

No one told me about that

Exploring adolescent access to
health services and information
in Gaza

Bassam Abu Hamad, Ingrid Gercama,
Nicola Jones and Eman Abu Hamra

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© All photos in this briefing were taken by adolescent researchers involved in our pilot study in Khanyounis.

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Introduction

The determinants of health for any population are broad: they include peace and security, economic resources, education, democracy, equity, women's empowerment, appropriate housing, access to clean water and nutritious food, and a safe and healthy environment. All these health determinants are negatively affected by the protracted conflict in Gaza, with 11 years of blockade and economic hardship, which has resulted in increased vulnerability and ill-health among Gazans, particularly women and children (Ministry of Health, 2014).

The chronic stress that people in the Gaza Strip face, alongside a largely sedentary lifestyle, restrictions on girls' mobility and conservative social norms, means the area is experiencing an 'epidemiological transition'. As Figure 1 shows, non-communicable diseases linked to lifestyle and stress (including heart disease, cancer, hypertension and cardiovascular diseases, and diabetes) are gradually

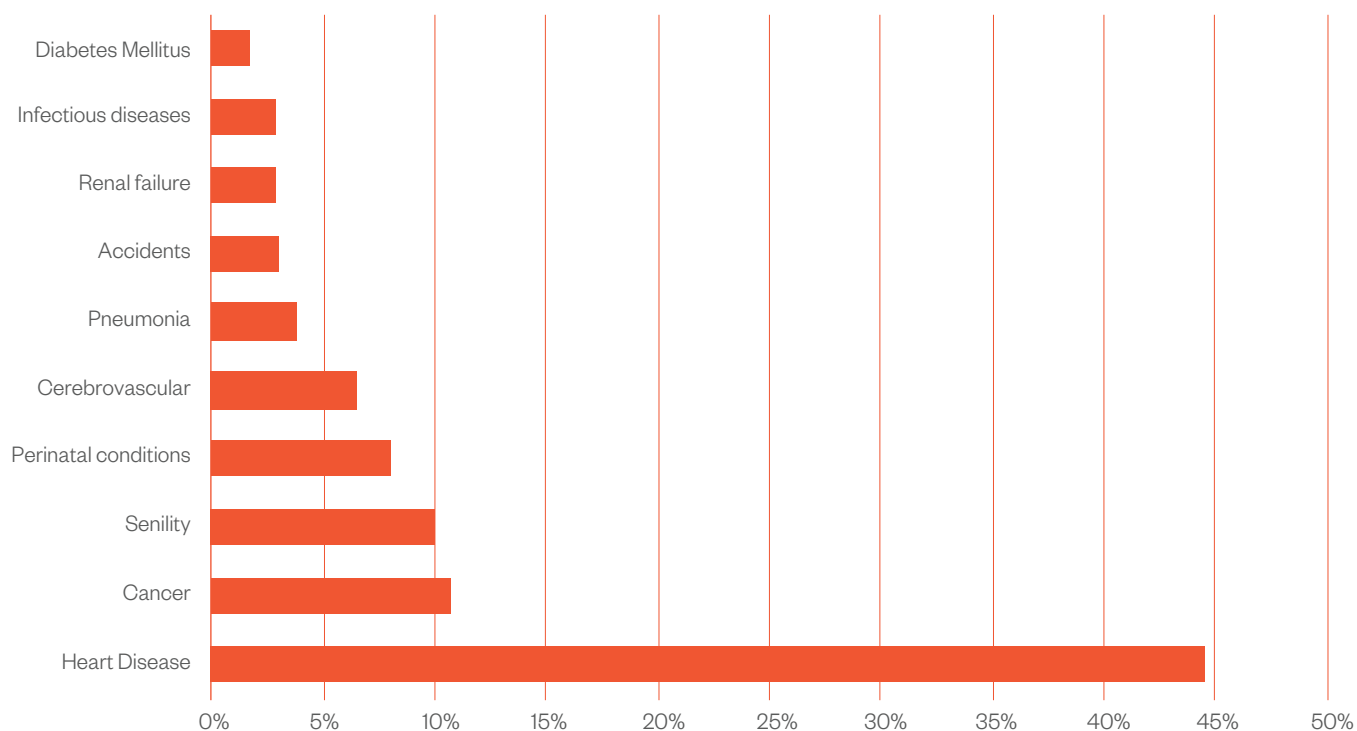
replacing infectious diseases as the leading cause of death (see also Box 1) (Ministry of Health, 2016).

In Gaza, adolescents (aged 10-19) comprise 23% of the population, but unlike young children and youth, little is known about their specific health status. According to a recent United Nations Population Fund (UNFPA) study (2016), 16% of youth had a health problem in the two weeks preceding household data collection, while 3% had at least one chronic disease, including disability. We know even less about adolescent experiences and perceptions of health services, and how these are shaped by gender relations and norms. This briefing paper addresses these gaps, drawing on findings from a participatory and qualitative research study undertaken in the Gaza Strip in camp and non-camp settings in 2016 and 2017 as part of the multi-country Gender and Adolescence: Global Evidence (GAGE) research programme, funded by the Department for International Development (DFID).

Image 1: These are the blistered feet of a 19-year-old adolescent mother (who already has two children) from Khanyounis. The floor of her house is made of earth, there are many insects and no water.



Figure 1: The ten leading causes of death among the population in Gaza in 2016



Source: Ministry of Health, 2016

Box 1: The Palestinian health system: a mixed equation

Compared to other countries at a similar level of economic development, the Palestinian population’s overall health outcomes are relatively good, partly due to strong performance of most basic public health and primary health care (PHC) functions (Ministry of Health, 2014).

Gaza performs better than many countries in the Middle East and North Africa (MENA) region on key indicators: the infant mortality rate is low, at around 22 per 1,000 live births; the maternal mortality ratio (MMR) is less than 20 per 100,000 live births (see Figure 5) ; and immunisation coverage is at 95% for most vaccines. There is near universal coverage of antenatal care, all Gazan women deliver in health facilities, and there has been a noticeable reduction in the fertility rate (Ministry of Health, 2017a).

Health insurance is mostly available (more than 90% of households are medically insured), but cover does not meet people’s needs; few medicines are covered by insurance or available, there are limited specialist services and long waiting lists for surgeries (PCBS, 2016a).

While people are generally able to access basic health services under ordinary conditions, access becomes very challenging during renewed outbreaks of conflicts. Access to advanced services outside Gaza (such as oncology, radiotherapy, advanced cardiac and neurosurgery) remains very challenging.

Sources: Ministry of Health data, 2017

1 Methods, research sample and research ethics

This paper explores the following key research questions:

- What are the health (including sexual and reproductive health (SRH)) challenges facing adolescent girls and boys in the Gaza Strip, and how are these shaped by gender relations and norms?
- What gender- and age-friendly health services and information (including SRH) aimed at increasing adolescents' physical wellbeing and development are available to adolescents and their families in the Gaza Strip, a protracted conflict setting?
- How relevant, accessible, user-friendly and effective, and of what quality, are the available health (including SRH services) in the Gaza Strip according to the beneficiaries of those services?

To explore these questions, GAGE employed a mixed-methods approach, using online and offline service mapping exercises with service providers and adolescents, a tablet-based QuickTapSurvey™ module completed by 107 adolescents, and a range of qualitative research tools with adolescents, their peers and families. These included focus group discussions (FGDs) and in-depth interviews (IDIs), visual participatory methods (including object-based interviews), community mapping exercises, vignettes, time use and social network mapping exercises (see the participatory research guide for GAGE) (see Table 1).

In total, the research team engaged with 239 adolescents and 69 service providers in two research sites – Shajaia neighbourhood and Jabalia refugee camp – in the summer and autumn of 2017 (see Table 2 for the demographic breakdown of the adolescents involved in our qualitative sample).

We also draw on findings from our 2016 Participatory Action Research project in Khanyounis, Gaza, involving 35 adolescents aged 15 to 19. The adolescent participants met on a weekly basis with GAGE research facilitators to undertake a wide range of research activities, including peer-to-peer interviewing and participatory photography and videography.

1.1 Research sites

Shajaia was chosen because of its central location in Gaza city and the availability of specialised services offered by humanitarian partners and the government, which are often not available in other areas of the Gaza Strip. It has the highest concentration of 'in need' people and refugees (United Nations Office for the Coordination of Humanitarian Affairs (OCHA), 2016). Shajaia neighbourhood is a non-camp settlement area with a population of around 120,000 residents. It was heavily affected during the 2014 Gaza-Israel war.

The second site, Jabalia camp, is the closest camp to the Erez border crossing with Israel. It is home to nearly 110,000 registered refugees and there is a large presence by the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA), non-governmental organisations (NGOs) and governmental institutions. It is, according to OCHA, home to the second largest population in severe humanitarian need, with even higher vulnerability levels than Gaza city (2016).

Table 1: Overview of research methods used

Method	Total participants
Focus group discussions	10 groups with 97 participants in total
In-depth interviews	35 in-depth interviews with adolescents
Adolescent surveys with QuickTapSurvey™	107 survey respondents
Key informant interviews	68 key informant interviews

Table 2: Demographic characteristics of the adolescent sample (N=132)

Type	%	Type	%
Refugees	61%	Out of school	36%
Aged 10-14	39%	Male headed household	72%
Aged 15-19	44%	Disability in the family	17%
> 19 years	17%	Social assistance beneficiary	64%
Female	57%	Adolescent services recipient	53%
Male	43%	Single	87%
Median age	15 years	Married	10%
Family size 7-9	49%	Divorced	2%
Family size >9	34%	Separated	2%
Family income 501-1000 ILS p/m	42%	No children	31%
Family income <500 ILS p/m	28%	One child	54%
Family income 1001> ILS p/m	30%	Two children	15%
In school	64%		

1.2 Research ethics

The research team adhered to stringent ethical measures to ensure the protection of adolescents and their families as set out under the GAGE Institutional Ethics approval document and GAGE child protection guidelines.

Participant anonymity and confidentiality were ensured and data were securely stored . Informed consent was obtained prior to commencing each data collection activity.

2 Research findings

Based on the GAGE (2017) conceptual framework, we present our findings according to the following outcome-level indicators:

1. Access to age-appropriate information and services to keep themselves healthy
2. Access to age-appropriate and stigma-free knowledge, supplies and support to manage menstruation
3. Access to age-appropriate, gender-friendly and stigma-free sexual and reproductive health and puberty-related information, services, supplies and support

2.1 Outcome 1: Access to age-appropriate information and services to keep themselves healthy

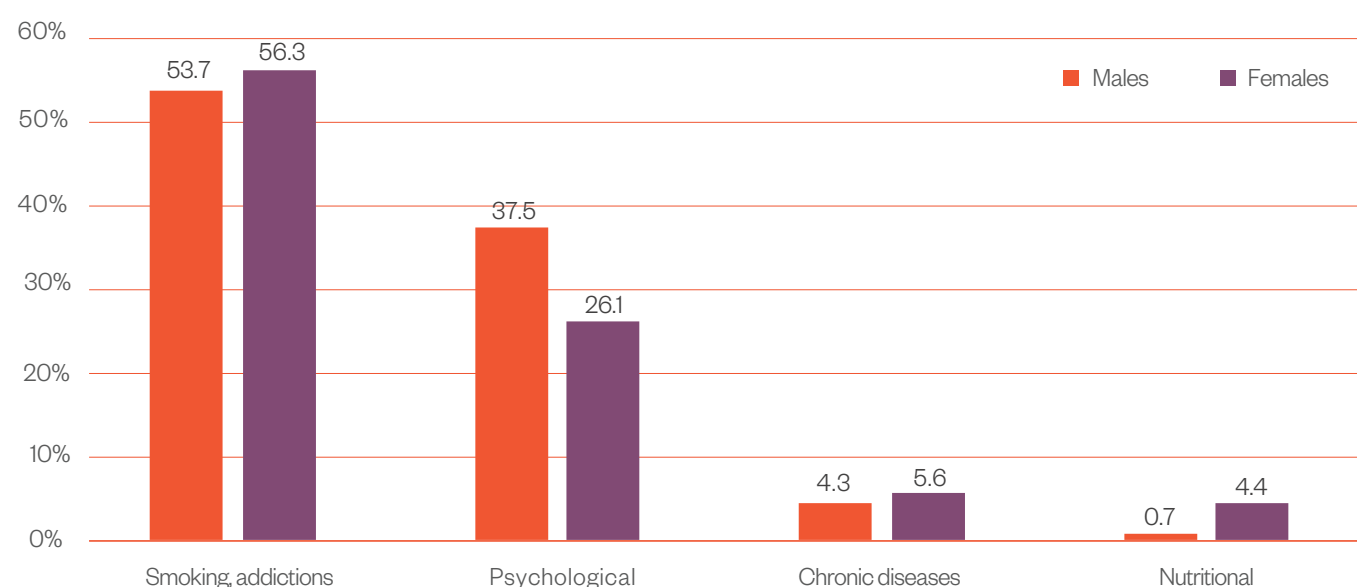
According to the PCBS' recent youth survey, 85.9% of young women and 90% of young men aged 15-29 believed themselves to be in either excellent or very good health; the remainder judged their health status as average or poor (PCBS, 2016b). The main health-related challenges cited by youth were smoking, addiction (see Box 2) and unhealthy

behaviours (males 53.7%; females 56.3%) and psychological problems (male 37.5%; females 26%) (see Figure 2).

Overall, adolescent health-seeking behaviours are quite proactive. UNFPA reported that more than two-thirds of adolescents tell their parents when they feel sick and seek medical services. When they experienced an illness, 70% saw someone about the problem: 54% visited a doctor's clinic, 21% visited a hospital, 34% visited a health centre, 14% a pharmacy, 3% a traditional healer, and 5% opted to self-treat (UNFPA, 2016). Taking medicine without a prescription was reported by 20% of young women in Gaza and 15% of young men (PCBS, 2016b).

Nevertheless, there are a range of barriers that prevent adolescents accessing health care services in Gaza. Adolescent girls who did not seek treatment for SRH issues cited the following reasons: the condition did not require treatment (61%); financial constraints (27%); difficulty accessing services (11%); social factors hindering their receiving services (5%); and being busy/having no time (21%). The barriers that prevented young women seeking general health services included: not knowing where to go (11%); not being able to get permission (17%); not being able

Figure 2: Young people's perceptions about the most important health issues they face



Source: PCBS, 2016b

to get money (36%); not being willing to go alone (39%); and lack of female health workers (32%) (UNFPA, 2013). The barriers preventing boys accessing health care services are financial rather than social, in addition to restrictions on movement outside Gaza and lack of resources at health facilities, especially drugs (WHO, 2013; Anan, 2011).

2.1.1 Limited tailored services for adolescent health

The GAGE adolescent service mapping found that although there are a range of health care services in the Gaza Strip,¹ specific and tailored adolescent services seldom exist. Female adolescents criticised the lack of age-appropriate services: ‘There are no clinics to support girls at our age’, explaining that ‘staff in clinics do not understand our needs’ (FGD, older girls, Shajaia). Similarly, boys noted that ‘Medicines are not available. Doctors don’t seem to be interested in treating us. They prescribe the medicines so quickly without diagnosing us well. The clinic isn’t clean either’ (FGD, older boys, Shajaia). Many male and female participants mentioned multiple gaps in government and UNRWA health services, including

Figure 3: Percentage of adolescents who speak to a health care provider about puberty-related concerns

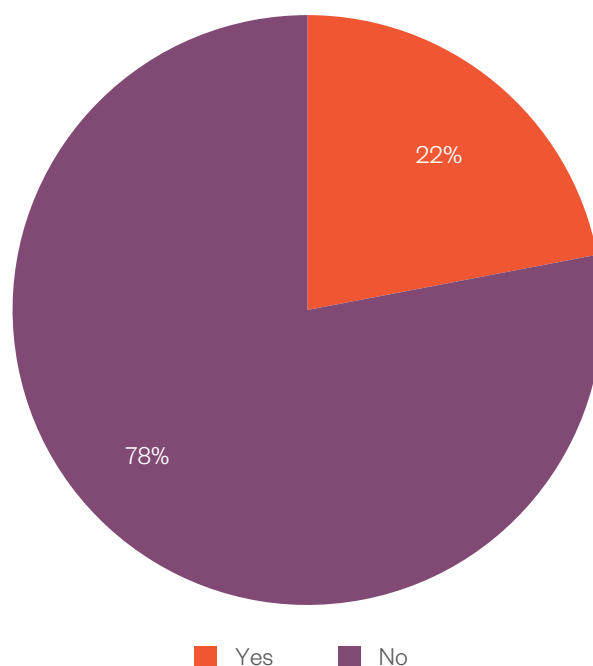
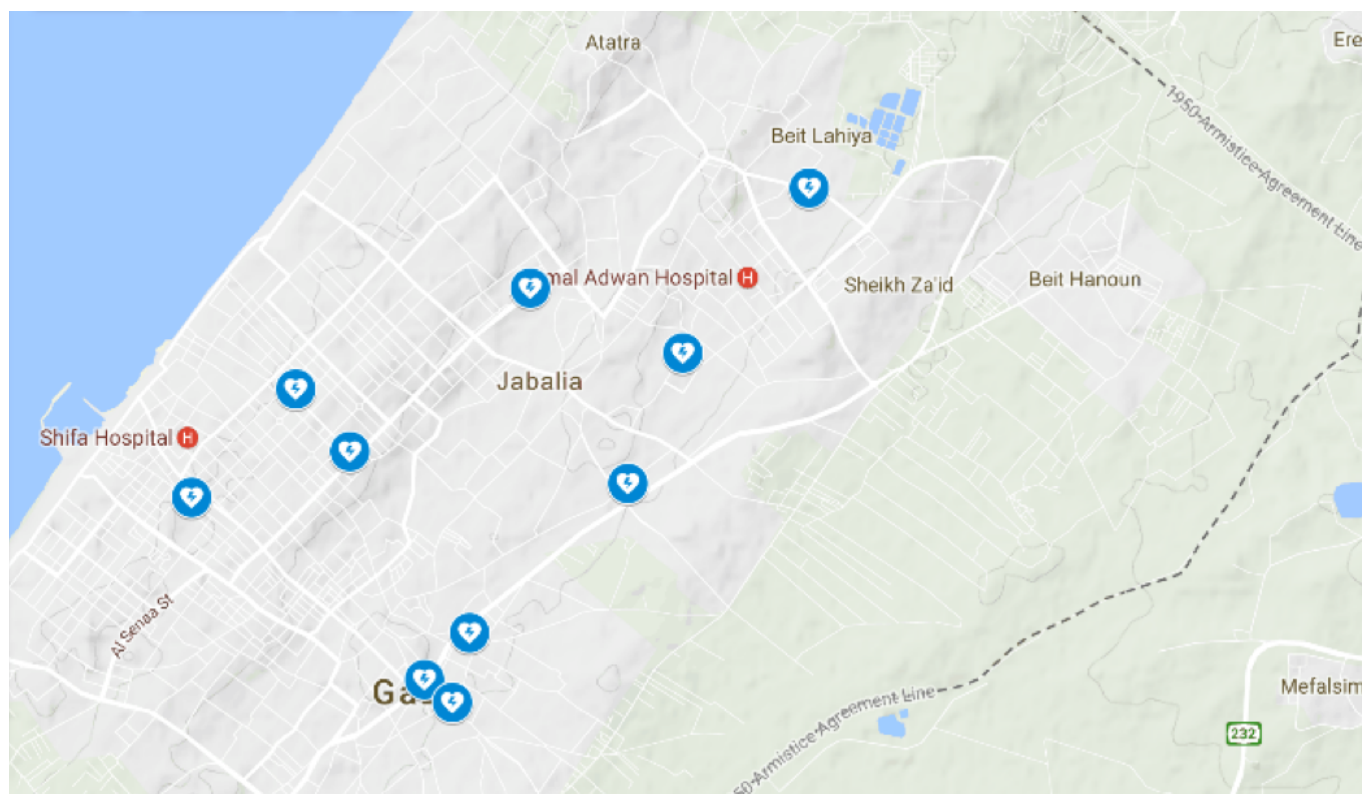


Figure 4: Map of health-related services in Shajaia and Jabalia



¹ The mapping showed that Shajaia has four government-run primary health care (PHC) centres and three NGO-run clinics. In addition, residents receive services from nearby UNRWA, NGO and government premises. Similarly, in Jabalia, there are two UNRWA clinics, three Ministry of Health clinics, three NGO clinics and two hospitals; one managed by the Ministry of Health, the other by an NGO.

overcrowding, uncleanliness and lack of privacy. In the adolescent beneficiaries' survey, when asked whether adolescents in their community ever speak to doctors or nurses about concerns they might have about their growing bodies and puberty, only 22% said yes (see Figure 3). Of those who did, only 5 reported that they had already spoken to a healthcare provider about concerns they might have around puberty. This reflects inadequate access to and utilisation of adolescent-related services and information.

Most adolescents in Gaza cannot afford private health care, although private providers are preferred for serious illnesses owing to their higher quality than public services. Adolescent boys and girls gave very positive feedback about private sector services: *'Private providers are the best of course! The doctors are more qualified, and the place is always clean'* (FGD, older boys, Shajaia). In a focus group with older girls in Jabalia, an 18-year-old noted: *'I went to Al-Awda hospital to be operated, they asked me to pay NIS 1,000, but I can't afford that, I ended up moving to another hospital. But I wanted Al-Awda because services are good there. Then I went to Al-Shifa hospital [Ministry of Health hospital], where I spent three days crying without any good health care. The rooms were unclean and blood all over. The curtains were dirty too. The smell was very awful there too.'*

2.1.2 Attitudes of health care providers

Adolescents expressed critical attitudes towards medical staff who were often insensitive to their needs. *'In Al-Shifa hospital, for example, the treatment is not good unless you know someone there'* and *'As for the cleanliness of places, bathrooms there are super dirty'* (FGD, older girls,

Shajaia). Another girl said *'I was so afraid when I went to the dentist in the UNRWA clinic. The dentist shouted at me and said "if you don't want to be cured, go home!" Then I went home without checking my teeth'* (FGD, younger girls, Jabalia). One boy said *'We don't like hospitals because the staff there do not like to help, they yell at us, and tend to ignore us'* (FGD with younger boys, Shajaia). A 17-year-old boy said, *'The doctors are not good. I once went to a clinic and I was complaining from headache and the doctor prescribed me a corset for my leg!!'* (FGD, older boys, Jabalia).

In sum, the level of trust and satisfaction of adolescents about health care services is low. Table 3 reflects adolescents' views on certain aspects of health services.

2.1.3 Health service affordability and uptake

Despite their families having medical insurance, most study participants cited drug shortages, cost of treatment and availability of laboratory tests among the main challenges they face when visiting health facilities. Some families borrow or seek help from NGOs or charitable bodies to pay for medications, which are often in short supply, especially at Ministry of Health clinics. This is especially true for more costly treatments, as this quote highlights:

'I have some problems related to growing normally; and my family can't afford growth hormone medication, which costs around \$1,000 monthly. We take financial aid from Ministry of Social Development and we have to borrow the rest of the money from people.' (FGD, younger girls, Jabalia)

Unaffordability of health care also leads to intra-household tensions, as one 12-year-old girl explained:

Table 3: Adolescents' levels of satisfaction with various domains of health care

Domain	Level of satisfaction	Domain	Level of satisfaction
Interpersonal relationship with service providers	Low	Communication and interaction	Low
Availability of medications	Low	Adolescent specific services	Low
Counselling	Low	Participation in care	Low
Satisfaction about waiting time	Low	Physical environment	Moderate
Physical access to care	High	Respect and understanding of adolescents' needs	Low
Information and health education	Low	Cleanliness of bathrooms	Low

'My parents would argue sometimes about the medicine cost and my dad would kick my mother outside the house. Sometimes he would say that he does not care what happens to me, saying "may she die"!!!' (IDI, Shajaia).

Because the health care system is curative rather than preventive, and staff are mostly disease-oriented (Ministry of Health, 2014), adolescents usually only go to a clinic when they have acute manifestations such as high fever or infection; otherwise, they use home remedies such as drinking herbs or eating garlic. Reports indicate that more and more people now rely on home remedies and cultural rituals, due to economic hardship and lack of trust in health care providers (Ministry of Health, 2014). Some girls also said that young people try to simply endure sickness until they feel better. One boy explained: *'When I need medicine that I cannot afford, I just sleep it off till I feel better'* (FGD, younger boys, Shajaia). In the same focus group, another boy said, *'When I need medicine that I cannot afford, I eat garlic'*. Another said: *'I do not go anywhere. I drink juice when I am sick'*. And a 16-year-old adolescent mother said: *'Once I had stomach ache and I told my mother about it, she advised me that I have to drink boiled parsley and eat watermelon'* (IDI, Jabalia).

Some girls believe that poor families would prefer spending on their sons because they are likely to financially support the family in the future, and 'investment' in girls' health is therefore a lower priority. However, generally adolescent respondents were of the view that families decided on health expenditure based on the severity of illness regardless of gender. Girls in FGDs in Shajaia commented: *'Females are usually denied health services because they don't work, while males work and earn money'* (FGD, older girls, Shajaia). Boys mentioned that younger children are prioritised, followed by girls: *'Younger children go to the health facilities more because they get sick more than older ones and girls also go more'* (FGD, younger boys, Shajaia). Disparities were also highlighted by older girls who thought that their parents care more about their younger sisters' health, as child illnesses are perceived as more dangerous.

2.1.4 Barriers to health care for adolescents with a disability

Due to structural and cultural factors, adolescents with disabilities face numerous barriers in accessing health and other public services. The basic package of health

services offered by the Ministry of Health and UNRWA is not disability sensitive (Jones et al., 2016) and most families pay for many medical services out of pocket. Rehabilitation services are almost non-existent, and adolescents with disabilities – especially girls – are severely stigmatised and denied their right to health care (UNFPA, 2017). Our findings are congruent with those of a recent study on Palestinian children with disabilities, which showed that the basic package of health services is not tailored to address their specific health care needs (Jones et al., 2016). Families of people with disabilities must rely on their own funds to meet the needs of their disabled family member, which has exacerbated socioeconomic inequalities (ibid.).

During the GAGE participatory pilot activity, a 19-year-old young woman with a physical disability noted, *'Access to health services is difficult for me. I need some diagnostic services but unable to receive that. I receive almost nothing from disability-related organisations. Also, to tolerate the annoying comments made by people, I need psychosocial support, which I can't find'*. She added: *'Because I use a wheelchair, drivers don't pick me up, they just ignore me at the taxi stations, and therefore, I can't easily access services. People with a disability, like me, need extra expenses – for medication, transportation and also to cover the costs of special equipment. My family alone can't afford that'* (case study, 19-year-old woman with a disability, Khanyounis).

Adolescents with a disability noted that there were few services tailored to their needs and those that did exist were of poor quality. As a 19-year-old girl from Jabalia said: *'I live with only a quarter of a kidney, and physicians in Gaza could not help me because my disease is rare...'*. She continued, *'It is very painful and I could not move because of the swelling in my kidney'*. An 18-year-old boy with a disability stopped attending physiotherapy sessions because he felt the treatment was worthless: *'I was taking physiotherapy for six years in Baitona [NGO-run service], then I stopped because I did not see any improvements'*. He continued, *'Then I have been treated at Maqased hospital in the West Bank, but the doctors made a mistake there too, I am still unable to walk!'* (IDI, Jabalia).

Additionally, lack of assistive devices makes daily life difficult for young people with disabilities. When the 18-year-old boy above was asked what his most precious personal possession is, (the object exercise), he answered *'My scooter, which is now broken, is my most precious object. Without it, I just stay in the house doing nothing'* (IDI, Jabalia).

Image 2: Mariam, 19 years old, from Khanyounis, has been quadriplegic since birth due to spinal paralysis. She was also injured in the 2014 war with Israel, during which time the area was heavily bombed. Although the house has not been adapted to meet her needs, she is very determined and has continued her education at the university!



2.1.5 Access to health care and information

Our findings also indicate that adolescents have limited access to information about health or healthy lifestyle. These findings are congruent with the literature, which shows that for girls, the main source of knowledge about the signs of puberty was their mothers (70%) followed by other relatives (41.5%), books (23%), friends (16%) and teachers (10%) (UNFPA, 2013). For boys, their main source of knowledge was friends (50%), followed by books (31%) and teachers (14%). None of the participants mentioned health care providers as a source of information (ibid.). School health programmes do exist within the Ministry of Health and UNRWA health services, but these are limited in scope and do not target school pupils.

Gendered social norms play a critical role in hindering girls' ability to practise a healthy lifestyle. In many schools, sport classes are cancelled and replaced either with

regular classes or by cleaning the classrooms! One girl explained: *'During sport class, we do not play or practice. Instead, we are handed sweepers to clean the place'* (FGD, older girls, Shajaia). Outside schools, the situation is equally restrictive: unlike boys, girls are not allowed to go out to practice sport at gyms and their movement outside the house is sharply constrained or scrutinised. Deeply rooted social norms about protecting family honour are the main driver limiting girls' movement outside the house. Most adolescent girls spend much of their time watching TV, vicariously observing lives which they are prohibited from living (Wehaidi et al., 2017). Only 19.6% of young women practised sports on a daily basis in 2015 compared to 45.1% of the male cohort (PCBS, 2016b). Even more telling, the vast majority of these girls (86.9%) engaged in physical activity at home, while only 4.9% and 3.8% of respondents exercised through a sport club or at school respectively.

Box 2: Substance abuse among Gazan adolescents

Of Gazan young people aged 15-27, 53% of girls/young women and 56% of boys/young men report that drug addiction and unhealthy lifestyles are their largest health challenge. Smoking prevalence among youth has increased in recent years, up to 23.5% (40.9% of males, 5.4% of females – probably due to social norms). Young people in Gaza also have high rates of addiction to Tramadol (an opioid painkiller), which reportedly affects between 50% and 80% of the adult population. Increasing access to harmful substances is exacerbated by a lack of outreach or educational programmes and a lack of integrated health and rehabilitation services.

Our research findings confirm that substance abuse is widespread among adolescents, especially boys/young men, reflecting the many stressors they face, including unemployment and anxiety. One boy mentioned that 'Tramadol use is common among youth. The worry comes not only from using it, but many are involved in dealing, because of the unemployment' (FGD, older boys, Jabalia). Many participants who were interviewed individually admitted having tried Tramadol or knowing people who take it. One 14-year-old said: 'The day before yesterday, I was at a wedding party for my friend, and someone came and he had Tramadol, he put it in juice and distributes to all' (IDI, orphaned boy, Shajaia).

Girls reported knowing people who take drugs, but did not admit taking it themselves. Girls also reported feeling more insecure moving around in the community because of increasing substance abuse. One said: 'Males are becoming more dangerous in Gaza. Safety is less in Gaza with the many male Tramadol users, after being addict, they turn violent and tend to steal to secure the money needed to buy the stuff. Our families prevent us going outside in order to protect us from those bad people and thieves' (FGD, older girls, Jabalia). A 19-year-old said: 'I heard many stories of females using Tramadol, my cousin and two girls at school (grade 9) are using it. They have it at the toilet of the school on daily basis and one day, the cleaner caught them and the school informed their parents' (IDI, early marriage, separated, Jabalia).

Source: Billing, 2016; PCBS, 2016a; UNFPA, 2017

Image 3: Adolescents from Khanyounis practising body building and self-defence at a boys only youth club



Image 4: Many girls in Gaza become TV addicts to ‘kill time’ as they don’t have access to other recreational resources such as girls’ clubs or libraries



2.2 Outcome 2: Access to age-appropriate and stigma-free knowledge, supplies and support to manage menstruation

Education on SRH, including menstruation, has been incorporated into the school curriculum (UNFPA, 2017) but it is not clear how fully this is applied (UNFPA, 2016). In Palestine, SRH education remains a controversial subject, circumscribed by political, economic, cultural and religious factors. Societal taboos are major obstacles to informed discussions about SRH issues, particularly in relation to young people (ibid.).

2.2.1 Adolescents have limited knowledge and information about puberty

Many adolescent girls reported feeling unprepared for puberty and the physical and emotional changes it brings, with 28% stating this phase had caused them problems (UNFPA, 2013). For instance, 22% had no idea about menstruation; 40% were afraid when they first experienced a period, and 19% felt embarrassed; and 43% taught themselves how to clean their bodies during a period. When asked who they would approach for more information (multiple response permitted), 7% said they would ask no one, 82% their mother, 43% their father, 9% an older sister,

7% an uncle/aunt/grandparent, 38% other relatives, 29% friends, 42% teachers, and 3% would read a book (ibid.).

Our findings indicate that the majority of girls had their first period at the age of 13 years, and most reported feeling fearful and shocked by it, though the situation was harder for younger girls (aged 10 or 11) and those who had never heard about periods before, either from their families or from schools. One girl said: *‘I was 11 years old when I had my first period, I was so scared. It happened that I was doing exams. I rushed to my mother and sisters. I was scared and young. I cried for a week. I didn’t know that there is something called a period, and that it happens every month’* (FGD, older girls, Jabalia). Another girl said: *‘A friend of mine had her first period in the school, she did not know that it is the period, our teacher assured her and helped her to keep herself clean’* (FGD, older girls, Jabalia).

2.2.2 Sources of knowledge and support about menstruation

In Gaza, menstruation and puberty issues are not openly discussed; most girls said they only approached their mothers or older sisters when they got their menses. This is congruent with the literature, which indicates that mothers are the main source of information about puberty for girls (70%), while friends are the main source for boys (50%) (UNFPA, 2013). Only one or two girls approached their teachers because they had their menses at school and needed help. Some girls who live with their extended family might face challenges to protect their privacy. As

one said: *'All the men in the family knew I had it. It was a spreading news in the larger family. They said to me "you are an adult now, you turned a woman"'* (FGD, older girls, Shajaia). Indeed, according to study participants, mothers and older sisters are the first and most important source of puberty-related information and support. Girls reported feeling happy to have a talk with their mother about this stage of their lives. Mothers support their daughters to accept the changes in their lives that the onset of puberty brings. As one girl said: *'My mother talked to me and told me about the period. She was assuring'* (FGD, older girls, Shajaia). Another girl said: *'She also tries to chat with us to make us forget our pain'* (FGD, older girls, Jabalia). Fathers are often told by the mother when their daughter gets their period, without any direct communication between fathers and daughters about this.

Given the prevailing stigma around menstruation, family members are either not aware or not supportive to girls during menstruation. While boys did not mention anything about girls' menstruation, girls themselves mostly reported experiencing embarrassing comments or teasing from family members, as the following quotes illustrate.

A participant in a focus group discussion reported that an adult male in her family said: *'Look, she got her period... She is still young!'* (FGD, older girls, Jabalia). In the same group discussion, another girl reported that: *'One day I asked my male cousin, who is 9 years old, to buy me pads and he said he knows that this is for the period. Two days after, I asked him to buy me more, and he shouted, "I bought her one two days ago". I was very embarrassed and he told my uncles about that.'*

'In Ramadan, when I have my period, she [younger sister] tells everybody at home and they laugh at me because I can't fast like them.' (FGD, older girls, Shajaia)
'If I have my period, my husband's family gets angry and says, "She has her period, that means she is not pregnant!'" (FGD, older girls, Jabalia)

2.2.3 Schools provide minimal SRH education

Schools (teachers or counsellors) start introducing information about menses for 7th grade students (aged 13 years) but according to participants, the knowledge they give is not sufficient. Some teachers refused to talk about menses with their students, believing that mothers should discuss the topic with their daughters at home instead. One girl said: *'Our teacher told us to go home and ask*

our mothers to explain this lesson for us... The teacher said "let your family explain this disgusting topic"!!!' (FGD, older girls, Shajaia). Another participant reported: *'There are some teachers who would be shy and don't talk about such topics [puberty and menses] and they would skip the pages that have this in the notebook, asking us to read it alone'. Similarly, in Jabalia, teachers either superficially discussed the topic or provided wrong information: 'In that lesson, our teacher explained that girls will have their period one day, and that means they will bleed for a week or so. This blood is poisonous and it causes pains. That's all what she said'. She continued: 'She [the teacher] didn't give enough information. We were young, so we needed more information'* (FGD, older girls, Jabalia).

One school took a different approach, using external consultants (health educators) rather than teachers – an experience that was highly valued by girls: *'The consultant advised us to talk to our parents if we have not our period yet, so we can receive treatment in the early stages and avoid potential problems. Some of our classmates reach their 9th grade and still have not their first period. After the session, they went to see doctors for treatment'* (FGD, older girls, Shajaia).

2.2.4 Puberty heralds more cultural restrictions on girls

Generally, families in Gaza impose restrictions on their daughters at the onset of puberty, such that girls stop playing outside the house, reduce contact with male cousins and wear hijab. One participant in a focus group discussion lamented: *'It is uncomfortable that all people link start wearing of hijab to the period. The girls, especially cousins, talk and make annoying comments when they see any girl from their relatives wearing hair scarf as they think that she has her first period. They ask her and it is a kind of embarrassment'* (FGD, older girls, Shajaia). Other community stressors include linking menstruation to evil or divine acts; one myth is that females during their menses should not visit a mother who has just given birth because of a belief that this will cause the baby disease or pain (FGD, older girls, Jabalia). Girls who have their period are also perceived as 'unclean or unblessed', according to participants from Shajaia. One 17-year-old participant from Shajaia explained: *'My 12-year-old sister called me: "You are dirty"!! You are "Nejsaa" [defiled]' because I was having my period. She continued, 'I feel upset when I hear my sister calling me by those terms'* (FGD, older girls, Shajaia).

Although, according to Islam, women during menses are forbidden from fasting, in Ramadan, most girls said they cannot eat or drink openly and pretend to be fasting although they are not, as this may signal that they are menstruating – something that is perceived as embarrassing and should remain a secret. One participant in Jabalia noted: *'We eat in Ramadan, but not in front of our families'* (FGD, older girls).

2.2.5 Absence of menstrual changing facilities

Girls often lack access to clean and private facilities to take care of personal hygiene at their schools since toilets are extremely dirty, as indicated by participants from Shajaia and Jabalia. However, some schools keep standby clothes and sanitary pads in a store room to be used by menstruating girls, which was highly appreciated by girls. Participants from Shajaia mentioned that they are rarely excused from exams during menstruation, and are not allowed to rest or leave the school to go home if they are experiencing menstrual pains, except when the teacher is supportive.

Adolescent girls are rarely prepared emotionally or physically for the changes that puberty brings. For most girls, the first time they talk about menstruation is at menarche (the onset of their first period). In the home, girls living in big families, before or after marriage, do not

have the minimum privacy or financial resources required to maintain hygiene. As one girl said: *'Fathers shout at us since they do not afford pads every month'* (FGD, older girls, Shajaia). Another girl noted: *'Some parents tell their daughters to use a piece of cloth instead of pads because they have no money for pads'* (FGD, older girls, Jabalia).

Water shortages exacerbate the situation (whether at home or school), while repeated outbreaks of conflict present specific challenges for young girls in managing menstruation (see Box 3).

2.3 Outcome 3: Access to age-appropriate, gender-friendly and stigma-free SRH and puberty-related information, services, supplies and support

The four major health care providers in Gaza are the Ministry of Health, UNRWA, NGOs and private for-profit operators. The Ministry is responsible for a significant portion of health care delivery, including SRH (Ministry of Health, 2017b), and is also the regulator and supervisor of all health services. It runs 56 PHC centres, 28 of which provide SRH services; it also runs 13 hospitals, 5 of which provide maternity services (Ministry of Health, 2014). UNRWA plays an important role in providing SRH services through 22 centres and financially supporting secondary and tertiary services for registered Palestinian refugees (UNRWA, 2017). Through 50 health centres, NGOs also play a complementary role in supporting vulnerable groups with health needs. The private sector is largely unregulated, and tends to focus on obstetrics and surgical intervention (Ministry of Health, 2014).

2.3.1 SRH services, achievements and caveats

The maternal mortality rate (maternal deaths/ 100,000 live births) in Palestine has significantly improved in the past decade (see Figure 5), reaching less than 20 maternal deaths per 100,000 live births in 2016 (Ministry of Health, 2016, 2017a). However, the 51 days of hostilities in 2014 resulted in the death of 20 pregnant women (UNFPA, 2014). Although there has been a great deal of improvement in the reporting and documentation of maternal deaths, there is still a need to further support safe delivery practices, especially during specific crises.

Box 3: Difficulty in managing menstruation during the conflict in 2014

Participants from Shajaia described their experience during the war, saying, *'We spent a whole year in UNRWA school – they were opened as shelters to displaced families. It was tough time and was hard to go to bathroom freely, the place was very crowded, very dirty and total lack of privacy. Our families prevent us from going alone to the bathroom at night because the school was full with men. They were afraid that any of us would be raped... three male relatives accompanied us for protection. Once I had my period at night when everyone was asleep, no one to come with me to toilet so I had to ask my sister to hold a blanket to give me some privacy to put pad till the morning.'*

'We face a lot of difficulties every time we need having a bath in the shelter. We did not use the bathroom. We bath in the same room we used to sleep in after we asked all the families who share the room to leave. Sometimes there were two or four families shared the same room and all of them had to get out if any of us would like to have a bath (FGD, older girls, Shajaia).'

Figure 5: MMR trends in Gaza, 2007 to 2016

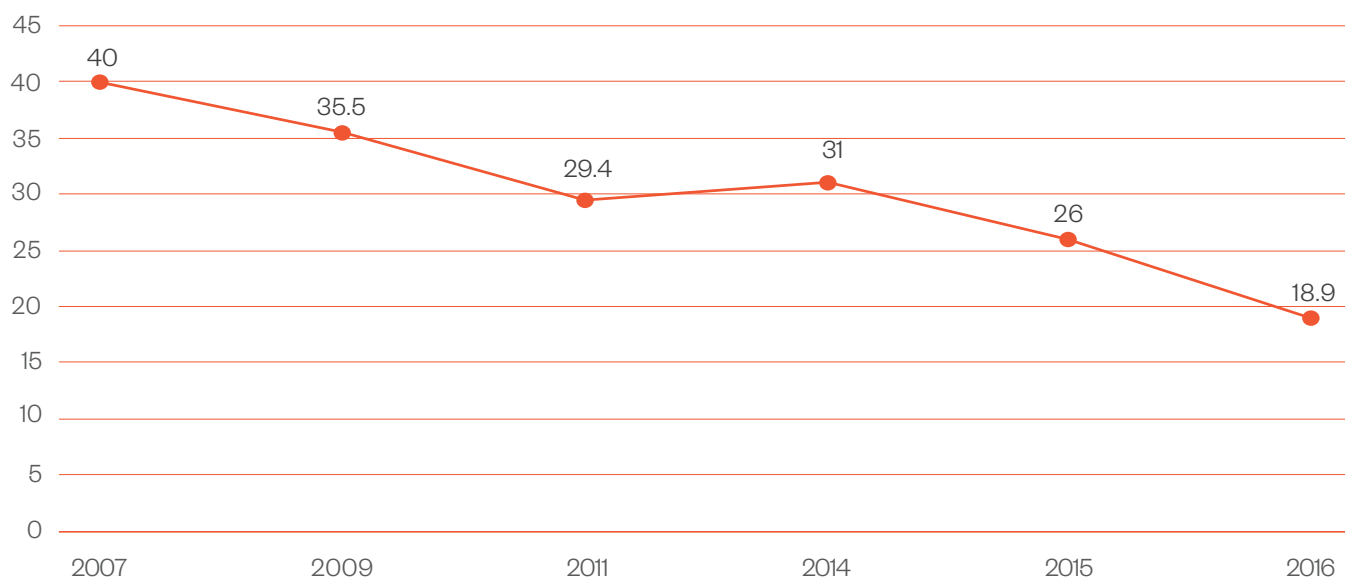
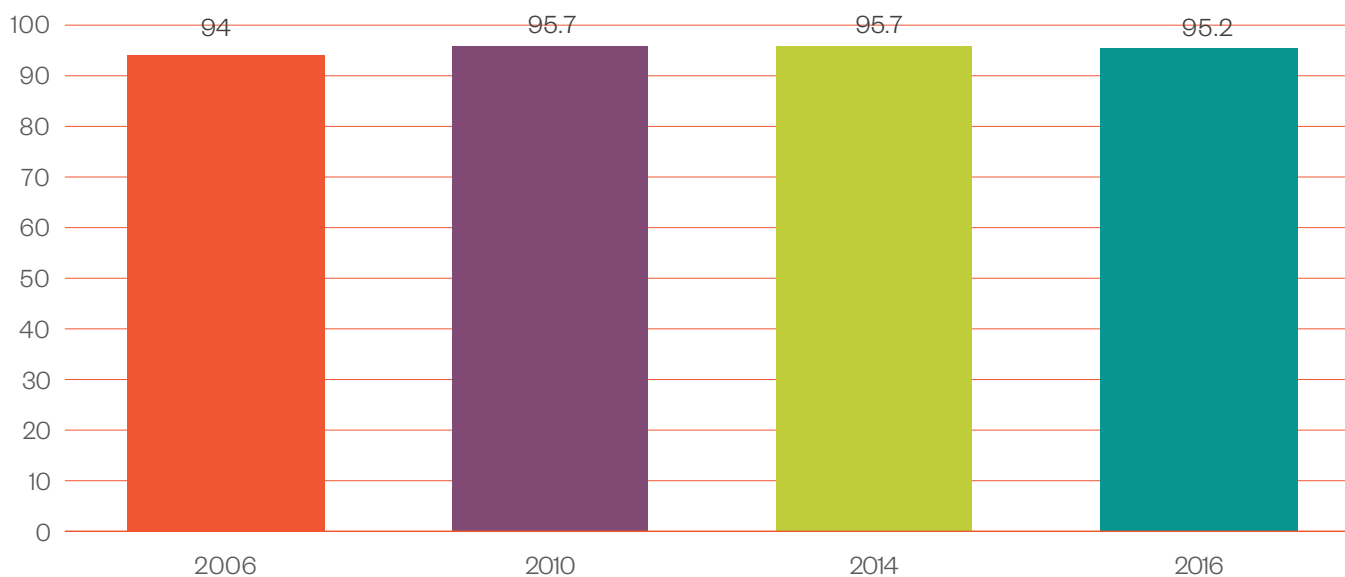


Figure 6: Percentage distribution of women who made 4 or more ANC visits in Gaza



Utilisation of antenatal care is improving and has reached almost universal coverage (see Figure 6); however, quality of care remains an issue (UNRWA, 2017). Problems include lack of adequate preconception care (only provided at UNRWA and the Near East Council of Churches (NECC) in Gaza), weak counselling, and inadequate access to information. Postnatal care remains unsatisfactory (Ministry of Health, 2017b), with many women post-delivery not receiving appropriate care for themselves.

Availability and accessibility of delivery services in Gaza are reasonable, but quality of care is often sub-optimal. Shortcomings during delivery include routine

unnecessary interventions, frequent examinations, lack of privacy, lack of respect, overcrowded delivery areas, and overstretched obstetricians (who practise in more than one institution) (UNFPA, 2016).

The total high fertility rate and the structure of fertility in Gaza give cause for concern (see Figure 7), with the concentration of births at a young age. The PCBS survey found an adolescent fertility rate (girls aged 15-19) of 66 per 1,000 (see Figure 8). Birth interval by mother's age shows that this is positively correlated with age – with adolescent mothers having birth intervals of 20 months in 2014.

Figure 7: Total fertility rate (births per woman) in Gaza

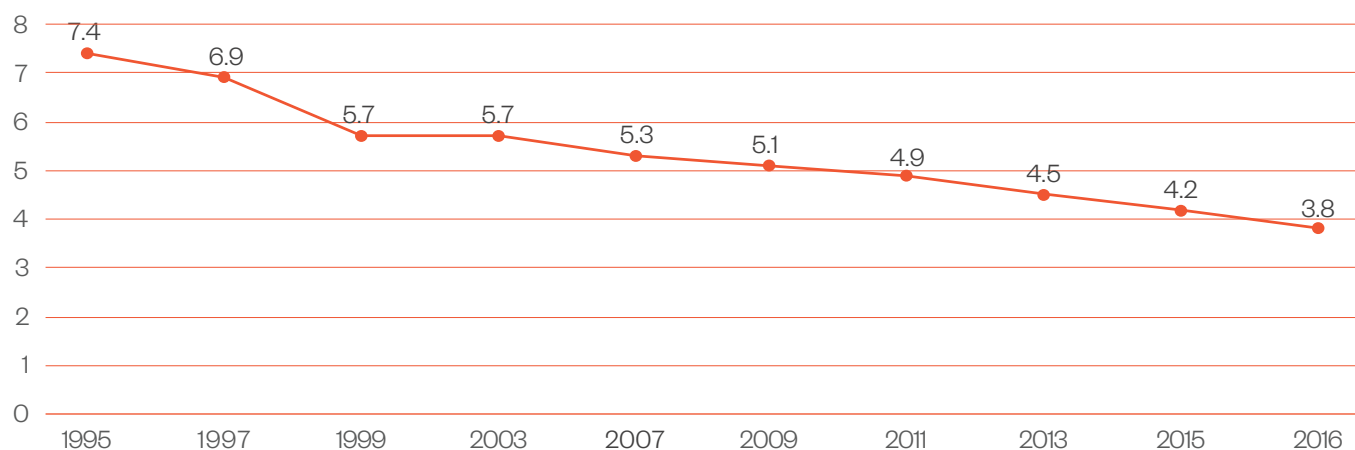
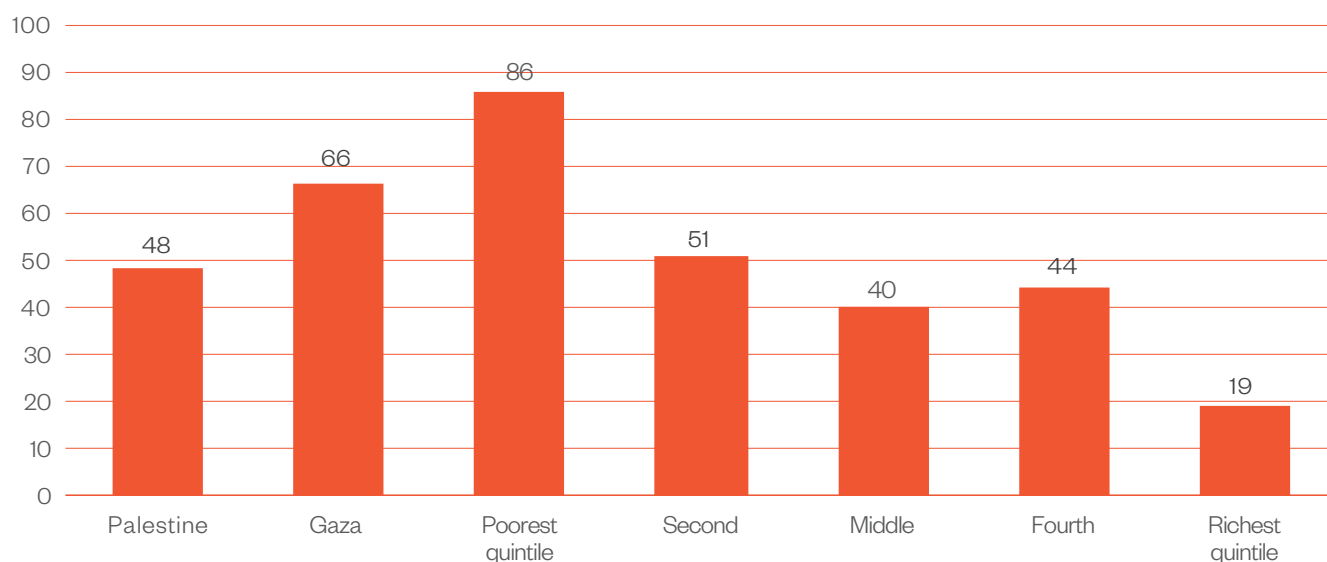
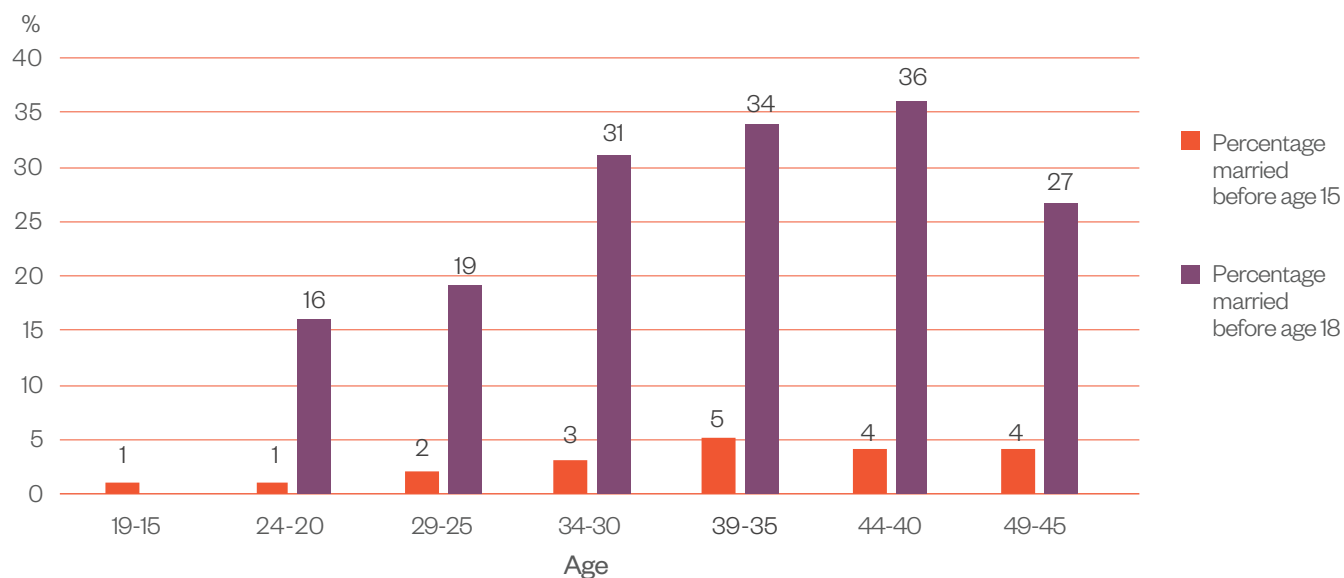


Figure 8: Adolescent fertility rates by sub-population (births to girls aged 15-19/ 1000)



Source: PCBS, 2015

Figure 9: Percentage of different cohorts married as children



Source: PCBS, 2015

Early marriage (Figure 9) endangers the health of adolescent girls, exposing them to early childbearing, while few adolescent mothers follow the recommended intervals of pregnancy spacing. Nearly 30% of girls in Gaza are pregnant before they turn 18 and about half are mothers before the age of 20 (MIFTAH et al., 2015). A recent PCBS survey showed that 28.6% of Gazan women aged 20-49 years were first married before the age of 18; 2.6% of those in the childbearing age married before the age 15 (PCBS, 2015). The median age of marriage among females is 20.3 years (24 years among males), having improved from 17 years two decades ago. .

On family planning, the most recent PCBS survey found that of married girls aged 15-19, 84% were not using contraception, compared to 62% of married women aged 20-24 (PCBS, 2015). In Gaza, family planning is usually initiated late, with the first contraceptive use (ever) tending to begin only after the fourth or fifth child and after having a satisfactory number of children, especially boys (UNFPA, 2016). Of girls aged 15-17, the mean ideal number of children is five (PCBS, 2016b). Gaps in family planning include limited access to information on family planning methods and weak counselling, which negatively affect service uptake. Social, cultural, political, economic and legal constraints mean that women and girls face particular challenges in realising their full SRH rights. For instance, a woman is required to have her partner's consent to use family planning services at facilities run by the Ministry of Health and UNRWA. While the contraceptive prevalence rate has increased slightly from 2006 to 2014, unmet needs for family planning among adolescents in Gaza remain high (17%) (UNFPA, 2016).

2.3.2 SRH: 'No one told me about that!'

Adolescents' access to SRH information and care appears to be particularly limited. Of teens aged 15-17, 40% had not heard about sexually transmitted infections (STIs) (other than HIV) and 20% had not heard of HIV (MIFTAH et al., 2015). While HIV is extremely rare in Gaza, lack of knowledge highlights broader concerns about discussing sexuality and ultimately limits adolescents' knowledge about how to protect themselves from sexual harassment and violence.

Indeed, evidence suggests that gendered social norms, which see girls' virginity as central to family honour, largely preclude girls' and young women's access to non-

maternity related care (MIFTAH et al., 2015). Parents often do not allow unmarried girls to visit a gynaecologist because they are concerned that any invasive procedure might lead to loss of the hymen. One girl said: *'Fathers will prevent girls from visiting a doctor no matter how severe the condition was because they believe there is a chance that her virginity will be ruined, and as a result she will not get married'* (FGD, older girls, Shajaia).

Due to their limited access to appropriate information, even on maternity-related matters, mothers themselves have insufficient knowledge/awareness of important danger signs related to SRH. For example, only 16% of women identified lack of foetal movement as a danger sign for their pregnancy. Only 15% of mothers were able to name at least five such danger signs (unprompted) (UNFPA, 2013).

Our discussions with adolescents confirmed that they know only a little about these topics, rendering them completely unprepared for the changes puberty brings. Most boys defined puberty as growing up and linked it with the ability to marry. As one boy said: *'It means I can marry'* (IDI, 16-year-old boy, Shajaia). Other signs mentioned by boys included growing body hair, growing facial hair, voice deepening, and feeling more like an adult. Similar to girls, most boys focused on the physical changes in their bodies, although a few mentioned that boys become more aggressive during puberty. Some boys expressed anxiety about going through puberty and the prospect of the *'scary adulthood'* stage. In some instances these feelings reflect young men's concerns over their sexual ability or ability to father children: *'I am afraid of being futile or sexually disabled and not being able to have children. I heard there are men who cannot have children. I'm afraid to be one of them'* (IDI, 16-year-old boy, Shajaia). Hence, most boys prefer their childhood, which involves fewer responsibilities. As one boy said: *'Childhood is better because it is a time that others take care of you but now I must depend on myself and may be asked to care for others as well'* (IDI, 16-year-old boy, Shajaia).

2.3.3 Sexuality: a taboo topic!

Talking about sexuality is a taboo, hence, sufficient information is very rare, hardly communicated and, in many situations, avoided. It was very rare for unmarried girls to mention that they had access to such information. Even for those who were about to become sexually active (because they were about to marry), information was

minimal. Some participants described their first day of marriage as the worst experience of their life, especially when they were completely unaware that they would expect to engage in sexual intercourse. As one girl said *'I had no idea what marriage was. I thought that marriage is all about supporting my husband. I had no idea that it included a sexual relationship. Nobody told me anything, even my family. The biggest shock I had about getting married was at the night of my wedding, I ran away from home and went back to my family. I was terrified. My husband came to my family's home and he told them to leave me as I wish, I returned to my husband after a month, I was afraid'* (IDI, 16-year-old girl, early marriage, Shajaia). Another participant said: *'One of my cousins got married when she was at the preparatory school because her family noticed that her body is suitable for marriage. She knew nothing about sexual relations, she even did not know what to do with her husband to the extent that led him to send her back to their parents, saying teach her about marital relationships before you send her back to me'* (FGD, older girls, Shajaia).

Interestingly, participants reported that their mothers feel shy communicating SRH information to them. At best, there will be a short talk with the girl before her wedding, either by her mother or a married sister or cousin. Few girls find relevant information through internet outlets (see more on this in the Voice and Agency briefing). Girls believed that grooms seldom support their wives through this transition. Instead, they would turn violent and raise questions related to honour (they assume that the bride avoids intercourse because she might not be a virgin or because she had previous relations), and complain to their parents and in-laws, heaping more stress on girls (see case study 3 in Box 4). Participants described their first experience of sexual intercourse as *'scary'* and *'strange'*.

Unsurprisingly, females rarely talk about their sexual needs, as one girl said: *'I do love him but I don't feel pleased like he may do, we never talked about such things'* (IDI, 16-year-old girl, early marriage, Shajaia). Moreover, issues around reproductive health create considerable stress for girls, who rarely have a say about the timing or spacing of pregnancies, how many children they have, or what type of family planning method they use. To a large extent, social norms dictate that it is not acceptable for a woman to leave an infertile husband, although it is acceptable for a man to leave an infertile wife. As one girl said: *'Husbands divorce their infertile wives while wives stay with them forever even*

if they are infertile, these women endure all difficulties and remain patient' (FGD, older girls, Jabalia). Additionally, women are blamed if they miscarry: *'I had miscarriages four times, my husband's family always blame me for not giving birth'* (FGD, older girls, Jabalia). Son preference tends to prohibit family planning, since mothers often have more babies hoping for a boy, fearing that their husband may marry again to have male offspring. Also, our research indicates that mothers-in-law have strong influence on family planning decisions. For example, a mother from Jabalia pushed her son to threaten his 16-year-old wife that he would divorce her if she continued using contraceptives (IDI, 16-year-old adolescent mother, Jabalia).

2.3.4 Low-quality adolescent SRH services

Adolescent girls who married early face challenges with health care services. As noted above, though access to antenatal care is nearly universal, the quality of services is suboptimal. The gender of the health care provider can be a barrier, with most participants preferring female health care staff given the very personal nature of problem. As one participant said: *'I feel shy to tell a male physician that I have a severe inflammation'* (FGD, older females, Jabalia). Other participants considered service provision by male doctors or nurses problematic, especially for unmarried girls. Participants reported concerns in prenatal care as including lack of cleanliness, modest levels of privacy, waiting times and drug shortages. As one commented: *'When I go to the midwife, I feel like I'm in a shop not in a clinic, because everybody enters and leaves in the same time, also she and clients don't respect appointments'* (FGD, older girls, Jabalia).

Our findings show that paying some money is essential to get qualified staff for delivery, whether at a private clinic or giving a 'bribe' for staff to provide better care; boys mentioned this less frequently, but this may be because they use health care services less frequently than girls. Participants said: *'Doctors ask for money gift after we successfully give birth, also, some nurses ask for money in advance in order to give better care for us while we are in the delivery room, they all blackmail us'* (FGD, older girls, Shajaia). One boy in a focus group discussion stated: *'The doctors' treatment is not nice. Plus, when the place is crowded, you have to pay 5 shekels so they let you in to receive the services!'* (FGD, younger boys, Shajaia).

Box 4: Compound vulnerabilities: terrifying reproductive health services

'I am broken' – that is how 17-year-old Hanna, from Khanyounis, described herself and her life.

Hanna was married at the age of 14 to a man more than twice her age. She lives with her husband, who earns only an intermittent income as a taxi driver, and his parents. She has already been pregnant four times and has two children. Because her husband insists on *'many children, especially boys'*, Hanna has been almost continuously pregnant since she was married. She found her first pregnancy terrifying – *'I was afraid when the baby was moving'* – because she had never been told what to expect during pregnancy, even by doctors at the UNRWA clinic. As she said, during delivery at the hospital, no one told her anything and *'the health personnel at the hospital were not supportive... I had no information,'* she explained, *'I am a child, I don't know about these things'*.

After her son was born, two months premature, she was sent home immediately. Her son died. *'I never forget him'*. Hanna feels that both her body and her soul have been broken by child marriage and motherhood. Her age, her continuous pregnancies and her poor diet have combined to leave her badly anaemic.

Seeing what Hanna's life has become, her father has not married any of her younger sisters. *'My father feels guilty now,'* she added, *'early marriage is a disaster for a 14-year-old girl, it is suffocation'*. Hanna also wishes that Gazan girls had better *'health services and information that consider their specific needs'*.

She ended by saying, *'No one should be terrified like I was'*.

Women who are about to give birth – and thus extremely vulnerable – have been exposed to verbal and physical violence from medical staff. One participant said: *'Once an obese doctor stepped on my belly, I screamed, she swore bad words rudely'* (FGD, older girls, Jabalia). Another participant from Shajaia said that: *'The doctor slapped me when I was giving birth for the first time and she said to me either you do as I tell you or I will kill you and your baby!!'* She added: *'Many people do several vaginal examinations*

and they don't even introduce themselves to us, there is no privacy, the space is dirty and blood all over. The smell was very awful there too' (FGD, older girls, Shajaia). The case study in Box 4 below summarises the difficulties many early-married adolescent girls experience during their first delivery.

Conclusions and implications for policy and programming

Overall, our findings underscore the complex and interlinked challenges to adolescents' full capability development in the Palestinian context, and the critical role that context-specific gendered norms and practices play in shaping adolescent girls' capabilities and wellbeing.

Our mapping exercise confirms that while adolescents' overall health outcomes are relatively good, the most pressing issues they face are related to SRH and risky behaviours like smoking and substance abuse. Girls are particularly affected by SRH issues. Our findings also show that health services are rarely tailored to the specific needs of adolescent girls and boys, which has a negative impact on their utilisation.

The basic package of health services is excessively medically oriented and does not include preventive services for adolescents, tailored to their distinct needs, especially around information and awareness. Rather, adolescents are served only when they present with medical conditions. Prevention efforts are negligible, which is a glaring omission given the high prevalence of

preventable conditions (especially anaemia, obesity and substance abuse) and the high number of adolescents who are not prepared for puberty, lacking information and awareness about menstruation and SRH. It is therefore essential to focus on health promotion and policy formulation to address these major problems through primary prevention, early screening, detection and appropriate management. Moreover, as many of the challenges affecting adolescents are multi-faceted, there should be greater coordination among providers to ensure provision of integrated health services that conceptualise health as a social rather than purely medical concept.

In terms of the implications for policy, programming and future evidence needs, Table 4 maps out our findings in relation to national policy commitments and the global Sustainable Development Goal (SDG)-related commitments. Where relevant, we highlight where additional investments in programming and evidence are urgently needed to support progress towards achieving these commitments.

Table 4: Summary of key findings as they link to the SDGs

<p>Goal 3.1 Reduce the global maternal mortality ratio to less than 70 per 100,000 live births</p> <ul style="list-style-type: none"> • More efforts are needed to reduce the MMR (currently 20 per 100,000 live births) further, especially for preventable deaths (e.g. due to haemorrhage). • There is a need to further improve the monitoring and surveillance system of maternal mortalities and morbidities, especially among vulnerable groups such as anaemic women, those experiencing hardship and women with limited access to services. • Despite progress made, safe delivery is not yet guaranteed for all. More needs to be done to address lack of counselling, respect and privacy for young women. • Strategies to support maternity care need to promote the capacity of service providers to deliver appropriate, comprehensive and client-centred care at all stages – pre-conception, antenatal care, natal care and postnatal care.
<p>Goal 3.3 End the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases</p> <ul style="list-style-type: none"> • Communicable diseases such as respiratory illness, viral hepatitis and diarrhoea are still common, with high morbidity rates among children and young adolescents. More efforts are needed to address key determinants of health such as appropriate housing, safe drinking water, safe environment and health promotion, particularly education about hygiene and sanitation. • There is an urgent need for better inter-sectoral cooperation, particularly between the Ministry of Health, Ministry of Education, UNRWA and municipalities. School health promotion provides a good forum to create a healthy environment, especially securing safe water, clean toilets and hygienic conditions. • Investing in health education programmes targeting adolescents through mass media, and re-prioritising the health chapter in the curriculum (focusing on implementing sessions about hygiene, menstruation and safe practices) are essential for the control of communicable diseases.
<p>Goal 3.4 Reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being</p> <ul style="list-style-type: none"> • In Gaza, many adolescents die prematurely due to non-communicable illnesses, including heart disease, accidents, violence and infections. Adolescent boys and girls alike have limited access to information and services that promote healthy practices. • Through comprehensive initiatives, actors need to develop a strategy to control the spread of communicable diseases. The focus should be on prevention, awareness-raising and early detection, considering key risk factors (particularly obesity, control of smoking, appropriate physical exercise, and reducing stress and anxiety). • People at greater risk, especially adolescent girls, need to be monitored with appropriate and proactive surveillance systems. • Schools provide a good place for promoting healthy lifestyles that include exercise and a healthy diet.

Goal 3.5

Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol

- There is an alarming increase in the numbers of Gazan adolescents that have taken up smoking or substance abuse (especially Tramadol) or are engaging in risky behaviours. This phenomenon requires further investigation to identify underlying causes and the effective modalities of interventions to combat its occurrence.
- Further investments are needed to develop outreach and educational awareness programmes combined with a surveillance system to monitor users, especially people at risk such as male adolescents, those experiencing psychological stress, unemployed and poor adolescents.
- Policies to prevent substance abuse and to support adolescent drug users should include psychosocial support, provision of information, support by school counsellors, adoption of non-punitive measures, and introduction of rehabilitation programmes within health services.
- Young people need more access to healthy, safe spaces for recreation, as well as integrated adolescent-friendly health services, and mechanisms to help them build resilience to deal with the many challenges they face.

Goal 5.7

Ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes

- Though availability and accessibility of SRH services in Gaza are reasonable, quality of services are problematic, and access is compromised during outbreaks of hostilities. Unmarried adolescents are rarely targeted by these services due to social norms and the lack of age- and gender-appropriate services.
- Gaps in the quality of antenatal, natal and postnatal care – particularly weak counselling, un-hygienic conditions, lack of privacy, lack of respect, and poor physical settings – require urgent bridging.
- Adolescents have insufficient awareness about menstruation, sexual relationships, important danger signs during pregnancy, delivery and the postpartum period, and how to stay healthy. Awareness-raising programmes should be implemented in schools, health facilities and the wider community. Pre-marriage counselling should be offered so that young girls can learn about marital life and sexual relationships.
- Collaborative efforts should aim to reduce the shame, taboos and stigma around SRH and menstruation.
- Investments are needed to create a more supportive culture at household, school and community levels, to support girls as they go through puberty, particularly with issues around menstruation and sexual relationships.

Goal 5.8

Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all

- Access to basic health services is guaranteed (theoretically) due to almost universal health insurance coverage. However, to address the barriers that prevent adolescents accessing services, there needs to be an adolescent age- and gender-specific package of services and information.
- It is essential to build staff capacity to interact with adolescents and address the challenges they face.
- Service providers should develop more positive and caring attitudes towards adolescents and women during delivery of care, with greater adherence to and respect for patients' rights and professional codes of conduct, focusing on caring rather than just curing.
- Service providers should create adolescent-friendly environments at health facilities together with provision of essential resources, particularly drugs.

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GAGE Programme Office

Overseas Development Institute
203 Blackfriars Road
London SE1 8NJ
United Kingdom
Email: gage@odi.org.uk
Web: www.gage.odi.org

About GAGE

Gender and Adolescence: Global Evidence (GAGE) is a nine-year longitudinal research programme generating evidence on what works to transform the lives of adolescent girls in the Global South.

Visit www.gage.odi.org.uk for more information.

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