

Men's Perceptions, Attitudes and Practices towards Reproductive Health and Sexuality in the Occupied Palestinian Territory, Lebanon and Jordan



A Transformative Rights-Based Approach to Engaging
Men in Sexual and Reproductive Health

*Commissioned by Alianza por la Solidaridad (ApS),
Nazioarteko Elkartasuna (NE-SI) and Health Work Committees (HWC)*

Alianza por la Solidaridad (ApS) is a Spanish Non-Governmental Organization, result of the merger of 3 NGOs :

Solidaridad Internacional, Habitafrica and IPADE, in 2013, combining more than 70 years of experience in cooperation for development, generation of knowledge, communication and advocacy campaigns. ApS believes that achieving freedom for women to enjoy their rights is a question of democracy and justice, therefore it's key to encourage men to question and transform power relationships, and become allies who work in favour of women's rights and for the social change necessary to create a world that puts its people without any discrimination at the center.

Nazioarteko Elkartasuna (NE-SI) is a Basque NGO established in 1989 whose mission is to eliminate poverty around the world, analysing its economic, political, cultural, social and environmental causes, combined with the defense of democratic governance and human rights.

Health Work Committees (HWC) is a non-governmental health and development organization. It was established in 1985 by a group of Palestinian volunteers who worked in the health sector for the purpose of meeting the health care needs of the Palestinian population living under Israeli occupation in the West Bank and Gaza Strip. In 2003 it was registered as an NGO in the Palestinian Ministry of Interior and Ministry of Health. HWC believes in the value of the Palestinian human and his/her right to a comprehensive health system as a basic human right based on all international human rights conventions and agreements. Therefore it provides health and development services in **16 health centers** and clinics throughout the West Bank. Recently HWC has opened "Dunya Women Cancer Center" the first and only diagnostic women cancer center in the West Bank, that provides high quality integrated medical services to women with breast and gynaecological cancers according to international standards.

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List of Acronyms

ABAAD	Resource Center for Gender Equality
AECID	Agencia Española de Cooperación al Desarrollo (Spain)
AIDS	Acquired Immune Deficiency Syndrome
ApS	Alianza por la Solidaridad (Spain)
AWO	Arab Women Organization of Jordan
BC	Birth Control
CBO	Community-Based Organisations
CFTA	Culture and Free Thought Association (the Occupied Palestinian Territory)
CSO	Civil Society Organisations
FG	Focus Group
FP	Family Planning
GAD	Gender and Development
GBV	Gender-Based Violence
HIV	Human Immunodeficiency Virus
HR	Human Rights
HWC	Health Work Committees (Occupied Palestinian Territory)
IDU	Injecting Drugs Users
INGO	International Non-Governmental Organisation
IPPF	International Planned Parenthood Federation
IUV	Intrauterine Device
JAFPP	Jordanian Association for Family Planning and Protection (Jordan)
KM	Knowledge Management
LGTB	Lesbian, Gay, Trans, Bisexual
LGTBQ	Lesbian, Gay, Trans, Bisexual, Queer
MCHIP	Maternal and Child Health Integrated Program
MENA	Middle East and North Africa
MSM	Men who have Sex with Men
NGO	Non-Governmental Organisation
oPt	occupied Palestinian territories
PARD	Popular Aid for Relief and Development (Lebanon)
PASSIR	Programa d'Atenció a la Salut Sexual i Reproductiva (Spain)
PMRS	Palestinian Medical Relief Society (Occupied Palestinian Territory)
PRCS	the Occupied Palestinian Territory Red Crescent Society (the Occupied Palestinian Territory)
RBA	Rights-Based Approach
RBM	Results-Based Management
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
SRR	Sexual and Reproductive Rights
STI	Sexual Transmitted Infections
UAWC	Union of Agricultural Work Committees (the Occupied Palestinian Territory)
UN	United Nations
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development (USA)
VAW	Violence Against Women
VFM	Value For Money
WATC	Women's Affairs Technical Committee (the Occupied Palestinian Territory)

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0. EXECUTIVE SUMMARY

This study was produced in the framework of the Regional Programme on Sexual and Reproductive Rights of Palestinian, Jordanian, and Lebanese Women in Vulnerable Situations, a project of Alianza por la Solidaridad (ApS), Health Work Committees (HWC), with the participation of NE-SI and the rest of the partners of the regional intervention: UHWC, WATC, PARD and AWO. The programme is funded by the Spanish Agency for International Development Cooperation (AECID) and co-funded by the Basque Government Aid Agency. It aims to “ensure sexual and reproductive rights and other related rights of women in the Middle East on the basis of gender equality.”

The study was conducted in order to provide ApS, HWC, Nazioarteko Elkartasuna (NE-SI), and other institutions and aid actors working in the area of **sexual and reproductive health and rights (SRHR)** with recommendations on how and why to engage men in SRHR from a gender equality and rights perspective in Palestine, Lebanon and Jordan. It also aims to create insights for policy-making and processes.

The research explores the relationship between men, masculinities, sexuality, reproduction, and rights in the three above-mentioned states. We discuss ways of understanding these relationships, and study the engagement of men in SRHR programmes. **We defend the argument that effective work on engaging men in SRHR through a rights-based approach needs to actively seek the transformation of gender and other socially constructed roles.**

We first present our **main findings and analyses of men’s attitudes, perceptions, and practices towards sexuality and sexual reproductive health.** We also present the meanings and main topics of SRHR that emerged in our conversations with stakeholders at three levels: 1) grassroots and community; 2) development and health actors; and 3) key influential actors, such as state, policymaking and religious leaders.

Next, we refine our analysis by **identifying and examining the approaches to and discourses of SRHR encountered during our fieldwork.** This analysis illuminates **how men’s role is understood in different SRHR approaches, communicates types of actions that can be taken to engage them,** and helps us understand the role of various SRHR rationales in perpetuating or transforming attitudes, perceptions, and practices towards sexuality and reproductive health.

This confrontation of discourses aims to determine a proper rights-based approach to SRHR, and accordingly **proposes a role for aid actors and project-based initiatives** to contribute to transforming men’s attitudes, perceptions, and practices towards SRHR in Jordan, Lebanon and Palestine.

Framework, Approach, and Methodology

The main objective of this research is to provide evidence-based information and ideas that will help inform policies, actions, and processes at various levels (community, organisational, and policy) in order to engage men in SRHR discussion and services in Palestine, Lebanon, and Jordan.

This is an exploratory study on the intersection between masculinity, sexuality, reproduction, and rights in the Middle East. Given the limited resources, and bearing in mind the complexity of these topics in practice, we have chosen to approach the concepts from an interpretive perspective. Our assumption is that in order to generate quantitative data that allows us to inform actions, it is important to first map out the social meanings of these concepts. In this sense, the study would hopefully be useful to support further quantitative research on these topics.

The main goals of the research are: (a) to explore **how** masculinities and gender identities are constructed in regard to men's attitudes, perceptions, and practices related to SRHR. (b) to understand **to what extent**, and in **what ways**, men's attitudes, perceptions, and practices related to sexual and reproductive health determine women's full enjoyment of their sexual and reproductive health in the region; and (c) **to learn** from different strategies and experiences of engaging with men in gender actions in Palestine, Jordan, and Lebanon and to extract relevant and applicable knowledge for SRHR.

As researchers, we position ourselves as follows:

- 1- Masculinities and Hegemonic Masculinity Framework:** We believe that hegemonic masculinity affects both women and men, and men are can be agents for change in redefining the concepts of manhood, benefiting from equitable attitudes and behaviours, and playing an active part in attaining gender equality.
- 2- Sexual and Reproductive Health, Gender Equality, and a Rights-Based Approach:** We believe that SRHR frameworks -- explored at the 1994 International Conference on Population and Development in Cairo and at the 1995 Fourth World Conference on Women in Beijing -- are still being developed, and thus we avoid defining SRHR here. In this research, SRHR will be related to all types of interventions addressing sexuality and reproduction from a health perspective; a rights-based approach to SRHR will address programmes that align with the Cairo and Beijing conference aims.
- 3- Intersecting Masculinities and SRHR:** There is a lack of international consensus on men's involvement in SRHR interventions, with the Cairo and Beijing conferences being clear examples of this. However, we consider and recognise the contextual and relational character of issues related to SRHR in the Middle East instead of the adoption of imported international frameworks.
- 4- Masculinities and SRHR in the Middle East:** We believe that masculinity and sexuality in the Near and Middle East are dynamic and open to change from both the inside and the outside.

Our **methodologies** were developed based on the above four groups of social anthropological literature, inspired by principles of social constructivism and interpretivism. They therefore take into account the meaningful nature of people’s participation in creating the social and cultural structures they follow and/or transform. This is done in order to interpret the meanings of gender roles, masculinity, sexuality, reproduction, and rights that participants produce and reproduce as a necessary part of their everyday activities.

Our **tools** included participatory activities such as focus group discussions (actors and concepts mapping, ranking, and scoring), narrative and discourse analysis tools, and semi-structured interviews. We have defined three groups of research participants: (a) grassroots, both men and women; (b) development and health actors; and (c) key influential actors. Each group was given specific questions that were, in part, developed during the fieldwork.

The following table summarises number of individuals interviewed in each group in the three states.

	Group 1	Group 2	Group 3	Total individuals interviewed
Palestine	62	13	6	81
Jordan	5	17	3	25
Lebanon	45	7	3	55
Total individuals interviewed	112	37	12	161

Group 1: grassroots, Group 2: development and health actors, Group 3: key influential actors.

Men’s Attitudes, Perceptions and Practices towards SRHR

On men’s perceptions, attitudes, and practices towards SRHR, our **main findings** at the **community level** are the **lack of both knowledge and interest** among male research participants on issues related to SRHR. We argue that this lack of knowledge is more complicated than a mere question of accessibility or availability of information. We believe the main obstacles to men’s involvement in SRHR programmes are social constructs of manhood -- social pressure and expectations of what it means to be a man -- in addition to what we term the **“feminisation” of SRHR services** in the targeted countries.

We studied both formal and informal spaces. The formal spaces included schools and households, while informal included friends, the Internet, and the street. We argue that both spaces are using a “ping pong” approach in which each assumes the other is supposed to be disseminating information related to SRHR. The majority of research

participants in Lebanon and Palestine believe that **change can start from formal spaces**, for example, among couples within households, and in schools. **Little importance** was given to the state in this regard.

At the **development actors' level**, we have mapped the features of SRHR programmes in the region by six themes: health (HIV and sexually transmitted infections); education (sexual education); customs and traditions (e.g. early marriage); patriarchy and gender inequality (e.g. honour crimes); politics (e.g. refugees); and sexuality (e.g. sexual identity). We believe that the variety of themes indicates that SRHR is perceived as a complex interplay of issues that extend beyond maternal health or family planning. Interviewees stressed the importance of structural SRHR issues such as gender roles, political and institutional discrimination against women, and the unstable political context. We argue that it is near impossible to disentangle reproductive or sexuality issues from larger social structures such as the state, the law, or tradition.

Approaches to SRHR and to Engaging Men in SRHR

Given the ambiguous concept of entities such as the “state” and “civil society” in the targeted countries, SRHR initiatives function in an environment where there is an absence of clear, shared, and agreed-upon policies, and only some basic protocols for action. The countries lack a normative framework, one in which public, private, and nonprofit (international and local NGOs) institutions guide their actions.

SRHR programmes depend on a complex network created by personal and professional relationships at institutional and informal levels. In this sense, and given the state institutions' illegitimacy in regulating private spheres, the various actors in the field search for legitimacy for their actions, sometimes internally from their targeted groups, and externally through the donor institutions and international NGOs that support them. In this context, different interests (national and international), diverse philosophies, accountability systems, and definitions of SRHR co-exist.

Based on a review of the literature and our fieldwork data analysis, we defined six approaches to SRHR in Jordan, Lebanon and Palestine:

- (a) **Birth control**, aiming to control population growth with the objective of a positive impact on the economy, particularly in a world with limited resources, what has been called a Malthusian argument;
- (b) **Family planning** or protective health, which is widely used. Since the family unit is where sexuality and reproduction occurs, family planning is considered the epicentre of interventions, and therefore any matters related to sexuality or reproduction occurring outside this institution are invisible and fail to be addressed.
- (c) **Mother-and-child healthcare**, which largely addresses pregnancy and postnatal care. This is a government public health service, promoting healthy practices and behaviours as well as the general population's health and wellbeing.

(d) **The women's health** approach, which views SRHR as a women's health issue, and targets women and their health in a global way. Maternity and childbearing are central to this approach; the rationale is that women need to find safe spaces to undergo necessary medical procedures, and therefore there is a need to address women's health in a comprehensive way. For birth control, family planning, and women's health approaches, targeting men is based on the belief that they are the decision-makers and power holders. Most importantly, these approaches target men as "fathers" and "partners," therefore excluding a significant portion of men who fall under neither category.

(e) **The epidemiological** approach, which has been highly criticised by scholars and actors, considers that SRHR policies are needed because sexuality and reproduction carry risk. Risk therefore becomes the rationale behind any SRHR policy, and the target groups of these types of programmes are always high-risk groups: largely men, due to their higher rate of sexual promiscuity. Traditional target groups for epidemiological programmes are men who have sex with men (MSM), drug users, sex workers, immigrants, refugees and prisoners.

(f) **The "under construction" rights-based** approach to SRHR, which is heavily influenced by the outcomes of the Cairo and Beijing conferences, is committed to gender justice, and gender relations are central to it. This approach therefore targets the population on the whole, rather than one particular sex, or specific, defined risk groups. Furthermore, it goes beyond health issues and education, as it also addresses policies, governments, society and the economy.

Specific Approaches	SRHR is considered:	Men should be engaged because:	General Approaches
Birth control; population control	- A demographic and economic issue (Malthusianism)		Instrumental approaches
Family planning, or Protective health (includes religious perspectives on family planning)	- A family-based approach - SRHR matters are only recognised within the confines of the family	They are viewed as authoritative/decision-makers: "Men should have a role because children listen more to their father." Focus Group Discussions with women, Beirut	
Mother and children's health care, or Maternal health care	- A biomedical and public health issue - A woman's issue (maternity and childbearing)	They are viewed as partners of the women and parents of the children: "Men are partners in the problem, therefore they need to be partners in the solution." Firyal Thabet, Cultural and Free Thought Association (CFTA), Palestine	
Women's health	- A feminist approach to health - Critical of androcentrism in science		
Epidemiology	- A public-health approach to SRHR - Concerned with risk and high-risk groups - Men are the primary target group	They engage in high-risk behaviours: "People getting infected by HIV in Lebanon are mostly MSM, IDUs, and sex workers. So, these are the most vulnerable populations." SRHR programme officer, Beirut	
Rights-Based Approach (RBA)	- A justice/equality issue related to health, religion, politics, education, gender roles, and law, among others	SRHR efforts focus on gender equality: Working with men should be an end in itself, as well as a means for empowering women." Charbel Maydaa, ABAAD, Lebanon	Relational approach

We have made two categories for the approaches to working with men in SRHR programmes. The first is **the instrumental** approach, in which working with men as holders of the power that will effect changes in women's lives is **a pragmatic technique**. From this perspective, changes in men's perceptions are important only insofar as they are necessary to secure their collaboration and support. Men's personal change is not an objective, nor is the reconsideration of gender power relations. This is the case in the first two justifications in the table above, in which men are considered the decision-makers, as well as partners of women and fathers of their children.

The second category is **the relational** approach, in which men play an active role in gender power relations, and working with men is framed in terms of gender dynamics, i.e., what it means to be a man or a woman). This approach is based on gender relations, which includes female empowerment, and it aims to transform gender relations and

the social constructs of masculinity and femininity. Finally, the relational approach recognises the existence of gender and sexual identities other than the conventional “man” and “woman,” tending to take the entire gender spectrum into account.

Conclusion and Recommendations

We believe that instrumental approaches to SRHR are ineffective in transforming men’s attitudes, perceptions and practices, and therefore advocate a relational approach and rights-based approach (RBA) to SRHR. We defend three main **conclusions**:

(a) The RBA approach to SRHR must commit to gender-role transformation. This means that working with men is a vital component of achieving gender equality, which will profoundly affect attitudes, perceptions, and practices towards sexuality and reproduction. This view employs a double aim of **changing the perceptions and understanding of masculinity, while simultaneously working to empower women and girls**. In this context men are perceived as agents of positive change, and can be positive examples of a new gender-equal masculinity by first analysing and then changing their patriarchal and gender-discriminate attitudes and behaviours.

(b) There is no profound RBA approach to SRHR in the region yet. Therefore, there is a need for a contextual definition of rights for those affected by specific as well as socio-cultural, economic, and political circumstances. In other words, a RBA to SRHR in these three states should be more experience-based and descriptive rather than prescriptive. **SRHR international frameworks and principles should be valued as sources of inspiration**. A RBA to SRHR is not adoptable, but rather is a work in progress, and the targeted population is a subject rather than an object of SRHR initiatives.

(c) Finally, it is important to go beyond health issues in constructing a RBA in SRHR programmes. Although SRHR affects general public health, it is not purely a health issue. Sexuality and reproduction are essentiality embedded in socio-political dynamics, from demographic control of health provision to gender roles and power inequalities. **SRHR is about law, politics, religion, education, gender, and social and legal norms**.

Based on the above-noted findings and conclusions, we have developed a theory of change for a RBA to SRHR. The theory is comprehensive and targets the three levels of this research, with its principle conclusions being:

(a) a process of change takes time. Social and moral norms constructed by gender roles and other. social roles do not change immediately;

(b) change cannot be controlled, and success cannot be foreseen due to the many stakeholders, interests and dynamics;

(c) change occurs on an individual level and in the social and legal spheres.

Accordingly, effective work in engaging men in SRHR would appear to be close to a **Network Model** based on **improvisational (learning by doing) work, reliant on varied knowledge and different teams working in flexible and interpretive manners.**

Our **recommendations** in working on SRHR, gender, and masculinities are inspired by and based on our fieldwork and literature review. We believe that actors and stakeholders must do the following:

- **Build trust and longterm relationships** to meet individuals' needs to access safe spaces and support in order to continue to analyse their beliefs, attitudes, behaviours and progress in achieving a gender-equal attitude in general, and particularly in the spaces/fields of SRHR. **Use a positive approach towards gender equality and SRHR**, which includes avoiding confrontation while supporting critical reflection and transformation.
- **Think of contribution as well as attribution to change when raising awareness.** In this regard, when designing, reporting or evaluating programmes, quantitative data should be complemented with qualitative data based on stories of change, personal reflection and narrative methods (such as critical stories of change) that help to explain the context and the project's contribution to change.
- **Focus on learning and facilitation.** Practitioners as well as participants are the main actors in generating knowledge, by making sense of their collective experiences. This suggests that SRHR initiatives need to promote reflection on specific experiences, and the role of aid actors should therefore be facilitating and opening those spaces for reflection. Creating communities of experience exchange is also in accordance with aid actors' facilitating role. Participation – understood as methods, tools, approaches, practices and attitudes – does not merely constitute good practice, but is key to informing processes of identification, implementation, and evaluation of SRHR initiatives.
- **Start with the individual**, and promote change at the personal level to facilitate and follow up a process of self-reflection and change in the programme targets.
- **Bridge knowledge.** Recognising that SRHR goes “beyond the clinic” implies working actively to promote dialogue and joint action among different disciplines.
- **Zoom in and out.** In order to implement effective programming, it is important to:
 1. zoom in on matters ranging from individual change to specific programmes aiming to support such changes;
 2. zoom out by investing time and resources in creating social conditions for supporting individual change towards a redefinition of gender roles.

In this sense, it is important to map what various SRHR actors do to understand the contribution of own programmes and how those programmes contribute to the wider picture of SRHR efforts in the region.

1. Introduction

This research is linked to the programme -- co-implemented by Alianza por la Solidaridad (ApS), Health Work Committees (HWC) and other partners -- called “Regional Programme on sexual and reproductive rights of the Palestinian, Jordanian and Lebanese women in a vulnerable situation” funded by AECID (Spanish Aid Agency) and co-funded by the Basque Government Aid Agency aimed to *‘ensure sexual and reproductive rights and other related rights of women in the Middle East on the basis of gender equality.’*

This work was conducted to provide ApS, Nazioarteko Elkartasuna (NE-SI), HWC, and other partners, institutions and aid actors working on Sexual and Reproductive Health (SRH) with recommendations and ideas to reflect on why and how to engage with men in Sexual and Reproductive Rights (SRR) from a gender equality and rights perspective in the Occupied Palestinian Territory, Lebanon and Jordan and in order to create insights to feed policies, actions and processes.

This paper explores the relationship between men, masculinities, sexuality, reproduction and rights in Jordan, Lebanon and the Occupied Palestinian Territory. We discuss ways this relationship is grasped and informs the engagement of men in SRH programmes. **We defend the argument that effective work on engaging men in SRH from a rights-based approach needs to actively seek the transformation of gender roles and other socially constructed roles.**

Using masculinities and a hegemonic masculinity framework, we present our main findings and analysis of men’s attitudes, perceptions and practices towards sexuality and reproduction based on our fieldwork. We also present the main subject matter and definitions of SRH that emerged in our conversations with stakeholders at the grassroots and community level; the development and health actors’ level; and the key, influential actors’ level (e.g., the state, policymakers and religious leaders).

In section 6, we refine our analysis by identifying and examining the approaches to SRH that we discovered in our fieldwork. This allows us, in section 7, to identify how men’s role in SRH is interpreted within various SRH approaches, and accordingly provides guidelines for engaging men in SRH. This analysis helps us understand the role of different SRH approaches in perpetuating or transforming attitudes, perceptions and practices in regards to sexuality and reproduction.

In section 8, we differentiate what a rights-based approach to SRH would look like and propose a role for aid actors and project-based initiatives to contribute to transforming men’s attitudes, perceptions and practices towards SRH in Jordan, Lebanon and the Occupied Palestinian Territory (section 9).

2. Objective

The principal objective of this research is to provide evidence and ideas that help to inform policies, actions and processes at different levels (community, organisational, policy) in order to engage with men in Sexual and Reproductive Health and Rights (SRHR) in the Occupied Palestinian Territory, Lebanon and Jordan.

To achieve this objective we have tried to reach the following goals:

- To explore how masculinities and gender identities are being built in Jordan, Lebanon and the Occupied Palestinian Territory, with regard to men's attitudes, perceptions and practices related to SRHR.
- To explore to what extent and in what ways men's attitudes, perceptions and practices related to sexual and reproductive rights determine women's full enjoyment of their sexual and reproductive health and rights in the region.
- To learn from different strategies and experiences of engaging with men in gender actions in the Occupied Palestinian Territory, Jordan and Lebanon, and to extract relevant and applicable knowledge for SRHR.

3. Literature review, conceptual frameworks and positioning

Concepts such as masculinity/ies and Sexual and Reproductive Health (SRH) or Sexual and Reproductive Rights (SRR) are highly complex, culturally sensitive, relative and contested. We hold the idea that any research on these issues must involve a researcher positioning the issues to inform the research questions, methodologies, tools and actions during the research.

This section presents a summary of the literature review on these topics. The summary is grouped in four sections:

- a. masculinities and hegemonic masculinity framework;
- b. Sexual and Reproductive Health, gender equality and rights approach;
- c. intersecting masculinities and SRH; and
- d. masculinities and SRH in the Middle East. In this section, we also describe how we position ourselves as researchers of these topics, and how we apply the theories and findings of previous research to this study.

3.1 Masculinities and the Hegemonic Masculinity framework

Since the influential work of Carrigan, Connell and Lee (1989) on "hegemonic masculinity" -- the promotion of the dominant social position of men and the subordinate social position of women -- men in Gender and Development (GAD) have occupied a controversial space in gender studies and in development practice.

Gender studies have begun to analyse representations and myths about gender roles (Standing, 2004, and Eyben, 2010). The concept of hegemonic masculinity has shown alternative ways of being a man by recognising multiple masculinities. It has also helped to overcome the binary analysis emerging from the concept of mythical masculinity, by which men are violent and aggressive by nature and women are their victims (Esplen and Creig, 2007).

The recognition of different kinds of masculinity has also shed light on men as victims of the same hegemonic masculinity that exerts power over women. Accepting that women are not “the only losers” (Sweetman, 1998, quoted in Chant, 2000) has provided the opportunity to explore alliances for gender equality and to reconsider the role of men in gender power relations.

Studies on masculinities have provided a framework of analysis arguably coherent with the social-structure analysis developed by GAD, and the result has shown that including men in the picture of gender relations enhances actions addressing gender equality¹.

Hegemonic masculinity affects both men and women. Tackling gender relations in a comprehensive way means addressing how men participate in the gendered system. Our understanding is that men are not just instruments to ensure women’s sexual and reproductive health and rights. In this research we have focused on men because we are convinced that they are agents for change in achieving gender equality. This research has therefore included male and female participants.

3.2 Sexual and Reproductive Health, a gender equality and a rights approach

The concept of Sexual and Reproductive Health (SRH) originated in the 1970s. Feminist organizations around the world opposed practices that had systematically violated women’s rights, especially women’s rights to bodily autonomy in relation to sexuality and reproduction (Correa and Petchesky, 1994).

Later, SRH was conceptualised as a right within the wider framework of Sexual and Reproductive Rights (SRR). This latter perspective was institutionalised in two important international conferences during the 1990s: the International Conference on Population and Development, held in Cairo in 1994, and the UN Fourth World Conference on Women, held in Beijing in 1995. The consolidation of the concepts of SRH and SRR has been the outcome of an evolution of struggles and claims. Since they have adopted many names and meant different things, we try to summarise their evolution and consolidation here, putting especial emphasis on the two international conferences.

At the end of the Cairo Conference in 1994, the Cairo Programme of Action incorporated the demands of feminist groups by recognising the existence of Reproductive Rights (RR), and placing a special emphasis on Sexual and Reproductive Health (SRH).

Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. (Article 7.2, Cairo Programme of Action, 1994)

Bearing in mind the above definition, reproductive rights embrace certain human rights that are already recognised in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. (Article 7.3, Cairo Programme of Action, 1994).

The programme described what RH was and considered it a human right. Although it mentions SRH, there is no emphasis on separating reproduction from sexuality issues and as an outcome, a year later, in 1995, in the Beijing Fourth World Conference on Women, the main challenge for feminist activists and the LGBT community was to emphasise the importance of sexuality and to consolidate the recognition of Sexual Rights and Health as separated from Reproductive Rights and Health (Girard 2008). Finally, the final report of the Beijing Conference consolidated the concepts established in Cairo and included, after strong debates, a paragraph that supports the right of women to have control over their sexuality, Sexual Rights, although the concept is not mentioned:

The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. Equal relationships between women and men in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behaviour and its consequences. (Article 96, Beijing Platform for Action, 1995)

A key challenge has been putting the Cairo and Beijing achievements into practice. Several international organizations have attempted to do so in developing lists of rights. For example, the International Planned Parenthood Federation (IPPF) presented its Charter of Sexual and Reproductive Rights in 1996. IPPF took 12 established human rights² and linked them to reproduction and sexuality, although it did not identify sexuality as independent from reproduction. In another effort to define SRR, the World Association of Sexology (now World Association for Sexual Health, or WAS) produced a Declaration of Sexual Rights in 1999 (revised in 2014), which declares that sexuality is an integral part of the personality of the human being and that sexual rights are fundamental and universal human rights. The use of human rights discourse has therefore been one of the main strategies in SRR activism and scholarships (Cook et al., 2003; Cottingham, 2010).

The Cairo and Beijing conferences are considered turning points in SRR, in shifting from a population-control viewpoint to a more gendered and rights-based one. They were also important in clarifying that sexuality and reproduction are not the same thing. The ideas that emerged from the conferences were the outcome of rich and complex discussions within and between feminist and other social movements, governments and academics. Definitions consolidated in both conferences were very broad and sometimes ambiguous (Barbieri, 1999), and so today it is still impossible to define Sexual and Reproductive Rights or Sexual and Reproductive Health unequivocally.

In this research we have employed the concept of Sexual and Reproductive Health (SRH) to discuss all the programmes and interventions that tackle sexuality and reproduction

from a health perspective, and to talk about a Rights-Based Approach to SRH (RBA to SRH or SRHR) to discuss SRH initiatives that adopt a rights-based approach committed with gender equality.

Sexual and Reproductive Health (SRH) emerged from feminist movements in claiming women's right to bodily autonomy, and since the beginning has been entrenched in gender equality and rights-based approaches. Sexual and Reproductive Health (SRH) and Sexual and Reproductive Rights (SRR) are separate concepts, as established at the Cairo and Beijing conferences; however, they are intimately related. The research acknowledges that the framework of SRH and SRR is still under construction, so we avoid offering a static definition of them. The decision of the authors of the text has been to talk about SRH when addressing all types of interventions addressing sexuality and reproduction from a health perspective, and to talk about a RBA to SRH (SRHR) regarding specific programmes that align with the Cairo and Beijing conferences' aims.

3.3 Intersecting masculinities and SRH

In general, Sexual and Reproductive Health (SRH) services contain an unresolved tension in relation to the inclusion of men. The social imaginary and scholarship tend to relate SRH to the female world, while men are rarely considered potential users of SRH services. The academic literature concerned with SRH has progressively addressed this tension and has identified some explanations in regards to the lack of men's access to SRH services.

Forrest (2001) and Kalmuss et. al. (2007) consider that men have been generally excluded as users of SRH services, and that when they are targeted it is as "partners of" women, or because they are considered Men who have Sex with Men (MSM). This may be primarily because SRH services are the result of a push by the women's movement (Olivella and Biglia, 2011) and other discourses on SRH, which have made SRH an exclusively women's issue.

According to Kalmuss et al. (2007) there is an apparent lack of professional consensus on how to deal with men's SRH, and limited awareness of available resources. Forrest (2001) also describes other barriers that emerge from the services themselves and from practitioners' lack of experience and skills in working with men on SRH issues.

Another body of literature on men's access to SRH services has centred on men's attitude towards SRH or health in general. This research, focused on men's behaviours and attitudes regarding health care, has concluded that men are reluctant to seek health care and in particular primary health care; this was crosscutting for men regardless of age, ethnicity or social background (Addis and Mahalik, 2003). The hesitation in seeking health care is seen as a product of hegemonic masculinity roles, such as being tough, competitive or emotionally inexpressive (Addis and Mahalik, 2003). This is not to simplify men's characters, as masculinity is a dynamic and complex process (Connell and Messerschmidt, 2005).

As Addis Mahalik (2003) and Lohan (2007) indicate, there is still a need for a coherent theory and research on men's attitudes towards SRH and on seeking health care, and a

requirement to carry out more research in order to have a complete picture.

Returning to the Cairo and Beijing conferences, the Cairo Programme of Action called to *increase the participation and sharing of responsibility of men in the actual practice of family planning* (Article 7.14), in three ways: (a) promoting men's use of contraceptives through increased education and distribution; (b) involving men in supportive roles to women's sexual and reproductive decisions, especially contraception; and (c) encouraging men's responsible sexual and reproductive practices to prevent and control Sexually Transmitted Infections (STIs), especially HIV/AIDS. It is important, however, to point out that neither conference (and especially that in Beijing) had a coherent position on men's involvement that was women-focused.

The literature review suggests that men's lack of access to SRH services must be addressed on several levels. On the one hand, there must be consideration of barriers that might be created by health policies and services that don't consider men as potential users. On the other hand, there has to be a focus on men's resistance toward seeking help in SRH matters that is profoundly influenced by hegemonic masculinity. Finally, some research indicates that men's resistance to access to SRH could be interpreted as resistance to being medicalised/domesticated by health institutions. This research takes these assumptions as a starting point and contextualises them in the region. The researchers also recognise the lack of international consensus on men's involvement in SRH interventions, the Cairo and Beijing conferences being examples of it.

3.4 Masculinities and SRH in the Middle East

In 1994, when the International Conference on Population and Development was held in Cairo, Sexual and Reproductive Health Rights in the Middle East were vigorously debated. The conference was strongly criticised by influential religious councils and groups, and organisers of the Cairo conference were accused of opposing local culture, values, and most importantly, *sharia* law. The religious Council of Senior Scholars in Saudi Arabia published a fatwa³ banning Muslims from attending the conference, and considered those who attended it to be practising a sin⁴.

However, since 2002 various scholars (Adibi, 2002; Sanousi, 2003; Kordvani, 2006) have contributed to a growing body of literature, in English and Arabic, tackling cultural specifics of masculinities and sexuality in Middle Eastern societies. Arab and/or Muslim researchers and development practitioners have depicted, analysed and deconstructed the cultural and historical factors that shape masculinities and sexuality, and in the context of sacred text, religion (mainly Islam) and its relationship with sexuality, gender and related topics (Abdel Samad Dailami, 1996, 1997, 2000).

Recent research from Arab scholars and practitioners explored how Arab men describe their own masculinity and shed light on common perceptions of men's role in society. Research conducted by Jinan Usta and Christine S. Hamieh (2011) in Lebanon describes how male research participants perceive the ideal man as *"Being a good provider for his family, a decision-maker, a protector who is powerful and strong and who punishes his family members when they make mistakes."* The same research argues that men are able to recognise the social pressure to perpetuate this hegemonic masculinity, that

they are also victims of this stereotype, and that they are being treated “*as incapable and cowards and, therefore, marginalised when they lack these characteristics.*” This reinforces the idea of hegemonic masculinity as a problem that affects both women and men.

Other research aims to unfold the myths of the immutable and monolithic perception of masculinity, femininity and sexuality in the Middle East. Researchers have criticised how Western popular cultures have depicted the Arab Muslim male as an “existential threat” (Adibi, 2002). Yet Middle Eastern Islam and Christianity are in the grip of powerful changes, and masculinity as a social construct may take a variety of forms in the Middle East. Some are tolerated by the larger society, and some are subject to profound changes by factors such as globalisation, growing Western cultural influence (Adibi, 2006) and liberalisation, Islamic fundamentalism, and democracy.

SRH is a relatively new area of study in the Middle East and it is considered sensitive and complex. However, in recent years there has been progression from considering it taboo, to writing and blogging on queer issues. There is existing literature, analysis and experiences of working on masculinities in the Middle East, and some of them have already been analysed. In this research, we build on that knowledge and use existing methodologies, treating masculinity and sexuality in the Middle East as dynamic and open to changes from within or without.

4. Approach, Methodology and Limitations

Since this research is an exploratory study of the intersection between masculinity, sexuality, reproduction and rights in the Middle East, and given the limited resources when bearing in mind the complexity of these topics in practice, we have chosen to approach these topics from an interpretivist perspective⁵. Our assumption is that, in order to generate quantitative data that allows us to inform actions, it is important to, first map out the social and organisational meanings of these concepts. In this sense, this study will ideally help to support further quantitative and qualitative research on these topics.

Our research has been inspired by principles of social constructivism and interpretivism. These disciplines study people’s participation in creating meaningful social and cultural structures. In this regard, this research attempts to make sense of attitudes, perceptions and practices towards SRH rather than finding a truth. We have looked at motives, meanings, reasons and subjective experiences of participants to better understand individual and social attitudes, perceptions and practices towards sexuality and reproduction. Specifically, our aim has been to interpret the meanings of gender roles, masculinity, sexuality, reproduction and rights that participants produce and reproduce as a part of their everyday activities.

We have ensured that there were opportunities for sense-making and discussion, rather than limiting engagement with stakeholders to data collection. Categories of analysis were not defined or restricted beforehand, but emerged according to different concerns, perspectives and ideas of stakeholders consulted. Accordingly, dialogue, reflections and conversations with stakeholders constitute the largest basis of analysis for this report.

4.1 Methodology

Following interpretivist methods we have taken a qualitative approach to research: “*a loosely defined group of research methodologies which involve ‘observation, interaction, interview, narrative and discourse analysis’*” (Biber and Leavy, 2004:3). Facilitating dialogue, critical reflection and analysis with stakeholders has been a primary role of the research team. As stated in our proposal, this research’s methodology was inspired by the principles of action research. In this regard, this research has used participatory tools to generate reflection and insight. We have also used quantitative data and numbers for categorising, ranking and prioritising (see section 5).

We have also used narrative and discourse analysis tools. We have paid attention on the use of words assuming that narratives help us in understanding veiled issues of our study, and how individuals and organisations use discourse to maintain or construct their own identities. We have used this analysis to, for example, understand different angles to tackle SRH and how they inform men’s engagement (see section 6).

Tools and activities developed during fieldwork maintained flexibility and paid attention to emerging patterns or ideas.

The research was conducted in five stages:

1. **A first approximation** of the study by the research team included refinement of the research questions, literature review (in English and Arabic) and research methods.
2. **A workshop** with ApS’s commissioning team in Madrid, which had the objective of discussing three documents produced by the research team: a literature review, a research questions proposal, and a methodology.
3. **A reflective process** based on the discussions held during and after the workshop, and review of the documents provided by the ApS team (studies, and ApS’s SRH programme evaluation report). The research objectives, research questions, fieldwork plan and tools to be used emerged at this third stage.
4. **Fieldwork** carried out in the Occupied Palestinian Territory, Jordan and Lebanon during the following dates:
 - **the Occupied Palestinian Territory:** Gaza Strip from November 17 through 20, 2013, and the West Bank on October 31, November 4, 5, 6, 7, 23 and 25, 2013 (four days in the Gaza Strip and seven days in the West Bank)
 - **Jordan:** November 8 through 13, 2013 (six days)
 - **Lebanon:** November 14 through 22, 2013 (nine days)
5. **Data analysis** and report writing based on the previous stages.

The main tools used to gather information and insights in the fieldwork were:

- Semi-structured/in-depth and “self-structured” interviews
- Focus groups and participatory methods

- Concept mapping (in focus-group discussions with women)
- Actors mapping (with experts on SRH and gender in Jordan, groups of youth in Palestinian refugee camps in South Lebanon)
- Ranking and scoring (with women’s and men’s groups)

4.2 Research levels and sampling

After the discussions held amongst the research team and commissioning team throughout this process, we agreed this research was not entirely aimed to inform ApS’s programme for engaging men in SRH, but also to produce relevant and usable information for other organisations or researchers interested in working with men in SRH/SSR in the Middle East. In this sense, the information produced in this research needs to be contextualised by partners and health providers’ realities and concerns. Nevertheless, we expect that this can be also considered useful and relevant for other potential users, such as NGOs and other aid actors.

To develop our research we identified actors at three levels:

Level 1: Grassroots

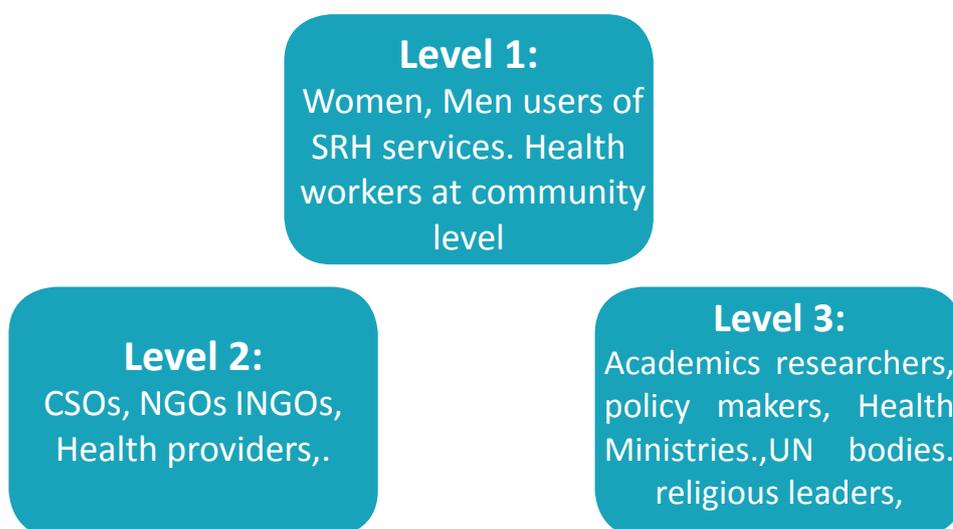
This level included men and women using SRH services at the ApS Programme partners’ clinics, as well as health workers at the grassroots level and medical staff.

Level 2: Development and health actors

This level included CSOs, INGOs, local NGOs including the ApS Programme partners working on one or some of the following topics: SRHR, VAW, men and masculinity, gender equality, women’s health.

Level 3: Key influential actors

This level included health and social services ministries and other policy makers, religious leaders, academics and U.N. bodies.



We interviewed the following numbers of people:

	Level 1	Level 2	Level 3	Total individuals interviewed
Occupied Palestinian Territory	62	13	6	81
Jordan	5	17	3	25
Lebanon	45	7	3	55
Total individuals interviewed	112	37	12	161

As mentioned previously, this research is linked to a programme being implemented by ApS in its countries of study. This has shaped the sampling of this research and the profile of participants. Countries were not targeted by research needs but by where the ApS programme is implemented. This research does therefore not present a broader country analysis nor a comparative study.

ApS partners in Jordan, Lebanon and the Occupied Palestinian Territory -- The Arab Women Organization of Jordan (AWO), Popular Aid for Relief and Development (PARAD) in Lebanon, and Health Work Committees (HWC) and Palestinian Medical Relief Society (PMRS) in the Occupied Palestinian Territory -- played an important role in providing contacts and coordinating interviews and focus groups. (Please see Section 5 for Level 1 participants' profiles.)

Accessing and even facilitating Focus Groups (FGs) with women was easier than with men. In the Occupied Palestinian Territory and Lebanon, reaching men at Level 1 was done through the partner organisations. We found the dynamics of the men's FGs were completely different than those for the women. For the women, it was easier and more comfortable to discuss the topics. In Jordan, we barely managed to speak to stakeholders at Level 1, since ApS partners do not work directly with communities in doing SRH work.

Participants at Levels 2 and 3 were reached through ApS, local partners and researchers' contacts. Most of those interviewed at these two levels were contacted through various personal and professional partner networks and the research team during the fieldwork phase.

4.3 Research questions

We developed general and initial research questions prior to field visits, according to the research topics defined in our proposal. The initial research topics envisioned for the fieldwork were:

- Language and the use of words.
- Sexual and Reproductive Health (SRH) services.
- Information and education.
- Gender roles.
- Sexuality, pleasure and wellbeing.

Research topics and questions were modified during the fieldwork to adapt to fieldwork development, to include elements that emerged after interacting with the participants, and to fill in information gaps. Below are the general questions that finally guided our fieldwork (though not necessarily the specific questions asked of participants).

Community-level questions:

1. What does sexual and reproductive health mean to you?
2. What does manhood mean to you? Who is the ideal man?
3. What do you think are the implications of “being a man”?
4. What are the major issues for you related to SRH?
5. Do you think it is important to involve men in SRH issues?
6. How do you think stakeholders can target men on issues related to SRH?
7. Who or what bodies should take a leadership role on issues related to SRH?
8. How do you perceive the role of state, school, NGOs, and religious leaders in SRH programmes?
9. Where do you learn about SRH matters?

Organisational-level questions:

1. What are the major obstacles you face when working on SRH programmes?
2. Do you work with men in SRH programmes?
3. Do you think it is important to work with men in SRH programmes?
4. Who are the main players in SRH in your environment?
5. What words do you use when talking about sexuality and reproductive health?
6. Do you think religious discourse is important in SRH programmes?
7. Do you think aid and development power relations have an influence on SRH programmes?
8. How do you perceive the role of the state on SRH programmes?
9. What are the SRH services you provide?
10. Do you coordinate with the state on SRH programmes?

Policy-level questions:

1. What is your understanding of sexual and reproductive health and rights?
2. Do you have a SRH policy or plan?
3. Do men have a role in SRH (programmes)?

4. If so, what do you think is the role of men in SRH (programmes)?
5. What is your relation to NGOs and INGOs on SRH issues?
6. What are your main programmes and initiatives on SRH issues (including services)?
7. What are your priorities on SRH issues?
8. What are the SRH services you provide?

4.4. Research limitations

Research limitations resulted from the approach and methodology used. Since interpretivism gives importance to subjectivism (how subjects interpret reality), researchers are not intended to be neutral or unbiased, but rather self-aware and conscious of their position, interaction, interpretations and worldview, and accordingly we attempted to externalise our position on issues such as SRH and masculinity. We accept that we may have wrongly interpreted stakeholder's ideas, and seek to share this document with some of the participants who kindly reflected with us on the research topics.

Participatory and interpretivist research perspectives imply higher levels of involvement by key stakeholders than does traditional research. This involvement should not be limited to providing information and reflection to the researchers, but should also be used to analyse and make decisions based on that information. We were able to generate reflection among partners, but were not able to conduct proper collective analysis and feedback on the research findings with ApS partners and other participants during the fieldwork due to time constraints.

We aimed to employ an intersectional analysis and perspective, to include intersectional social divisions that influence men's perceptions, attitudes and practices towards SRH such as class, ethnicity, sexual orientation, etc. However, we were not able to do so, largely due to time limitations.

In Section 6, we use "word clouds" for discourse analysis purposes. A word cloud is a "visual depiction" of words that shows the most used words in a piece of text. In essence, a word cloud plots word frequency. Word clouds are increasingly being employed as a simple tool to identify the focus of written material. They have been used in politics, various discourses on SRH in different organisations' strategic documents. By analysing the words most used, or the ones absent, we characterise different ways of understanding SRH.

However, there are limitations to the use of word clouds, notably the assumption that the frequency and the importance of a word are one and the same thing. This is not necessarily the case, and could depend on the application and context. In addition, word clouds do not necessarily portray the context in which the word was used (Ramsden and Bate, 2008). This could lead to wrong interpretations of words frequency. We acknowledge these limitations in Section 6.

or evaluating social, developmental and/or humanitarian programmes that are using international, national, public and/or private aid funding.

5- Men's attitudes, perceptions and practices towards Sexual and Reproductive Health

This section is aimed first to present our main findings and analysis of men's attitudes, perceptions and practices towards sexuality and reproduction based on our fieldwork at community and grassroots level. Second, it presents the main topics (5.6) and meanings of SRH that emerged in our conversations with different stakeholders.

The main finding from our fieldwork about men's attitudes, perceptions and practices towards SRH was the **lack of knowledge** and lack of interest among male research participants on the subject. This lack of knowledge is not only due to accessibility or availability of information on SRH. We believe that it is also related to:

(a) **Gender dynamics** and gender power relations within patriarchal structures, including social construction of masculinity, manhood and the social pressure and expectations of being a man. Such dynamics specify different roles for men and women within communities, which require different types of knowledge for each sex, to allow them to meet the expected and constructed gender roles;

(b) The **"feminisation" of SRH services** in the three countries we surveyed; these services are perceived and perhaps introduced (for reasons to be explained below) by stakeholders as a women's issue.



Example of Actors Mapping Activity. Tyre, South Lebanon

The following will elaborate on the features of the identified lack of knowledge; we will then examine how gender dynamics and feminisation of SRH services enhance this lack through the social construction of manhood and masculinity. After that we will discuss the main spaces of knowledge on SRH and the principal realms for change as defined by our research participants. Finally, we link our discussion in this section with the analytical framework of hegemonic masculinity and why it is important and relevant to the research topic.

5.1 Lack of knowledge: "Why are you talking to us about it [SRH]? It's a women's issue."

The above quote was articulated by various men commencing focus groups in the Occupied Palestinian Territory and Lebanon. Men's first reaction to questions on their understanding of SRH was that it was irrelevant to them, and they proposed that we were targeting the wrong gender; some of them even proposed to introduce researchers to their wives.

In some cases, men interviewed at the community level expressed regret at attending the workshop, saying they were uninterested and not able to see the value of being engaged on issues related to women and women’s bodies.

In order to understand how men perceive SRH, we conducted a simple exercise on what SRH means to them, and asked the same question to women’s groups in order to help form our analysis.

SRH means/is related to...	
Women’s ranked answers	Men’s ranked answers
Mutual understanding [tafahum] between the couple	Women’s health and women’s diseases
Gender roles, in particular within the home	Children’s safety
Childbirth	Pregnancy (including food and clothes)
Family planning	Feeding
Equity: participation of the woman in the couple relationship	Fertility
Sexual relations	Blood testing before marriage
Pregnancy	Shared responsibilities
Masturbation	Masturbation
Early marriage	Sexual intercourse and sexual relations, in particular during pregnancy
Relationships with children	
Postnatal depression	
Being a teenager	

The above table summarises answers of 20 women and 8 men from Palestinian refugee camps in Lebanon, and 30 women and 28 men in West Bank and Gaza Strip. Although our research sample is not representative and we cannot generalise knowledge, we believe that these answers are valuable and have allowed us to make an analysis of what men know about SRH and how they perceive it. We found some crosscutting points between men’s and women’s responses, but believe that women have a more holistic understanding of SRH than do men, and women were more open to discussing more sensitive SRH topics. Women also believed that SRH is a mutual responsibility for men and women, while the majority of men believed that it is mainly women’s responsibility.

Male participants in this research tended to believe that SRH is linked to women’s reproductive role, and introduced it in medical terms, and as part of the “natural role” of women as mothers, including pregnancy and breastfeeding, which men cannot fulfil. Some male participants included children’s safety and sharing responsibility between men and women as part of SRH, yet it was not a significant point for them and was linked and introduced in the context of women’s natural role. Women were more apt

to discuss social, non-medical issues concerning the entire family's well-being, including early marriage and equal gender relations between men and women.

Interestingly, women were also more open in discussing sexual relations (both perceptions and practices), even with a male researcher. Even if the above-noted answers of "masturbation" and "sexual relations" were not communicated orally with the researcher, they were written on a piece of paper for the researcher to read later.

To deal with men's relative silence on sexuality in group situations, we decided to focus more on individual interviews based on the assumption that talking in groups can be an obstacle for men to express themselves freely on issues related to SRH. Our assumption was correct; a research participant from Lebanon said:

"I would bet 100 dollars that around 85 percent of divorces in this community are due to the lack of men's knowledge about sexual and reproductive health." Fakhri, a Palestinian refugee of Shabriha refugee camp in South Lebanon.

Another participant from the West Bank said:

"To be honest, lots of us don't know many things about SRH and in particular sexual relations; the other day a friend of mine called me saying what the rubber hymen is. He was close to divorcing his wife because he didn't know that there are different kinds of hymen." Moussa – Nablus – West Bank

This lack of knowledge does not only relate to sexuality, but to reproductive health. For instance, in women's focus groups participants discussed men's "ignorance" of issues related to postnatal depression, and of the importance of psychological support of women during pregnancy. Dr. Jameel Fanoun of the Union of Health Work Committees (UHWC) in the Gaza Strip shared a relevant story with us:

"A woman came to a clinic to have an IUD contraceptive [device inserted] without informing her husband, and the next day she came to remove it because her husband didn't approve her taking this step without his approval.

A day after removing it, she came again to put it again; when the nurse asked about the matter, the woman said: 'First my husband didn't know that I put in an IUD contraceptive device, and he asked me to take it out; after I took it out he said: 'Now you can go and put it in again with my approval'."

Dr. Fanoun used this story to illustrate the man's lack of knowledge about what an IUD is, and what the process of inserting and removing it requires. *"if he knew what he was imposing on his wife, he wouldn't do that."*

This lack of knowledge is more about "not knowing," but about who needs to know what and why. It is part of a social structure that creates different roles and spaces, both private and public, for men and women.

A health educator from the West Bank shared another story:

"Once I held a workshop with a group of men and I distributed brochures on male contraception such as the condom; when they left the centre they threw the brochures

out on their way out, or left it at the reception desk.”

Those who “knew” more were cautious that such knowledge could cause them troubles. Muhammad, a single man from Jordan, explained:

“Every year, in particular in the summer, we have lots of weddings. Lots of brides go to the hospital on the wedding night because of bleeding due to violent sexual intercourse; lots of men have no clue how to have sex with their wives, [and] some of them are my friends. I don’t talk to them about it; it is a sensitive issue and I fear them questioning my intentions.”

Muhammad feared that communicating his knowledge with friends would be seen as a challenge to a social structure and social division of spaces; most importantly, it would be seen as an invasion of another man’s private space. A male participant in a personal interview was explicit in this division where he drew two circles; in the first one he wrote “private” and in the other he wrote “public.” Then he said:

“SRH is in the first circle; I don’t talk about it in public.”

To examine what we are defining as a lack of knowledge, we created our discussions with research participants to develop deeper and contextual understanding of it. The following extends beyond the surface by discussing two main issues: (a) gender dynamics in which we focused on the construction of manhood and the social pressure to be a man, and (b) feminisation of SRH and the “exclusion” of men from SRH.

5.2. Sho Ea’ne Zalameh? What does it mean to be a man?

Gender dynamics and power relations within patriarchal structures influence stereotypes of masculinity and femininity; most importantly, such stereotyping creates problematic dichotomies such as male/female, oppressor/oppressed, citizen/state, and subject/agent. To avoid such “essentialising,” we worked with our research participants on unpacking “masculinity” by asking them a very basic question: what does it mean to be a man?

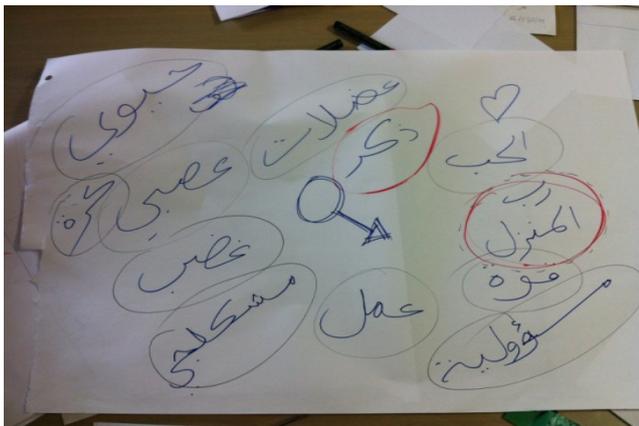
“Man is the pillar of the tent.” A popular saying; Naji Hija, farmer from the Gaza Strip

“The only thing that shames a man is his pocket [financial status].” A popular saying; Muhammad, Bedouin from the West Bank

We facilitated a discussion and brainstorming exercise with research participants at the community level in Lebanon and the Occupied Palestinian Territory⁶. This exercise was carried out in focus groups of seven young women and five young men Lebanon, and 20 women and 18 men in the West Bank and Gaza Strip⁷. The exercise began with the following questions: “What are the first words that come to your mind when you hear the word ‘man’?,” “What does ‘man’ mean to you?,” and, “What does *Rujula* [manhood] mean in your context?”

Answers from the men’s groups included words such as: ability to meet family needs; strong; respectful; has a good reputation; protector. Women’s group answers involved

words such as: friend to his children; appreciates married life; responsible; *mutafahim* [understands]; meets his family's needs; troublemaker, muscles; love; work; football; power.



Drawing at left: “What does “man” mean for you”? Drawing at right: “What does woman” mean for you”?

Analysing these words from a gender perspective, we can observe that this dominant stereotyping of masculinity or *rujula* is defined in opposition to femininity⁸. Therefore, when a culturally dominant understanding of a man is someone strong, then a woman is fragile; when he is the protector, this makes the woman in need of protection.

We tried to “unpack” these words in our discussions with the research participants. Participants began to examine them, criticised their generalisation, and gave personal examples that ran contrary to sexual stereotypes. For instance, a female participant from Gaza Strip said:

“I don’t agree that men are not emotional; at my daughter’s wedding my husband cried like a baby. He was very sad seeing her room empty, even though he was happy for her.”

The majority of research participants argued later that the above-named attributes can be applied equally to men and women, yet they believed that a man cannot be feminine and a woman cannot be masculine. Our discussions of the above-noted words led us to issue: social pressure to be a man.

5.3 Dynamics of social pressure to be “man enough”

Social pressure on men was one of the expressions we heard more often during fieldwork, particularly from professionals and practitioners (Level two). Raeda, a gender scholar from Amman, gave a striking example:

“For instance, men who do kill their sisters or wives in the name of ‘honour’ do this under social pressure; they do this because they will be accused by the community of not being ‘real men’ and not protecting their honour.”

The question of social pressure was asked of research participants at the grassroots and community level. A male participant from the West Banks said:

“If I help my wife in domestic work, they will call me mahkoum [controlled by one’s wife].”

In a personal interview, Fadi from Amman said: “I don’t understand why I have to be responsible for my sisters’ behaviour; I feel the social pressure of being their protector.”

Interestingly, in group discussions women were more open than men in discussing social pressure on men. A woman from the West Bank shared a personal reflection:

“My husband is very kind and nice with me and my daughters; sometimes the other family members accuse him of not being enough of a man, but he never listens to them.”

Another woman from the same focus group added:

“My husband sometimes helps me with domestic work, but he asks me to lock the door first, and he refuses to hang the laundry, for instance, because it requires going to the roof and then everyone will see him.”

Men who recognised social pressure placed on them were more likely to talk about it in individual interviews. While in group discussions, they were more likely to discuss issues that were more general and less personal, such as the economic situation and the lack of job opportunities. Men who were more open in discussing and recognising such social pressures tended to be activists, middle-class and educated. This is not to suggest that other men are not aware of such social pressure; they may have developed different mechanisms for dealing with it. The difficulty in discussing such a topic lies at the heart of *rujula* and masculine identity. During fieldwork in the Gaza Strip, one of the male participants commented on a question related to social pressure on men:

“Why are you asking such private questions?”

This question suggests that challenging social pressure on men could be seen as a threat, and therefore not talking about it is a defence mechanism, especially when discussed in group situations with other men. Mohammed Bader, a nurse and trainer on SRH issues for university students in Amman, says:

“Sometimes it happens with patients that if you ask him about what does he know about SRH issues, you are kind of challenging his masculinity; you are challenging his role as decision-maker.”

We argue that part of men’s lack of involvement in SRH programmes is due to social pressure on men to be men. A health educator in the West Bank says:

“Lots of men don’t come to our clinics because they think SRH is a pure women’s issue. Maybe one woman out of one hundred comes with her husband to the clinics during the pregnancy; some of them think that they will be accused by the community that they are spoiling their wives and they are mahkomen [controlled by their wives]. They think it makes them more feminine and less masculine.”

Based on our fieldwork and literature review, we believe that social pressure on men is associated and interlinked with what we are calling the “responsibility/authority” discourse. Part of being a man is being responsible, including putting food on the table, providing for all family needs, and protecting the family’s honour. A good example of the responsibility discourse was given by Sheikh Diyab, a religious leader in South Lebanon:

“Men’s responsibility works like in a company: your boss gets more money than you but he also has more responsibility than you. More responsibility needs to be paid. My wife, for example, she prefers me to take responsibility, to make decisions.”

Some research participants were honest and brave enough to question this link between responsibility and masculinity, and recognised it as placing pressure on men. Abu Fayez from the Gaza Strip said:

“Women and children think that men are capable of doing everything.”

Another young man from the West Bank complained:

“I am still single, not married. Every time I go to ask for the hand of a woman, her family asks me for lots of money as a dowry; this puts lots of pressure on us [men].”

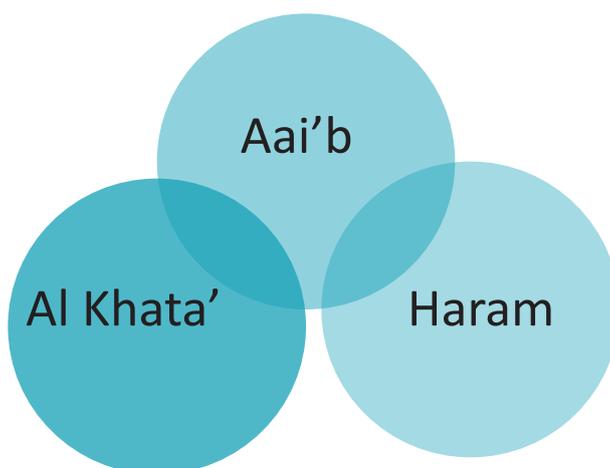
Some women recognised this link between responsibility and masculinity and how it places pressure on men. A female participant from the Gaza Strip said:

“Life is difficult, and there are no jobs; I feel for my husband and I know how sad he is when he can’t afford to put food on the table. The other day my daughter asked my husband for one shekel; he didn’t have any shekels! I saw tears in his eyes.”

Responsibility/authority discourse and pressure is part of hegemonic masculinity, which affects both men and women in all aspects of life, including SRH.

5.3.1 Shame [Aai’b], Forbidden [Haram], Vice [Al Khata’], and Custom and tradition [Adat wa Taqalid]

Some research participants’ conceptualised social pressure and responsibility on them with three words: **Shame [Aai’b]**, **Forbidden [Haram]**, and **Vice [Al Khata’]**. They argued that these three concepts intersect in a way that creates social pressure, and that SRH is located at a point at which these three concepts meet:



“SRH intersects with three main circles: Aai’b [shame], Haram [forbidden], Al Khata’ [vice].” Male participant, West Bank focus group.

These three key concepts were introduced through words that we heard regularly in the field: *Adat wa Taqalid* (custom and tradition), and religion.

Adat wa Taqalid was mentioned during fieldwork in all three countries as a major obstacle to discussing issues related to SRH and men. Rami, an activists and a researcher from the Gaza Strip, says:

“People created Adat wa Taqalid (custom and tradition) to organise and protect communities, but now we are scarifying the people to protect Adat wa Taqalid.”

Men and women whom we met in focus groups or individual interviews, including activists and scholars, all emphasised the strong influence of *Adat wa Taqalid*. Nadia Abu Naheleh, head of Women’s Affairs Technical Committee (WATC) in the Gaza Strip said:

“Adat wa Taqalid are stronger than laws and religion.”

Some FG participants noted that in some matters religion is more progressive than *Adat wa Taqalid*. Nora from Amman said:

“In the sexual and marriage relations between husband and wife, prophet Muhammad tells men to be nice and gentle with their wives; he even used to help his wives in domestic work, but if you tell this to any man, he would disagree.”

A woman in Beirut said:

“If I had religious power I would go to the teachings of the Quran. I would convince people through the Quran on gender-based violence (GBV); I would say that the Quran says it’s Haram [forbidden] to hit a wife.”

Many participants used verses from the Quran or Hadith to support their argument that SRH is not against Islam; yet it is *Adat wa Taqalid* that control people’s perceptions, attitudes and practices towards SRH.

Stakeholders and organisations working on SRH (health CSOs, and NGOs) realised the importance of working with religious leaders in order to access communities and implement SRH programmes. Dr. Jameel Fanoun of the UHWC in the Gaza Strip said:

“We started working on reproductive health issues a long time ago; some religious men attacked us and talked about us in the mosques, so we decided to talk to them. Some of them became very supportive; even some of them did their postgraduate studies on reproductive health from an Islamic perception.”

Working with religious leaders and using religious discourse is seen as added value to promoting SRH. Firyal Thabet, Director General of the Culture and Free Thought Association (CFTA) in the Gaza Strip, said:

“Ten years ago I gave a lecture in one of the Gaza refugee camps on issues related to reproductive health; it was a Thursday, so at Friday preaching, the topic was me! The imam attacked me and accused me of many things, such as destroying the Palestinian family and bringing Western ideas and so on. On Saturday morning I heard about it; I went to his house at 8 o’clock in the morning, I asked him if he attended my lecture, he said no. Then I explained to him, by using religious discourse

and Quranic verses, that what I was really saying is something pro-Palestinian family. At the end he apologised and now he is one of our supporters.”

Thabet’s story is not unique in the Occupied Palestinian Territory or Jordan or Lebanon; the research team heard several stories of religious leaders becoming supporters of SRH issues. Some of them were targeted through trainings and programmes on SRH and GBV in these three countries.

Adat wa Taqalid, Aai’b, Haram, Al Khata’ and religion are important and influential concepts/structures. They articulate and enhance certain gender dynamics, roles and stereotypes that affect men’s involvement in and knowledge of SRH, and form their perceptions, attitudes and practices.

5.4 Feminisation of SRH services: “It’s called the Women’s Centre!”

“I was shy going to the women’s centre, because it’s called “Women’s Centre.” [I was afraid] some men would make fun of me.” Abu Fayez, Jabalia, Gaza Strip

“We wanted to change the name from Women’s Centre to Family Centre, so men can come, but it will be a complicated process; we are registered as Women’s Centre.” Mariyam, head of women’s centre, Gaza Strip

By the “feminisation” of SRH, we mean that the majority of SRH programmes and projects target women as the main beneficiaries of SRH services and activities. Fieldwork data shows that there is an impression among male (and female) research participants that governmental and non-governmental stakeholders and key players of SRH engage mostly women on SRH issues, including early marriage, GBV, honour crimes, pregnancy and family planning. Even though actors including ApS partners⁹ have already started targeting men in their SRH programmes, the majority of CBOs, local NGOs and other actors have targeted mainly women.

We argue that focusing on women creates an impression of SRH as being a women’s issue. Knowledge of SRH becomes a feminine matter; it is what women need to know because they are women. But this association between women, gender and SRH was challenged by men and women alike in the Occupied Palestinian Territory, Lebanon and Jordan.

Abu Fayez is in his fifties, retired, and married. He used to work for a UN agency in the Gaza Strip, and is now a male leader in the women’s centre in Jabalia. He told us his story:

“I used to be nervous and anxious at home with my wife and children, after I was retired. I met Mariam [head of the women’s centre] and I started volunteering with them on working with other men. In the beginning men used to laugh at me for going to the women’s centre. But women are our wives, daughters and sisters; I am worth nothing without my wife. Last year, I got very sick and it’s only my wife who took care of me, she follows all my health issues, she walks with me on the beach every day. In my work with the women’s centre I go to places where men gather. In the beginning very few men listened to me; I found another two men who were convinced of the importance of talking to them. Mainly I talked to them about domestic violence, and how we have to be nice and

raheem (merciful) to our wives and children. I use Quranic sentences and Hadith to convince them. I think some of our common sayings are wrong and against men and women; our religion has more mercy than all these sayings which God wouldn't agree with."

Abu Fayeze's story is not unique, although he does not represent the majority of men in his community. In Abu Fayeze's case, he began by changing his own perceptions, attitudes and practices (on gender equality and SRH), then worked on change at the community level. Abu Fayeze is one of the very few men who visits a women's centre, and works there as a volunteer where he participates in community activities. He is aware of the challenges (men had laughed at him, and few used to listen to him). Yet he was eventually able to develop the proper discourse in talking to men on SRH issues.

"I use Quranic sentences and Hadith to convince them. For instance, Allah says in the Holy Quran: 'They [your wives] are your garment and you are a garment for them.' A garment gives comfort and security to a person, so this is how the relations should be between a wife and a husband. The prophet Muhammad says Paradise is under a mother's feet." Abu Fayeze, Gaza Strip.

The aim of presenting this story is to challenge the image of men in SRH literature. Some scholars (Sternberg and Hubley, 2004; Dudgeon and Inhorn, 2004) argue that men were initially largely narrated in SRH literature as "uncaring, unconcerned victimisers," hampering women's empowerment and contraceptive agency. Part of the reason for men's lack of knowledge of SRH is the absence of a model for men's reproductive health services¹⁰, and a lack of knowledge of their role in fertility and family planning, a feature of theoretical, methodological, and even ideological aspects of demographic research (Greene and Biddlecom, 2000).

Furthermore, some scholars argue that "SRH programmes have arguably been modelled after Western norms about women's primary responsibility for childbearing, and male and female agreement on reproductive issues" (Greene 2000). Although the male condom is one of the most important contraceptives, the fact that the medicalised contraceptives (hormonal) only target women proves this social focus on women and SRH. Most importantly, "population studies have largely been preoccupied with the approximate determinants of fertility and contraceptive use, and 'gender' studies have historically been conflated with 'sex,' and the focus has remained on women's bodies" (Greenhalgh, 1995).

5.5 SRH and spaces of knowledge (or, where do you learn about SRH?)

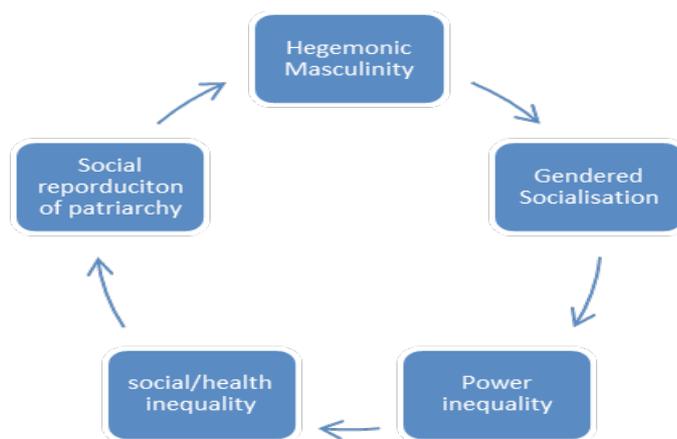
"Currently no entity is providing sex education as a holistic concept that is not only confined to information on the reproductive system, but tackles the emotional, affective, psychological and relational aspects that leads to a healthy, balanced personality of an individual. Sex education should start from birth and should continue to be provided incrementally by parents in an appropriate family environment." Jumana Jurdi, Director of the Reproductive Health Unit at the Ministry of Social Affairs, Lebanon)

"Sex education curricula in MENA schools are rare, and where they do exist, the sections on sexual and reproductive health are often skipped because teachers are unprepared or embarrassed to teach them. Only Algeria, Iran, Morocco, Tunisia, and more recently Bahrain have included a human reproduction and health education module in their national school curricula." (DeJong et al., 2007:3)

We have identified two main spaces of knowledge on issues related to SRH. We call them formal and informal spaces, and use these categories for analytical purposes only, in order to understand the main characters in and obstacles of each space, and make recommendations for interventions and programme design.



The Cyclical Pattern of Hegemonic Masculinity



The above analysis and demonstration of fieldwork data was important for the research team in order to link the relation between hegemonic masculinity and SRH in the context of the researched countries. “Hegemonic Masculinity” is a critical concept in understanding men’s relation with SRH. Dr. Connell (1995) first used the concept as the dominant form of masculinity within gender hierarchy. In simple words, it is how a “man” needs to be, or what does a real man looks like.

“Hegemonic masculinity” is important in the context of this research due to the importance of its impact in determining unequal social and political relations which are deleterious to the health of both men and women on a global scale (Scott-Samuel, A., D. Stanistreet, and P. Crawshaw. 2009).

The diagram above explains the “life cycle” of hegemonic masculinity according to Connell, and how its affect men’s and women’s lives. It explains how hegemonic masculinity, and the pressure of “being a man” influence the social division of gender roles which is based on unequal relations between men and women which privileges the “ideal man” over women and other types of masculinities.

Where do you get your information on SRH?

Mahmoud¹¹, aged 20 and from the West Bank answered this question as follows:

“If I have any questions I ask my father when there is no one around; he always answers me, but I have other friends who can’t ask their parents about these things.”

Another research participant from the West Bank shared a story of how his father took the responsibility to instruct him what he should do on his wedding night:

“Before my wedding my father told me in a very mechanical way, you do this and do that and that’s it.”

A similar question was asked of married women and married men who have children: “Do you talk to your children about issues related to SRH?” Um Mahmoud from the Gaza Strip said:

“I never talked to my daughters about anything related to their period, for instance. They can learn this at school; no one told me about my period, I had my [first] period when I was 15, and didn’t tell anyone about it for one year. I think my daughters know about it without me telling them anything; it is a different generation, they know lots of things.”

Some women agreed with Um Mahmoud that the new generation is different, that they know more and study different topics at school; yet other women didn’t agree, and believe that they should talk to their daughters, in particular, about issues related to their period and how to maintain hygiene. Um Tariq from the Gaza Strip said:

“I always try to talk to my daughters about their bodies and hygiene during their period. It’s true no one told us about it; as our children are from a different generation, we are also different from our parent’s generation, [and] we should talk about it with our daughters. I do talk to my daughter; I don’t want her to live my life, I want her to live a better life than mine.”

In personal interviews, few fathers said that they talk to their boys about issues related to SRH. Abu Ibrahim from the Gaza Strip said:

“I always talk to my little boy about issues such as not allowing anyone to touch his private parts, or with the older one I tell him that it’s haram (forbidden) to watch porn movies or bad things on the Internet.”

Based on fieldwork discussion, it seemed that when issues related to SRH were discussed within the household it was usually mothers who spoke to their daughters while fathers spoke to their sons. There was a perception that discussions of SRH needed to be directed mainly to female children, while boys could “manage.”

Focus groups of young men agreed that they do learn about SRH issues from different sources. Tariq from the West Bank said:

“I get my information from the Internet and friends; we always talk about these things.”

When asked about learning about SRH at school, Mustafa shared a story:

“When I was at school we used to have a public health topic where we should learn about reproductive health, but the teacher gave us so sport instead and asked us to read it at home by ourselves”

“Thirty years ago, when I was at school, I remember our teacher being embarrassed or shy giving us the lecture on reproductive health. These days and after more than 30 years, it’s still the same, teacher still don’t do it.” – Head of a village council, West Bank

One schoolteacher from the West Bank said:

“I don’t dare [teach on] the topic of reproductive health in the school, even though it is part of the curriculum; I don’t dare face the community’s reaction.”

Another West Bank teacher added:

“We lack the knowledge; that’s why we don’t give this class. Sometimes students ask us questions [and] we don’t have the answers for it.”

Schools and the educational system were seen by all stakeholders as the major and main realm for knowledge of SRH issues; yet, fieldwork reveals a major deficit here. Schools and teachers are more or less functioning in harmony with their communities’ structure and culture, and school staff are part of the community they are serving. They carry their own values and beliefs with them, and, most importantly, they might lack accessibility to knowledge spaces on SRH issues. A teacher from the West Bank shared a story:

“I remember when I was a student, one of my classmates asked the teacher a question about the IUD. The teacher’s reaction was very violent and he started beating the student because of this question. This student is a teacher now, and he never ever presents the topic of reproductive health to his students.”

The situation above was used to create a group discussion about the teacher’s reaction, focusing on his lack of knowledge about IUDs in the first place, and then lack of self-confidence in discussing such a topic in the classroom.

Another story was shared by a health educator in the West Bank:

“I worked as a health educator for the last 15 years. In one of the schools, after I gave a lecture for female students on reproductive health, a mother came to the school; she was very angry and accused me of spreading immorality. The headmaster was not supportive, and he prevented me from going to the school and stopped the programme. But I challenged him and organised a meeting with all women in the community through a local CBO, and continued the programme.”

Such stories underline the importance of targeting school staff in order to build their knowledge, capacity and self-confidence on SRH issues, to enable them to teach SRH topics to boys and girls without creating conflict or confrontation with the local community.

Both schools and households lack the knowledge of SRH and the techniques of how to talk about it. Both parties assume that it is the responsibility of the other, or simply assume that students can “manage.” Safa Tamish, head of Muntada Al-Jensaneya¹² in the Occupied Palestinian Territory, comments on this:

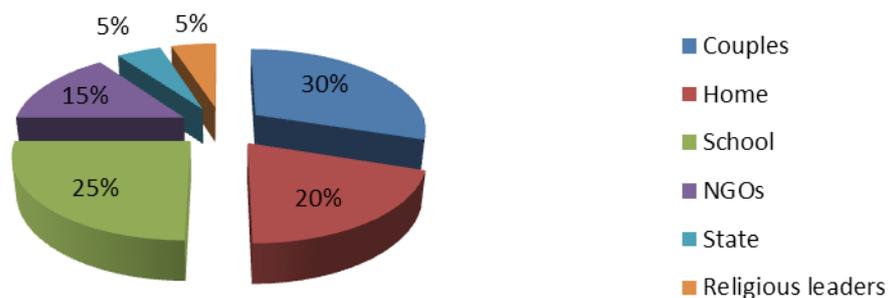
“We lack the knowledge, and we feel shy because we don’t know how to deliver the information; our faces turn red when someone asks us a question on sexual issues.”

In most cases those in “formal spaces” lack knowledge of SRH issues, and we believe that recognising and tackling this issue is a must for any programmes aiming to involve men in SRH and to improve reproductive and sexual rights for all.

Where do you think change in SRH and gender relations needs to come from?

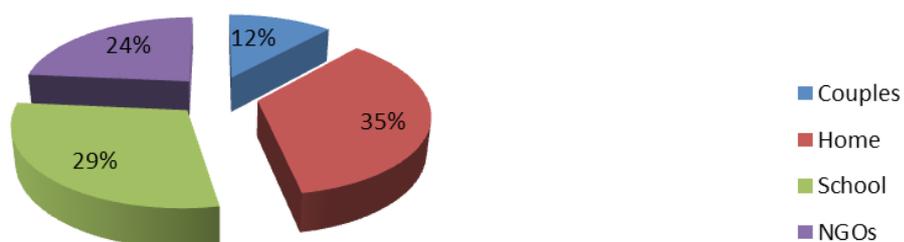
Twenty women and eight men from Palestinian refugee camps in Lebanon, along with 30 women and 28 men in the West Bank and Gaza Strip at the community and grassroots level, were asked to rank the most important areas where change need to start on issues related to SRH.

Women: Change agents



Women believed that major agents for change to perceptions, attitudes and practices of SRH and gender relations – at both individual and community levels – are couples themselves, in particular young couples, the home and the school. Women argued that change needs to come within and through these main three bodies. While they gave a middling role to NGOs and religious leaders, they did not see the state as an agent for change.

Men: Change agents

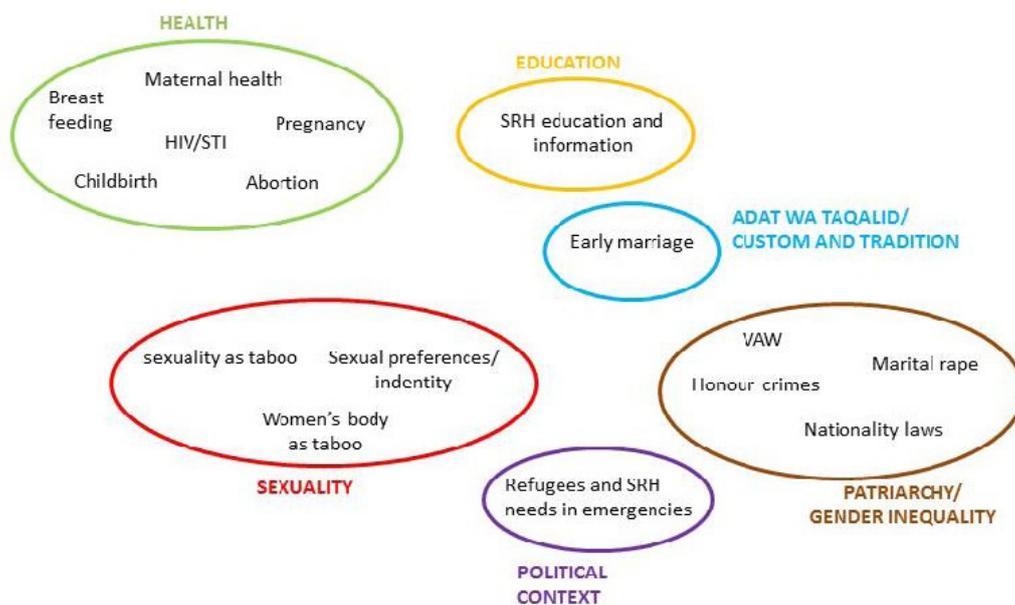


Interestingly, men did not see any role for the state or religious leaders as drivers of change. They emphasised the important role of the household, men and women as the main agents of change, and the need for change to start in the home. They also recognised the importance of schools and NGOs in such change.

Analysis of the above pie charts indicates that change must happen in a parallel way in the private (household) and public (NGOs and schools) spaces (this will be elaborated in section 9). Although our research participants are not a strong representative sample, we believe that the information gathered provides us with good data to analyse, and helps to recognise areas in which stakeholders need to focus in order to engage men in SRH programmes.

5.6 Topics

Our fieldwork showed us that SRH is perceived by different participants as belonging to different social dimensions. We asked our participants, in focus groups and semi-structured interviews, to identify the topics that could be framed as SRH; the image below was created through the analysis of those individual and group interviews.



Topics related to SRH that emerged during our fieldwork

The salient topics were those related to **health**, such as **maternal health**. Gynaecologist Ahmad Sultani, of PARD in Lebanon, told us:

“We have just had a congress of the Lebanese Society of Obstetrics and Gynecology a few days ago. It was about decreasing postpartum mortality. We didn’t tackle other issues.”

Pregnancy and the right to decide when to have children and how many to have were also common topics, especially amongst female participants. A female FG participant via PARD in Lebanon said:

“Pregnancy should not only be decided by men. Daughters [women] should have a say.”

Said another female participant in the same focus group:

“Oriental males love to have children.”

Childbirth and **breastfeeding** were indicated as important topics. **Abortion** also came up among female participants, although only when a comfortable and safe space had been created. A Lebanese feminist activist in Beirut told us:

“Abortion is illegal, is happening underground, with no safety, no regulation.”

Another feminist activist, from the Occupied Palestinian Territory, said:

“Abortion is not tackled by the majority of organisations. It is a very sensitive issue, even abortion for women who were raped or got pregnant due to incest. Abortion is haram in Islam in particular when the foetus is over 40 days old, and even if tests show that the foetus is abnormal.”

According to our participants in the Occupied Palestinian Territory and Lebanon, some pregnant women go to private clinics and pay a lot to doctors to give them an abortion. Both doctors and the women take a great risk.

HIV and STIs were also discussed in our conversations. Johnny Tohme, a psychosocial officer for MARSА in Lebanon, told us:

“HIV is increasing in MENA countries [according to UNAIDS, the Joint United Nations Programme on HIV/AIDS, in 2013]. Governments are in denial that the numbers of [those infected with] HIV are going up.”

Sexuality also came up in the discussions, with interviewees indicating the difficulties of talking about SRH because of the **taboos surrounding sexuality**.

“In the region, SRH is a sensitive topic because of the word sexuality. Some organisations take out the word and continue doing SRH.” Charbel Maydaa, Emergency Response Programme associate, ABAAD, Lebanon

Pre-marital sexuality, women’s bodies, and sexual preferences and identity came up in some conversations with some activists, yet it was not brought up in our focus groups discussions. LGTB is still not a salient topic in the region, although there are organisations in the Occupied Palestinian Territory and in Lebanon working on LGTB issues. Some research participants indicated difficulties in addressing LGTB issues because it is still taboo. As one participant noted:

“LGTB is important, but there is a need to go slowly and to be strategic.”

In addition, we observed the “queer”¹³ approach and language reclaimed by some organisations, such as alQaws in the Occupied Palestinian Territory and Nassawiya in Lebanon, and providing tools for critiquing the imposition of LGTB frames on same-sex sexualities in postcolonial settings:

“LGTB is about labelling. It reproduces roles and gender. Coming out, the pride ... We went to the ILGA conference in Sweden and we felt uncomfortable. They had replaced the word Jesus for the

word gay!” Activist from Nassawiya, Lebanon

“‘Coming out of the closet’ and being visible in our communities is important to many LGBTQ Palestinians, but many others have different goals and aspirations. And so we urge journalists who are interested in representing our stories and experiences to the world not to impose some predetermined standard, but to consider our own, equally valid ideas about ‘freedom’ and ‘liberation’ and what it means to be an LGBTQ person ¹⁴”. alQaws website

Participants also placed **gender inequality and patriarchy** at the centre of SRH. **Violence against women (VAW)** was a key topic in the focus groups, where we learned that VAW is very common in the informal refugee camps (or gatherings) and planned refugee camps. **Honour crimes** and **marital rape** were also mentioned.¹⁵ Some participants also indicated that, although some improvements had been made,¹⁶ the discriminatory **nationality laws**¹⁷ in Jordan and Lebanon affected SRH.

Many women interviewed also pointed to **early marriage** to be an urgent issue to be tackled:

“Men need to know that women have to be a woman when marrying them. If a girl marries too early, if he dies she is left with nothing.” FG female participant, PARD, Lebanon

For these participants, early marriage is a **custom and tradition** in their region, and some were carrying out campaigns in their neighbourhoods or towns to prevent them.

Finally, **refugees and special SRH needs in emergencies**, part of the **political situation** in the region, was mentioned in various conversations as affecting SRH.

“In emergency contexts there are different types of SRH needs.” Charbel Maydaa, Emergency Response Programme associate at ABAAD

The literature also suggests that refugee camps (planned or informal) are places where SRH becomes more vulnerable (Petchesky, 2008; Krause et al., 2000). As Rosalind Petchesky explains, there is a *“need for a better analysis and understanding of the ways in which sexuality and sexual violence, pregnancy, childbirth, HIV and AIDS, and racialised and gendered power relations take on whole new meanings and help give meaning to situations of armed conflict and disaster”* (Petchesky, 2008:5).

Sexual and reproductive health, therefore, is as a complex interplay of issues that goes beyond maternal health and family planning. Interviewees stress the importance of gender roles, political and institutional discrimination against women, or an unstable political climate as affecting SRH. The opinions of the participants are very relevant in understanding that it is almost impossible to disentangle issues on reproduction or sexuality from wider social structures such as the state, the law or tradition.

6. Approaches to SRH in Lebanon, the Occupied Palestinian Territory and Jordan

This section aims to refine the analysis provided in the previous section. Here we identify and examine the approaches and discourses of SRH that we found in our fieldwork from a gender-roles perspective in order to see, in the next section, how these approaches inform men's role in SRH. This section is based on interviews, dialogues and reflections held with stakeholders at Levels 2 and 3.

It is important to understand the relationships among various actors developing SRH initiatives. Mapping the main SRH actors in Jordan, the Occupied Palestinian Territory and Lebanon was not an easy task. Categories such as 'State' or 'Civil Society'¹⁸ do not help to define actors developing SRH initiatives in Lebanon, the Occupied Palestinian Territory and Jordan. The lines that differentiate the different actors tend to be blurred. It is common to find state actors performing as NGOs¹⁹ and Community-based Organisations (CBOs) performing state roles²⁰ in this area of intervention.

This complexity leaves SRH initiatives to function in an environment without clear, shared and agreed policies, and only some basic protocols for action. As one SRH programme officer at an NGO stated (reflecting on the situation in Lebanon): *"People (SRH actors/stakeholders) don't communicate with each other unless something is officially released."*

In general, there is not a normative framework through which public, private and semi-private/semi-civil society institutions (international and local NGOs) guide their actions. SRH programmes depend on a complex network created by personal and professional relationships at institutional and informal levels. In this sense, and given the lack of legitimacy of state institutions regarding the regulation of private spheres (see more on this on section 8), the different actors in the field search for their own legitimacy for their actions, sometimes internally by their targeted groups, and sometimes externally, through donor institutions and international NGOs that support them.

"In Lebanon there are neither strategies nor policies on SRH. External funding agencies have their own rules, regulations and limitations and as recipients, we have very little control over re-channelling the funds, so we accept them with the terms and conditions stated. Most of the funds are dispersed on sporadic projects rather than on those of developmental or strategic natures. Donors are much less interested in strategies and policies." Jumana Jurdi, Director of the Reproductive Health Unit at the Ministry of Social Affairs, Lebanon

In this context, various interests (national and international), diverse philosophies, accountability systems and definitions of SRH co-exist. This section attempts to describe different existing understandings of SRH that we have found in Jordan, Lebanon and the occupied Palestinian territories.

6.1 Main paradigms and coexisting approaches

As already stated, there are many actors that could be considered stakeholders of SRH in the region, with diverse agendas and different ways of understanding what SRH is and what strategies should be applied. At the same time, we may observe a wide diversity of subjects considered to fall within the SRH rubric, some shared by many of the actors and others claimed by only some of them. This observation leads to our understanding that **there are many approaches to SRH coexisting in the region**, and that before any intervention is carried out there is the need of identifying them and to identify which one every programme adopts.



A Reproductive Health Unit at the Social Affairs ministry office in Lebanon uses a UN campaign to gain (from our perspective) legitimacy within the ministry.

Drawing upon specialised literature in the topics, combined with the analysis of the interviews to all type of stakeholders and our observations in the field, we can identify the following approaches to SRH in theregion.

Approach	SRH it is mainly a ...
Birth control – control of population	Demographic and economic issue (Malthusianism)
Family planning or Protective Health (Islamic perspective on FP)	Family issue; sexuality and reproduction are only visible within the family
Maternal and child health care, or Maternal health Care	Biomedical and public health issue; maternity and childbearing are a women’s issue
Women’s health	Feminist approach to health; criticism of androcentrism
Epidemiological	Public Health issue; concerned with risk
Rights-Based Approach (RBA) to SRH	Justice/equality issue related to health, religion, politics, education, gender roles, law

In the following pages we will elaborate on the chief characteristics of the above-noted approaches; however, it is important to note that:

1. These will be simplifications and generalisations of an approach.
2. We have drawn on specialised literature, and fieldwork interviews and observation, but concede there may be other approaches that we have not included.

read these answers through the lenses of the different SRH perspectives described, and we present here various perspectives on engaging men that are linked to the various SRH approaches.

As stated previously, rationales for men’s engagement in SRH programmes are not presented as single rationales; in fact, many of the organisations already engaging with men in Jordan, Lebanon and the Occupied Palestinian Territory use many of these rationales at the same time.

7.1 Rationales for engaging men in SRH programmes

Approaches	SRH it is mainly a ...	Men should be engaged because ...	
Birth Control: control of population	-Demographic and economic issue (Malthusianism)	They are decision-makers. “Men should have a role, because children listen more to the father.” Female participant in a focus group discussion in Beirut	Instrumental approaches
Family Planning or Protective Health (Religious perspectives on FP)	-Family approach -Sexuality and reproduction are only recognised within the family		
Maternal and Child Health, or Maternal Health	-Biomedical and public health issue -Women’s issue, because women bear and give birth to children		
Women’s Health	-Feminist approach to health -Criticism of androcentrism in science		
Epidemiology	-Public health issue -Concerned with risk -Men’s issue	They are partners of women and parents of their children. “Men are partners in the problem; therefore, they need to be partners in the solution.” Firyal Thabet, CFTA, the Occupied Palestinian Territory	
Rights-Based Approach	-Justice/equality issue related to health, religion, politics, education, gender roles, law	They have risky behaviours. “People getting infected with HIV in Lebanon are mostly MSM, IDU and sex workers. So these are the most vulnerable populations.” SRH programme officer, Beirut	
		SRH is also about gender equality. Working with men should be an end in itself, not just a means for empowering women.” Charbel Maydaa, ABAAD, Lebanon	Relational approach

Men are the decision makers

“Men should have a role, because children listen more to the father.” Female participant in a focus group discussion in Beirut

Sometimes a SRH programme will target men since they hold significant family and

community power, in order to increase the chances of success of the programme. This rationale is used in programmes adopting Birth Control, Family Planning, Maternal Health, or Women's Health approaches. These four SRH approaches have women as their main target, but because they acknowledge the imbalance of power relations they also include men.

One example of this rationale is USAID's Maternal and Child Health Integrated Program (MCHIP)²⁸, which employs a Maternal Health approach. According to the U.S. aid agency's website, *"We need to involve men in our programs since they are the decision makers about health care in the family."* This type of justification acknowledges gender power relations but does not address or question them.

Another organisation adopting this rationale is the Jordanian Association for Family Planning and Protection (JAFPP), whose project on men's participation targets male religious scholars and imams because, according to their website, *"they are the ones who are in direct contact with the local communities and have direct impact on these communities."*

Finally, in 2012 the Lebanese organisation ABAAD launched the media campaign "We Believe ... Partners to End Violence Against Women," engaging Muslim and Christian religious leaders in Lebanon to speak out against violence against women. Although ABAAD does not justify the campaign by arguing that male religious leaders hold the power in society, it acknowledges that *"Religious leaders have an undeniable ability to catalyse changes in attitudes, behaviours and beliefs for many in the Lebanese society"*²⁹.

Men are "partners of" and "fathers of"

"Men are partners in the problem; therefore, they need to be partners in the solution." Firyal Thabet, CFTA, Occupied Palestinian Territory

SRH programmes also engage men because they are partners of women and fathers of their children. Yet men are included in these programmes as long as they are partners or fathers, which means excluding a large number of men.

One example of this approach is the Sexual and Reproductive Health programme (PASSIR) in Catalonia, Spain. This program, which straddles the Women's Health and Rights-Based Approaches to SRH, targets women and their partners, meaning that any man who is not a partner or a father is not expected to use the services. In the Middle East, Popular Aid for Relief and Development (PARD) in Lebanon has a few men accessing their SRH services who are largely partners of the female clients, or fathers of the children in the Mother and Child Health Care Program.

This approach is heteronormative³⁰, since it suggests that all women's partners in the household are men, that all children have a present father, and that all men will eventually get married and have children and thus will be targeted by SRH programmes. This rationale also acknowledges gender power relations within the household but doesn't tackle them.

Men engage in high-risk behaviours

“People getting infected by HIV in Lebanon are mostly MSM³¹, IDU³² and sex workers. So these are the most vulnerable populations.” SRH officer, Beirut

According to this rationale, SRH programmes should engage with men because of their higher-risk behaviours. This justification is normally seen in the Epidemiological approaches to SRH, although we can also see it in other discourses.

The epidemiological approach tends to frame these risky behaviours in a gendered way: by saying that men engage in more risky practices, masculine and gender roles are reproduced. In fact, we have observed in the fieldwork a perception about the Arabic hegemonic masculinity to be linked with having an intense sexual life. As one of our participants stated:

“A man in Lebanon, if he has a lot of sexual relations and a lot of girlfriends, he is a man. He is the man that everyone will look up to.” Anonymous, Beirut.

This justification for men’s inclusion in SRH services takes for granted hegemonic masculinities while not addressing gender power relations. This approach can also make women invisible by treating them as less vulnerable and leaving them out of preventive policies.

We have perceived that this rationale is growing in the region. Several journals and academic institutions have raised the concern in past years about the increase of the AIDS epidemic in the region, and MSM and drug injectors are treated as the main risk groups. Cornell University has found that the cases of HIV in Lebanon are mainly of MSM³³, and the U.N. agency UNAIDS recently published a strategy to promote outreach to MSM in the MENA region in order to prevent an HIV epidemic (UNAIDS, 2012). The SRH centre Marsa, in Beirut, told us that 50 percent of its users are MSM because they are the most vulnerable population for STI, including HIV, while the other 50 percent of Marsa users are heterosexual women.

SRH affects everyone; men should take responsibility; SRH is also about gender equality

“Reproductive health is an issue related to the man and the woman; therefore, we need to work with both.” Firyal Thabt, CFTA, the Occupied Palestinian Territory

“Men should have a role, because women have all the responsibilities [for SRH].” Female participant in a FGD, PARD, Beirut

“Working with men should be an end in itself, not just a means for empowering women.” Charbel Maydaa, ABAAD, Lebanon

There are other rationales for the decision to include men in SRH that adopt a very different focus than the previous ones. The statements above show us that there are motives for engaging men that are consistent with a RBA to SRH.

As described in Section 6, gender relations are at the centre of a RBA to SRH, and since men are also victims of patriarchy and hegemonic masculinity, this population should also be included in SRH programmes. Charbel Maydaa's quote summarises this argument by saying that working with men cannot be subsumed by other goals; it must be a goal in itself. In addition as also seen in section 5 SRH is often feminised, which often empowers women but also overburdens them with responsibilities regarding SRH care. Including men in SRH programmes also responds to this fact, understanding it as an issue of gender justice.

A good example of including men through a RBA to SRH is seen in ABAAD's men's centre in Beirut³⁴, which is in partnership with the International Medical Corps. Although the men's centre initially responded to the need to tackle violence against women (VAW), the rationale used by the organisation is that men need to be accountable for gender equality, and they also suffer the burden of hegemonic masculinities.

We believe a programme that includes these rationales for engaging men in SRH programmes employs a RBA to SRH.

7.2 Instrumental and relational approaches

Drawing on previous research on engaging men in VAW programmes³⁵, we will divide the rationales for including men in SRH programmes into two categories: instrumental approaches and relational approaches.

Instrumental approaches

The instrumental interpretation of men's engagement in SRH considers men pragmatically, as holders of the power that will allow changes to be made in women's lives and opportunities. From this perspective, changes in men's perceptions are important only insofar as they are necessary to secure their collaboration and support. Their personal change is not an objective, nor is a reconsideration of gender power relations. This approach responds to the justifications "Men are decision-makers," and "Men are 'partners of' and 'fathers of.'"

Relational approaches

The relational interpretation of men's engagement in SRH considers that men are an active part of gender power relations, and engaging men needs to be framed in terms of gender dynamics. We can see this approach in other justifications for including men in SRH programmes. A relational perspective is one for which instrumental approaches do not work because they do not tackle gender dynamics.

A relational approach therefore focuses on gender relations, which includes but is not limited to female empowerment. It is about transforming gender relations, and transforming social meanings of what is to be a man or a woman. It is about experiencing

and promoting processes of gender de(re)construction. A relational approach also recognises the existence of gender and sexual identities other than man/woman, and takes them into account.

8. A transformative Rights-Based Approach to SRH that engages with men in Jordan, the Occupied Palestinian Territory and Lebanon

This section aims to help in constructing a RBA to SRH that engages men in Jordan, the Occupied Palestinian Territory and Lebanon based on the findings of this study. It starts by proposing three main conclusions emerging from the fieldwork, which constitute the basis for recommendations and more practical implications for NGOs and aid actors (Section 9).

- A RBA to SRH needs to commit to gender-role transformation.
- A RBA has not yet been achieved, and needs to promote an active interpretation of SRR.
- A RBA to SRH goes beyond health issues.

8.1 A RBA to SRH must commit to gender-role transformation

In line with the analysis presented in Section 7, we argue that instrumental approaches to engaging men to SRH appear to be less effective than relational ones, since they do not challenge the status quo of power imbalances between men and women. In fact, they could even reinforce hegemonic gender roles, for example, by making women solely responsible for SRH, or by victimising them. This widens, for example, the knowledge gap identified in our FGDs and interviews with adult and young men.

An approach based on justice and equity must commit itself to challenging socially constructed gender roles. These gender roles, as analysed in Section 5, are formed by education, laws, politics, religion, custom and tradition. Control of women's bodies and women's health, or the differentiation between sexuality and reproduction, were established principles of the Cairo and Beijing conferences.

From the relational perspective, we would argue that these socially constructed roles and rules affect both men and women (as discussed in Section 5). A relational or gender relations transformation-centred approach to engaging men in SRH implies overcoming a binary analysis of gender roles. It also accepts complexities in the conformation, performance and dominance of hegemonic masculinity.

Women are not only mothers, or victims of a patriarchal society, but can in fact be oppressors, controlling the ways of being a man or a woman. In like manner, men are not only fathers of children, partners of women or STD transmitters; they are not only oppressors or potential perpetrators, but also oppressed by the rules of hegemonic masculinity.

Accordingly, our fieldwork suggests that men engage in SRH, as they also feel the need to get rid of the patriarchal structures that affect them and, consequently, those around them. This includes, in further states of awareness and transformation, the renouncing of privilege that men hold in relation to SRH (e.g., decision-makers on when and how to have sex, whether or not to use contraception).

This relational view understands that working with men is a vital component of achieving gender equality, which will profoundly affect attitudes, perceptions and practices towards sexuality and reproduction. This view also implies the double aim of addressing both **changing perceptions and the practices of masculinity** while **working to empower women and girls**. In this view, men are perceived as positive agents of change, who by changing themselves promote wider changes.

8.2 A RBA has not yet been achieved, and needs to promote an active interpretation of SRR

As explained in previous sections, rights are necessarily linked to recognising gender and other social inequalities when tackling SRH issues. A RBA starts from basic notions of justice and equity affecting sexuality and reproduction.

Despite the fact that the normative SRR framework offers specific values (e.g., mutual respect, consent and shared responsibility) to deal with inequalities of sexuality and reproduction, justice and equity need to be specifically defined and addressed by those affected by their absence in specific circumstances and specific socio-cultural, economic and political contexts.

In this regard, the normative human rights frameworks must be nurtured by a dialogue among global, national and local spheres. As Zwingel (2005) puts it in exploring the social impact of the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), *“instead of assuming a ‘trickle-down’ dynamic as a consequence of global agreements, it is argued that the legitimacy and authority of global norms depends on their active interpretation and appropriation within national and local contexts all over the world.”*

SRR are entrenched with human rights and intended to create norms and justiciable principles to promote protective laws at global and national levels. These frameworks tend to understand social change as coming from changing laws. Our findings show that this is problematic in the three states visited in this research, where social and legal norms do not always correspond. In this sense, Zwingel’s statement may be applied to the gap between social and legal norms in these three countries.

As one participant in Lebanon said:

“Change in law is only a piece of paper. Social norm doesn’t relate to law. We should work at the social and religious level”.

Moral norms, custom and traditions (*Adat wa Taqalid*) seem to be more influential in affecting social behaviours than in legal norms, as explained in Section 5. A dialogue between the global, national and local levels on human rights is still needed. Otherwise, efforts to change social meanings of sexuality or reproduction could run the risk of being perceived as “westernising” (even when promoters of SRR are not necessarily from the West), or even neocolonialist.

As a gynaecologist put it: “Any initiative that improves health is good. There are limits, though. We cannot apply European standards here because of religion and society. We must be prepared. We cannot come with easy solutions. We need to work it out before coming up with any recommendations.” (Gynaecologist Ahmad Sultani, Lebanon)

It is worthwhile to say that the state and its legislation in Jordan, Lebanon and the Occupied Palestinian Territory (and in other Arab countries) have less control, and perhaps “legitimacy,” as Ayubi (1996) argues, in regulating private spheres of life such as sexuality and reproduction than in other (Western or Western-inspired) nation states (Bamyeh, 2003). As one of the interviewees in Lebanon said: “*Laws here stop at the family level.*”

This issue involves a balance between top-down and bottom-up theories of change. Societies change not only by improvement or by creation of laws, nor from the grassroots level. A right is a legal entitlement, and therefore justiciable, but it is also a “*claim that is made in connection with justice and equity in relations between people*” (Eyben, 2011) no matter whether it is justiciable and potentially or actually included in specific national and/or international laws.

In this line of thought, a RBA to SRH in these three states should be more experience-based and descriptive than prescriptive. Hence, **SRR’s international frameworks and principles should be valued as a source of inspiration** and not only an aspiration. A RBA to SRH is a work in progress. Accordingly, targeted individuals are subjects rather than objects of SRH initiatives. **They are not only “right holders” but “right builders,”** since they must actively interpret and participate in the creation of SRR.

8.3 A RBA to SRH goes beyond health issues

A key point from this research is that SRH is not purely a health issue, although it has important consequences on personal health and public health. The fieldwork and the literature tell us that sexuality and reproduction are embedded in sociopolitical dynamics such as demographic control or health provision, and in other sociocultural dynamics including gender roles and power inequalities. **SRH is about law, politics, religion, education, gender, and social and legal norms.**

Interviewees defending a SRH approach based on rights, or simply recognising the complex nature of SRH (amongst whom were medical doctors), insisted that medical approaches to SRH failed to see SRH from other disciplines and bases of knowledge. This prevents SRH initiatives from being truly transformative. Without tackling underlying

causes of SRH actions, there will be no transformative impact.

Practised Lebanese gynaecologist Dr Sultani would recommend, for example, *“to hold a roundtable with health practitioners, local health educators, social workers. That could be great ... to come up with ideas.”*

Charbel Maydaa, a programme associate working in emergence response with Syrian refugees at ABAAD in Lebanon, told us that ***“SRH is a social issue rather than a medical one.”***

In Lebanon there are already organisations adopting a more holistic approach to SRH by offering training to medical students to sensitise them to social issues. There are also programmes in schools to train teachers to tackle issues of sexual education and reproduction.

Nevertheless, as Jumana Jurdi, Director of the Reproductive Health Unit of the Ministry of Social Affairs in Lebanon stated, ***“SRH is not only about knowledge; it is also about values and attitudes.”***

Apart from identifying knowledges (medical, social, demographic, political) required to change attitudes towards SRH, actors developing SRH initiatives must identify how specific disciplines and paradigms construct the reality of SRH. As explained in the last section, demographers will more likely see SRH through the lens of population dynamics, a doctor through a health lens, etc.

As the Director of the Reproductive Health Unit at the Ministry of Social Affairs in Lebanon reflects, *“there is a need to work in parallel on all levels, and in different places and with different organisations.”* Clinics are not the only places where SRH initiatives should focus on. In fact, they are not the places most frequented by men. As one SRH programme officer put it, *“providing services to men won’t make them come (to clinics)”* Lara Shehabeddine, PARD.

Drawing on the definition of holism -- that parts of a whole are in intimate interconnection, such that they cannot exist independently of the whole -- we argue that **addressing only parts of SRH does not result in substantial change**. For example, many times during our fieldwork we were told about investing in future generations, since it was not considered worthwhile to try to change the minds of men and women over the age of 40, including older doctors and teacher. A holistic view recognises that those youngsters are embedded in specific relations and dynamics with others. Hence, working with individuals alone is not effective if no work in parallel is done with those around them.

9- Recommendations for aid actors³⁶ and project-based initiatives to engage men in a RBA to SRH

9.1 What changes can aid actors and project-based initiatives support?

This last section provides recommendations based on the previous sections. These recommendations are aimed at supporting an approach to engaging men in a RBA to SRH. To this end, it is important to explore the practical and methodological implications of working from a RBA to SRH for aid actors and project-based initiatives, bearing in mind the limitations and potentialities of their role.

In order to identify the contribution that these actors can make, we must first define the process of change that a RBA approach to SRH that engages men entails. We are proposing here a specific theory of change which, in coherence with the three basic principles proposed in the last section, needs to be necessarily improved, specifically defined or contested after practice and experimentation.

Again, the findings of this research suggest that men's perceptions, attitudes and practices towards SRH are profoundly embedded in gender and other social identities, custom and traditions, religious and moral norms, educative and health cultures, legal norms and political contexts.

This complexity suggests the following **key messages for the process of change**, and implications for aid actors and project-based initiatives:

A process of change takes time. Social and moral norms from where gender roles and other social roles are constructed do not change in the short term.

1. Build trust and longterm relationships.
2. Be strategic.

Change cannot be controlled. Success cannot be foreseen since there are many players, interests and dynamics amongst different actors.

3. Think in terms of your contribution to change, for example, by making changes to your programmes.
4. Focus on learning and facilitation.

Change happens both on the individual level and the social and legal spheres.

5. Start with the individual.
6. Bridge knowledges.
7. Zoom in and out.

9.2 How to support this change?

Effective change must be based on accepting the complexity of the issue itself, and on interdependence amongst actors. Bearing this in mind helps us to recognise the work model and knowledge management for the desired change.

Level of interdependence: Collaboration	1-Process model <ul style="list-style-type: none"> • Systematic, repeatable work • Highly reliant on formal processes, methodologies or standards • Dependent on tight integration across functional boundaries Knowledge Management: Methodologies, standardisation	3-Network model <ul style="list-style-type: none"> • Improvisational work • Highly reliant on multidisciplinary knowledge • Dependent on fluid deployment of flexible teams Knowledge Management: Alliances, facilitation, reflection, communities of practice
	2-Systems model <ul style="list-style-type: none"> • Routine work • Highly reliant on formal procedures and training • Dependent on individual workers and enforcement of strict rules Knowledge Management: Automatisation, training	4-Competence model <ul style="list-style-type: none"> • Judgement-oriented work • Highly reliant on individual expertise and experience • Dependent on star performers Knowledge Management: Apprenticeships, recruit individual experts
Individuals	Complexity of work: Routine Interpretation/Judgement	

As illustrated above, different work settings operate with different knowledge management styles. The Process and Systems models (1 and 2) are appropriate for work settings that are simple and highly routine and do not require elements of interpretation. Work settings lean more toward standardised mechanisms, through the use of manuals and guidance materials.

Network and Competence models (3 and 4) are more effective when success or completion depends on a far more complex environment of factors and actors, such as exist in the perceptions, attitudes and practices towards sexuality and reproduction. For this reason, practitioners need to rely more than in other work settings on judgement and improvisation to carry out tasks. In these work environments, trainings, protocols and manuals are not always effective (Pasteur in Eyben, 2006).

For this reason, the **Network Model**, based on **improvisational (learning-by-doing) work, reliant on different knowledges and teams working in a flexible and interpretive manner**, appears to be suited to an effective engagement of men in a RBA to SRH.

1- Build trust and longterm relationships

“Changing attitudes, beliefs and practices take time. We need to persist in letting men question socially constructed roles, and exteriorising their feelings.” Anthony Keedi, ABAAD, Beirut

It is apparent that promoting a process of change which attempts to question gender roles needs to be based on **building trust and longterm relations**. People need to be able to access safe spaces and support to continually review their beliefs and attitudes, their behaviours and progress.

In Jordan we held a meeting with social workers in the offices of a large NGO, and asked about their experiences in engaging with men in different gender-related programmes. This conversation led to talk about changes in mentalities and social behaviours. One of the participants said that sometimes aid funding and development programmes fail to support this kind of change. *“These processes of change need time, which is what development programmes often lack ... They want quick and visible results.”*

A young leader of a youth organisation in Jordan also made us reflect on the importance for aid actors of **recognising the limitations of their role when developing project-based initiatives**. *“A project, by definition, cannot be longterm. The end is decided from the very beginning. We prefer to work on initiatives that are more open and organic.”*

Another volunteer and social facilitator in South Lebanon, reflecting on her own process of change in the past 15 years, added that *“changes in attitudes and behaviours need more time, motivation and dedication than money.”*

2- Be strategic

Challenging and de(re)constructing gender and other social roles it is particularly difficult since identities in which those roles are based and social acceptance are fundamental for everyone. Successful initiatives to engage with men suggest that an effective strategy is trying **to avoid confrontation while supporting critical reflection and transformation**: for example, by focusing on aspects of hegemonic masculinity that men find unfair both to themselves and to women, and those that affect men and women. Without losing the final goal of supporting gender relations' transformation, aid actors might need to discern when to fight battles or how to fight them in order to create strong relationships needed for the kind of longterm changes pursued.

Other strategies used are based on the idea of *“meeting men where they are,”* meaning where their concerns and interests are. For example, we had the chance to learn about a future programme for young males which will analyse gender dynamics through football and values related to collectivism, respect and communication.

In some of the FGDs and interviews we asked about their knowledge about reproductive health, but only when we focused attention on the issues of their concern did we find a way of tackling gender topics. For example, in a conversation with two Palestinian refugees in Beirut, they spoke of the economic situation and we started to make them

reflect on gender issues by discussing the social construction of “exclusive” gender roles, such as the role of “breadwinner.”

3- Think in terms of contribution instead of attribution to change

The network model proposed in this section supposes a big challenge for those aid actors and project-based initiatives using systems of accountability thought to only satisfy donor demands of information, such as Results-Based Management (RBM). Several authors and practitioners have highlighted in the past years how RBM and results and evidence artefacts³⁷ can hinder longterm and locally led transformative processes (Whitty, 2013; Eyben, 2013; Shutt, 2009).

On one hand, most of these artefacts tend to **see reality through a cause-and-effect lens which does not help to understand complex realities or processes of change**. On the other hand, the excessive emphasis on **upward accountability (or accountability to donors) makes programmes focus on *attributable* changes rather than contribution to change**. Thus, this emphasis provides simplistic and idealistic pictures of the reality that programmes aim to influence.

In simple environments, it is easier to create change. However, in complex settings where change depends on multiple factors and dynamics, it is more difficult. Aid actors are less in control of change, although they contribute to change.

In this sense, a project which seeks to support men’s personal reflection and change cannot, realistically or ethically, attempt to control the nature or scope of those changes. For this reason, it is very important to distinguish between **areas of activity and change which fall under the scope and control of the project**, which can be planned and monitored, and those which are the domain of the individual participants, which will inform understanding of the effectiveness of the project but cannot be predetermined or limited by it.

In this regard, **when designing, reporting or evaluating programmes, quantitative data should be complemented by qualitative data based** on stories of change, personal reflection and narrative methods that help to give context and understand the project’s contribution to change.

4- Focus on learning

Accepting uncertainty about how or where the change in men’s attitudes, behaviours and practices will come from also determines the kind of knowledge suitable for aid actors’ project-based initiatives. As illustrated in Table 1 above, in contexts where complexity of work is low there are more possibilities to develop work routines for individuals and teams. Standardised work routines, procedures and methodologies guide practice, since knowledge is already available, theorised and systematised.

In complex settings, knowledge must be created by doing. Learning appears to be one of the main drivers of work. In simple settings, factors and actors behave in a more or less patterned manner. Thus, practitioners are valued for their capacity to be systematic and stick to procedures while in complex settings practitioners are valued for their capacity to interpret reality and make sense of it.

In this sense, any expertise and knowledge need to be developed from practice and from contextualised experiences. **Hence, practitioners on the ground and participants are the main actors in generating knowledge by making sense of their experiences.**

This suggests in practical terms that RBA to SRH initiatives need **to promote reflection on specific experiences.** The role of aid actors would be **facilitating and opening those spaces for reflection and sense-making among actors on the ground.** Creating communities of practice and promoting the exchange of experiences appears to also be in coherence with aid actors' facilitating role.

Accordingly, participation – understood as methods, tools, approaches, practices and attitudes – **constitutes a core, pragmatic principle** to inform processes of identification, implementation and evaluation of SRH initiatives. As explained above, since knowledge is to be created by actors on the ground RBA to SRH programmes need to be informed by practitioners' interpretation and participation in making sense of their experiences.

5- Start with the individual

The theory of change we defend, which will engage men in effective SRH programmes from a rights perspective, envisions change coming from the individual and society at the same time and reciprocally. The individual creates and/or changes society by behaving in a certain way, as society builds individuals' identities by creating roles for them.

Experiences of engaging men in SRH and in anti-VAW programmes in the Occupied Palestinian Territory, Jordan and Lebanon show the key importance of **promoting processes of personal change.** Different initiatives have indicated that men, contrary to women, inhibit themselves when talking about SRH issues in group settings. They are not used to sharing on intimate subjects with their peers.

According to the director of the ABAAD men's centre in Beirut, *"it is not easy for men I work with even to express feelings and emotions; they need to feel they are in a safe space."* Most are afraid that in being expressive, others will laugh at them or question their manhood.

Nevertheless, when thinking about wider community or societal changes, both **conviction and passion seem to be very important drivers of change.**

"I started working on masculinities as the result of the review of my own masculinity ... as a need to work on my change all the time." Anthony Keedi (ABAAD's Men Center Director) *"Only those really convinced are able to convince others."* Adla Manari, volunteer at PARD

As another participant reminded us, *“In humanitarian issues you should work on yourself before helping others.”* In fact, some went even further by suggesting that *“working on gender roles should start in our own organisations, in NGOs delivering SRH services.”* NGO Programme Officer

We would add also, that those organisations should let those passionate, convinced and committed to their own personal processes of change lead initiatives addressed to support change in others. Maybe in further stages, collective spaces or peer support initiatives can be facilitated to share strategies and build strength to make changes in their own environments.

As stated above, workshops seem to be useful for introducing new concepts. They may inspire reflection and questioning, and perhaps new behaviours and attitudes about what, for example, it means to be a man. But once back in a very socially conservative environment, this change may be difficult to maintain. This is when there should be an individual approach in order to facilitate and follow up a process of self-reflection and change.

6- Bridging knowledges

Apart from identifying how specific disciplines and paradigms construct the reality of SRH, as we showed in Sections 6 and 7, **working holistically and in awareness of complexity implies paying attention to multidisciplinaryity**. As discussed, different disciplines moved by different interests and world views understand SRH differently and develop different theories of what SRH is about, and therefore why and how men should be engaged.

Recognising that SRH goes beyond the clinic implies working actively to promote dialogue and joint action amongst different disciplines. Doctors need to talk to social workers and vice versa. Teachers need to talk to doctors, social workers and so on. Roundtables, encounters and the encouragement of the creation of communities of practise could constitute good examples of initiatives that aid actors can promote.

Since aid actors and project-based initiatives are not neutral or unbiased by their specific understanding of SRH, they would need first to critically reflect on the lenses they use to see SRH: that is, to understand what approach to SRH they are endorsing. This would allow them to start and promote conversations and bridges amongst different knowledges.

7- Zoom in and out

Finally, this complexity of actors, factors, viewpoints and disciplines that play a role in conforming gender roles and attitudes and practices towards sexuality and reproduction, also suggests iterative work of zooming in and zooming out. **Zooming in focuses on individual change** and on specific programmes aimed to support these individual

changes. **Zooming out invests time and resources in not losing the wider picture**, and creating social conditions for supporting individual change towards a redefinition of gender roles. In this sense, it is important to map out what different actors do in SRH to understand the contribution of own programmes.

At the same time, zooming in and out implies accepting that project-based initiatives need to see how the groups they target relate to others in a broader scale. For example, as mentioned above, many organisations visited highlighted the importance of working with young people, using the rationale that young people are the future and therefore more worthy to invest in. In these conversations, we always questioned how programmes can be effective if they do not try to include their families and the wider social environment surrounding them.

Zooming in is useful in order to simplify, conceptualise and categorise in order to make sense of reality (e.g., through maps, signs, concepts, numbers). **At the same time, we need zooming out to understand things in context** (in a story, in a testimony). Using both modes of thinking may imply an exercise of zooming out and zooming in, an iterative process of experiencing, feeling, listening-reflecting- conceptualising, thinking-acting, and experiencing again.

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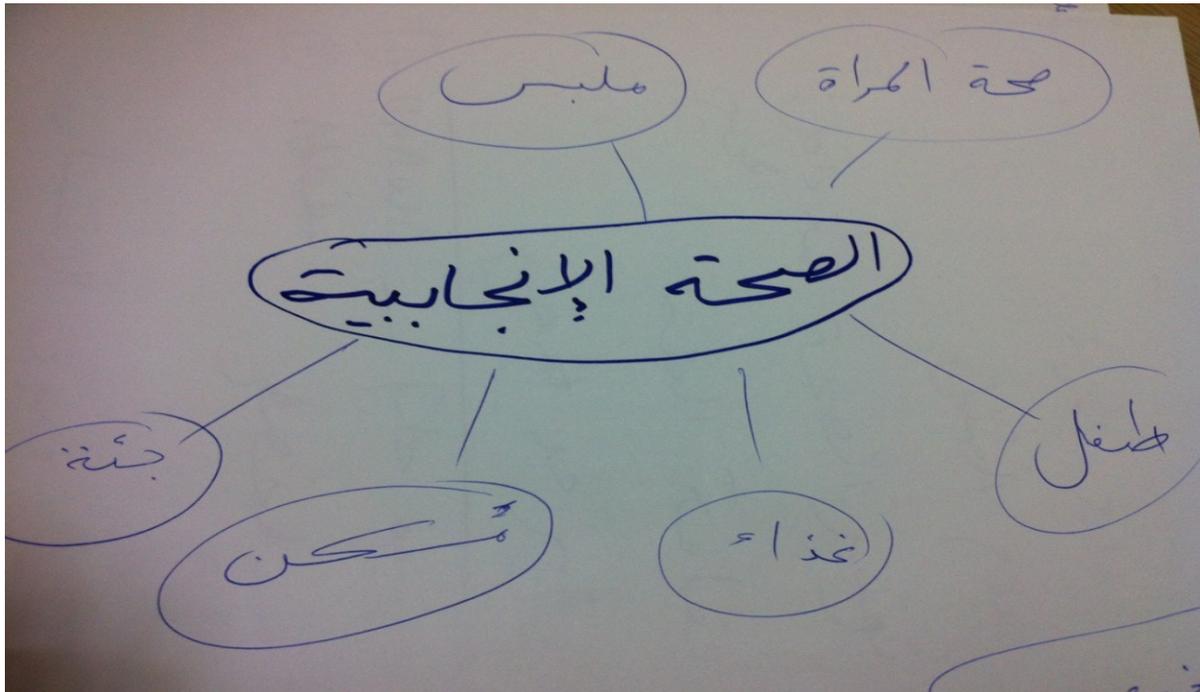
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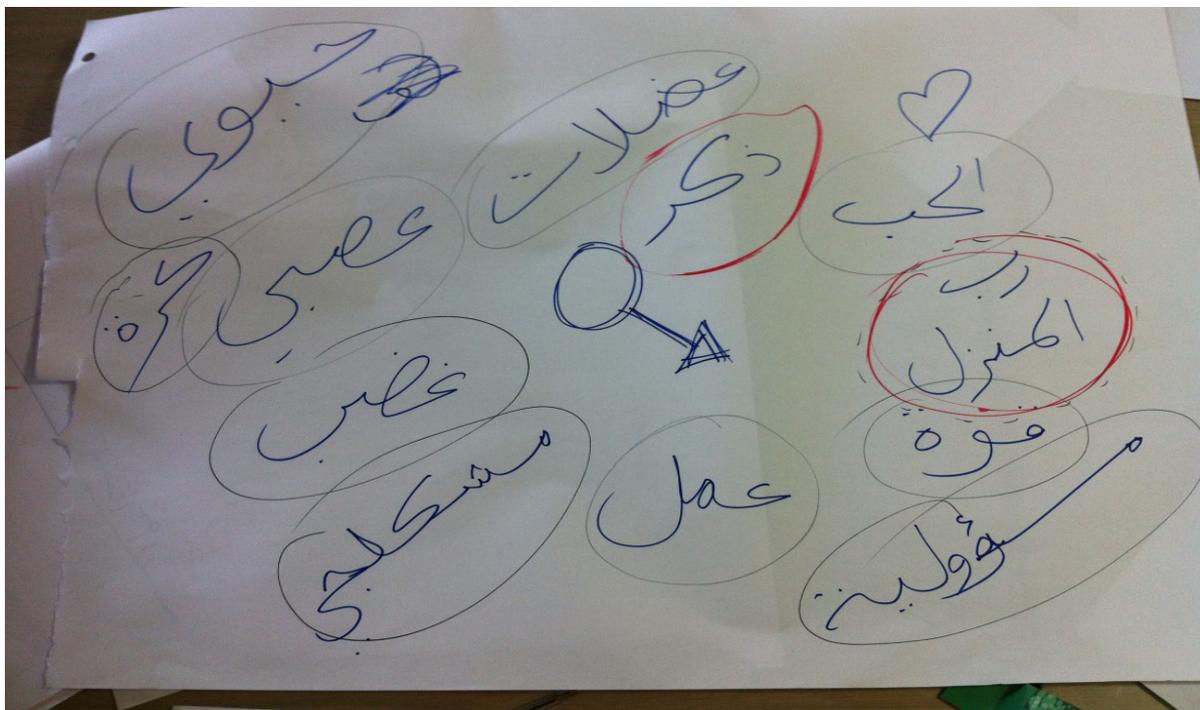
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Appendix 1

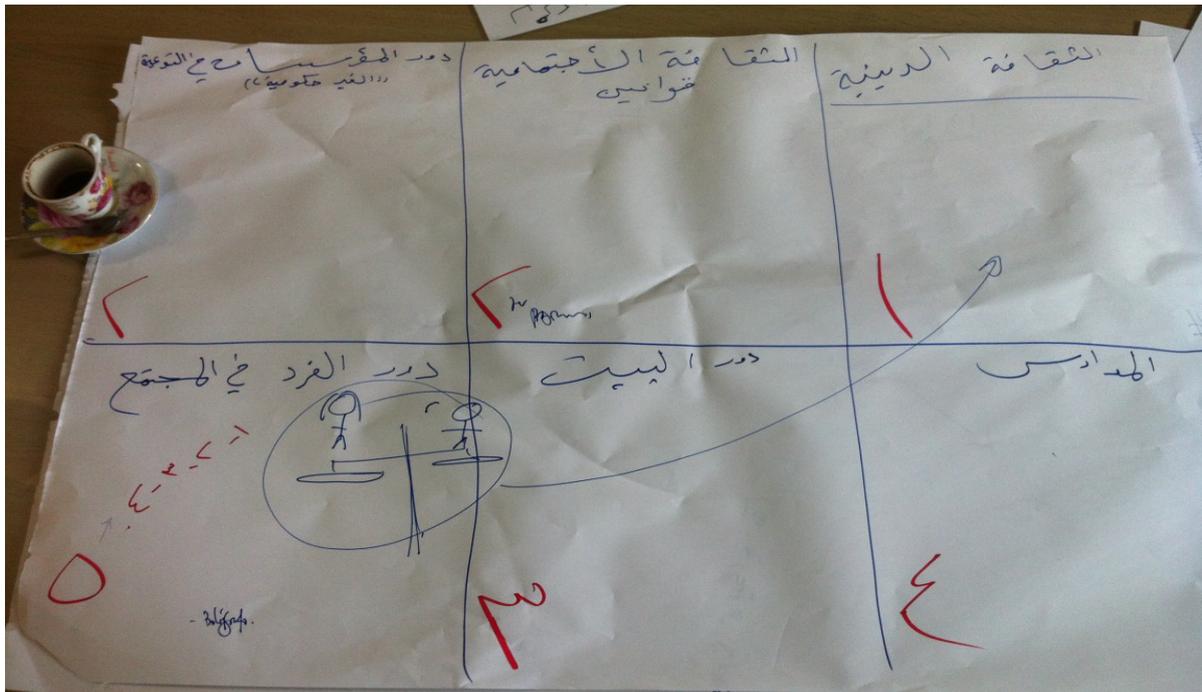
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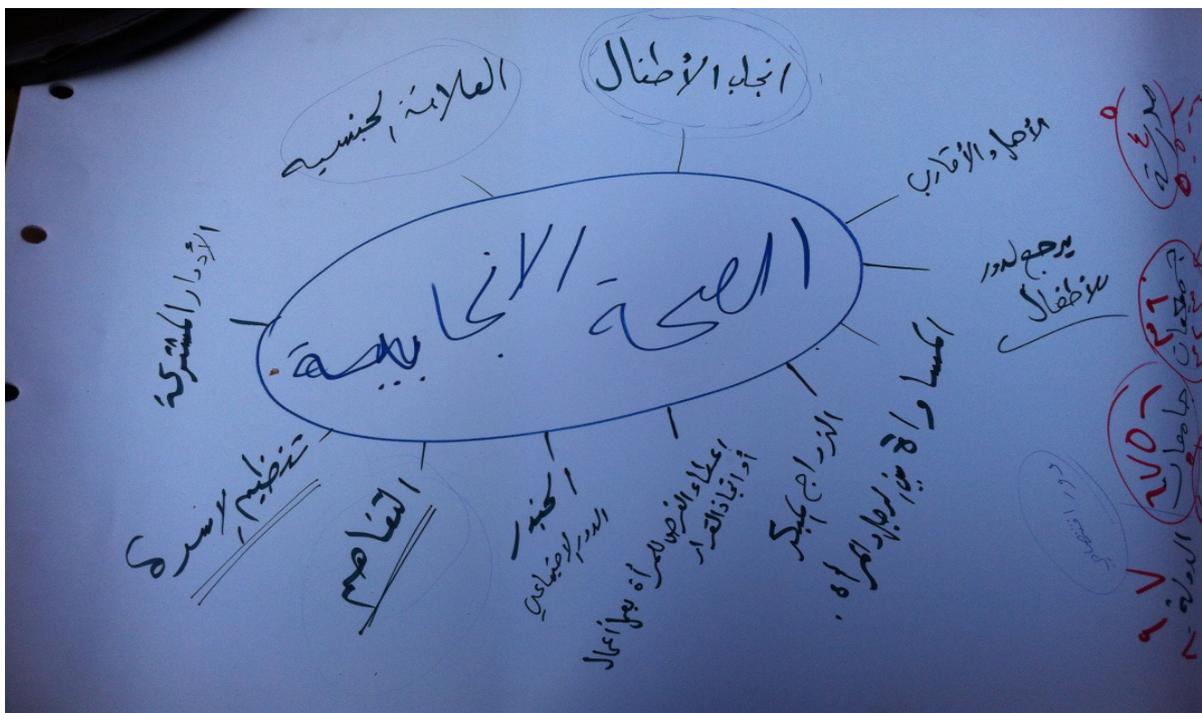
Picture 1: Concept Mapping on 'Reproductive Health', Men's Group in Beirut Lebanon.



Picture 2: Gender roles exercise with Young people in Beirut, Lebanon



Picture 3: Ranking and Scoring Exercise, women's group, Beirut, Lebanon



Picture 4: Concept mapping on 'Reproductive Health', in Maashuq Refugee camp in Tyre, South Lebanon



Picture 6: Gender roles exercise with young people in Beirut, Lebanon



Picture 7: Actors mapping exercise with Young people in Tyre, South Lebanon.



Picture 8: Participants in the Gender roles exercise with Young people in Beirut, Lebanon



Picture 9: Refugee camp in Tyre, South Lebanon



Picture 10: Campaign by ABAAD against violence against women that counts with the participation of religious leaders, Lebanon



Picture 11: Campaign by ABAAD about Gender Equality that includes boys and girls, Lebanon. The text says “Let’s play for gender equality”.

Endnotes

1. This is adapted from Daniel Guijarro's unpublished paper entitled "Hegemonic masculinities and the role of male development practitioners on women's empowerment."
2. 1. Right to life; 2. Right to liberty and security of the person ; 3. Right to equality, to be free from all forms of discrimination; 4. Right to privacy; 5. Right to freedom of thought; 6. Right to information and education; 7. Right to choose whether or not to marry and to found and plan a family; 8. Right to decide whether or when to have children or not have them, or when to have them; 9. Right to health care and health protection; 10. Right to the benefits of scientific progress; 11. Right to freedom of assembly and political participation; 12. Right to be free from torture and ill-treatment
3. Arabic word meaning "opinion". Yet "fatwa" carries more weight than just the random opinion of any person. Muslim scholars are expected to give a "fatwa" based on religious evidence, not on personal opinion. A "fatwa" is therefore often regarded as a religious ruling and so obligatory for a Muslim.
4. <http://www.alifta.net/Fatawa/FatawaChapters.aspx?View=Page&PageID=5988&PageNo=1&BookID=2&languageName=>
5. Interpretivism contrasts with positivism on ontological, epistemological and methodological levels. At the ontological level, interpretivists believe that there is no single reality. Epistemology for interpretivists is understood through "perceived" knowledge within specific contexts, while at the methodological level interpretivist research focuses on understanding and interpretation.
6. In Jordan, fieldwork focused mainly on development and health actors and on key influential actors levels.
7. The majority of men who participated in FGs in the Gaza Strip were unemployed, educated (secondary school or university degree), and poor. The majority of men who participated in FGs in the West Bank were educated and middle-class. The majority of women who participated in FGs in West Bank and Gaza Strip were unemployed outside the home, educated (secondary school or university degree), yet women from the Gaza Strip came from poor communities. In Lebanon, the majority of men and women who participated in FGs were employed and unemployed, but poor, and with secondary-school-level education.
8. The sexualisation report: 2013 (see bibliography).
9. Partners of "Regional Programme on sexual and reproductive rights of the Palestinian, Jordanian and Lebanese women in a vulnerable situation"
10. In addition, there is a lack of sexual education and gender-sensitive curricula.

11. Names as given by the researchers.
12. <http://www.jensaneya.org/>
13. Queer is, according to Beatriz Preciado, a post-identity sexual movement that criticises the processes of exclusion and marginalization that identity politics generate. “The queer movement is not a gay or homosexual movement, but a movement of sexual and gender dissidents who resist the rules imposed by the dominant heterosexual society, criticising also any standardisation processes or internal exclusions within gay culture.” Translated from the Spanish at http://www.scribd.com/fullscreen/79992238?access_key=key-2l64jqncgsgodxmcd3jr
14. <http://www.alqaws.org/q/content/who-are-we>
15. A law against marital rape law that was supposed to be approved in the Lebanese parliament was stopped by religious authorities in 2013. The law was widely promoted by the feminist organisation KAFA:
<http://edition.cnn.com/2013/02/17/world/meast/lebanon-womens-rights-law/>
<http://beirutspring.com/blog/2012/01/03/kafa-is-delusional-the-lebanese-state-neither-has-the-will-nor-the-way-to-get-into-lebanese-bedrooms/>
16. <http://jordantimes.com/govt-to-grant-foreign-spouses-children-of-jordanian-women-full-civil-rights----lawmaker>
17. In Lebanon and Jordan nationality is transmitted by fathers. That means that any woman that has a child with a non-national is not able to pass her nationality to her children.
18. There is a vast amount of literature criticising “state” and “civil society” and the relationship between these two bodies in postcolonial Middle Eastern countries.
19. This is the case with some of the royal NGOs in Jordan.
20. This includes some organisations in the Occupied Palestinian Territory and Lebanon working in SRH.
21. This information can be requested from the authors.
22. ‘Birth control measures advocated for Syrian refugees in Lebanon’, (http://news.xinhuanet.com/english/world/2013-06/13/c_132453013.htm).
23. Israel gave birth control to Ethiopian Jews without their consent, (<http://www.independent.co.uk/news/world/middle-east/israel-gave-birth-control-to-ethiopian-jews-without-their-consent-8468800.html>);
‘Birth control shots forced on Ethiopian women’, <http://www.aljazeera.com/video/middleeast/2013/01/2013130145259573156.html>)

24. That would be the case, for example, for many of the IPPF organisations, which are currently using a rights-based approach (RBA) or women's health approach, but that continue using the umbrella of FP to develop their programmes.
25. <http://www.un.org/millenniumgoals/maternal.shtml>
26. <http://www.unfpa.org.lb/PROGRAMME-AREAS/Reproductive-Health-and-Rights.aspx>
27. The women's health approach is not the only feminist approach. However, it received the most promotion by second-wave feminists.
28. <http://blog.usaid.gov/2010/06/increasing-the-involvement-of-men-in-womens-health/>
29. <http://www.foundationforfuture.org/en/Portals/0/Conferences/Think percent20Tank percent20Forum/ABAAD.pdf>
30. The term heteronormativity was coined by Michael Warner in the early 1990s and defines, in his words, "the institutions, structures of understanding, and practical orientations that make heterosexuality seem not only coherent – that is, organised as a sexuality – but also privileged." (Lauren Berlant and Michael Warner, 2000:312)
31. Men who have Sex with Men (MSM)
32. Injecting Drug Users (IDU)
33. <http://www.aljazeera.com/indepth/interactive/2013/12/interactive-hivaids-middle-east-201312192211421315.html>
34. <http://internationalmedicalcorps.org/document.doc?id=251>
35. Specifically, we relied on the evaluation conducted by Hannah Beardon and Daniel Guijarro of Oxfam GB/Kafa's programme on strategies of engaging men to stop VAW.
36. As explained previously, 'aid actors' refers to international, national, local, governmental, semi-governmental, non-governmental, public or private organisations or institutions, identifying, (co)implementing or evaluating social, developmental and/or humanitarian programmes using international, national, public and/or private aid funding.
37. Examples of results artefacts (Eyben, Guijt, Roche, Shutt and Whitty, 2013): Base-line data, Results reports, Logical framework analysis, Payment by Results. Examples of evidence artefacts: Systematic reviews, Cost-effectiveness analysis, Social return on investment, Impact evaluation.

