening and services[87], having developed a new STI strategy and updated the protocol for STIs in 2022.

In addition to the overcrowding in hospitals and maternity wards, specifically in Hebron, which is the largest governorate based on population size, a participant of the focus group talked about her experience in the maternity ward and said,

> "In the maternity ward, for example, there is blood and extracts (placenta) on the floor. According to my experience during childbirth, these are not well cleaned. The maternity ward is indescribable... We were three in one room" [88]

82) UNFPA (2022). State of Palestine: Country Programme Document 2022-2026. Retrieved from https://palestine.unfpa.org/sites/default/files/pub-pdf/dp.fpa_.cpd_.pse_.7_-_palestine_cpd_-_final_-_5dec22.pdf
83) UNFPA (2019). Assessment of the Family Planning Situation in Palestine. Retrieved from https://palestine.unfpa.org/sites/default/files/pub-pdf/FP-Study-Final-Ver-Sept19.pdf
84) NGO Staff – West Bank. Interview conducted on 22/11/2022
85) Validation workshop in Ramallah.
86) Consultation with MoH.
87) Ministry of Health Palestine. (2017). National Reproductive Health Strategy. https://site.moh.ps/Content/Books/kPjNja4GhFYwgaY98s9rQBen7Vnn2poe4yWGVPhTEZ8Nu6SrPY4DED_njgr6oa3k6xFltgtsjvOtOVjxEvwzepckDDJVJy7aPUHy2z6eUTWoQ.pdf
88) Female focus group – Hebron.

SRHR projects should embrace a life-cycle approach, taking care of women's health prior and beyond the reproductive age. Single women also need SRHR services and guidance, there is no recognition of their needs and a huge social stigma, which makes them embarrassed to reach clinics that provide SRH services. The specific needs of menopausal and post-menopausal women are also areas of work that require further attention, though afforts are shifting. The MoH published its menopause guidelines in collaboration with UNFPA[89], however, since this is a recent policy, follow up is needed in terms of implementation and adherence of providers to this protocol.

Currently, work is underway to strengthen reproductive health, sexual health, and maternal and child health in the Gaza Strip. An initiative is being implemented by three UN agencies, in collaboration with local partners and the MoH. The primary goal of the project is to enhance reproductive health services for mothers in hospitals and child health services in primary care. The project also aims to provide therapeutic counseling to women who may need it to ensure a positive childbirth experience. The MoH has shown its commitment to this cause by developing the National Strategy for Reproductive and Sexual Health 2018-2022. This strategy has three main objectives:

1. Ensure the provision and access to high-quality reproductive and sexual health services.
2. Enhance the level of reproductive and sexual health across different stages of life through community awareness, adoption of healthy behaviors and preventive care.
3. Enhance the sustainability and governance of the sexual and reproductive health sector.

The West Bank and the Gaza Strip face challenges in fertility control due to misconceptions, limited contraceptive options, and male involvement in decision-making. To expand women's options, it is crucial to inform male community members

89) Ministry of Health and UNFPA (2021) Menopause Guidelines. https://palestine.unfpa.org/en/publications/ministry-health-menopause-guidelines

about contraception. Increasing the availability of long-acting reversible contraceptives like hormonal IUDs and implants can help reduce unintended pregnancies and maternal deaths. Access to a diverse range of contraceptives is essential for quality family planning and universal rights-based voluntary family planning. Involving men in family planning programmes is crucial for gender balance and promoting greater gender equity in contraceptive practice. Barriers such as method-related dissatisfaction, flaws in services, false views, and lack of male partner support need to be addressed. [90]

Gender-based violence (GBV)

GBV inflicts severe immediate and long-lasting effects on one's health and wellbeing, leading to physical harm, mental health disorders such as depression and anxiety, and in extreme cases, death. GBV also correlates with adverse SRH outcomes, such as increased unintended pregnancies, miscarriages, unsafe abortions, stillbirths, and intrauterine hemorrhages. There are instances where GBV manifests in the form of imposed or coerced family planning. GBV's repercussions often span generations, with children exposed to or victims of violence more prone to perpetrate or experience violence in their later years. Research suggests that boys who've encountered violence are thrice as likely to be violent towards their partners.[91]

In the oPt, around 1.9 million people are exposed to or are experiencing GBV, with 80 per cent being women, and 65 per cent residing in Gaza. [92] Violence against women (VAW) saw a rise during the COVID-19 pandemic, evidenced by a 57 per cent surge in helpline calls related to violence[93].

57%

Increase in helpline calls related to violence during the COVID-19 pandemic

The 2019 Violence Survey revealed that 59% of women experience violence from their intimate partners[94]. Disproportionately, women and girls with disabilities encounter a variety of psychological, social, and physical violence. They endure humiliation, deprivation, and mistreatment at home and in society, suffering from discrimination, exclusion, abuse, isolation, and a lack of inclusion in family or public events, heightening their vulnerability to violence in comparison with other social groups[95].

Multiple factors contribute to GBV including, patriarchal societal norms, social policing, acceptance of violence, economic and psychological stress, correlations between food insecurity and domestic violence/intimate partner violence, women's restricted mobility, and substance abuse.[96] The MICS 2019/2020 discovered that 16 per cent of women believed husbands beating their wives was justified. Children across the oPt are frequently victims of violence at home, with 90 per cent subjected to some form of violent discipline.[97]

The National Referral System in the West Bank was developed as an encompassing framework for referring women survivors of violence within the social/legal/health services in the civil and government sectors. The updated system was approved and launched in December 2022,

90) UNFPA, & Palestinian Ministry of Health. (2023). ***Family planning method mix in Palestine – Challenges and opportunities*** . https://palestine.unfpa.org/sites/default/files/pub-pdf/unfpa_family_planning_method_mix_study_2023.pdf
91) Violence against women. (n.d.). Retrieved May 15, 2023, from https://www.who.int/news-room/fact-sheets/detail/violence-against-women
92) UN OCHA oPt. (2023). Humanitarian Needs Overview (HNO). http://www.ochaopt.org/content/humanitarian-needs-overview-2023
93) UN Women (2020). Rapid assessment on covid-19 and domestic and family violence services across Palestine. https://palestine.unwomen.org/en/digital-library/publications/2020/5/rapid-assessment-on-covid-19-and-domestic-and-family-violence-services-across-palestine
94) PCBS. (2019). Violence Survey in the Palestinian Society. https://www.pcbs.gov.ps/site/lang__en/699/default.aspx
95) Humanity and Inclusion (2023) Preparedeness Rapid Needs Assessment (RNA) report.
96) International Alert. (n.d.) Preventing gender-based violence Retrieved May 15, 2023, from https://www.international-alert.org/expertise/preventing-gender-based-violence/
97) UN OCHA oPt. (2023). Humanitarian Needs Overview (HNO). http://www.ochaopt.org/content/humanitarian-needs-overview-2023

and officially published in March 2023[98]. The procedures aim to promote effective cooperation between partners to deliver urgent services like counselling, legal aid, emergency protection, and medical treatment, along with enhancing the service providers' capabilities.

The MoH included a goal in its 2017-2022 strategy to develop a programme addressing VAW and institutionalise and implement the national referral system. Significant advancements have been made in the provision of specialized GBV services in the West Bank. The number of family counseling clinics/rooms has increased four-fold, from 8 to 32, and there are now 60 GBV focal points in hospitals, primary health care (PHC) centres, and district offices. Furthermore, Al-Shifa Hospital in the Gaza district established a GBV room, and the number of GBV focal points rose from 17 to 30.

In the West Bank, eight forensic doctors and 23 specialised nurses are engaged in medico-legal investigations and the provision of GBV-sensitive services through three forensic clinics in MOH hospitals. In Gaza, two forensic doctors and a "virginity committee" comprising four female gynecologists and obstetricians address sexual violence, including rape. However, four out of five districts in Gaza lack GBV rooms and specialised teams.

The response services of GBV teams and clinics were disrupted by the shift in focus to the COVID-19 pandemic response. Additionally, further support and specialisation are required for the forensic medical team in Gaza.[99].

The MOH has made efforts to improve accessibility of GBV services for women and girls with disabilities in the West Bank. However, female survivors of GBV continue to face challenges in accessing services outside of working hours at PHC centres and district offices. Additionally, although GBV survivors are exempted from first aid fees and medical report costs thanks to ministerial decisions, there is a need for further improvement in terms of follow-up treatment, forensic examination, and medico-legal reporting, as these services still require payment[100]. The Ministries of Women and Social Development have joined forces in this endeavour, with the MoH integrating violence education into its health and school programmes.[101] UNFPA and WHO have primarily focused on strengthening the MoH's response to GBV, providing training to health workers and supporting the implementation of The National Referral System for Women survivors of violence and WHO guidelines for CMR. However, there's a pressing need for improvement given the underreporting of GBV cases, suggesting that services need to be more survivor-oriented. Less than 2% of these women seek help[102], often due to stigma, lack of awareness about available services, and fears over safety. Addressing these barriers is crucial to support survivors and reduce the prevalence of intimate partner violence.

Health service integration is taking place to improve the availability of essential care for survivors like co-locating mental health care services into primary health care facilities. Training and capacity building of MoH staff on GBV issues reached 300, although it remained introductory[103]. Data collection and reporting transitioned from paper forms to an electronic system, Al-Marsad, which allows for improved

98) Issue no.200 of the Official Gazette (Palestinian Gazette) (2023). https://lab.pna.ps/ar/Category/20/%D8%A7%D9%84%D8%AC%D8%B1%D9%8A%D8%AF%D8%A9-%D8%A7%D9%84%D8%B1%D8%B3%D9%85%D9%8A%D8%A9-#close
99) UNFPA. (2022). Review of health, justice and police, and social essential services for women and girls survivors of violence. https://palestine.unfpa.org/sites/default/files/pub-pdf/review_of_health_justice_and_police_and_social_essential_services_for_women_and_girls_survivors_of_violence.pdf
100) Ibid
101) MoH staff
102) PCBS. (2019). Violence Survey in the Palestinian Society. https://www.pcbs.gov.ps/site/lang__en/699/default.aspx
103) UNFPA. (2022). Review of health, justice and police, and social essential services for women and girls survivors of violence. https://palestine.unfpa.org/sites/default/files/pub-pdf/review_of_health_justice_and_police_and_social_essential_services_for_women_and_girls_survivors_of_violence.pdf

data standardisation and security. However, the GBV data collection was impacted during the COVID-19 pandemic, shifting to a different data set - the OCHA reporting mechanism 5Ws tool.

In 2022, a collaborative effort funded by the Haya Programme and involving UNFPA, WHO, UNODC, and the Women's Health and Development Department (WHDD) at the MoH, aimed to implement the CMR training programme. The programme trained 75 social and health service providers, with 30 individuals receiving Training of Trainers (ToT) sessions. It focused on enhanced the clinical management of rape cases, providing psychosocial support, and improving case identification through the national referral system. This initiative aimed to strengthen the skills of service providers in addressing the needs of GBV survivors.

The MoH has increased its commitment to address GBV at the policy level. GBV protection was incorporated into two key health frameworks (revised internal GBV referral guidelines and updated CMR standard operating procedures (SoPs) in the West Bank), while a free-of-charge policy for GBV health services was adopted, currently awaiting endorsement. Efforts were also made to institutionalise GBV initiatives and interventions in the health sector, including establishment of a GBV Steering Committee in Gaza.

Despite these strides, various challenges persist. The implementation of policies is inconsistent, especially in Gaza. There's a lack of a clinical management of rape protocol, and mental health policies have not been sufficiently prioritised. Women's mandatory reporting to the police is legally binding, which discourages them from seeking help due to potential social stigma and fear. COVID-19 has caused a shift in focus, further interrupting GBV services.

Services are limited and gaps in infrastructure persist, particularly in Gaza. Training and staffing are not sufficiently regular or professional, and funding is highly dependent on sporadic external sources. Finally, the data collection form needs to be revised for confidentiality, and an information-sharing protocol has yet to be established. Overall, although significant progress has been made, more needs to be done to address GBV effectively, especially in terms of resources, specialised training, data management, and policy implementation[104].

104) UNFPA. (2022). Review of health, justice and police, and social essential services for women and girls survivors of violence. https://palestine.unfpa.org/sites/default/files/pub-pdf/review_of_health_justice_and_police_and_social_essential_services_for_women_and_girls_survivors_of_violence.pdf

All interviewees highlighted the pervasive social stigma associated with seeking help from centres providing services to survivors, as well as the fear of divorce and loss of children. Women are hesitant to report violence until it escalates to a high-risk level, often reaching hospitals or health services with severe harm[105]. The Ministry of Women has documented that the failure to report violence against women undermines all efforts to combat it, in addition to community and family interference that resolves issues at the expense of women's rights.[106]

> "Stigma is a major barrier in requesting for and receiving services, and when it comes to gender-based violence. Women are certainly ashamed to seek help for fear of potential social stigma. One of the reasons why we decided to work in safe spaces, which are rooms where we provide psychological, social, and legal advice to women, is to avoid social stigma. Hence, we make sure that these safe spaces are inside the health centres. It makes it seem like women are coming to receive general health care services, while in reality they are coming for social, psychological, or legal service" [107]

> "190,000 people have signed a petition that calls for killing the Rafah girls who fled their home, which means that social customs and traditions still exist, and that it is necessary to work in a different way by including boys and men in issues linked to gender-based violence" [108]

According to focus group discussions, GBV is predominantly viewed as a family matter. The 2019 Domestic Violence Survey revealed that women initially turn to their families in the event of violence, with the family often controlling whether she can seek external service, and sometimes preventing her from doing so. Although the percentage of women approaching the police and relevant civil institutions has increased, the rates remain low due to the stigma associated with using these services. A woman often faces blame if she's abused by her husband and files a complaint against him. There is also a high fear of stigma or scandal if women approach service providers, as they fear those providing the service might not maintain confidentiality or blame the victim.

Most institutions and facilities provide services in cities, with only five sheltering services present in the West Bank and Gaza Strip.

> Currently, there are five shelter services in the West Bank and the Gaza Strip. These are the Mehwar Centre, Nablus Safe Home, Jericho Shelter in the West Bank, and the Hayat Centre and Aman Centre (Safe Home) in Gaza.

Rural areas lack easy access to services due to limited operating hours in Area C and access issues. Safe spaces for women are also few and not available in all governorates.

As mentioned in the previous section, the behaviours and attitudes of service providers, their sensitivity to GBV survivors, their attitudes towards GBV issues, their abilities to create trust, respect for privacy and confidentiality are all factors that enhance or prevent access to services. There is a lack of capacity building in the detection of GBV cases and sensitivity, with many cases remaining undetected. Moreover, it is a bit early to evaluate the implementation of GBV services in the MoH, as this is still fairly recent (it was formally agreed by the Cabinet in 2013 and implementation started in 2016). There's still a need to enhance the experience and work on the ideas, beliefs, and attitudes of health service providers to promote appropriate and sensitive handling by all technical and administrative staff. The absence of laws that protect health service providers from backlash contribute to their fear ofintervention.[109]

105) Interview with NGO staff.
106) Ministry of Women Palestine. (2019). National report on Beijing + 25 accomplishments, challenges and procedures. https://www.unwomen.org/sites/default/files/Headquarters/Attachments/Sections/CSW/64/National-reviews/Palestine-en.pdf
107) NGO staff, WB on 22/11/2022
108) UN Staff on 26/10/2022
109) Interviews NGO service providers, both in Gaza ad WB 7/11/2022 and 10/11/2022

Mental health

To date, every 15-year-old Palestinian has lived four wars, including the most recent in May 2021 and the escalation in Gaza in May 2023. Such high levels of violence are likely to have long-lasting and traumatising effects on the population. The burden of poor mental health resulting from this trauma is significant and has a crippling effect on the rest of society.[110] According to a study conducted by MdM-France and AIDA in 2021, around 60% of Palestinians surveyed expressed a sense of helplessness when it comes to protecting their families from attacks by settlers and demolitions. The respondents indicated that feeling safe at home and having access to education were their primary aspirations.[111]

Living in areas of confinement and occupation can have severe consequences on mental health, resulting in conditions such as PTSD, anxiety, mood changes, agitation, disobedience, sleeplessness, and other issues[112]. Children are particularly vulnerable, with approximately 54% of boys and 46.5% of girls aged 6-12 experiencing mental health or behavioural problems, including permanent disabilities from physical injuries sustained during conflicts or bombings. This leads to harmful coping mechanisms and

Children aged 6-12 years **experiencing mental health or behavioral problems**

Boys **54%**

Girls **46.5%**

in the levels of mental disorders amongst the population of the Gaza Strip, especially among children, many of whom were already in need of mental health services and psychosocial support.[116] This came on top of the 2021 escalation in Gaza which had already left difficult feelings of fear, anxiety, insecurity, and heightened worries about protection, loss of hope in life and the expectation of death at any moment as expressed by all women and girls participating in the 2022 MSNA. They stated that they still felt insecure and afraid even after the cessation of the violence. Displaced, wounded, disabled, and widowed women were the most fearful.[117] The increasing violence in the West Bank is also causing similar effects.

110) Aghajanian , A., & Finn, A. (2022). The importance of measuring mental health in trauma-exposed populations: The case of West Bank & Gaza. World Bank Blogs - Arab Voices. https://blogs.worldbank.org/arabvoices/the-importance-of-measuring-mental-health-in-trauma-exposed-populations-the-case-of-west-bank-gaza
111) Médecins du Monde. (2022). No peace of mind—Palestinian mental health under occupation. https://reliefweb.int/report/occupied-palestinian-territory/no-peace-mind-palestinian-mental-health-under-occupation-june-2022
112) Thabet, A.A.M., Abed, Y., & Vostanis, P. (2004). Comorbidity of PTSD and depression among refugee children during war conflict. Journal of Child Psychology and Psychiatry and Allied Disciplines, 45(3), 533–542. https://doi.org/10.1111/j.1469-7610.2004.00243.x
113) Khamis, V. (2008). Post-traumatic stress and psychiatric disorders in Palestinian adolescents following intifada-related injuries. Social Science & Medicine, 67(8), 1199–1207. https://doi.org/10.1016/j.socscimed.2008.06.013
114) Al-Tell, M. (2019). Factors associated with antenatal depression in Palestinian Refugee Camps in West Bank/Palestine: A cross-sectional study. Global Journal of Reproductive Medicine, 7(3), 50–56. https://doi.org/10.19080/gjorm.2020.07.555712
115) Sheikh Shoib, A., Gupta, A., Saleem, S. M., Shellah, D., Javed, S., & Handuleh, J. I. M. (2021). Mental health in Palestine amid war and COVID-19 pandemics. Asian Journal of Psychiatry, 66, 102909. https://doi.org/10.1016/j.ajp.2021.102909
116) UN News. (2022). One third of Gaza Strip population in need of psychological and social support https://news.un.org/en/story/2022/09/1125712
117) Women's Affairs Center and the United Nations Population Fund (UNFPA) 2021.Report identifying urgent and urgent needs of women and girls after the May 2021 aggression

Among some of the harmful coping mechanisms, many young people in Gaza––especially adolescent males––are addicted to Tramadol, an opioid painkiller, which has also been reported to affect large a proportion of the population. Of the young people aged 15–29 in Gaza, 53% of girls/young women and 56% of boys/young men report drug addiction and unhealthy lifestyles as their biggest health challenge.[118] [119] In the aftermath of the GMR, many people became accustomed to using it as medicine and eventually developed an addiction. Its use is also increasing in other areas, such as East Jerusalem and H2[120].

There is generally a social stigma attached to seeking mental health services. This is due to a range of cultural, social, and religious factors that contribute to the perception that seeking help for mental health issues is a sign of weakness or a lack of faith. Men who seek help for mental health issues may be seen as less manly or less capable of handling stress and adversity. In many cases, women may be viewed as weak or unstable when seeking mental health services and may face social consequences as a result.

Most participants perceived that the stigma of mental health is gendered[121] [122]. However, mental illness or disability are also hidden, and sometimes women do not go to seek services for fear of people knowing about her disease or condition[123]. Men often feel out of the mental health support frameworks and do not see complaining as acceptable, often they do not seek mental health services because of harmful masculine attitudes, or maybe go to private centres so it does not appear on their medical history. There are people with psychological issues who are unable to or not allowed to leave their homes for fear of being called "crazy" or for fear of social stigma. This is especially true if the patient is female and has sisters as families prefer to hide the disease so as not to affect marriage prospects of their other daughters. Interviewees also reported knowing people with disabilities who have been confined and neglected in isolated rooms for many years.

Women are often expected to take on most of the caregiving responsibilities within their families, including caring for children, elderly family members, and sick family members. This expectation can lead to increased anxiety for women, as they may feel overwhelmed and overburdened by the demands of such caregiving roles. However, the root cause of this anxiety is not solely due to cultural expectations but is also influenced by broader social conditions and gender stereotypes. Physical symptoms may be considered more acceptable or legitimate than mental health symptoms. As a result, people may present physical complaints that are actually related to mental health issues. Women in particular may experience gender-specific stress and discrimination, which can exacerbate mental health issues and lead to somatisation of symptoms. Unfortunately, in some cases, health care providers may overlook or dismiss mental health issues as the cause of these physical symptoms, leading to inadequate treatment and management of mental health conditions. [124].

The health care system in Palestine faces a significant challenge in addressing the escalating mental health crisis. An underlying issue is the insufficient prioritisation of mental health, particularly during periods of crisis. There is a tendency to fund interventions focused on physical health, considered more tangible and immediate, thereby overlooking the importance of mental health and psychosocial support. There is an urgent need to acknowledge the necessity

118) Abu Hamad, B., Jones , N., & Gercama, I. (2021). Adolescent access to health services in fragile and conflict-affected contexts: The case of the Gaza Strip. Conflict and Health. https://doi.org/10.1186/s13031-021-00379-0
119) Abu Hamad, B., Gercama, I., Jones, N., & Abu Hamra, E. (2017). No one told me about that: Exploring adolescent access to health services and information in Gaza. Gender and Adolescence Global Evidence (GAGE).
120) Gender Analysis Validation Workshop. Ramallah (2023/02/21) & Gaza (2023/03/07).
121) This was discussed in 9 KII and 4 of the focus group discussions, both in the West Bank and Gaza, and both validation workshops in the West Bank and Gaz
122) Gender Analysis Validation Workshop. Ramallah (2023/02/21) & Gaza (2023/03/07).
123) This was mentioned explicitly in two KII, two of the focus group discussions and the two validation workshops
124) Gender Analysis Validation Workshop. Ramallah (2023/02/21) & Gaza (2023/03/07).

of prioritising funding to enhance mental health services, develop workforce knowledge, and construct sustainable resources throughout the health care system at both donor and response levels. Additionally, social stigma surrounding mental health within the Palestinian society needs to be addressed, advocating at both community and service provision levels to ensure secure, reliable, and easy access to mental health and psychosocial support services (MHPSS).

In the face of mounting need, the mental health care system urgently calls for reform. This system, currently under-resourced, under-developed, and frequently inaccessible to those in need, requires significant bolstering in terms of funding, human resources, and improved referral systems. The chronic shortages of medications and the weakening social service structures, which are integral to enhancing accessibility, require strengthening and development. Cross-sectoral humanitarian interventions are critically needed to support community mental health services, including psychosocial rehabilitation services for survivors of GBV. Prioritising the integration of mental health into existing health facilities, such as primary health care facilities and general hospitals, is necessary. Furthermore, building on children's and communities' resilience and positive coping mechanisms, strengthening school mental health, and developing a comprehensive suicide prevention strategy to enhance detection, treatment, and referral to specialized services for suicide attempts are crucial steps in fortifying the mental health landscape in the oPt.

In emergency situations, limited resources often mean that only basic services can be provided. However, there is a growing recognition that mental health support should also be a priority during crises. This includes integrating Mental Health Gap Action Programme (MhGAP) into primary healthcare and providing Psychological First Aid (PFA) training. Unfortunately, people with severe mental health disorders often do not have access to specialised services during emergencies, and may not receive psychotropic medication in a timely manner, which can lead to increased agitation and relapses[125].

The participants of the validation workshops also noted that there is very low awareness about postpartum depression. It is not seen as a priority and not socially accepted, due to several reasons such as feeling of not meeting religious or societal expectations, unemployment, a poor relationship with the husband's family, and lack of understanding of postpartum depression as a valid psychological ailment.

Overall, while the specific nature and intensity of stigma may differ somewhat between men and women, it is clear that mental health stigma is a significant barrier to care for both genders in the oPt. As such, efforts to promote mental health awareness and reduce stigma are essential for improving access to care for all Palestinians.

Trauma and emergencies

The 'tyranny of the urgent' in the post-disaster context means that gender is likely to be reduced to a lower priority, resulting in gender being overlooked in the emergency response[126] [127]. However, gender identities and roles play a crucial role in shaping people's experiences and vulnerabilities during emergencies, influencing their access to resources, protection, and decision-making. Unfortunately, when resources are limited, allocations for non-emergency are first to be cut, further exacerbating gender disparities. Studies have shown that sex

125) OCHA oPt. (2021). The deterioration of the mental health situation in the Gaza Strip. Retrieved from https://www.ochaopt.org/content/deterioration-mental-health-situation-gaza-strip#ftn_ref14
126) Kottegoda, S. (2011). Mainstreaming Gender in Disaster Management Policy: Key issues and Challenges in the Asia-Pacific Region. Retrieved April 8, 2013, from http://www.apww-slwngof.org/index.php?option=com_content&view=article&id=88:mainstreaming-gender-in-disaster-management-policy-key-issues-and-challenges-in-the-asia-pacificregion&catid=10:news&Itemid=17
127) However, during the validation workshops, some organisations part of the cluster noted how they are working to improve the inclusion of gender in their emergency planning.

differences exist in access to trauma care, with men often receiving better outcomes in the pre-hospital setting. [128] This could be due to perceived differences in injury severity, assumptions about the likelihood of benefiting from trauma centre care, or subconscious gender bias.[129]

In the oPt context, men tend to be disproportionately affected in emergencies and mass casualty incidents because they are more likely to be involved in protests and confrontations with security forces. In conflict settings, men are often more likely to be seen in public spaces due to gendered notions of protection and masculinity. Societal expectations that men should assume the role of protectors and defenders may lead them to venture into public areas despite the inherent risks associated with conflict[130]. This behaviour has been observed in various studies, highlighting the influence of gender norms on men's mobility during conflicts[131,132].

Emergencies affect women and girls disproportionally. When a house is demolished or bombed, they are often forced to live with the extended family or in public facilities, which increases their responsibilities and care burdens. They carry out health care for the family without financial return, such as caring for the elderly or the wounded, or searching for relief aid, and the provision of medicines. This is significantly reflected in the mental and physical health of the family. The frequency of violence on women and girls increases during emergency periods.

Women and girls of all ages suffer during periods of conflict and emergencies, especially those with disabilities, cancer, and chronic diseases, as well as pregnant and lactating. A key problem for the operation of the health system in the oPt is not only the availability of services, but also the fact that the closure of health centres or the inability to reach them due to violence or checkpoints

128) Gomez D, Haas B, de Mestral C, et al. Gender-associated differences in access to trauma center care: a population-based analysis. Surgery. 2012;152:179–85.
129) Sethuraman, K. N., Marcolini, E. G., McCunn, M., Hansoti, B., Vaca, F. E., & Napolitano, L. M. (2014). Gender-specific issues in traumatic injury and resuscitation: consensus-based recommendations for future research. Academic emergency medicine : official journal of the Society for Academic Emergency Medicine, 21(12), 1386–1394. https://doi.org/10.1111/acem.12536
130) Ingham, B. (2018). Gender, conflict, and international humanitarian law: A critique of the 'Women and War' framework. Journal of International Humanitarian Legal Studies, 9(2), 220-255.
131) Kołaczek, J., & Zebrowski, A. (2020). Spaces of (in)security: Gendered geographies of conflict in Eastern Ukraine. Gender, Place & Culture, 27(4), 479-497.
132) Korf, B., de Lange, M., Mamadouh, V., & Zárate, D. A. (2015). Conflict cities: Changing urbanity in times of peace and war. Routledge.

could result in Palestinians being unable to meet their basic health needs for extended periods of time.

During a visit coordinated by OCHA on 24/10/2022 to the Nablus area after incursions, 41 health centres out of 47 complained about the difficulties health workers faced in reaching their places of work. The outpatient clinics in the hospitals also witnessed irregularity and impunctuality. Maternity departments reported 30 less deliveries. It is noteworthy that mothers might not be able to reach the maternity hospitals due to the closure of checkpoints or escalations and are forced to deliver at home or at primary health care facilities, which are not prepared for handling such cases. In emergencies, medical attention and resources are diverted to cope with the huge influx of injuries, at the expense of other groups/services i.e. obstetric care, non-communicable diseases etc. For example, during the 2014 military incursions, operation theatres in Shifa Hospital's maternity department were dedicated to cope with urgently needed surgeries. As a result more than 40,000 pregnant women could not access basic reproductive health care, and neonatal mortality reportedly doubled from 7 per cent to 14 per cent at hospital[133].

Most primary health care centres are closed during violence and emergencies, which impedes treatment for patients with noncommunicable diseases, pregnant women, children, the elderly, and people with disabilities, who often rely on primary health care the most. Hospitals remain open but are unable to cope with the increased influx of patients and often lack proper organisation (including crowd control, cleanliness, and hygiene standards). The institutions operating in Gaza stressed that the attacks and the war prevented access to facilities, and some institutions had to closed their doors. Although primary health care might be closed, primary health care staff could be better utilised during emergencies. Emergency teams (including health professionals, community volunteers, CBR workers, etc) distributed geographically might be helpful to ensure linkage and coordination between the affected population and health facilities.

Given the cultural norms and attitudes explained earlier, there is a general perception that women are not suited to work in emergencies because they are seen as fragile, not well prepared and/or burdened by their caregiving responsibilities. For example, at the onset of the COVID-19

133) ESCWA. (2015). Social and economic situation of Palestinian women and girls (July 2012—June 2014). https://archive.unescwa.org/publications/social-and-economic-situation-palestinian-women-and-girls-july-2012-june-2014

pandemic in Gaza more than 45% of those staying in quarantine centres in April 2020 were women, while the medical and security staff stationed there were all men. The prevalence of male medical and security staff in emergencies creates barriers for women accessing health care, mental health support, and basic hygiene needs, as well as the right to privacy and comfort, given taboos and norms related to gender mixing.

The participants of the Gaza focus group complained about the lack of respect for privacy in the emergency departments.

> "Often the privacy of women and girls is not taken into account. There isn't always a cloth curtain separating one bed from another. This violates the privacy that women should enjoy. The reception area is for both men and women" [134]

There are gaps in resources, infrastructure, and funding for emergency departments. A recent study conducted by MdM-France, which assessed the emergency preparedness of level four primary health care centres concluded that in 31.3 per cent of emergency rooms patient's privacy is not maintained, and that only 6.3 per cent and 25 per cent had an especially assigned doctor and nurse available respectively. Fifty per cent of the participants working in these clinics reported to have been trained on MISP for SRH in the past two years [135].

The COVID-19 pandemic clearly affected the provision of regular and essential health care services for non-COVID-19 patients. It limited their ability to access health services due to emergency measures, closures, and calls to stay at home as much as possible to reduce exposure to the virus. It also massively impacted the mental health of health workers[136]. There was a marked decrease in access to services by people with disabilities, the elderly and pregnant women, in addition to gender-based violence services.[137] There was a significant decrease in the number of visitors in the various primary health care centres, especially during the beginning of the crisis, due to the policy of closure and the calls to stay at home. There was also a significant decrease in access to family planning services and care for expectant mothers.

134) Focus group for males in Gaza on 22/11/2022
135) Medecines du Monde. (2022). The Emergency Preparedness of Level-Four Primary Health Care Centres in the Gaza Strip, the Occupied Palestinian Territory: An Assessment of Primary Care Providers' Competencies and Facilities Preparedness. https://drive.google.com/file/d/1_7KQZFaTnX4FWjkrXmX6GJvI0k6tng7P/view?usp=embed_facebook
136) MAP UK. (2021). Dealing with death and distress: The impact of COVID-19 on the mental health of Palestinian health care workers. https://www.map.org.uk/downloads/briefing-papers/dealingwithdeathanddistress.pdf
137) Palestinian Ministry of Health. (2021). Ministry's Annual Report.

GENDER BARRIERS AND FACILITATING FACTORS AFFECTING ACCESS TO HEALTH SERVICES

Gender is a key factor in determining a person's health outcomes and access to health care services. For example, women may face additional barriers to accessing health care due to gender-based discrimination, limited financial resources, and cultural norms that prioritise men's health needs over women's. Similarly, men may face stigma or cultural expectations that prevent them from seeking care for certain health issues, such as mental health or reproductive health.

Prevailing social culture and masculine values constitute an obstacle to women's access to services (particularly: divorced, separated, young women, women with disabilities, and those who live in rural/remote areas, mostly area C but also H2). Women are sometimes not allowed to go to health centres unless they are accompanied by a male family member (husband, father, brother...)[138].

> "Women do not receive the health service and access the services on their own, unless there is a companion, and this is customary in the field of health"[139]

The purpose of having a male companion might be to ensure that women are protected, especially given the context of Israeli military presence in the abovementioned areas. For example, in the Access Restricted Areas (ARA) in Gaza, protection is deemed necessary, but this can lead to overprotection and control and may deprive women from getting timely health care.

> "The social obstacles are grater for women than for men, and the reason for this is the distance one must travel from the village to the city"[140]

In the West Bank, there are protection concerns related to the presence of Israeli Security Forces (ISF) or settlers, as well as transportation challenges, especially in rural areas. In addition, companions, especially in rural areas, may simply be there to provide company on long trips to health centres. The gendered and family links of decision-making are also quite intricate, it might not always be men who decide on health services, but sometimes mothers-in-law might have more decision-making

138) This was reported in 3of the focus groups, 3 KII and the two validation workshops.
139) Focus group with service providers, Jabalia, North Gaza.
140) Focus group with men, Tulkarem.

power. Health professionals participating in the focus group discussions noted that the type of companionship patients receive can vary widely, with breast cancer patients often accompanied by female companions, while pregnant women often come alone. The lack of male involvement and support in pregnancy is a growing concern and underscores the need for greater awareness and engagement of men in supporting their partners.

In some cases, cultural beliefs and social norms related to honour may result in limiting access to health care for women and marginalised communities. Those who violate social norms and violate family honour risk forced marriage to the rapist (if this is the case), severe physical abuse, imprisonment, restriction of freedom, and even murder in extreme situations because of "honour" - all violations of a woman's right to life and protection[141].

In addition, cultural beliefs, and fear of stigma around honour may also prevent individuals from seeking treatment for certain conditions that are perceived as shameful or embarrassing. This can include mental health issues, sexually transmitted infections, or reproductive health problems. In some cases, individuals may avoid seeking treatment altogether, which can lead to serious health consequences. Moreover, the issue of honour can also impact health care providers' ability to provide care to certain patients. For example, health care providers may be hesitant to provide care to individuals who have been forced or involved in activities that are perceived as dishonourable, such as premarital sex, drug use, or homosexuality.

On the other hand, young women and the chronically ill may not seek treatment and health services because of societal pressures related to lower chances of marriage if diagnosed with a disease. Families fear the stigma. The social stigma associated with some diseases, such as cancer, can lead to treatment negligence, violence, separation, divorce, or marriage to another woman. Women may not seek health services for fear of people knowing about it[142].

It has also been reported that certain diseases are concealed, such as cardiovascular disease in girls. Husbands may not be informed of their new wives' illnesses at the time of engagement, even though this poses a threat to her health. Women may be exposed to complications during pregnancy and childbirth because they are pressured to ignore their health conditions, even to the point of death. Fears of abandonment among women with cancer may also hinder them from seeking care. In extreme cases a cancer diagnosis can lead to women being abandoned[143]- a societal practice that can put women at risk of losing their lives.

Women are praised for their commitment to caring for their families and often bear the responsibility of caring for children, husbands, and other family members, including the elderly and disabled. As a result, women may prioritise the care of others over their own health, leading to delays in accessing needed medical services. Some women even prioritise the health of their fetus over their own, if there is gender-based violence during pregnancy[144] [145], reflecting the belief that women exist solely to serve others.

Most of the interviewees agreed that women often do not have full control or are allowed to make decisions about their health, for example when it comes to using family planning methods or getting pregnant[146]. Even in cases not tied to SRHR, if a woman wants to seek health services, she probably has to wait for her husband or

141) Report of the Special Rapporteur on violence against women, its causes and consequences on a human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence (2019) A/74/137. https://digitallibrary.un.org/record/3823698?ln=en
142) Reported in 3 KII (2 with NGO staff and 1 with UN staff) and 5 out of the 6 focus groups with right holders. It is notable that all the female focus groups mentioned this.
143) Almuhtaseb, M. I. A., Alby, F., Zucchermaglio, C., & Fatigante, M. (2021). Social support for breast cancer patients in the occupied Palestinian territory. PloS one, 16(6), e0252608. https://doi.org/10.1371/journal.pone.0252608
144) Participation in a discussion group in the women's group in Hebron on 16/11/2022.
145) UN staff on 20/10/2022.
146) Mentioned in 10 of the KII, 4 focus groups and the 2 validations workshops, both in the West Bank and Gaza.

family members to agree. Health seeking may be disrupted due to the lack of facilities available nearby, and sometimes, when the approval is not given or delayed, the health status deteriorates.[147]

The conservative culture can end up preventing access to services depending on the gender of the service provider. Some people only consider male doctors "good doctors". Some women may refuse to be examined by a male doctor, and some men may refuse to be examined by a female doctor. This is often reported especially by service providers in mobile clinics and remote areas[148].

Reports indicate that people are increasingly relying on home remedies and cultural rituals, due to economic hardship and lack of trust in health care providers[149]. Such methods can have a devastating effect on health, since the treatments and ailments used in this kind of alternative medicine are not always scientific and can even exacerbate health problems. These services are mostly sought for those who suffer from mental illness, infertility, delayed marriage or chronic disease patients, whose desperation to deal with their disease can lead them to seek alternative treatments[150]. There needs to be more awareness about the importance of getting check-ups and going to the doctor from the very beginning of feeling ill. However, health services in primary health care are increasingly becoming more preventive, with more work being done on health promotion and community awareness.

147) Focus group discussions in Tulkarem, both men and women.
148) Interview with NGO staff - Gaza 31/10/2022.
149) Abu Hamad, B., Jones , N., & Gercama, I. (2021). Adolescent access to health services in fragile and conflict-affected contexts: The case of the Gaza Strip. Conflict and Health. https://doi.org/10.1186/s13031-021-00379-0
150) Interview with NGO staff – West Bank 13/11/2022.

CONCLUSION

Examining gender dynamics in the oPt reveals the profound and multi-layered impact of entrenched gender discrimination and social norms on the accessibility and quality of health care. This situation is exacerbated during humanitarian crises such as escalations or the COVID -19 pandemic, which disproportionately burden women with additional unpaid care responsibilities. As a countermeasure, the inclusion of gender analysis in humanitarian response planning has emerged as an important tool. However, there remains an urgent need for more detailed, sector-specific gender analysis and its subsequent application in the design of targeted interventions.

The oPt faces significant challenges in providing health services, largely due to the longstanding crisis and the ongoing occupation. Measures such as incursions, enforced closures, settlement construction, tight security checkpoints, and severe restrictions on movement pose significant obstacles to access to health care. The harmful effects of the ongoing violence and occupation exacerbate gender inequalities in health care. Often arbetiary policies, combined with strong opposition from conservative groups, are a persistent obstacle to progress in eliminating gender inequalities. Societal norms place undue pressure on men, provoking potentially harmful behaviors and limiting access to necessary services. Women in particular face significant barriers to accessing health care, resulting from societal constraints and economic pressures.

In summary, improving the health situation in the oPt necessitates a multifaceted approach. It is crucial to challenge established gender norms, advocate for gender equality, and create health systems that not only address gender issues but also promote inclusion. Policies must be developed and implemented to break down long-standing cultural taboos regarding violence against women and mental health, minimise stigma, improve service delivery, and ensure adequate resources for health services, especially in times of crisis. Legislative reform and increased funding for gender-specific projects are critical to addressing these overarching issues. Initiatives to strengthen reproductive health services, including diversifying contraceptive options and increasing men's involvement in family planning, must be further supported and expanded. Finally, the pressing issue of mental health deserves urgent attention through targeted campaigns to raise awareness and expand access to vital mental health services.

RECOMMENDATIONS

General recommendations

Long term recommendations

1. Mobilise the necessary resources, expertise, and competencies to develop the capacity of the government to mainstream gender in its activities and budgets. Disseminate the concepts of gender mainstreaming and human rights-based approaches among all government and health sector staff, at all levels.
2. Support Palestinian diplomacy efforts at the international level and cooperate with international bodies on the ground to highlight violations of Palestinians' right to health, as well as attacks on health facilities and services protected by the international humanitarian law.
3. Increase the number of qualified professionals trained in gender issues, PSEA, GBV referral systems, and sexual and reproductive health and rights (SRHR), with special attention to those in most vulnerable situations.
4. Provide regular and professional training for health care providers on GBV issues. Ensure sustainable funding for GBV services, improve data collection and reporting, revise confidentiality protocols, and establish an information sharing protocol. Prioritise mental health interventions, strengthen staff and resources, and address infrastructure gaps, particularly in Gaza.
5. All health managers and health professionals should be trained to meet core competencies - ethical awareness/ gender awareness, provision of first line support (LIVES) for communicating compassionately with GBV survivors, and commitment to act/practice with integrity. It is critical that they be equipped with the necessary skills to apply these principles in their practice.
6. All health care facilities must develop, adopt, and consistently enforce a comprehensive code of conduct. This code should explicitly include gender-sensitive protocols, nondiscriminatory practices, and provisions that ensure respectful treatment of all genders. By implementing and adhering to such a code, health facilities can provide equitable, unbiased, and respectful treatment to all.
7. Improve accessibility of GBV services for women and girls with disabilities. Address problems in accessing out-of-hours services and ensure that follow-up care, forensic medical examinations, and medico-legal reports are accessible without payment. Promote survivor-centered services, raise awareness, and reduce stigma to encourage more survivors to seek help.
8. Strengthen the adequacy of health facilities, increase safe spaces for women and adolescents, enhance health workers'capacity to discreetly and confidentially recieve and respond to reports of violence against women in health facilities such as PHCs and family medicine. This allows survivors to discuss their health issues, ask questions, and receive information and support without fear of judgment or discrimination. Protection and privacy must always be ensured.
9. Prepare health facilities, expand SRHR services, and promote SHR service utilisation for all populations,

including men. This may include long-term family planning methods, clinics for adolescents that provide services according to their needs, and awareness programs for men.

10. Require the private health sector to include clinical care for survivors of sexual violence and intimate partner violence (IPV) in their facilities and referral procedures in their health facilities.Develop indicators to show the progress made in fulfilling the right to health and its components (availability, access, acceptability, and quality) as well as its contribution to achieving equality.
11. Promote equitable access to services without discrimination on any grounds.
12. Develop systems of control, follow-up, and accountability to guide for employee performance and behaviour towards patients, particularly women. Implement policies to deal with sexual harassment and extortion, anti-corruption policy to reduce nepotism and other types of corruption, and develop complaint and reporting mechanisms to inform the public of their availability.
13. Adopt evaluation studies on health professionals' attitudes toward gender, ethics, and integrity.
14. Develop and implement a comprehensive national strategy to promote women's right to health care throughout their lives. Such a strategy should include measures to prevent and treat women's illness and diseases, as well as policies to ensure access to a wide range of health services for women.
15. Accelerate and support the translation of CEDAW into national laws and legislation, as well as the implementation of other international human rights covenants signed by Palestine into national legislation and policies.
16. Enhance advocacy efforts and sensitise policymakers to address GBV effectively, particularly in Gaza. Develop a comprehensive strategy and plan to establish specialised GBV services, improve infrastructure, and strengthen cooperation between MoH and the Ministry of Justice (MOJ). Prioritise the endorsement of the Clinical Management of Rape (CMR) protocol and implementing a national CMR strategy.
17. Incorporate gender-responsive approaches into the development of work plans and budgets across the health sector. This entails integrating a gender perspective into the planning and budgeting processes to ensure that the unique needs and priorities of women, men, girls, and boys are considered. By adopting a gender-responsive approach, health programmes and initiatives can address gender inequalities, promote equitable access to health care services, and foster gender-transformative outcomes. This includes conducting gender analyses, setting specific gender-related targets, allocating resources to address gender disparities, and monitoring and evaluating the gender responsiveness of implemented activities. Such efforts will contribute to more inclusive, effective, and sustainable health interventions that cater to the diverse needs of all individuals.

Short term recommendations

1. Ensure that medicines and treatments for chronic diseases that primarily affect women, such as breast cancer and cervical cancer, are available and accessible to female patients. Monitor and enhance the regularity of availability of medicines and treatments for chronic diseases that disproportionately affect women, such as autoimmune diseases, osteoporosis, and thyroid disorders.
2. Establish and strengthen community-based support networks for women, including mental health services, and support groups to address the unique psychosocial challenges they face.
3. Allocate gender-sensitive and emergency-responsive budgets and planning to cover women's needs even under the state of emergency.
4. Build the capacity of service providers in gender and health issues, including PSEA, GBV case management and gender attitudes. Assess the attitudes of service providers when responding to GBV and gender equality issues. Develop a programme to cover their needs in this area.
5. Include women in committees formed to develop policies and strategies.
6. Enhance participation, integration, and exchange of experiences with health cluster partners to develop policies and protocols, distribute tasks, carry out joint activities and campaigns related to gender-based violence and reproductive and sexual health.
7. Increase community health education through large-scale campaigns and specific goals related to reproductive and sexual health, GBV, and social stigmas linked with certain diseases and disabilities. Use different means of communication and allocate adequate budgets.
8. Conduct a participatory gender audit of the Ministry of Health.
9. Support women in taking on managerial positions and changing the attitudes of decision-makers.
10. Incorporate gender-sensitive perspectives in the prevention, diagnosis, and treatment of mental health issues, and to address the underlying gender-related determinants of mental health problems151.
11. Prioritise the expansion of minimum essential SRH services to comprehensive care. This entails ensuring that a wide range of SRH services, including family planning, antenatal and postnatal care, safe delivery services, and prevention and management of sexually transmitted infections, are accessible and available to all individuals. Expanding SRH services to comprehensive care, can improve the overall reproductive health outcomes, promote gender equality, and empower individuals to make informed choices about their sexual and reproductive well-being. This recommendation emphasises the importance of integrating comprehensive SRH services into health care systems and strengthening the capacity of healthcare providers to deliver these essential services effectively.

151)

Recommendations for Health Cluster partners

Long term recommendations

1. Support the development of gender transformative projects in areas such as SRHR for adolescents, promote the meaningful participation of women in health sector leadership and key sectors such as surgery or emergencies, train health care providers to recognise and respond to cases of gender-based violence, as well as engage men and boys in efforts to prevent gender-based violence and promote gender equality.
2. Pay more attention to marginalised and impoverished areas and cooperate with partners to expand coverage, days of presence, and services provided, including SRHR, GBV response, and address the needs of women with disabilities. Also, focus on East Jerusalem, given that the Palestinian Authority is not able to operationalise policies and service delivery in these areas. Health Cluster partners located or operating in these areas are best suited to providing needed services, emphasising the significance of coordination and collaboration between the government and NGO actors at national and subnational levels.
3. Conduct gender analysis during the Humanitarian Needs Overview (HNO) phase to identify gender-specific needs and considerations. The findings of the gender analysis should then be incorporated into the content and indicators of the Humanitarian Response Plan (HRP). This will ensure that gender issues are adequately addressed and that the response efforts are tailored to meet the specific needs of all genders. By integrating a gender perspective at an early stage of the planning process, the humanitarian response will be more inclusive, effective, and responsive to the diverse needs of the affected population.

Short term recommendations

1. Comply with the minimum standards of Protection[152], MISP for SRHR[153], GBV in emergencies[154], disability mainstreaming[155], gender in humanitarian action guidelines[156], accountability to affected people[157] and PSEAH mechanisms,[158] when designing, implementing, and evaluating all emergency interventions.
2. Use results based management approaches to achieve intended outcomes and make a real difference in the lives of people. Track progress towards key indicators such as the number of women receiving antenatal care, the number of deliveries attended by skilled birth attendants, and the availability of essential medicines and

152) Global Health Cluster & Global Protection Cluster. (2023). Health and protection joint operational framework. https://healthcluster.who.int/publications/m/item/health-and-protection-joint-operational-framework
153) Inter-Agency Working Group on Reproductive Health in Crises. (n.d.). Minimum initial service package (MISP) resources. Retrieved May 19, 2023, from https://iawg.net/resources/minimum-initial-service-package-misp-resources
154) GBV AoR (Gender-Based Violence Area of Responsibility). (s.f.). GBV Information Management System. Retrieved May 19, 2023 from: https://gbvaor.net/gbviems
155) UNFPA (United Nations Population Fund). (2022). Disability Mainstreaming Checklist_HRP 2022.pdf
156) IASC . (2018). IASC Gender in Humanitarian Action Handbook. https://www.gihahandbook.org
157) World Health Organization. (2019). Operational Guidance on Accountability to Affected Populations. https://www.who.int/docs/default-source/documents/publications/operational-guidance-on-accountability-to-affected-populations.pdf?sfvrsn=ec7fb6c8_1
158) IASC. (2020). Indicators Guidance Note IASC PSEA Country-Level Framework (Protection against Sexual Exploitation and Abuse). http://bitly.ws/IFbY

supplies, the number of people (sex-disaggregated) receiving essential health services, the number of health facilities that meet minimum quality standards.

3. Share good practices of the Health Cluster partners in gender-responsive projects, response to GBV and SRHR. Disseminate lessons learnt, and coordinate with the Ministry of Health to adopt similar approaches where possible. Strengthen the quality and accessibility of existing SRH interventions in line with humanitarian standards. This includes prioritising the improvement of services such as clinical management of rape and intimate partner violence, as well as safe referral systems. Enhancing the quality and accessibility of these interventions, can ensure that survivors of sexual violence receive appropriate and timely care, support, and referrals, thereby addressing their immediate needs and promoting their overall well-being.

4. Ensure essential service coverage for SRH care in line with humanitarian standards, particularly focusing on clinical management of rape and intimate partner violence services. It is crucial to prioritise the provision of comprehensive and survivor-centered care to individuals who have experienced sexual violence. This includes establishing and strengthening the necessary infrastructure, resources, and trained personnel to deliver these essential services. Ensuring the coverage of essential SRH care,can better support survivors, protect their rights, and contribute to their physical and psychological recovery.

Annex 1 –METHODOLOGY

The main goal of this gender analysis is to explore the dynamics of gender and health within the context of the oPt. This analysis aims to highlight the nuanced interplay among women, girls, men, and boys in all their diversity, and its impact on health care delivery and accessibility.

A social constructionist perspective on gender and gender relations is adopted, recognising that societal norms, attitudes, and practices around gender are continuously reinforced and internalised. The analysis utilises a life-cycle framework, understanding that gender norms are shaped by experiences from early childhood and evolve throughout one's life. An intersectional viewpoint is also applied, considering the intersection of gender with other social determinants. The methodology used in this study combines both quantitative and qualitative research methodologies, ensuring a rich and comprehensive exploration of the complex and multifaceted issues being investigated.

The objectives of this gender analysis are:

1. To describe and explore the current roles and capacities of the Health Cluster partners in supporting gender responsive efforts and promoting gender equality in the oPt.
2. To explore the gender barriers and facilitating factors that women, girls, men, and boys face to access health services provided by the Health Cluster partners.
3. To explore the impact of gender norms, roles and relationships on health needs and access to health services provided by the Health Cluster partners.

Quantitative Data: The quantitative research methodology included a comprehensive literature review and a detailed survey. The literature review involved analysis of numerous secondary sources of data. These encompassed a wide range of local and international studies, reports from authoritative bodies such as the UN and the MoH, institutional data from the Palestinian Central Bureau of Statistics (PCBS), and other pertinent health and gender-related documents.

Simultaneously, a 29-question survey was distributed to 58 Health Cluster partners in the oPt. This survey aimed to gather information about the size and staffing structures of these organisations, the experience of the staff in dealing with gender issues, and their roles within their respective organisations. Out of 58 potential respondents, 21 partners submitted completed surveys, representing a response rate of approximately 36%. The findings from these surveys were critical in identifying potential areas for capacity building among the Health Cluster partners, as well as for shaping the further stages of the analysis.

Qualitative Data: The qualitative research methodology encompassed semi-structured interviews and focus groups. These qualitative approaches allowed researchers to gain an in-depth understanding of the issues beyond what could be gathered from the quantitative data alone.

1. **Semi-structured interviews:** 28 interviews were conducted in the West Bank and Gaza Strip with key stakeholders from 25 organisations (UN Agencies, government, civil society organisations and organisations part of the red crescent movement). A set of open-ended interview questions were prepared in advance, with adaptation of questions to build on ideas emerging in the interview. Separate interview questions were prepared for organisations focused on service delivery, compared to those not directly providing services; additional questions were also identified for organisations engaged in work on health policy and advocacy.

2. **Focus groups**: Eight focus groups were held with service providers and beneficiaries from different areas in the West Bank and Gaza Strip. There were six focus groups with rights-holders, three for men and three for women: four in the West Bank (two in Hebron and two in Tulkarem) and two in the Gaza Strip (one in Jabalia for men and one in Bureij for women). There were two focus groups with health workers in the Gaza Strip: one at Shifa Hospital in collaboration with the MoH and another one in Jabalia in collaboration with Al Awda Hospital. There were 66 participants among rights holders (in groups ranging between nine and 13 people) and 17 participants in the focus groups for health workers (eight participants from Al Shifa Hospital and nine from Al Awda Hospital).

After the completion of the data collection phase and the initial data analysis, the findings and recommendations of the gender analysis were discussed in two validation workshops. These workshops, held on February 21, 2023, in Ramallah and on March 7, 2023, in Gaza, brought together Health Cluster partners for extensive discussion on the findings of the analysis.

Finally, key counterparts of the Health Cluster, such as the women's health unit of the MoH, other UN agencies and the cross-cutting issues focal points of the cluster also provided comments on the draft and were consulted on several occasions to ensure that the final product is accurate, relevant, and acceptable to its intended audience.

Annex 2 – QUESTIONNAIRES AND LIST OF INTERVIEWS

Survey questions

Questions	Arabic translation
To which extent do you consider that your organisation mainstreams gender? (Grade 1 to 10, meaning 1 "not able to mainstream gender" up to 10 "excellent gender mainstreaming")	إلى أي مدى تعتقد أن مؤسستك تدمج النوع الاجتماعي؟ (الدرجات 1 إلى 10 ، أي 1 "غير قادر على ادماج النوع الاجتماعي" حتى 10 "ادماج ممتاز لنوع الاجتماعي")
Does your organisation have a dedicated gender focal point or gender unit?	هل مؤسستك لديها منسق لشؤون النوع الاجتماعي؟
If not, who usually covers or is in charge of gender issues? (i.e. protection officer(s), for example)	إذا اجبت بـ"لا" على السؤال السابق، من الذي يغطي عادة قضايا النوع الاجتماعي؟
How many years of experience on gender mainstreaming do you have?	كم سنة خبرة لديك في قضايا ادماج النوع الاجتماعي ؟
Does your organisation carry a gender analysis when designing a project?	هل تقوم مؤسستك بالتحليل القائم على النوع الأجتماعي عند تصميم المشروع؟
If not, do you use an external analysis? For example, UN Women's Gender Alert or others, in that case, which one?	إذا لم يكن كذلك ، فهل تستخدم تحليل خارجي؟ على سبيل المثال ، برنامج تنبيه الأمم المتحدة للمرأة بشأن النوع الاجتماعي أو غيره ، في هذه الحالة ، أيها؟
Does your organisation include a PSEA clause on work contracts?	هل تقوم مؤسستك بتضمين بند الحماية من الاستغلال والانتهاك الجنسيين على عقود العمل؟
Do they perform a background check (or require a certificate of absence of sexual offences)?	هل يقومون بعمل فحص الخلفية (أو يطلبون شهادة عدم وجود جرائم جنسية)؟
Are male and female staff (including health care workers) trained on gender equality and women´s rights?	هل الموظفون والموظفات (بما في ذلك العاملون في مجال الرعاية الصحية) مدربون على المساواة بين النوع الاجتماعي وحقوق المرأة؟
How often it is offered? Is it compulsory or voluntary?	كم مرة يتم اتاحة التدريب؟ هل هو إجباري أم طوعي؟
Who, in your opinion, are the local groups and stakeholders in the health sector that can help bring a women's or a men's perspective into our work?	من هي ، برأيك ، المجموعات المحلية وذوي الاطلاع في قطاع الصحة الذين يمكنهم تقديم منظور المرأة أو الرجل؟
Is action needed to create permission and space for girls and boys to voice their needs and ideas, as well as participate in age-appropriate ways?	هل يلزم اتخاذ إجراء ما لإيجاد مساحة للفتيات والفتيان للتعبير عن احتياجاتهم وأفكارهم ، فضلاً عن المشاركة بطرق مناسبة لأعمارهم؟
Do men/boys and women/girls show different literacy levels or other barriers to receiving health information?	هل يظهر الرجال / الفتيان، والنساء / الفتيات مستويات مختلفة من القدرة على القراءة والكتابة (أو غيرها من العوائق) التي تحول دون تلقي المعلومات الصحية؟
Could you specify the barriers and for whom (gender and age)?	هل يمكنك تحديد هذه العوائق ولمن (الجنس والفئات العمرية)؟
What barries do women/girls and men/boys face to safely access health services?	ما هي برأيك متطلبات النساء / الفتيات والرجال / الأولاد للوصول بأمان إلى الخدمات الصحية؟

Questions	Arabic translation
What action is required so 'hard to reach' individuals receive appropriate health care? Are different actions needed here for women/girls compared to men/boys?	ما هو الإجراء المطلوب حتى يتلقى الأفراد "الذين يصعب الوصول إليهم" الرعاية الصحية المناسبة؟ هل هناك حاجة إلى إجراءات مختلفة هنا للنساء / الفتيات مقارنة بالرجال / الأولاد؟
Are data on utilization of health services disaggregated by sex, age and diversity?	هل البيانات المتعلقة باستخدام الخدمات الصحية مصنفة حسب الجنس والعمر والتنوع؟
What are the barriers faced by your organisation to obtain Sex, Age and Diversity Disaggregated Data?	ما هي العوائق التي تواجهها مؤسستك للحصول على بيانات مصنفة حسب الجنس والعمر والتنوع؟
Is data analysed for disparities in utilization of services by men and women according to prevalence rates?	هل تم تحليل البيانات الخاصة بالتفاوت في استخدام الخدمات من قبل الرجال والنساء وفقًا لمعدلات الانتشار؟
Is there a human resource policy at the national or district levels on gender equality and/or non-discrimination based on gender? Does it include PSEA?	هل توجد سياسة موارد بشرية على المستوى الوطني أو مستوى المحافظات بشأن المساواة بين الجنسين و / أو عدم التمييز على أساس النوع الاجتماعي؟ هل يشمل الحماية من الاستغلال والانتهاك الجنسيين؟
Are any of the workplace policies discriminatory against men or women?	هل أي من سياسات مكان العمل الذي تعمل به تميز ضد الرجل أو المرأة؟
Are gender-related needs analysed and included during budgeting phase?	هل يتم تحليل الاحتياجات المتعلقة بالنوع الاجتماعي وإدراجها خلال مرحلة إعداد الموازنة؟
Are men's and women's different health needs taken into consideration in planning, program design and budget development?	هل تؤخذ الاحتياجات الصحية المختلفة للرجال والنساء في الاعتبار عند التخطيط وتصميم البرامج وتطوير الميزانية؟
Are there family-friendly policies in place? Does the organisation of health work take into consideration women's disproportionate responsibilities for childcare, food preparation, and other family care?	هل توجد سياسات مراعية للأسرة؟ هل تأخذ مؤسستك في الاعتبار مسؤوليات المرأة غير المتكافئة عن رعاية الأطفال وإعداد الطعام والرعاية الأسرية الأخرى؟
Do interventions/policies take into consideration men's and women's different time constraints and mobility restrictions regarding the location of health services and times they are open?	هل تأخذ التدخلات / السياسات في الاعتبار المحددات الزمنية المختلفة للرجال والنساء ومحدودية القدرة على التنقل فيما يتعلق بموقع الخدمات الصحية وأوقات فتحها؟
Do research protocols include both women and men of different ages?	هل تشمل بروتوكولات البحث النساء والرجال من مختلف الأعمار؟
Is political leadership committed to gender equality in the health system?	هل القيادة السياسية ملتزمة بالمساواة بين الجنسين في النظام الصحي؟
How is the health system leadership accountable for implementing existing gender equality policies? Do they conduct periodic assessments, issue reports, or measure performance on a regular basis?	كيف تقوم ادارة النظام الصحي المسؤولة عن تنفيذ سياسات المساواة بين الجنسين الحالية بمهامها؟ هل يجرون تقييمات دورية أو يصدرون تقارير أو يقيسون الأداء على أساس منتظم؟

Interview Questions

Interviews with Ministry of Health

Domain	Question
Policy	Is there gender equality at the national level in health indicators, such as the age of marriage, gender-based violence, and child preference?
Policy	Do government institutions have the capacity to mainstream a gender perspective in the health sector? How do they cooperate with the Ministry of Women's Affairs?
Policy	How are gender dimensions embedded in health sector policies and strategies? Are there barriers to embed a gender perspective policies? Are national policies, strategies and action plans for gender equality considered? How are national guidelines, strategies and action plans on gender equality adopted, implemented, monitored, and mainstreamed into the health sector? To what level are these policies applied? in the sector? Are there examples of good or promising practices?
Policy	Have institutions in the health sector adopted policies and practices to achieve gender balance in their employees and management, and practices that are gender-sensitive or gender-responsive in relation to individuals, service recipients, consultants, producers, and suppliers? In case of absence of clear policies, are there potential underlying reasons/barriers? Are there examples of good or promising practices?
Policy	Does the health sector promote, unite, and address existing social norms and attitudes and existing social and economic exclusions? To what extent do social norms (e.g., about masculinity, femininity, gender relations, and disability status) affect access, delivery and use of services, and the selection of suppliers and producers, in the health sector?
Policy	Are the recent data available in the sector disaggregated by gender and/or other gender-related statistics and indicators?
Policy	Are men and women equally involved in programme planning?
Policy	Are the budgets of the regions analyzed and allocated in accordance with the principles of gender equality?
Laws & Regulations	How does men's access to health resources compare to women?
Laws & Regulations	Are the varying effects on men and women taken into account in relation to different forms of cost recovery, such as fees and insurance? (e.g. health insurance coverage)
Laws & Regulations	Are proposed health reforms and new policies assessed in terms of their potential differential impact on men and women, and on male and female health workers? How?
Laws & Regulations	How is the health system leadership responsible for implementing current gender equality policies? Do they conduct periodic evaluations, issue reports, or measure performance on a regular basis?

Domain	Question
Access to Services/Assets	Do men and women have equal opportunities to choose any health career?
Access to services (RSH)	In your opinion, what areas have not been planned and implemented in the areas of reproductive and sexual health and why? (Traditional areas are commonly known as the care of pregnant women and family planning, and unmet areas include: infertility, adolescent and youth health, menopause etc.)
Access to services	What types of services exist in the community and health sector designed for women? Is there privacy for reproductive and sexual health services? How they are promoted, and the extent of fairness in the distribution of these services geographically and according to age, sex and disability
Access to services	To what extent health services and programmes take into account the needs of women, men, boys, girls (adolescents), youth and persons with disabilities?
Access to services (RSH)	What challenges do you face in providing reproductive and sexual health services? What obstacles do women face in accessing reproductive health services (question about obstacles: social customs, traditions and culture, economic in terms of poverty and inability to pay, infrastructure such as the availability of transportation and the absence of services in remote areas, the quality of services and impressions of them, the treatment and understanding of the health staff and the presence of the female component in it, etc.).
Access to services (RSH)	What are the worrying health indicators for women's health? What indicators need to be worked on and services developed on them (violence, maternal and child mortality, early marriage, average family size)?
Access to services (RSH)	What policies/actions/services do you work with to enhance women's access to reproductive and sexual health services as well as men, adolescents, youth and persons with disabilities?
Access to services (RSH)	How sufficient are the budgets allocated to reproductive and sexual health programmes? How does this adequacy affect access to services?
Access to services (RSH)	To what level are reproductive and sexual health services planned and evaluated with the participation of beneficiary groups (men, women, youth, persons with disabilities)?
Access to services (RSH)	How are the reproductive and sexual rights of persons with disabilities recognized? To what extent are their needs integrated and their abilities strengthened to access reproductive health services are being strengthened? Are the infrastructure and the capabilities of health personnel trained and sensitive to their needs according to their disability?
Access to services (GBV)	To what extent is the health sector responsive to gender-based violence? What policies exist within this framework and what nature of the services are applied?
Access to services (GBV)	How are the sector's policies and services related to combating gender-based violence promoted?
Access to services (GBV)	The readiness of the health sector to receive victims of violence in terms of: infrastructure, adequate cadres competent, trained, sensitive to violence issues and applied to the rules of professional conduct?

Domain	Question
Access to services (GBV)	What are the barriers for GBV survivors to access health service?
Access to services	Are there enough midwives and doctors to care for women who prefer female health care providers?
Gender-sensitive information	Are health information/indicators at the facility level disaggregated by sex and age and relatively analysed for decision-making?
Gender-sensitive information	Is there a similar investment in disseminating health information to men and women?
Gender-sensitive information	Are the data on the use of health services disaggregated by sex and analyzed to find out disparities in the use of services by men and women according to prevalence rates?
Gender-sensitive information	Are statistics on the health workforce disaggregated by sex and type of occupation (e.g., nurse, doctor, etc.)?

NGO and UN Interview questions

Domain	Question
Customs and beliefs	Do men or women have physical (i.e., checkpoints, settler violence…) or social/cultural restrictions on their movement? What are the restrictions? How does it affect women's access to public services and health services in particular? To support social networks?
Customs and beliefs	What are the attitudes of society towards women/men working in the health sector? Why? How do the attitudes of healthcare professionals towards women versus men differ?
Policy	Do men and women enjoy equal status in health sector under all national, regional and local laws?
Policy	What gender equality policies and/or action plans exist in Palestine that are relevant to the health sector, including anti-discrimination provisions? How are national gender equality guidelines, strategies and action plans mainstreamed to the health sector?
Policy	What factors influence the adoption of gender-sensitive policies?
Policy	Is there gender equality at the national level in health indicators, such as the age of marriage, gender-based violence, and child preference?
Policy	To what level do the regime's policies and procedures support women? Women's needs? (At work, working conditions, salaries, benefits, vacations, etc..)? Are there any special laws/policies/specific in this regard?

Domain	Question
Policy	Does the health sector promote, consolidate, and address existing social norms and attitudes and existing social and economic exclusions? To what extent do social norms, for example, about masculinity, femininity, gender relations, and the state of disability affect access, delivery and use of services, and the selection of suppliers and producers, in the health sector? How do people of both sexes participate in decision-making processes in the health sector?
Policy	Are the different health needs of men and women taken into account when designing programs and developing the budget?
Laws & Regulations	Do referral systems treat men and women equally?
Laws & Regulations	How does men's access to health resources compare to women?
Laws & Regulations	Does the organization, spatial arrangement, and customer flow in the health facility affect men and women differently, making them more or less likely to use the services? Do they have privacy at work?
Laws & Regulations	Are the varying effects on men and women taken into account in relation to different forms of cost recovery, such as fees and insurance? (e.g. health insurance)
Laws & Regulations	Are workplace policies gender-fair? Do any workplace policies discriminate against men or women?
Laws & Regulations	Is there a specific policy and procedures related to combating sexual harassment in the health sector, both for workers and beneficiaries? Are you aware of the implementation of PSEAH practices in your organization?
Laws & Regulations	Are male and female staff members entitled to equal benefits? (E.g., Paternity leave, flexible working hours for breastfeeding mothers, or training opportunities. Ensure that the implementation of activities does not reinforce or uphold existing inequalities among different groups of men and women through unequal incentives or benefits paid). If posted in rural or high-security areas, are there any mechanisms to facilitate equal access for men and women to these posts?
Laws & Regulations	Are proposed health reforms and new projects assessed in terms of their potential differential impact on men and women, and on male and female health workers? How?
Laws & Regulations	Are budgets evaluated to see if they are gender-fair?
Laws & Regulations	How is the leadership responsible for implementing current gender equality policies? Do they conduct periodic evaluations, issue reports, or measure performance on a regular basis?
Social Culture	Are there any specific criteria that contribute to harm or discrimination against certain groups of the population (i.e. discrimination on the basis of sex or associated with other additional factors)?

Domain	Question
Access to Services/Assets	How does men's and women's access to and control over society's resources affect their ability to: »Make a decision to seek care? » Reaching the right level of care? » Access to transport and transportation for care? » Access to health information? And get proper care?
Gender-sensitive information	Is facility-wide health information disaggregated by sex and age and relatively analyzed for decision-making? What problems do you face to gather, access and share such data?
Gender-sensitive information	Is there a similar interest in disseminating health information to men and women? Do programmatic materials or publications contribute to eliminate gender-based stereotypes? If yes, how?
Gender-sensitive information	Are the data on the use of health services disaggregated by sex and analyzed to find out disparities in the use of services by men and women according to prevalence rates?
Gender-sensitive information	Are statistics on the health workforce disaggregated by sex and type of occupation (e.g., nurse, doctor, etc.)?

Appendix to interview questions for institutions providing health services:

Domain	Question
Laws & Regulations	Does the organization, spatial arrangement, and customer flow in the facility affect men and women differently, making them more or less likely to use the services? Do they have privacy at work?
Access to Services	Are the health needs of men or women prioritized or ignored? Is screening influenced by a person's gender? For example, are women with obstetric complications treated as quickly as men with injuries from car accidents or work injuries?
Access to Services	How responsive are health workers to the different health needs of men and women?
Access to Services	Are men and women treated differently by: male service providers/women service providers?
Access to Services	Are women or men subject to stereotypes and different attitudes in their workplaces, in what form and pace?
Access to Services	Do men and women, in all their diversity, have equal access to health sector services? Are there specific gaps in service delivery that hinder gender equality and affect women and girls disproportionately (specific medical services such as SRH, breast cancer screening), or affect certain groups, such as persons with disabilities (e.g., access to affordable childcare, access to transportation, communication/distribution restrictions)?

Domain	Question
Access to Services	Are men and women treated equally with regard to confidentiality of information (non-disclosure of health information)?
Access to Services	Does the health facility have a code of conduct and mechanisms for reporting PSEAH? Disrespectful treatment?
Access to Services	Due to the protocols and procedures of the facility, do men or women suffer from stigma about various diseases? What about the differences between groups of men and women, based on things like marital status?
Access to Services	Are ambulances and emergency services deployed fairly to meet the different needs of men and women?
Access to Services	Are health messages, illustrations, and other media presentations free of stereotypes and prejudices for a particular gender?
Access to Services	Are women prevented from moving alone outside their families or communities, which may restrict access to services?
Access to Services	Are there awareness-raising activities for men/women who do not have access to health centres? How are they recognized?
Access to Services	Do the region's policies on the location and opening times of health services take into account the different time constraints for men and women and movement restrictions?

Focus Groups

Service users (men and women)

Domain	Question
Customs and beliefs	Do men or women have restrictions on their movement? What are the restrictions? How does it affect women's access to services? To support social networks?
Customs and beliefs	What are the attitudes of society towards women/men working in the health sector? Why?
Customs and beliefs	How do the attitudes of healthcare professionals towards women versus men differ?
Customs and beliefs	Are there beliefs about what it means to be a man that may prevent sick men from seeking or receiving care in health centers?
Customs and beliefs	Are there beliefs about what it means to be a woman that may discourage patients from seeking or receiving care?
Laws & Regulations	How does men's access to health resources compare to women?

Domain	Question
Social Culture	What social norms prevail about masculinity, femininity, gender relations, and gender identity in Palestine (e.g., concepts based on gender integration that require different rights and obligations; traditional law that includes a specific understanding of gender roles, etc.)
Social Culture	How do these standards affect areas such as physical and mental health, including sexual and reproductive health and rights, gender-based violence, harmful practices, employment, and social participation among others?
Access to Services/Assets	How does men's and women's access to and control over society's resources affect their ability to: »Make a decision to seek care? » Reaching the right level of care? » Access to transport and transportation for care? » Access to health information? » Get the right care?
Access to Services	How responsive are health workers to the different health needs of men and women?
Access to Services	Are men and women treated differently by: male service providers/women service providers?
Access to Services	Are you aware about the mechanisms to report harassment or assault in health facilities, in what form and at what pace?
Access to Services	Do men and women, in all their diversity, have equal access to health sector services? Are there specific gaps in service delivery that hinder gender equality and affect women and girls disproportionately, or affect certain groups, such as persons with disabilities (e.g., access to affordable childcare, access to transportation, communication/distribution restrictions)?
Access to Services	Are men and women treated equally with regard to confidentiality of information (non-disclosure of health information)?
Access to Services	Due to the protocols and procedures of the facility, do men or women suffer from stigma about various diseases? What about the differences between groups of men and women, based on things like marital status?
Access to Services	Are women prevented from moving alone outside their families or communities, which may restrict access to services?
Access to Services	Do women or men face time restrictions that may limit their ability to access services when they are open?
Access to Services	Are there awareness-raising activities for men/women who do not have access to health centres? How are they recognized?
Access to Services	Does taking other domestic or social roles hinder the pursuit of treatment?

Health workers

Domain	Question
Customs and beliefs	What are the attitudes of society towards women/men working in the health sector? Why? How do the attitudes of healthcare professionals towards women versus men differ?
Customs and beliefs	What are the beliefs of service providers about gender differences and equality? On the whole? In the workplace of health care? For their patients? How does this affect their treatment of patients?
Customs and beliefs	Do health workers believe that men should receive preferential or different treatment over women? How does this affect caregiving?
Laws & Regulations	How does men's access to health resources compare to women?
Laws & Regulations	Does the organization, spatial arrangement, and customer flow in the facility affect men and women differently, making them more or less likely to use the services? Do they have privacy at work?
Laws & Regulations	Do referral systems treat men and women equally?
Laws & Regulations	Are workplace policies gender-fair? Do any workplace policies discriminate against men or women?
Access to Services/ Assets	How does men's and women's access to and control over society's resources affect their ability to: »Make a decision to seek care? » Reaching the right level of care? » Access to transport and transportation for care? » Access to health information? » Get the right care?
Practice/ Recruitment	Are there enough midwives and doctors to care for women who prefer female health care providers?
Practice/ Recruitment	How and when is information collected and analysed about the different experiences of men and women with services? Are you able to collect, use and access sex-disaggregated data?
Practice	Have you ever been trained or recently received a refresher session on topics such as: Do no harm, protection, gender equal practices, GBV prevention and protection mechanisms?
Practice	In your opinion, what are the main issues regarding gender and health that should be addressed in Palestine? What are the most prevalent problems for women's health? For men? For girls and boys?
Practice	How do you think that health services and practices at service delivery could be improved regarding gender equality and non-discrimination?
Practice	How do you think that you could be better supported as a service provider?

World Health Organization
occupied Palestinian territory

HEALTH CLUSTER
OCCUPIED PALESTINIAN TERRITORY