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Sexual and Reproductive Health Rights of Children and Adolescents
Baseline Knowledge, Attitudes and Practices (KAP) Survey

Baseline Report for oPt

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SUBMITTED TO

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ACRONYMS

CPP – Child Protection Policy

DHS – Demographic and Health Survey

FGD – Focus Group Discussion

FGM – Female Genital Mutilation

GSHS – Global School based Student Health Survey

HIV and AIDS – Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome

ICPD – International Conference on Population and Development

IEC – Information, Education, Communication

KAP – Knowledge, Attitudes and Practices

MDG – Millennium Development Goal

MENA – Middle East and North Africa

MoSA – Ministry of Social Affairs

NGO – Non-Governmental Organization

oPt – Occupied Palestinian Territory

SCS – Save the Children Sweden

SPSS – Statistical Package for Social Sciences

SRH – Sexual and Reproductive Health

STIs – Sexually Transmitted Infections

UNRWA – United Nations Relief and Works Agency for Palestine Refugees in the Near East

WHO – World Health Organization

EXECUTIVE SUMMARY

In January 2010, Save the Children Sweden (SCS) and its partners started an EC funded project "Investing in People: Good Health for All -Capacity Development and Advocacy on Sexual and Reproductive Health (SRH) and Rights Policies" aiming to ensure that children and adolescents in Yemen, oPt and Lebanon enjoy and claim their right to SRH.

As a preparatory activity, a baseline survey was carried out in the target countries: Lebanon, oPt, and Yemen. Yemen had implemented two Knowledge, Attitudes and Practices (KAP) surveys in 2007 and 2008, among refugees and Yemenis.

The baseline for the two other countries (Lebanon and oPt) was carried out from May till August 2010, and focused on SRH Knowledge, Attitudes and Practices of children, their parents and service providers. The purpose of the surveys was to:

- Gather data to develop/adapt information and education materials as well as capacity building programs addressing children, adolescents, parents, and service providers, based on country specific needs;
- Gather data to develop the advocacy plan of civil society organizations, SCS and partners for national and regional advocacy;
- Establish a baseline against which the impact of the project will be measured by the end of the project.

The survey was conducted with children aged 10-17, their parents, and service providers in one impact area in Lebanon (Bourj Hammoud-Sin El Fil), and five impact areas in oPt (Aqabet Jaber, Arrub, Ayda & Azzah, Ein El Sultan, and Dura). The participants were reached through random sampling in NGOs, health centers, and schools identified by the SCS partners. The survey instruments were adapted from the Yemen baseline surveys questionnaires, and enhanced based on new indicators.

The following are summarized results of the oPt survey, which will be depicted in further details within this report.

General Characteristics

Children

A total of 137 children were interviewed out of the 284 sampled households, due to refusal (2.9%), duplication, and cancellation of some interviews. However, only 120 interviews were considered for analysis. Around 32.5% were boys and 67.5% were girls. The underlying causes for this might be related to social norms, as the data collectors found more girls at home than

boys. The children were aged between 10 and 17 with mean age of 14.36. The children were all Palestinian. 30.8% came from Arrub, 31.7% from Dura, 25% from Ayda and Azzah, 11.7% from Ein El Sultan, and only one child from Aqabet Jaber. This low frequency in Aqabet Jaber was due to a high percentage of participants that were not found at home, incomplete interviews, and some missing questionnaires (see Limitations). The children of Aqabet Jaber are therefore underrepresented in the sample. Most of the children lived with both their parents (95%), while 3% had separated parents, 1% had a deceased father, and 1%'s father were married to someone else.

Parents

A total of 157 parents were interviewed out of the 284 sampled households, due to refusal (1.7%), duplication, and cancellation of some interviews (see limitations). However, only 142 interviews were considered for analysis. The majority were females (87.9%), and 87.8% were the "mother of the child". Other interviewed respondents included "father", "aunt/uncle", "older sister/brother", "grandparent", and "other". The "parents" were aged between 21 and 74, with mean age of 41.1. The majority were Palestinian (99.3%), with only one respondent being Syrian. Most parents were married (96%), while 1% were separated, 1% were widowed, 1% single, and 1% engaged.

Service providers

A total of 58 service providers were interviewed; however, only 53 will be considered for analysis because of duplication. The service providers came from the 5 impact areas: 27.5% came from Arrub, 23.5% from Ayda and Azzah, 21.6% from Aqabet Jaber, 17.6% from Dura, and 9.8% from Ein El Sultan. Around 66% provided health services – the "health workers", and 34% provided services in education, counseling, and social work – the "other service providers". The health workers included doctors (15.4%), nurses (36.5%), and a midwife (13.5%). The other service providers included teachers (17.3%), head teachers (9.6%), and psychosocial counselors (7.7%). They were mostly females (73%). Most of them (45.3%) were aged above 40, while 35.8% were between 30 and 40, and 18.9% were between 20 and 29. Around 26.4% have been providing services for children aged 10-17 for 1 to 9 years, and the majority (73.6%) have worked with children for 10 or more years.

Education

All children can read, most being able to read Arabic (96.6%), followed by English (57.9%). About 95.7% of children are presently enrolled in school, with more girls being enrolled than boys. The enrollment status of boys increases by age, while there is no pattern for the enrolment status of girls by age. Out of those who are presently attending school, the majority are attending UNRWA schools (57.6%), while 27.1% are attending public schools, 12.7% semi-private schools, and 2.5% private schools.

Overall, 4.3% are not enrolled in school; all having dropped out. Out of these, 33.3% had dropped out before grade 8, while all had dropped out by grade 10. Around 60% were aged between 13 and 15 years. Also, most of them were females (60%). The reason given by those who are currently not enrolled was: "school was boring".

Around 42.6% of the children are enrolled in non-formal education, with slightly more girls being enrolled than boys. The most attended form of non-formal education is private language courses (22.5%), followed by religious education (14.2%).

Also, only 12.5% of children are members of youth groups, with more girls than boys being members. About 23.8% of children 10-12 were members of youth groups, followed by the age group of 13-15 (7.4%), and the age group 16-18 (5.9%).

Personal Hygiene

Only 37% of children bathe "once a day or more", while 38% bathe "every other day", 18% "twice a week", and 7% "once a week or less". The bathing frequency decreases with age. However, the frequency in bathing is slightly higher for girls. On the other hand, most parents (90.8%) said their children wash their genitals "once a day or more".

Most children mentioned their mother (84.1%) as source of information on personal hygiene, followed by their teacher (30%), sister (27.5%), and father (25.8%). Mothers were mentioned by 88.9% of girls and 74.3% of boys, suggesting that mothers are the main source of information regardless of gender. Other relatives also play a role as sources of information for 11.6% of children. Neither social workers, health workers, counselors, friends, nor the media were identified as important sources of information.

Around 52% of girls identified 3 or more causes for infection/irritation of the genitals. The most identified causes were: "nylon underwear", followed by "tight clothing". The least identified causes were: "pantyhose" and "soap that contains perfume or deodorant".

Regarding menstrual hygiene, 76.3% of girls knew that the tampon/pad should be changed many times during the day during menstruation.

Changes during puberty

Children

Children were asked questions about changes occurring during puberty. More girls (49.4%) identified 3 or more physical changes (occurring in girls) than boys (41%) (occurring in boys). The most identified physical changes by girls were: "breast growth" and "start of menstruation". The most identified physical changes by boys were: "hair growth" and "height and weight increase".

When asked about worries and problems adolescents face during puberty, 24.1% didn't know, while 8.3% said that adolescents do not face any problems during puberty. Only 20% identified 3 or more worries/problems. The most identified worries/problems were: "irritability and anger" and "sadness and depression".

Parents and service providers

Parents identified less physical changes in both boys and girls than service providers. About 45% of parents, 94.3% of health workers, and 100% of other service providers identified 3 or more physical changes in girls during puberty. The most identified changes were: "breast growth", "start of menstruation", and "hair growth (genitals and underarms".

The percentages decreased when identifying changes in boys; around 39.4% of parents, 94.3% of health workers, and 88.9% of other service providers identified 3 or more physical changes in boys during puberty. The most identified changes were: "voice changes" and "hair growth (face, arms, legs, and pubic)".

The parents and service providers' knowledge regarding worries faced by adolescents was much lower than knowledge about physical changes. This reflected a strong need of awareness-raising regarding the psychosocial health of children, which would improve communication between the children and their care-givers as well. Only 10.6% of parents, 44.4% of other service providers, and 54.3% of the health workers identified 3 or more worries or problems faced during puberty. The most identified worries were: "irritability and anger", followed by "sadness and depression".

The large majority of health workers (91.4%) and other service providers (94.4%) recognized that children aged 10-17 face SRH risks, as opposed to only 40.8% of parents. Few parents (8.6%), 28.1% of the health workers, and 35.3% of the other service providers identified 3 or more SRH risks faced by children. The most identified SRH risks were: "un-intended pregnancy", for health workers and service providers, and "sexual violence and exploitation" for parents.

STIs, HIV and AIDS

Children

Around 39.2% of children couldn't identify any sexually transmitted infection (STI) a person can get through sexual intercourse. Only 3.3% could identify 3 or more STIs, while 49.2% identified 1 STI, with more girls identifying 1 STI than boys. The most identified STI was: "HIV & AIDS".

Around 79.2% of children couldn't identify any signs or symptoms that suggest that a person has an STI. Only 2.5% could identify 3 or more STI symptoms, while 12.5% identified only one. The most identified STI symptoms were: "loss of weight" and "sores or warts on penis/vagina".

Around 72% of children have heard of HIV and AIDS, with more girls than boys, and with increase of awareness with older age.

Out of those who heard of HIV and AIDS, only 32.1% could identify 3 or more modes of transmission of HIV, with no difference between girls and boys, and with increase of knowledge with older age. The most identified modes of transmission were: "sexual relations" and "blood transfusion". The least identified were "mosquito or other insect bites" and "breast milk". 42.3% believed that "casual contact with an infected person" is a mode of transmission.

Also, out of those who heard of HIV and AIDS, only 25.6% could identify 3 or more ways to avoid getting HIV, with more boys than girls, and with increase of knowledge with older age. The most identified ways to avoid getting HIV were: "abstinence from sex" and "avoiding sharing razors and blades". The least identified ways to avoid getting HIV were: "using condoms for every sexual act" and "avoiding commercial sex workers". 43.6% believed that "avoiding casual contact with an infected person" is a way to avoid getting infected with HIV.

Parents and service providers

Health workers were the most knowledgeable about STIs. About 88.6% of health workers, 72.2% of other service providers, and only 18.3% of the parents identified 3 or more STIs. The most identified STI was: "HIV & AIDS" followed by "syphilis" and "gonorrhea".

Around 77.1% of health workers, and 72.2% of other service providers, and only 10.6% of parents could identify 3 or more STI symptoms. The most identified STI symptoms for service providers were: "discharge from penis/vagina", and "burning pain or itching in penis/vagina". Parents identified few symptoms, with "painful urination" being mentioned the most.

All service providers and 90% of parents have heard of HIV and AIDS.

Out of those who heard of HIV and AIDS, 43.1% of parents, 78.8% of health workers, and 88.9% of other service providers could identify 3 or more modes of transmission of HIV. The most identified modes of transmission of HIV were: "sexual relations" and "blood transfusion". The least identified mode of transmission was "mosquito or other insect bites" and "breast milk". Also, 20.7% of parents, 42.4% of health workers, and 38.9% of other service providers though that "casual contact with an infected person" is a mode of transmission. This relates misconceptions that need to be corrected in future awareness raising activities, to reduce the stigma against HIV infected people.

Out of those who heard of HIV and AIDS, 34.5% of parents, 87.9% of health workers, and 100% of other service providers identified 3 or more ways to avoid getting HIV. The most identified ways to avoid getting HIV were: "abstinence from sex" and "Avoiding contaminated blood". The least identified ways to avoid getting HIV were: "avoiding commercial sex workers" and "encouraging partner to stay faithful". Also, 31% of parents, 30.3% of health workers, and

38.9% of other service providers though that "avoiding casual contact with an infected person" is a way to avoid getting infected with HIV. This misconception also needs to be corrected.

Around 79% of service providers have received training and health education sessions on HIV/AIDS. However, misconceptions still need to be addressed through a training of the service providers on STIs, HIV and AIDS.

SRH seeking behavior and services utilization

Children

76.7% of children identified their "mother" as primary source of information or help in matters of sexual and reproductive health. This was followed by "father", "sister", and "gynecologist or doctor". More girls sought their mother and sister, while more boys sought their father and doctor. "Teachers", "social workers", "counselors", "midwives/nurses", and the media were not mentioned by many children. Only 0.8% do not seek help or advice in SRH, with no reason mentioned.

Around 49.6% of children had not asked their teacher about reproductive and sexual health topics. Boys were more likely than girls not to have asked their teacher about such topics. Children were also asked about the teacher's response when asked a question about SRH. About 37.4% said that the teacher answered their question (rather than scolding, refusing to answer, or referring).

In addition, 34.8% of children had not asked their parents about reproductive and sexual health topics. Boys were more likely than girls not to have asked their parents about such topics. About 60% said that the parents answered their question (rather than scolding, refusing to answer, or referring).

Around 22.7% of children believe that education on sexual and reproductive health should begin before the age of puberty. Girls were more likely than boys to state so.

The majority of children (84.2%) support the discussion of SRH topics in classrooms and awareness sessions, with the main reason being: "improvement of youth awareness". Other children do not support the discussion of SRH topics because they do not believe there's a need for it, or think that youth might be embarrassed.

On the other hand, the large majority of parents (91.4%) believe that sexual and reproductive health rights should be included in the school program. Around 86% of those who support the SRHR education in schools believe it should start before the age of 16, with the average age being 13.64.

About 28.3% children do not use the health centers' SRH services, with more girls stating so than boys. The most stated reason for not using the health center services was that children do

not know what services are available. This demonstrates the need for making the health centers child-friendly by advertising to the children the services available to them.

Parents and service providers

Most parents and service providers believe that the "mother" is the primary source of information and help in matters of sexual and reproductive health. This is followed by "father". However, parents and service providers' answers were different from the children as to the importance of friends, social workers, nurses/midwives, and the media. In fact, the caregivers believed that friends, social workers, nurses/midwives, and the media were important sources of information on SRH to children, who in their turn sought little information and help from these sources. This misconception is very indicative for planning future communication activities through the right channels.

Around 64.5% of parents consider themselves to be knowledgeable enough to provide advice on RH issues, with more female respondents stating so than male respondents. Additionally, 75% of service providers consider themselves to be knowledgeable enough to provide advice on RH issues, with more health workers believing so than other service providers.

However, 66% of service providers were asked by only 1-10 children for SRH information in the month preceding the survey, and around 28.3% were approached by between 21 and 30 children.

Around 58.5% of service providers have received training in sexual and reproductive health. However, less health workers (57.1%) have received training in SRH than other service providers (61.1%).

Engagement, marriage, and childbirth

Children

All interviewed children were single (5 missing).

More children (91.2%) believed that the ideal engagement age for boys is above 18 years than girls (79.6% of children). This shows that gender issues need to be tackled as they relate to engagement age. An increase is observed with regard to ideal age for marriage. With very close percentages, 91.8% and 91.2% of children believe that the ideal age for marriage is above 18 years for girls and boys respectively. However, more children thought that boys should get married at a later age (25 or older) than girls. Interestingly, when comparing girls' responses to boys' responses, it is noticed that girls' ideal ages for engagement and marriage were lower in trends than boys.

About 84.2% of children believe that children under 18 who are engaged should continue their education. These numbers decrease with regard to continuation of education of married children

under 18, where 77.9% of children are in favor. In both cases, considerably more girls are in favor of continuation than boys.

Around 74.6% of children thought that the ideal age for having a first child is above 18 years, with the majority of those stating the ideal age to be between 19 and 24 years. More boys than girls thought that the ideal age is above 25 years. About 60% of children think that pregnancy and child birth should be avoided during adolescence. Out of these, only 14.9% identified 3 or more complications of delivery during adolescence; while most (44.8%) did not identify any complications. The most identified complications were: "overweight newborns" and "spontaneous abortion". These findings show that even among the children who believe pregnancy should be avoided during adolescence, very few know the reasons why, suggesting that a concentrated awareness effort is needed in this area.

Parents

More parents (96.9%) believed that the ideal engagement age for boys is above 18 years than girls (76.6% of parents). An increase is observed with regard to ideal age for marriage. Also, more parents (98.6%) believe that the ideal age for marriage of boys is above 18 years than for girls (91.4%). However, considerably more parents thought that boys should get married at a later age (25 or older) than girls. When comparing the trends between male respondents and female respondents, it is noticed that female respondents tended to give a "higher" ideal age for both girls and boys engagement and marriage than male respondents.

About 92.8% of parents believe that children under 18 who are engaged should continue their education, with more female respondents in favor of continuation of education than male respondents. These numbers decrease with regard to continuation of education of married children under 18, where 83.5% of parents are in favor of continuation, with more female respondents than male respondents being in favor.

Only 75.5% of parents think that pregnancy and child birth should be avoided during adolescence. Out of these, only 21.9% identified 3 or more complications of delivery during adolescence. The most identified complications were: "spontaneous abortion" and "premature birth".

Service providers

All service providers thought that the ideal age for engagement and marriage of both girls and boys to get engaged is above 18 years. However, the ideal ages of engagement and marriage are lower for girls than for boys; in fact, most service providers thought that girls should get engaged and married between 19 and 24 years, while boys should do so after the age of 25 years.

About 98.1% of service providers believe that children under 18 who are engaged or married should continue their education.

Around 96.2% of service providers think that pregnancy and child birth should be avoided during adolescence. Out of these, 60.4% identified 3 or more complications of delivery during adolescence. The most identified complications were: "premature birth" and "spontaneous abortion".

Violence

Children

There were only two reports of violence from one adult and one child respondent, in Arrub, and Ayda and Azzah; however, signs of abuse were noted by data collectors in all impact areas.

Children were asked some questions regarding their attitude towards violence. Regarding violence at home, 95.6% of children disagreed with the statement: "it is appropriate for a husband to hit his wife or for a brother to hit his sister", with more girls disagreeing than boys, and no remarkable differences among age groups.

On the other hand, 94.3% of children agree with the statement: "I have the right to live without any kind of violence", with slightly more boys agreeing than girls, and the age group 13-15 having the least percentage of children agreeing.

Furthermore, 92.1% of children agree with the statement: "I have the responsibility to make sure I don't hurt others", with slightly more boys agreeing than girls, and the age group 13-15 having the least percentage of children agreeing.

A large majority of children (76.1%) said that there is violence against children aged 10-17 in their community. This shows that children are aware of violence in their community, and is indicative that violence is witnessed by the children themselves.

The large majority (91.7%) have identified 3 or more forms of physical abuse, with more boys than girls, and the age group 16-18 having the lowest knowledge level. The most identified forms were: "Hitting with a hand", and "pulling child's hair". The least identified forms were: "forcing a child to stay in an uncomfortable position" and "shaking".

Similarly, the large majority (91.7%) have identified 3 or more forms of emotional and psychological abuse, with no differences between girls and boys, and the age group 16-18 having the lowest knowledge level. The most identified forms were: "parents abandoning their child", and "bad name calling".

Finally, 83.8% of children have identified 3 or more forms of sexual abuse, with no remarkable differences between girls and boys, and the age group 16-18 having the lowest knowledge level. This shows that the children's are less knowledgeable about sexual abuse than physical or emotional abuse, which might be explained by the "taboo" nature of the subject. Therefore, awareness raising interventions should focus more on sexual abuse than the two other subjects.

The most identified forms of sexual abuse were: “having sex with a child”, “making a child touch his or her private parts or someone else's private parts”, and “touching a child’s private parts”.

Around 28% of children didn’t know the identity of the perpetrators of sexual abuse. Most children thought that the perpetrators of sexual abuse are males. “Male strangers” was the most identified perpetrator, mentioned by 30% of children. Around 14.2% of children mentioned “friends” as the perpetrators, as opposed to only 9.6% who mentioned “boyfriends”. This should be taken into consideration when selecting peer educators, especially in interventions related to SRH.

On the other hand, only 10% of children have identified 3 or more protection strategies from violence. Interestingly, more girls identified 2 or more protection strategies than boys. The most identified protection strategies were: “telling a grown-up you trust” and “running or getting away” and “yelling”.

Around 47.7% of children have heard of the term “dating violence”, with more girls than boys, and more children in older age groups than younger. Around 70% of the children believed that all forms of dating violence are not acceptable.

Children were also asked what they would do in case they were victims of any form of dating violence. Around 44.2% said that they would “break up with their partner”; while 41.7% would report it to someone they trust. Very few would report to the police (11.7%), or to an NGO (0.8%). This suggests that children need to be educated on protective mechanisms to be able to respond adequately to dating violence. Their knowledge of available support NGOs and services also needs to be raised. It is noted that more girls would break up with their partners or inform someone they trust than boys. However, more boys would report to the police than girls.

Parents

The majority of parents (86.2%) said that there is violence against children aged 10-17 in their community. This shows that parents are aware of violence in their community.

Nearly all parents (95%) have identified 3 or more forms of physical abuse, with more male respondents than female respondents. The most identified forms of physical abuse were: “pulling a child’s hair” and “hitting with an object”. The least identified forms were: “forcing a child to stay in an uncomfortable position” and “shaking”.

Similarly, 94.3% of parents have identified 3 or more forms of emotional and psychological abuse, with more male than female respondents. The most identified forms were: “neglecting the child’s emotional needs”, “bad name calling” and “saying to the child that no one loves him or her”.

Finally, 85.1% of parents have identified 3 or more forms of sexual abuse, with more male than female respondents. This decrease in knowledge as compared to physical and emotional forms of abuse might be explained by the "taboo" nature of the subject. It is suggested to concentrate awareness raising efforts on forms of sexual abuse, and create interventions to tackle the lack of communication around this issue. The most identified forms of sexual abuse were: "telling a child 'dirty' stories or 'dirty' jokes", and "showing a child magazines or films which show pictures of people with little or no clothes on".

Most parents thought that the perpetrators of sexual abuse are males. "Father" was the most identified perpetrator, mentioned by 34.5% of parents. This was followed by "male stranger" "brother", and "uncle", suggesting that parents mostly think that the perpetrators of sexual abuse are family members.

Service providers

The majority of service providers (92.5%) said that there is violence against children aged 10-17. This shows that they are aware of violence in their community. However, health workers seemed to be less aware of violence than other service providers. This might be due to the nature of services that allows some service providers to be involved in responding to violence more than others. Health workers might know less because they are less exposed or sought after by victims of violence, while counselors might be more acquainted with the community's social realities.

Most service providers (71.4%) believe that violence against children occurs "at home from adults". This is followed by "between youth themselves in the neighborhood".

Most service providers (90.4%) observe among their child patients/students signs that indicate violence. If violence is suspected as cause of the signs, most of the service providers (66%) refer the child to their supervisor. This is followed by "referring to a specialized service" and "providing counseling to the child". Very few reported to the police (5.6%).

Around 25.7% of the health workers reported "treating the physical symptoms", suggesting that few health workers in the impact area health centers treat victims of violence. It is suggested to reinforce the health workers at the impact area health centers and equip them to be able to respond to victims of violence and be available for referral.

On the other hand, not all the service providers' workplaces (health centers, schools, etc) have established systems for violence response. For instance, 43.4% have treatment and follow up, while 37.7% have referral systems. These centers however seem to lack the most in investigation and appropriate judicial involvement.

Furthermore, 66.6% of the service providers' workplaces do not have any programs addressing the prevention of sexual abuse. However, more health centers didn't have such programs than UNRWA schools. The least available intervention was "Research" (17.8%).

All service providers have identified 3 or more forms of physical abuse. The most identified forms of physical abuse were: "burning with a match, cigarette, or hot water", "Hitting with an object", and "Forcing a child to stay in uncomfortable position".

About 83% of service providers identified 3 or more signs of physical abuse as per the SCS guidelines. Contrary to expectations, less health workers identified 3 or more signs than "other service providers" working in education, counseling, and social work. This is perhaps due to victims not being referred or treated by health workers. It is therefore recommended to focus more on health workers in awareness raising efforts regarding identification of physical abuse signs. The most identified signs of physical abuse were: "unexplained recurrent injuries" and "injuries which have not received medical attention".

Similarly, 96.2% of service providers have identified 3 or more forms of sexual abuse, with more health workers than "other service providers". The most identified form of sexual abuse was: "touching a child's private parts". However, all forms were identified by over 90% of service providers.

Only 81.1% of service providers identified 3 or more signs as per the SCS guidelines. Contrary to expectations, less health workers identified 3 or more signs than "other service providers" working in education, counseling, and social work. This is perhaps due to victims not being referred or treated by health workers. It is therefore recommended to focus more on health workers in awareness raising efforts regarding identification of sexual abuse signs. The most identified signs of sexual abuse were: "being isolated and withdrawn" and "depression, self-mutilation, suicide attempts".

Most service providers thought that the perpetrators of sexual abuse are males. "Father" was the most identified perpetrator, mentioned by 73.6% of service providers. This was followed by "brother" and "uncle" by 58.5%, suggesting that service providers believe most sexual abuse is perpetrated by close male family members.

Furthermore, 80.8% of the service providers feel that they have a responsibility to address violence in the community. However, only 44.2% of the service providers feel they have enough knowledge and skills to deal with children who have been sexually abused. In fact, 41.5% have received training on dealing with children who have been subject to violence or sexual abuse. Furthermore, 50.9% have received training regarding communication with children and their families, and facilitating children participation.

However, and although the service providers lack in knowledge, skills, and training in adequate response to children victims of sexual abuse, 80.8% of them feel confident in supporting children who have been sexually abused. It is recommended therefore to channel the service providers' motivation into good practices, and train them based on standard guidelines and procedures.

INTRODUCTION

Background

The International Conference on Population and Development defines Reproductive Health as "a state of complete physical, mental and social well-being in all matters relating to the reproductive system and to its functions and processes. Reproductive health care also includes sexual health, the purpose of which is the enhancement of life and personal relations".

International agreements affirm that adolescents have a right to age-appropriate sexual and reproductive health information, education, and services that enable them to deal positively and responsibly with their sexuality. Yemen, oPt and Lebanon are signatory of most relevant international agreements yet, the right of women men and especially children to sexual and reproductive health is not respected. This has had a direct negative effect on reaching the Millennium Development Goal 5 (MDG5) in these countries.

Child marriage defined as a marriage involving a child under the age of 18 – is widely acknowledged as a form of gender-based violence due to the physical and psychological harm it bears on a child. Not only does child marriage oblige girls to have regular sexual relations prior to the age of 18, it puts them at increased risk of health complications related to childbirth and exposes them to heightened protection threats associated with domestic violence and divorce. In Yemen, there is a comparatively high rate of child marriage: 52.1 percent[1] in rural areas where 32.3 percent of child marriages involve girls between the ages of 10-14.[2] In Palestine, the most recent national demographic and health survey (DHS) carried out in 2004 reported that 50% of Palestinian women get married during childhood at or before the age of 18. Early marriage is an existing phenomenon also in Lebanon where family status laws allow for early marriage (as young as 9, in the case of the Shi'a) and, in some cases, allow parents to waive child consent provisions.

Sexual abuse although a much more hidden phenomena, more and more evidence is starting to appear from children themselves. In oPt research[3] showed that out of 365 abused children, assisted by the MoSA in the year of 2004, 18 where sexually abused and 182 emotionally abused. The results of the study also suggested a relationship between violence against children and poor socioeconomic status of the family, whereby in Palestine the percentage of Palestinian living under the poverty line is alarmingly increasing. In Lebanon, a SCS study by the partner organization KAFA was found that 16.1% of respondents (N=165) experienced at least one form of sexual abuse (as defined by KAFA): 12.5% experienced sexual acts, 8.7% were subjected to

[1] Oxfam et al (2005) Early Marriage in Yemen. Research to Inform a Campaign on Early Marriage, Oxfam, Shima (network on violence against women), Women's National Committee, Women's Studies Development Center, University of Sana', Sana', Republic of Yemen.
[2] SOUL (2004) Child Rearing Practices Study. In Districts of Ul Udayn and Zaydiua, Society for the Development of Women and Children with UNICEF. Sana', Republic of Yemen.
[3] Musleh and Taylor (2005)

attempted sexual acts, and 4.9% were exposed to sexual photographs or movies.[4] The average age of victims was 10.3 years. Furthermore, fifty-five per cent of incidents of sexual abuse occurred at the home, 27% at the school, 5.5% at a neighbor's house and 5.1% in a relative's house. The 2006 study by SCS in Yemen showed that 20% of health workers in basic health services in the Lahej governorate had observed the symptoms of sexual abuse among children[5]. The study also showed that health workers were unable to appropriately respond to these children as they all reported that they had responded by the treatment of the symptoms, and were unable to refer due to the absence of a referral system. Sexual abuse is influenced by a range of factors including illiteracy and gender gaps; Yemen ranks for the second year in a row on the last place in the Global Gender Gap Report, has low levels of female youth literacy (36 literate young women per 100 young men) and a high incidence of youth motherhood (recent increase of 2% to 17%)[6].

Other forms of sexual abuse are represented by non-consensual sex within the wedlock which is a spread practice still in all the three countries targeted and sexual intercourses practiced without the appropriate knowledge and understanding of related emotional, physical and social consequences. Being sexual and reproductive health still a strong taboo in most countries, children do not have the appropriate knowledge of their body and sexuality affecting their capacity to take decision on their best interest. Unfortunately, schools currently lack any program in sexual education for children, and so it is usually up to the parents to speak with their children about sex and to respond to their questions, and very often parents either shy away from it or give their children inadequate and sometimes harmful information.

Regarding **FGM**, most of the types as identified by the World Health Organization occur in Yemen, especially in the coastal areas, such as in the proposed impact area of Lahej[7]. Country wide FGM is prevalent among 26% of the women and 20% of the daughters[8]. However in the coastal areas prevalence is much higher and a recent study by SCS[9] in Lahej and Aden shows that more than 80% of school aged girls reported to have been circumcised and that despite recent activities to reduce the occurrence of FGM it is still widely supported. A Ministry of Health Decree in 2001 banned the practice of FGM by all public and private health personnel. The same study also showed that a majority of health workers had observed complications of FGM, both immediate complications and long term complications.

[4] Kafa (March 2008) "Child Sexual Abuse: The Lebanese Situation." (Draft)
[5] Save the Children (2008). Knowledge Attitudes and Practices Survey among Youth in Basatin and Kharaz Refugee Camp (unpublished)
[6] Yemen Youth Assessment Final Report (2008). Equip3. USAID mission, Cairo, Egypt.
[7] Soheir Stolba, A Clinical-Based Research Study of FGM/C in Selected Areas of Yemen, December 2000, Pacific Institute for Women's Health and International Health and Development Associates.
[8] UNCEF(2005). At a glance Yemen. Statistics. www.unicef.org/statistics/yemen. Accessed October 13th, 2008.
[9] Save the Children (2008). Ibid.

About the project

Save the Children Sweden (SCS) and its partners Juzoor Foundation for Health and Social Development in Palestine, KAFA (enough) Violence and Exploitation in Lebanon, Community Based Rehabilitation Association for Children with Special Needs in Yemen, started in January 2010 an EC funded project "Investing in People: Good Health for All -Capacity Development and Advocacy on Sexual and Reproductive Health and Rights Policies" aiming to ensure that children and adolescents in Yemen, oPt and Lebanon enjoy and claim their right to SRH.

The project's overall goal is to enhance protection of children and adolescents (10-17 years) in the MENA Region from gender based violence (early marriage, FGM and sexual abuse) through promoting their right to Sexual and Reproductive Health.

The project activities will contribute to the achievement of the overall goal by improving quality of and access to information and services for children and adolescents (aged 10 to 17) at risk or victims of sexual and reproductive health rights, and by improving the policy environment in the three countries of operation: Yemen, Lebanon and oPt.

Purpose of the baseline survey

As a preparatory activity, a baseline survey was carried out in the target countries: Lebanon, oPt, and Yemen. Yemen had recently implemented two Knowledge, Attitudes and Practices (KAP) surveys:

- The first in 2007, in Kharaz Refugee Camp (Lahej) and Basatin (Aden), among refugees and Yemeni returnees from the Horn of Africa;
- The second in 2008, in Aden, Abyan and Lahej, covering 35 school impact areas, among the Yemeni population.

The baseline for the other two countries (Lebanon and oPt) was carried out from May till August 2010, and focused on Knowledge, Attitudes and Practices of children, their parents and service providers on:

- SRHR knowledge
- related risks and protective behaviors
- utilization of protective mechanisms

Results of the survey will be used for three main purposes:

1. Develop/adapt information and education materials as well as capacity building programs addressing children, adolescents, parents, and service providers, based on country specific needs;

2. Use the collected evidence to develop the advocacy plan of civil society organizations, SCS and partners for national and regional advocacy;
3. Measure the impact of the project by the end of the action through the establishment of a baseline of the specific indicators.

This report describes the findings of the survey conducted in oPt among children, their parents, and service providers, in the 5 impact areas of Al-Arroub, Aqabet Jaber, Ayda & Azzah, Ein El-Sultan, and Dura.

METHODOLOGY

Preparatory phase

Although the original plan was to conduct a school based survey using a random sampling framework, the closing of schools made it impossible. The survey was instead conducted through the UNRWA health centers in the 5 impact areas, based on Juzoor's postulation that the project interventions will target the whole population of the 5 impact areas.

This induced recollecting basic information about the target populations in the selected impact areas. This, along with a strike of UNRWA staff that lasted from 26 May to 7 June 2010, caused delays to the preparatory phase of the survey.

Sampling

Children and parents:

The sampling population consisted of beneficiaries of the 5 UNRWA health centers in the 5 distinct geographic locations in Palestine: Al-Arroub, Aqabet Jaber, Ayda & Azzah, Ein El-Sultan, and Dura. The random sampling was done through the maternal health records, by the UNRWA staff themselves, to ensure confidentiality. These were given a set of randomly sampled number corresponding to the numbers of the sampled files. The sampling frame consisted of the maternal health records of families that:

- have at least 1 child aged 10-17 years,
- and are residents of the 5 areas.

It was anticipated that after the intervention the knowledge of the children will increase to 60% (based on the SCS project proposal). The current proportion was expected to be of 45%. At 5% significance level and 90% power a minimum sample size of 231 was needed according to Fleiss's calculations. A continuity correction factor was incorporated based on the normal approximation to the binomial distribution, which increased the size approximately by 2/|Pbefore-Pafter|, for each group. A 10% inflation was added to account for an expected none-response rate, and an additional 5% for incomplete questionnaires. The resulting sample size was 281. This number was then divided on the 5 health centers proportional to size. Numbers were rounded up to account for fractions which increased the total sample size to 284.

Center	Pop	Sample
Dura	**773**	**81**
Aqabet Jaber	**539**	**57**
Ein El-Sultan	**214**	**23**
Ayda + Azzah	**523**	**55**
Arrub	**653**	**68**
Total	**2702**	**284**

Service providers:

The service providers were identified by Juzoor. These were:

- Health workers of the UNRWA health centers: Doctor, nurse, midwife,
- Psychologists, teachers, and psychosocial counselors in the UNRWA health centers and schools.

Since the schools were closed, very few teachers could be reached at the time of data collection. This was another limitation of the survey timing. Furthermore, NGOs' service providers were not included in the sample as it was not certain whether they would be involved in future project activities.

Survey instrument

Three KAP questionnaires were developed for Lebanon and oPt, one for each of the target populations: children, parents, and service providers (Appendix I and II). The questionnaires were developed based on SCS indicators (Appendix III). The indicators were broken down to be more specific ones in order to allow for focused measurement of the populations' knowledge, attitudes, and practices. Because the baseline objectives and areas under investigation were many, a few sub-indicators could be developed for each indicator. Furthermore, two of the indicators proposed were not included in data collection:

- Indicator 1: Number of service providers responding to signs of violence in an appropriate way;
- Indicator 2: Percentage of improvement of number of criteria for adolescent friendly services.

The reason was that, for each of these indicators, a list of criteria needed to be developed to be measured against. Furthermore, data collection for these two indicators would have to involve qualitative methods, and specialized staff. The development of criteria and the qualitative data collection will be taking place during monitoring in a later phase of the project.

The questionnaires were adapted from the questionnaires used for the baseline surveys in Yemen; however, this presented challenges as the Yemen baselines used different questionnaires each, and no "final versions" could be identified.

The adaptation of the Yemen questionnaires consisted of:

- Removing questions that did not serve the objectives of the KAP, based on the SCS indicators (Appendix III), and the sub-indicators;
- Retaining some basic questions;
- Modifying questions' answers, based on educational material, and on country-specific characteristics;
- Adding other questions that serve to measure indicators not included in the Yemen surveys;
- Modifying the sections ordering.

The adaptation of the questionnaires has allowed for more focused results; however, it has also restricted the comparison between the 2 countries and Yemen. After adaptation, the questionnaires were reviewed by both SCS's partners and SCS Regional Office staff. They were translated and piloted in Lebanon and oPt. Pilot results helped to fine-tune the questionnaires, and revealed the need to shorten the Children questionnaire.

The final questionnaires included the following:

1. Visits register: to assess participation rate, and logging the status of the interviewer attempts/visits. This was used to monitor the field data collection.
2. General Characteristics and Demographics
3. Education
4. Personal hygiene
5. Changes during puberty
6. STIs, HIV and AIDS
7. SRH information seeking behavior and services utilization
8. Engagement, marriage, and child bearing
9. Violence

Data collection

In total, there were 25 data collectors involved in the survey. These were divided by teams of two, and assigned to the impact areas. Each team consisted of at least one UNRWA health worker (nurse, psychosocial counselor, etc) or Juzoor health field worker, paired with a volunteer. The teams were given file numbers and names of the random sample to be interviewed in the area. The teams in each area grouped the names to their respective neighborhoods, and visited the families in their household. They would introduce themselves to the family, introduce the survey objectives, and get the parent's and child's consent to participate. Usually the female data collector would work with the child if it was a girl and with the parent if the child was a boy. In the case more than one child aged 10-17 was present, the data collector alternated picking the children between oldest, youngest, and middle in each household. If the family was not at home at the time of visit, the team would fill out a parent and a child survey and indicate the status of visit as "not present at time of visit". In some cases the team would try to contact the family by

phone, otherwise they would ask around the neighborhood if the family is coming soon, or if they were traveling, or have moved. To further ensure the protection of children, data collectors wore name tags, and presented the children interviewed with the phone number of Juzoor for any complaints.

A field supervisor was also recruited with the specific task to monitor the interviews, collect the questionnaires, check for missing and erroneous data, and report to the researcher, among others.

Prior to data collection, the project coordinator and field supervisor were trained on survey administration via Skype. They in turn trained the data collectors in a one-day training on the survey objectives, child protection, interviewing skills, questionnaire administration, proper introduction of the survey to the participants, child participation guidelines, and the importance of the voluntary participation and informed consent. After the training, the data collectors signed the SCS Child Safeguarding Policy, a document which states that the data collectors must behave in a way that will not be harmful and considered offensive towards children and their families. The data collectors were also trained on measures to be taken in the case of reporting of violence by respondents, in which case they would provide them with a list of contact numbers of the impact area's Protection Supervisors, and would make sure that those who want support will receive it.

Data collection started on July 20 (instead of July 14), and ended on August 7, 2010; the reason being a recruitment of UNRWA data collectors who could not be available before July 20. Around 36 households (72 interviews) were cancelled from the survey, due to exceeding the time allocated for data collection. The delay in data collection was due to the long distances between households in the selected impact areas.

The completed questionnaires were collected in envelops, checked by the supervisor, photocopied, and sent to SCS office in Lebanon. This allowed more or less for data entry to be conducted simultaneously. The field supervisor monitored and updated the researcher on the process of data collection, and the status of the interviews.

Data analysis

After data cleaning, data analysis was done using SPSS (Statistical Package for Social Sciences) version 16.

LIMITATIONS

1. Extension of the survey's timeframe

The original timeframe for conducting the surveys in Lebanon and oPt was of 13 weeks. However, the timeframe for preparing, implementing, and report writing was extended to 20 weeks. The 7 weeks extension was due to a lot of factors:

- The preparatory phase was extended of 4 weeks. As a result of schools being closed, the surveys needed to be conducted through other channels within the impact areas. The research team had to identify new access to the populations targeted, which would allow representativeness of the segments that will be participating in the future project interventions. SCS's partner Juzoor had to regain access to UNRWA health centers in the 5 impact areas. This process required time, and involved gathering necessary data for the sampling.

- Furthermore, a strike of UNRWA staff that lasted from 26 May to 7 June 2010, caused delays to the preparatory phase of the survey.

- More time was allocated to data entry and analysis, on account of some delays in the data collection in oPt, which postponed reception of questionnaires in Lebanon, and in turn affected data entry and analysis. Data collection was time-consuming because of the long distances between households in each impact area.

2. Smaller sample reach due to time constraints

- The survey's aim sample in oPt was of 281 households, rounded up to 284. Only 120 children and 142 parents' interviews could be used for analysis. Many reasons account for this:
  - About 36 households were cancelled due to time constraints, and data collection exceeding its deadline by a week.
  - A further 60 households were not at home during the time of visit. This was a major constraint for conducting the survey in the summer, when people tend to move or be on vacation.
  - Refusal rates were of 2.9% for children and 1.7% for parents.
  - Incomplete questionnaire accounted for 2.9% of children's questionnaires and 3.5% of parents' questionnaires.
  - Some respondents declared having participated in the survey, and were counted out for duplication.

- Some questionnaires (specifically from Aqabet Jaber area) were missing partly during the process of sending the hard copies from oPt to Lebanon, and partly from data entry mix up. This was found during preliminary analysis results, and could not be corrected because it would have required resending the lost questionnaires, entering the data, and redoing the analysis, which was not achievable within the survey's allocated timeframe.

The sample in oPt is therefore considered to be a convenience sample.

- Only 8 teachers and 3 head teachers could be reached in oPt due to schools being closed in the summer.

3. Tool development

- The lack of identification of the final tools used for the Yemen surveys presented another hindrance, which led to a time-consuming process of tracking the questions used through the tables in the Yemen surveys reports.

- The adaptation of the questionnaires has restricted the possibility to compare the Lebanon and oPt results with the 2 Yemen surveys' results.

- The indicators were too many for one survey. This was reflected by the length of the questionnaires, which had to be shortened after the piloting. More focused survey objectives could have allowed a more in-depth investigation of the target populations.

- The section about "media habits" was removed from the questionnaires. The information gathered under this section would have allowed for better future planning of campaigns (as per project activities). It is suggested to re-gather data on media habits and reach with a smaller sample prior to planning campaign activities.

- Time constraints allowed for use of quantitative methods (KAP questionnaires) only. It is suggested to follow up with qualitative research before the development of educational material, peer-to-peer education, and campaigns.

4. Sample sizes

In sample size determination, the sample size was calculated in view of detecting a 15% pre-post difference level. In case the estimation would have been reduced to 10% difference, the sample sizes would have considerable exceeded the allocated budget.

RESULTS AND DISCUSSION

A) General Characteristics

Out of 284 sampled households, 36 households were cancelled from the study due to data collection exceeding the appointed time by more than a week. Sixteen of these households were not contacted, while 20 needed to be revisited due to faulted information. Furthermore, 60 households were excluded because the parents and/or children were not at home. This was a major limitation caused by the timing of the survey, as a large percentage of the sampled population were on vacation or had moved. The sample in oPt is therefore considered to be a convenience sample.

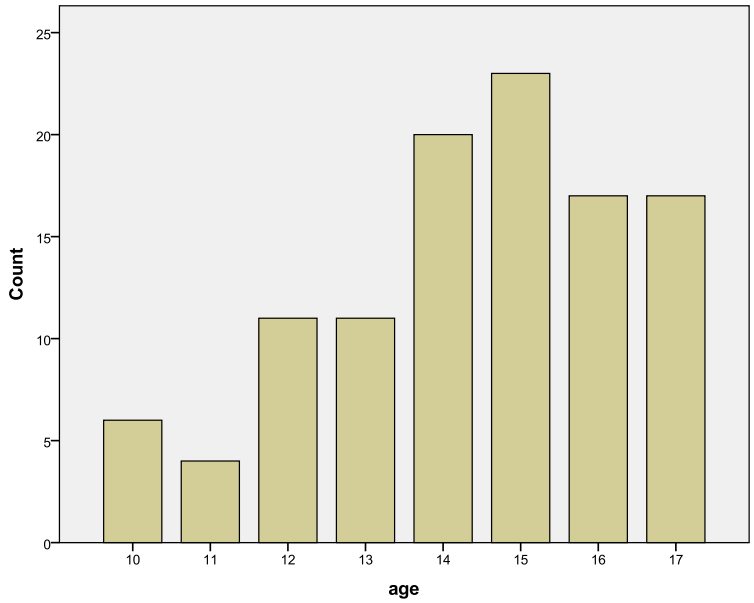
Children

A total of 137 children were interviewed. The refusal rate was of 2.9%, with the main reason being "the father not accepting the research topic". Furthermore, out of the 137 children, only 120 interviews will be considered for analysis since these were the ones who had complete interviews, and had participated in the survey for the first time.

Out of the interviewed children, 32.5% were boys, and 67.5% were girls. The underlying causes for this might be related to social norms, as the data collectors found more girls at home than boys. This shows that boys are more allowed to participate in outdoor activities, while girls are not.

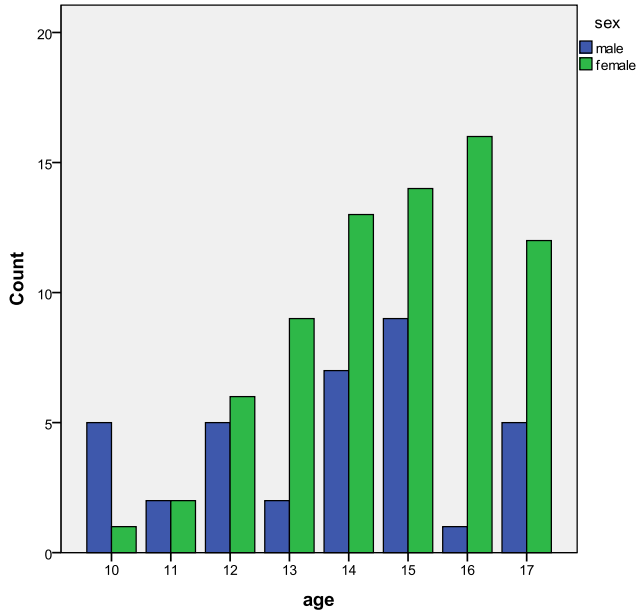
The children were aged 10 to 17 years, with the age distribution shown in graph 1 below. The mean age was 14.36; 13.67 for boys, and 14.7 for girls.

Graph 1: Age distribution of children



Regarding age distribution by gender (graph 2), boys aged 11, 13, and 16 as well as girls aged 10 and 11, are underepresented.

Graph 2: Age distribution of children by gender



The children were distributed among the impact areas: 30.8% came from Arrub, 31.7% from Dura, 25% from Ayda and Azzah, 11.7% from Ein El Sultan, and only one child from Aqabet Jaber. This low frequency in Aqabet Jaber was due to a high percentage of households that were not at home (12 households in that area), incomplete interviews, and some missing questionnaires (see Limitations). The children of Aqabet Jaber are therefore underrepresented in the sample.

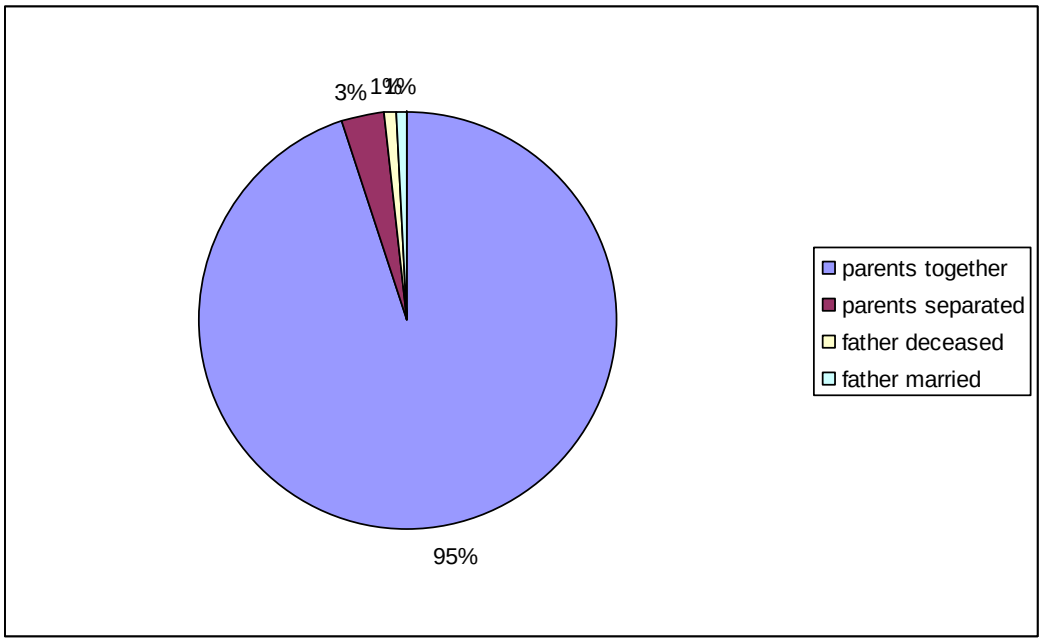
Table 1: Distribution of children by impact area

		Frequency	Percent
Valid	Arrub	37	30.8
	Aqabet Jaber	1	.8
	Ayda & Azzah	30	25.0
	Ein El-Sultan	14	11.7
	Dura	38	31.7
	Total	120	100.0

The children were all Palestinian. The children were mostly refugees (94%), with only 6% being non-refugees.

Most of the children lived with both their parents (95%), while 3% had separated parents, 1% had a deceased father, and 1%'s father were married to someone else (Graph 3).

Graph 3: Family structure



Parents

A total of 157 parents were interviewed. The refusal rate was of 1.7%, with the main reason being "the father not accepting the research topic". Furthermore, out of the 157 parents, only 142 interviews will be considered for analysis since these were the ones who had complete interviews, and had participated in the survey for the first time.

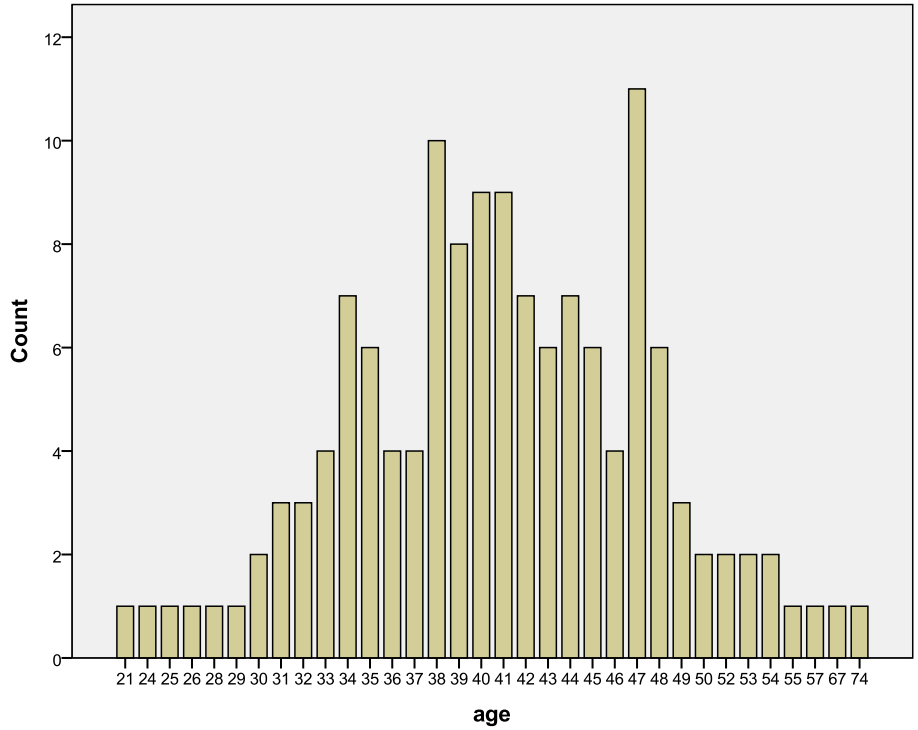
The majority of parents respondents were females (87.9%). Similarly, most of the respondents (87.8%) were the mothers of the children, followed by the father (7.9%), older sister/brother (1.4%), grandparent (0.7%), and other (2.2%).This might be due to three reasons:

- The parents identifying the "caregiver" as being the mother,
- The mothers being most available to conduct the interview,
- The mothers being the usual contact person for the maternal health clinic.

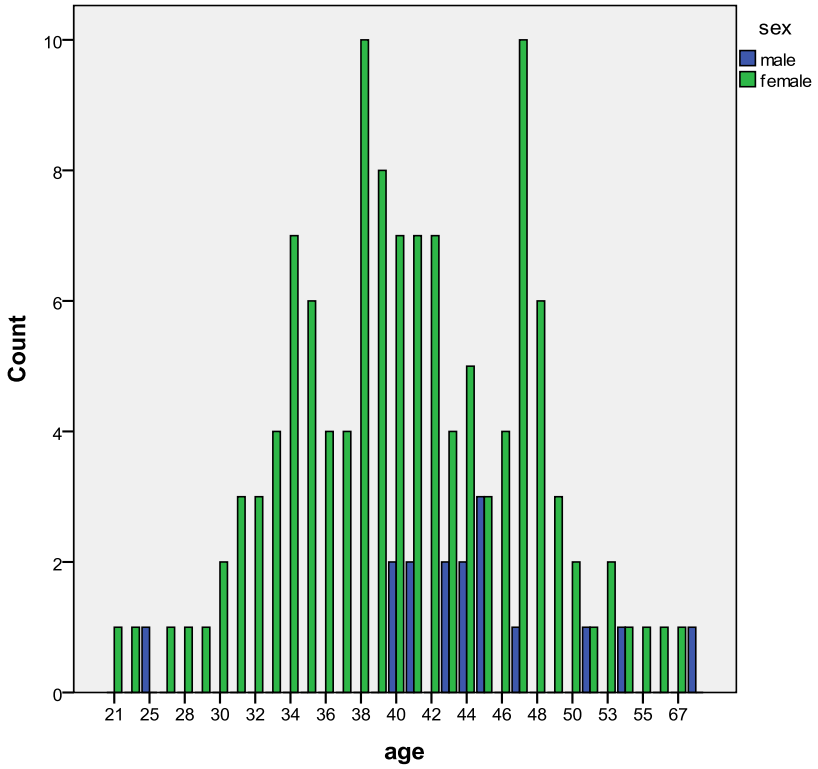
Regardless of the relationship to the child in the family, the respondents will be referred to as "parents", since the majorities (95.7%) are the mother and father of the child.

The parents' age varied between 21 and 74 (Graphs 4 and 5), with the mean age being of 41.1 years (45.2 for males, and 40.6 for females).

Graph 4: Parents' age distribution

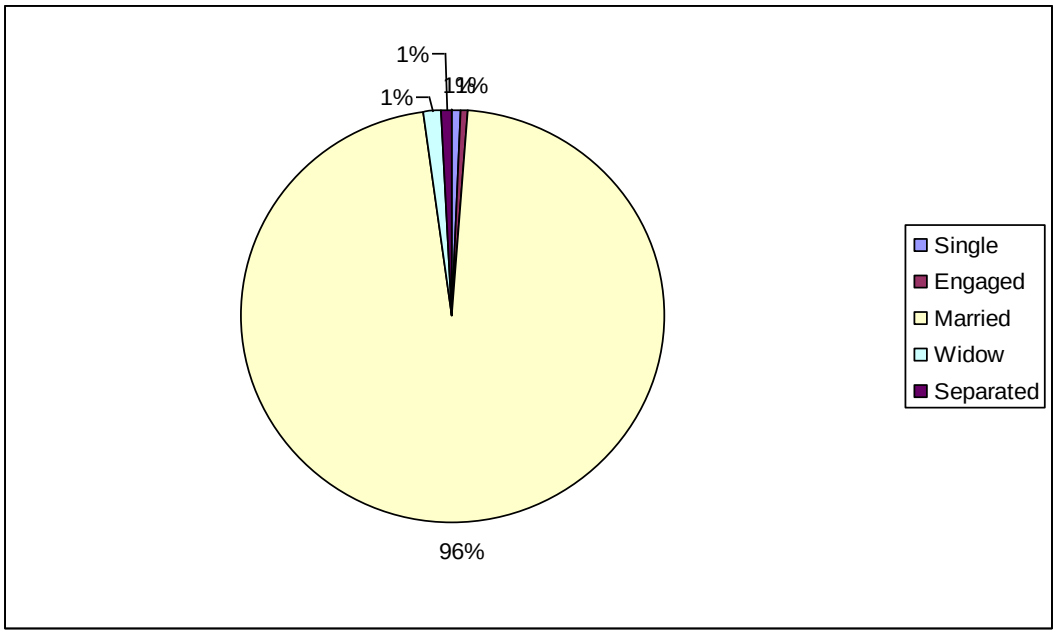


Graph 5: Parents' age distribution by gender



The majority of parents were Palestinian (99.3%), with only 1 respondent being Syrian. The parents were mostly refugees (87.3%), with 12.7% being non-refugees. Most parents were married (96%), while 1% were single, 1% were engaged, 1% widowed, and 1% separated (Graph 6).

Graph 6: Parents/relatives marital status



Service providers

A total of 58 service providers were interviewed. However, because of duplication (5 service providers), 53 interviews were considered for analysis. The service providers came from the 5 impact areas: 27.5% came from Arrub, 23.5% from Ayda and Azzah, 21.6% from Aqabet Jaber, 17.6% from Dura, and 9.8% from Ein El Sultan.

Out of the 53 service providers, 35.6% worked at an UNRWA school, while 64.4% worked at a health center/clinic. Also, 66% provided health services- and will be labeled throughout the analysis as "health workers"-, and 34% provided services in education, counseling, and social work- and will be labeled throughout the analysis as "other service providers". The health workers included doctors (15.4%), nurses (36.5%), and midwives (13.5%). The other service providers included teachers (17.3%), head teachers (9.6%), and psychosocial counselors (7.7 %).

The service providers interviewed were mostly females (73%), with 27% being males. Most of them (45.3%) were aged above 40, while 35.8% were between 30 and 40, and 18.9% were between 20 and 29.

Table 2: Distribution of service providers by impact area

		Frequency	Percent	Valid Percent
Valid	Arrub	14	26.4	27.5
	Aqabet Jaber	11	20.8	21.6
	Ayda & Azzah	12	22.6	23.5
	Ein El Sultan	5	9.4	9.8
	Dura	9	17.0	17.6
	Total	51	96.2	100.0
Missing	System	2	3.8	
Total		53	100.0	

Table 3: Position of service providers

		Frequency	Percent	Valid Percent
Valid	Doctor	8	15.1	15.4
	Nurse	19	35.8	36.5
	Midwife	7	13.2	13.5
	Teacher	9	17.0	17.3
	Head teacher	5	9.4	9.6
	Psychosocial counselor	4	7.5	7.7
	Total	52	98.1	100.0
Missing	System	1	1.9	
Total		53	100.0	

Table 4: Service providers' age distribution

		Frequency	Percent
Valid	20-29	10	18.9
	30-40	19	35.8
	>40	24	45.3
	Total	53	100.0

Around 26.4% have been providing services for children aged 10-17 for 1 to 9 years, and the majority (73.6%) have worked with children for 10 or more years. The average number of years for working with children aged 10-17 was 15.2.

B) Education

Children

Ability to read

All children (1 missing) have reported being able to read. Most of them reported being able to read Arabic (96.6%), followed by English (57.9%), with only one child reporting being able to read French (Table 5).

Table 5: Languages read

	Count	N %
can read Arabic	115	96.64
can read English	69	57.98
can read French	1	0.84
can read other languages	0	0

School Enrollment

The majority of children (95.7%) have reported being presently enrolled in school; these represented 94.6% of the boys and 96.2% of the girls.

Table 6: Enrolment status by gender

		Sex					
		Male		Female		Total	
		Count	N %	Count	N %	Count	N %
Currently attending school	No	2	5.4%	3	3.8%	5	4.3%
	Yes	35	94.6%	75	96.2%	110	95.7%

The enrollment of boys increases with age, although with a small sample it's not statistically significant.

Table 7: Enrollment status of boys by age group

		Categorical age							
		10-12		13-15		16-18		Total	
		Count	N %	Count	N %	Count	N %	Count	N %
Currently attending school	No	1	8.3%	1	6.3%	0	.0%	2	5.9%
	Yes	11	91.7%	15	93.8%	6	100.0%	32	94.1%
	Total	12	100.0%	16	100.0%	6	100.0%	34	100.0%

The enrollment of girls is 100% for the age group 10-12, with a decrease in the age group 13-15 to 94.3%, and in the age group 16-18 to 96.2%.

Table 8: Enrollment status of girls by age group

		Categorical age							
		10-12		13-15		16-18		Total	
		Count	N %	Count	N %	Count	N %	Count	N %
currently attending school	No	0	.0%	2	5.7%	1	3.8%	3	4.3%
	Yes	9	100.0%	33	94.3%	25	96.2%	67	95.7%
	Total	9	100.0%	35	100.0%	26	100.0%	70	100.0%

Out of those who are presently attending school, the majority are attending UNRWA schools (57.6%), while 27.1% are attending public schools, 12.7% semi-private schools, and 2.5% private schools.

Table 9: Type of school

		Frequency	Percent	Valid Percent
Valid	Public	32	26.7	27.1
	Private	3	2.5	2.5
	Semi-private	15	12.5	12.7
	UNRWA	68	56.7	57.6
	Total	118	98.3	100.0
Missing	System	2	1.7	
Total		120	100.0	

However, 55.3% of children interviewed from Dura attend public schools, while 34.2% attend UNRWA schools. The results by impact area are shown in table 10.

Overall, 4.3% of children reported not being enrolled in school, all having dropped out. Out of those who dropped out, 33.3% had dropped out before grade 8, while all had dropped out by grade 10. The children who were not presently enrolled were 60% were aged between 13 and 15 years, 20% between 10 and 12, and 20% between 16 and 18.
The reason given by those who are currently not attending was: "school was boring".

Table 10: Type of school by impact area

		Impact area											
		Arrub		Aqabet Jaber		Ayda & Azzah		Ein El Sultan		Dura		Total	
		Cnt	N %	Cnt	N %	Cnt	N %	Cnt	N %	Cnt	N %	Cnt	N %
Type of school currently attended	**Public**	2	5.6%	0	.0%	7	23.3%	2	15.4%	21	55.3%	32	27.1 %
	Private	1	2.8%	1	100.0%	0	.0%	1	7.7%	0	.0%	3	2.5%
	Semi-private	9	25.0%	0	.0%	2	6.7%	0	.0%	4	10.5%	15	12.7 %
	UNRWA	24	66.7%	0	.0%	21	70.0%	10	76.9%	13	34.2%	68	57.6 %
	Other	0	.0%	0	.0%	0	.0%	0	.0%	0	.0%	0	.0%

Non formal education

Around 42.6% of children (12 missing) are presently enrolled in non-formal education. Most of the children aged 10-12 (75%) attended non-formal education, while 40.6% of those aged 16-18, and only 28.9% of those aged 13-15 did.

Table 11: Non-formal education attendance by age group

		Categorical age							
		10-12		13-15		16-18		Total	
		Count	N %	Count	N %	Count	N %	Count	N %
Attending any form of non formal education?	No	5	25.0%	32	71.1%	19	59.4%	56	57.7%
	Yes	15	75.0%	13	28.9%	13	40.6%	41	42.3%
	Total	20	100.0%	45	100.0%	32	100.0%	97	100.0%

The most attended form of non-formal education is private languages courses (22.5%), followed by religious education (14.17%). Other results are shown in table 12 below:

Table 12: Non formal education attendance

		Count	% of whole sample
Attending Youth club (including health lectures)	Yes	14	11.67
Attending Private Language courses	Yes	27	22.50
Attending Remedial classes (including literacy)	Yes	2	1.67
Attending Technical/vocational training	Yes	10	8.33
Attending Religious education	Yes	17	14.17
Attending Other education	Yes	0	0.00

Membership in youth group

Only 12.5% of the children are members of youth groups, with more girls (88.9%) than boys (84.6%) being members (Table 13). About 23.8% of children 10-12 were members of youth groups, followed by the age group of 13-15 (7.4%), and the age group 16-18 (5.9%).

Table 13: Membership in youth group

		Sex					
		Male		Female		Total	
		Count	%	Count	%	Count	%
Member of youth group	No	33	84.6%	72	88.9%	105	87.5%
	Yes	6	15.4%	9	11.1%	15	12.5%

Parents

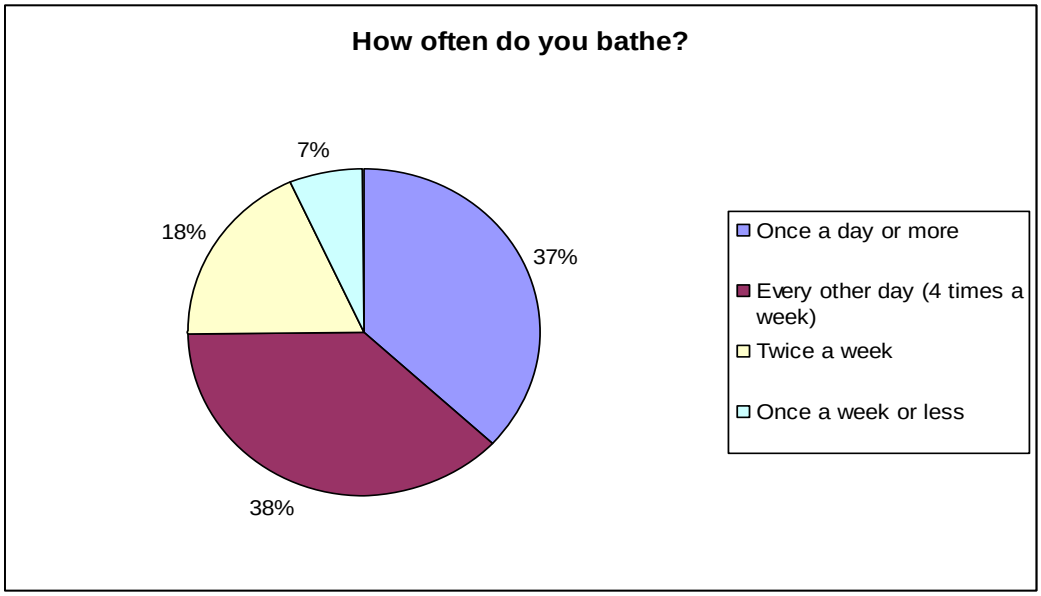
Results from the parents' interviews were not very different from the children's answers, except regarding the reasons of not being enrolled in school. These were: "cost is too high", "boys are given priority to attend", and "needing to help the father at work". This reflects that children might not always be aware of the reasons why they have dropped out of school, and therefore may not be included in the decision making.

C) Personal Hygiene

Hygiene practices

Regarding hygiene practices, around only 37% of children bathe "once a day or more", while 38% bathe "every other day", 18% "twice a week", and 7% "once a week or less".

Graph 7: Frequency of children bathing



The bathing frequency decreases with age, whereby the percentage of children bathing "once a day or more" is highest in the age group 10-12 (61.9%), followed by the age groups 13-15 (35.2%), and 16-18 (33.3%).

Table 14: Frequency of bathing by age

		Categorical age							
		10-12		13-15		16-18		Total	
		Count	N %	Count	N %	Count	N %	Count	N %
How often do you bathe?	Once a day or more	13	61.9%	19	35.2%	11	33.3%	43	39.8%
	Every other day (4 times a week)	5	23.8%	20	37.0%	13	39.4%	38	35.2%
	Twice a week	1	4.8%	9	16.7%	9	27.3%	19	17.6%
	Once a week or less	2	9.5%	6	11.1%	0	.0%	8	7.4%

Also, the frequency of bathing is slightly higher for girls.

Table 15: Frequency of bathing by gender

		Sex					
		Male		Female		Total	
		Count	N %	Count	N %	Count	N %
How often do you bathe?	Once a day or more	14	35.9%	30	37.5%	44	37.0%
	Every other day (4 times a week)	14	35.9%	31	38.8%	45	37.8%
	Twice a week	9	23.1%	13	16.3%	22	18.5%
	Once a week or less	2	5.1%	6	7.5%	8	6.7%

On the other hand, 90.8% of the parents (1 missing) have reported that their children wash their genitals "once a day or more", 24.1% reported they do so "every other day", and 5% "twice a week".

Table 16: Parents reporting about frequency of children washing their genitals

		Frequency	Percent	Valid Percent
Valid	Once a day or more	100	70.4	70.9
	Every other day (4 times a week)	34	23.9	24.1
	Twice a week	7	4.9	5.0
	Total	141	99.3	100.0
Missing	System	1	.7	
Total		142	100.0	

<u>Sources of information on personal hygiene</u>

Most children mentioned their mother (84.1%) as source of information on personal hygiene, followed by their teacher (30%), their sister (27.5%), and their father (25.8%). Mothers were mentioned by 88.9% of girls and 74.3% of boys, suggesting that mothers are the main source of information regardless of gender. This also shows that boys are comfortable sharing this kind of information with their mothers. The same observation can be made for sisters being considered as a source of information by both boys and girls with close percentages. "Sister" is also more mentioned by boys as being a source of

info on personal hygiene than "brother". This is not true however for girls and their fathers, since only 8.6% of girls consider their fathers to be a source of information, while 61.5% of boys did. These findings suggest that females (mothers, sisters, etc) are considered as a source of information on personal hygiene more than males.

Other relatives also play a role as sources of information for 11.6% of children. Friends were mentioned as source by only 7.5% of children.

Only 2.5% mentioned health workers to be a source of information, while 9.1% mentioned psychosocial counselors, and none mentioned social workers. Furthermore, regarding media, the most mentioned source was "books" (8.3%). Printed materials were mentioned by a very low percentage of children (4.1%) as sources of information, suggesting either of the following:

- The lack of availability of printed materials tackling personal hygiene issues for adolescents;
- The printed materials are not accessible to the children;
- The printed materials are not attractive or child-friendly.

Table 17: Sources of information on personal hygiene by gender

	Sex					
	Male		Female		Total	
	Count	N %	Count	N %	Count	N %
Don't Know	3	7.69	1	1.23	4	3.33
Teacher	13	33.33	23	28.40	36	30.00
Mother	29	74.36	72	88.89	101	84.17
Father	24	61.54	7	8.64	31	25.83
Brother	9	23.08	3	3.70	12	10.00
Sister	10	25.64	23	28.40	33	27.50
Friend	5	12.82	4	4.94	9	7.50
Relative	7	17.95	7	8.64	14	11.67
Gynecologist/doctor	1	2.56	2	2.47	3	2.50
Nurse/midwife	0	0.00	0	0.00	0	0.00
Psychosocial counselor	3	7.69	8	9.88	11	9.17
Social worker	0	0.00	0	0.00	0	0.00
Health center	0	0.00	0	0.00	0	0.00
Youth center	1	2.56	1	1.23	2	1.67
Printed material (brochures)	0	0.00	5	6.17	5	4.17

Radio	0	0.00	2	2.47	2	1.67
TV	3	7.69	5	6.17	8	6.67
Book	3	7.69	7	8.64	10	8.33
Internet	0	0.00	2	2.47	2	1.67
Other	0	0.00	5	6.17	5	4.17

Girls' knowledge about personal hygiene issues

Girls were asked whether the following caused irritation/infection of the genitals:
- Tight clothing
- Nylon underwear
- Perfumed and colored toilet paper
- Soap that contains perfume or deodorant
- Pantyhose
- Using feminine hygiene spray
- Wiping back to front when going to the bathroom

Around 52% of girls identified 3 or more causes for infection/irritation of the genitals, with 48% identified less than 3 causes.

Table 18: Percentage of girls by number of identified causes of infection/irritation of the genitals

		Frequency	Percent	Valid Percent
Valid	0	10	12.3	13.3
	1	16	19.8	21.3
	2	10	12.3	13.3
	3 or more	39	48.1	52.0
	Total	75	92.6	100.0
Missing	System	6	7.4	
Total		81	100.0	

The most identified causes were: "nylon underwear" (48.1%), followed by "tight clothing" (45.7%). The least identified causes were: "soap that contains perfume or deodorant" (24.7%), and "pantyhose" (25.9%). Furthermore, these were the two answers that revealed girls' misconceptions. This showed by a very low percentage of girls answering "I don't know" to these two answers, as opposed to the rest of the items asked, which suggests that they were more sure of these two answers than the other answers.

Table 19: Causes for irritation/infection of the genitals

		Count	N %
Tight clothing cause irritation/infection of the genitals?	No	28	34.57
	Yes	37	**45.68**
	Don't know	13	16.05
	Total	78	96.30
Nylon underwear cause irritation/infection of the genitals?	No	26	32.10
	Yes	39	**48.15**
	Don't know	13	16.05
	Total	78	96.30
Perfumed and colored toilet paper cause irritation/infection of the genitals?	No	36	44.44
	Yes	27	**33.33**
	Don't know	15	18.52
	Total	78	96.30
Soap that contains perfume or deodorant cause irritation/infection of the genitals?	No	55	67.90
	Yes	20	**24.69**
	Don't know	4	4.94
	Total	79	97.53
Pantyhose cause irritation/infection of the genitals?	No	49	60.49
	Yes	21	**25.93**
	Don't know	9	11.11
	Total	79	97.53
Using feminine hygiene spray cause irritation/infection of the genitals?	No	39	48.15
	Yes	22	**27.16**
	Don't know	16	19.75
	Total	77	95.06
Wiping back to front when going to the bathroom cause irritation/infection of the genitals?	No	38	46.91
	Yes	34	**41.98**
	Don't know	7	8.64
	Total	79	97.53

Regarding menstrual hygiene, 76.3% of girls knew that the tampon/pad should be changed many times during the day during menstruation.

Table 20: Girls' knowledge about menstrual hygiene

		Frequency	Percent	Valid Percent
Valid	Should use one during whole period	1	1.2	1.3
	Change daily	9	11.1	11.3
	Change many times during the day	61	75.3	76.3
	Other	3	3.7	3.8
	Don't know	6	7.4	7.5
	Total	80	98.8	100.0
Missing	System	1	1.2	
Total		81	100.0	

D) Changes during puberty

Children

Number of identified physical changes during puberty

Children were asked questions about changes occurring in puberty. Girls were asked about physical changes occurring in girls, and boys were asked about physical changes occurring in boys. Half of the girls (49.4%) identified 3 or more physical changes that occur in girls during puberty, while only 41% of boys identified 3 or more physical changes that occur in boys during puberty.

Table 21: Percentage of girls by number of identified physical changes in puberty

		Frequency	Percent
Valid	0	9	11.1
	1	10	12.3
	2	22	27.2
	3 or more	40	49.4
	Total	81	100.0

Table 22: Percentage of boys by number of identified physical changes in puberty

		Frequency	Percent
Valid	0	7	17.9
	1	6	15.4
	2	10	25.6
	3 or more	16	41.0
	Total	39	100.0

Knowledge about physical changes occurring in girls during puberty

The most identified physical changes by girls were: “breast growth” (71.6%), and “start of menstruation” (59.3%).

Table 23: Physical changes identified by girls

	Count	% of all girls
Don't know	10	12.35%
Breasts start to grow	58	71.60%
Hair growth (genital/underarms)	41	50.62%
Height increases	31	38.27%
Body becomes more muscled	19	23.46%
Widening of hips	15	18.52%
Menstruation starts	48	59.26%
Oily skin, pimples	14	17.28%
Increase in perspiration gland secretion	8	9.88%
Other changes	2	2.47%

Knowledge about physical changes occurring in boys during puberty

The most identified physical changes by boys were: "hair growth" (59%), and "height and weight increase" (48.7%).

Table 24: Physical changes identified by boys

	Yes	
	Count	% of all boys
Don't know	8	20.5%
Hair growth (face, arms, legs, pubic)	23	59.0%
Voice changes (hoarse voice)	16	41.0%
Height and weight increase	19	48.7%
Body becomes more muscled/strong	15	38.5%
Broadening of shoulders	8	20.5%
Changes in sex organs	4	10.3%
Oily skin, pimples	8	20.5%
Increase in perspiration gland secretion	7	17.9%
Other changes	4	10.3%

Knowledge about worries/problems faced by children during puberty

When asked about worries and problems adolescents face during puberty, 24.1% didn't know, while 8.3% said that adolescents do not face any problems during puberty. Only 20% identified 3 or more worries/problems.

Table 25: Percentage of children by number of worries/problems identified

		Frequency	Percent
Valid	0	57	47.5
	1	26	21.7
	2	13	10.8
	3 or more	24	20.0
	Total	120	100.0

The most identified worries/problems were: "irritability and anger" by 30.8% of children, followed by "sadness and depression" (23.3%). Also, 15% of children related "other" worries that they face during puberty, the main ones being: "conflict with parents" and "attraction to the other sex". The children's answers suggest that they are open to share the worries and problems they face. It is thus suggested to investigate these areas qualitatively in order to get a more in-depth analysis of the children experiences and concerns.

Table 26: Worries/problems identified by children

	Count	% of total sample
Don't know	29	24.17%
No problems	10	8.33%
Abdominal cramps	5	4.17%
Nocturnal emissions	2	1.67%
Feeling fatigued / tired	15	12.50%
Eating too much	5	4.17%
Get sad / depressed	28	23.33%
Irritability / Anger	37	30.83%
Cannot concentrate on study	22	18.33%
Timidity/shyness	26	21.67%
Other worries	18	15.00%

Parents and Service Providers

Number of identified physical changes during puberty

The children's parents and the service providers were asked the same questions about changes during puberty. About 45% of parents, 91.4% of health workers, and 100% of other service providers (social workers, psychosocial counselors, teachers, etc) identified 3 or more physical changes in girls during puberty.

Table 27: Percentage of parents, health workers, and other service providers by number of identified physical changes in girls

		Parents	Valid Percent	Health Workers	Valid Percent	Other SP	Valid Percent
Valid	0	19	13.4				
	1	22	15.5	1	2.9		
	2	37	26.1	2	5.7		
	3 or more	64	45.1	32	91.4	18	100.0
	Total	142	100.0	35	100.0	18	100.0

These percentages slightly change when identifying changes in boys; in fact, around 39.4% of parents, 94.3% of health workers, and 88.9% of other service providers identified 3 or more physical changes in boys during puberty. A decrease in parents and other service providers' knowledge is observed, while an increase in health workers knowledge is noted.

Table 28: Percentage of parents, health workers, and other service providers by number of identified physical changes in boys

		Parents	Valid Percent	Health Workers	Valid Percent	Other SP	Valid Percent
Valid	0	23	16.2				
	1	27	19.0				
	2	36	25.4	2	5.7	2	11.1
	3 or more	56	39.4	33	94.3	16	88.9
	Total	142	100.0	35	100.0	18	100.0

Knowledge about physical changes occurring in girls during puberty

Only 9.1% of the parents responded not knowing any physical changes in girls during puberty.

The most identified physical changes in girls were:
-"Breast growth", by 97.1% of the health workers, 100% of other service providers, and 66.2% of parents;

-"Start of menstruation", by 97.1% of health workers, 94.4% of other service providers, and 57.7% of parents;

- and "Hair growth" by 82.8% of health workers, 88.9% of other service providers, and 30.3% of parents.

Table 29: Physical changes in girls during puberty

	Health workers		Other SP		Parents	
	Count	% of all HW	Count	% of all other SP	Count	% of all parents
Don't know	0	0.00	0	0.00	13	9.15
Breasts start to grow	34	97.14	18	100.00	94	66.20
Hair growth (genital/underarms)	29	82.86	16	88.89	43	30.28
Height increases	18	51.43	6	33.33	57	40.14
Body becomes more muscled	11	31.43	7	38.89	21	14.79
Widening of hips	13	37.14	11	61.11	25	17.61
Menstruation starts	34	97.14	17	94.44	82	57.75
Oily skin, pimples	16	45.71	9	50.00	15	10.56
Increase in perspiration gland secretion	5	14.29	1	5.56	4	2.82
other	2	5.71	2	11.11	3	2.11

Knowledge about physical changes occurring in boys during puberty

Around 12.7% of parents responded not knowing any physical changes in boys during puberty. This reflected slightly lower knowledge of changes occurring in boys than in girls during puberty.

The most identified physical changes in boys were:

-"Voice changes", by 88.6% of the health workers, 94.4% of other service providers, and 59.1% of parents;

-"Hair growth", by 85.7% of health workers, 94.4% of other service providers, and 52.8% of parents.

Table 30: Physical changes in boys during puberty

	Health workers		Other SP		Parents	
	Count	% of all HW	Count	% of all other SP	Count	% of all parents
Don't know	0	0.00	0	0.00	18	12.68
Hair growth (face, arms, legs, pubic)	30	85.71	17	94.44	75	52.82
Voice changes (hoarse voice)	31	88.57	17	94.44	84	59.15
Height and weight increase	23	65.71	9	50.00	59	41.55
Body becomes more muscled/strong	17	48.57	12	66.67	36	25.35
Broadening of shoulders	20	57.14	11	61.11	26	18.31
Changes in sex organs	23	65.71	10	55.56	20	14.08
Oily skin, pimples	12	34.29	9	50.00	17	11.97
Increase in perspiration gland secretion	7	20.00	3	16.67	7	4.93
Other	3	8.57	1	5.56	3	2.11

Knowledge about worries/problems faced by children during puberty

Around 54.3% of health workers, 44.4% of the other service providers, and only 10.6% of the parents identified 3 or more worries or problems faced during puberty.

Table 31: Percentage of parents, health workers, and other service providers by number of identified worries/problems

		Parents	Valid Percent	Health Workers	Valid Percent	Other SP	Valid Percent
Valid	0	48	33.8	4	11.4	4	22.2
	1	49	34.5	4	11.4	4	22.2
	2	30	21.1	8	22.9	2	11.1
	3 or more	15	10.6	19	54.3	8	44.4
	Total	142	100.0	35	100.0	18	100.0

The most identified worries by parents (55.6%) and health workers (68.6%) were: "irritability and anger". The most identified worries by other service providers (61.1%) were: "sadness and depression", followed by "irritability and anger" (50%).

Table 32: Worries/problems faced during puberty

	Health workers		Other SP		Parents	
	Count	% of all HW	Count	% of all other SP	Count	% of all parents
Don't know	1	2.86	1	5.56	17	11.97
No problems	0	0.00	0	0.00	10	7.04
Abdominal cramps	4	11.43	1	5.56	0	0.00
Nocturnal emissions	7	20.00	1	5.56	7	4.93
Feeling fatigued / tired	9	25.71	4	22.22	8	5.63
Eating too much	8	22.86	6	33.33	10	7.04
Get sad / depressed	20	57.14	11	61.11	30	21.13
Irritability / Anger	24	68.57	9	50.00	79	55.63
Cannot concentrate on study	9	25.71	7	38.89	12	8.45
Timidity/shyness	16	45.71	6	33.33	18	12.68
Other	7	20.00	6	33.33	8	5.63

"Other" worries mentioned by parents and service providers included "conflict with parents". This answer is similar to the children's answers (above), however it is described as "rebellious behavior" by the service providers, and as "parental pressure and restrictions" by the children.

Knowledge about sexual and reproductive health risks during puberty

When asked whether children aged 10 to 17 face SRH risks, 91.4% of health workers and 94.4% of other service providers answered "yes", as opposed to only 40.8% of parents.

Around 34.4% of the parents who answered "yes" did not know what kind of SRH risks are faced by children 10 to 17. Only 8.6% of the parents who answered "yes" identified 3 or more SRH risks, as opposed to 28.1% of the health workers and 35.3% of the other service providers.

Table 33: Percentage of parents, health workers, and other service providers by number of SRH risks identified

		Parents	Valid Percent	Health Workers	Valid Percent	Other SP	Valid Percent
Valid	0	27	46.6	2	6.3	1	5.9
	1	21	36.2	11	34.4	4	23.5
	2	5	8.6	10	31.3	6	35.3
	3 or more	5	8.6	9	28.1	6	35.3
	Total	58	100.0	32	100.0	17	100.0

The most identified SRH risk was "un-intended pregnancy" for 59.3% of health workers and 76.4% of other service providers, and "sexual violence and exploitation" for 27.6% of parents (out of those who answered "yes").

Table 34: Knowledge about SRH risks faced

	Parents	Valid Percent/58	Health Workers	Valid Percent/32	Other SP	Valid Percent/17
Don't know	20	34.48	0	0.00	0	0.00
Unintended, too-early pregnancy	11	18.97	19	59.38	13	76.47
STIs, including HIV and AIDS	5	8.62	6	18.75	3	17.65
Unsafe abortion	6	10.34	11	34.38	11	64.71
Sexual violence and exploitation	16	27.59	8	25.00	6	35.29
Menstruation problems	10	17.24	18	56.25	6	35.29
Other	0	0.00	4	12.50	3	17.65

E) STIs, HIV and AIDS

Children

Sexually Transmitted Infections and their symptoms

Around 39.2% of children couldn't identify any sexually transmitted infection (STI) a person can get through sexual intercourse. Only 3.3% could identify 3 or more STIs, while 49.2% identified 1 STI, with more girls (50.6%) identifying 1 STI than boys (46.2%).

Table 35: Number of identified STIs by gender

		Sex					
		Male		Female		Total	
		Count	N %	Count	N %	Count	N %
STIs identified	0	15	38.5%	32	39.5%	47	39.2%
	1	18	46.2%	41	50.6%	59	49.2%
	2	4	10.3%	6	7.4%	10	8.3%
	3 or more	2	5.1%	2	2.5%	4	3.3%
	Total	39	100.0%	81	100.0%	120	100.0%

The most identified STI was HIV &AIDS, identified by 59.2%.

Table 36: Sexually Transmitted Infections identified

Infections a person can get through sexual intercourse	Yes	
	Count	Total N %
Don't know	40	33.3%
HIV &AIDS	71	59.2%
Gonorrhea	6	5.0%
Syphilis	3	2.5%
Chlamydia	3	2.5%
Pubic lice	5	4.2%
Thrush	1	.8%
Genital warts	0	.0%
Genital herpes	0	.0%
Hepatitis B	2	1.7%
Hepatitis C	1	.8%
Other	8	6.7%

Around 79.2% of children couldn't identify any signs or symptoms that suggest that a person has an STI. Only 2.5% could identify 3 or more STI symptoms, while 12.5% identified only one.

Table 37: Number of STI symptoms by gender

		Sex					
		Male		Female		Total	
		Count	N %	Count	N %	Count	N %
STI symptoms identified	0	32	82.1%	63	77.8%	95	79.2%
	1	4	10.3%	11	13.6%	15	12.5%
	2	2	5.1%	5	6.2%	7	5.8%
	3 or more	1	2.6%	2	2.5%	3	2.5%

The most identified STI symptoms were:

- "Loss of weight", by only 11.7%,
- "Sores or warts on penis/vagina", by only 8.3%.

Children mentioned "other" symptoms, the main one being: "face acne".

Table 38: STI symptoms

	Yes	
	Count	N %
Don't know	58	48.3%
Discharge from penis/vagina	6	5.0%
Burning pain or itching in penis/vagina	4	3.3%
Abnormal vaginal bleeding	0	.0%
Loss of weight	14	11.7%
Sores or warts on penis/vagina	10	8.3%
Abdominal pain	5	4.2%
Painful urination	0	.0%
Swelling in groin region	1	.8%
Other	25	20.8%

HIV and AIDS

Furthermore, around 72% of children have heard of HIV and AIDS, with more girls (75.7%) than boys (65.8%), and with increase of awareness with older age. In fact, only 42.1% of children aged 10-12 have heard of HIV and AIDS, as opposed to 72.5% of those aged 13-15, and 85.2% of those aged 16-18. It is therefore recommended to focus awareness raising efforts regarding HIV and AIDS on the younger age groups.

Table 39: Awareness of HIV and AIDS by gender

		Sex					
		Male		Female		Total	
		Count	N %	Count	N %	Count	N %
Ever heard of HIV/AIDS	No	13	34.2%	17	24.3%	30	27.8%
	Yes	25	65.8%	53	75.7%	78	72.2%

Table 40: Awareness of HIV and AIDS, by age group

		Categorical age							
		10-12		13-15		16-18		Total	
		Count	N %	Count	N %	Count	N %	Count	N %
Ever heard of HIV/AIDS	No	11	57.9%	14	27.5%	4	14.8%	29	29.9%
	Yes	8	42.1%	37	72.5%	23	85.2%	68	70.1%

Out of those who heard of HIV and AIDS, only 32.1% could identify 3 or more modes of transmission of HIV, with no difference between girls and boys.

Also, the older the children, the more they identified modes of HIV transmission. In fact, none of those aged 10-12 who heard of HIV and AIDS identified 3 or more modes of HIV transmission, as opposed to 18.9% of those aged 13-15, and 47.8% of those aged 16-18.

Table 41: Number of identified modes of HIV transmission, by gender

		Sex					
		Male		Female		Total	
		Count	N %	Count	N %	Count	N %
Modes of transmission of HIV	0	5	20.0%	16	30.2%	21	26.9%
	1	7	28.0%	8	15.1%	15	19.2%
	2	5	20.0%	12	22.6%	17	21.8%
	3 or more	8	32.0%	17	32.1%	25	32.1%

Table 42: Number of identified modes of HIV transmission, by age group

		Categorical age							
		10-12		13-15		16-18		Total	
		Count	N %	Count	N %	Count	N %	Count	N %
Modes of transmission of HIV	0	3	37.5%	14	37.8%	2	8.7%	19	27.9%
	1	5	62.5%	9	24.3%	1	4.3%	15	22.1%
	2	0	.0%	7	18.9%	9	39.1%	16	23.5%
	3 or more	0	.0%	7	18.9%	11	47.8%	18	26.5%

The most identified modes of transmission of HIV were:

- "Sexual relations", by 56.4%,
- "Blood transfusion", by 52.6%.

The least identified modes of transmission were:

- "Mosquito or other insect bites", by 1.3%,
- "Breast milk", by 2.6%.

Also, 42.3% though that "casual contact with an infected person" is a mode of transmission, with slightly more boys (44%) than girls (41.5%). This misconception needs to be corrected in future awareness raising activities, to reduce the stigma against HIV infected people.

Table 43: Modes of transmission of HIV by gender

Ways of getting HIV	Sex					
	Male		Female		Total	
	Yes		Yes		Yes	
	Count	Total N %	Count	Total N %	Count	Total N %
Don't know	1	4.0%	7	13.2%	8	10.3%
Sexual relations	16	64.0%	28	52.8%	44	56.4%
Sharing syringes	5	20.0%	19	35.8%	24	30.8%
Unclean medical equipment	4	16.0%	12	22.6%	16	20.5%
Blood transfusion	12	48.0%	29	54.7%	41	52.6%
Mother to child	5	20.0%	15	28.3%	20	25.6%
Mosquito or other insect bites	0	.0%	1	1.9%	1	1.3%
Breast milk	0	.0%	2	3.8%	2	2.6%
Casual contact with infected person	11	44.0%	22	41.5%	33	42.3%
Other	2	8.0%	4	7.5%	6	7.7%

Also, only 25.6% of those who heard of HIV and AIDS could identify 3 or more ways to avoid getting it, with more boys (36%) than girls (20.8%).

Table 44: Number of identified ways to avoid getting HIV, by gender

		Sex					
		Male		Female		Total	
		Count	N %	Count	N %	Count	N %
Ways to avoid getting HIV	0	6	24.0%	14	26.4%	20	25.6%
	1	6	24.0%	23	43.4%	29	37.2%
	2	4	16.0%	5	9.4%	9	11.5%
	3 or more	9	36.0%	11	20.8%	20	25.6%

As expected as well, older children identified more ways of HIV transmission. In fact, none of those aged 10-12 who heard of HIV and AIDS identified 3 or more ways to avoid getting HIV, as opposed to 16.2% of those aged 13-15, and 43.5% of those aged 16-18.

Table 45: Number of identified ways to avoid getting HIV, by age group

		Categorical age							
		10-12		13-15		16-18		Total	
		Count	N %	Count	N %	Count	N %	Count	N %
Ways to avoid getting HIV	0	3	37.5%	12	32.4%	1	4.3%	16	23.5%
	1	5	62.5%	12	32.4%	10	43.5%	27	39.7%
	2	0	.0%	7	18.9%	2	8.7%	9	13.2%
	3 or more	0	.0%	6	16.2%	10	43.5%	16	23.5%

The most identified ways to avoid getting HIV were:
- "Abstinence from sex", by 42.3%,
- "Avoiding sharing razors and blades", by 35.9%.

The least identified ways to avoid getting HIV were:
- "Using condoms for every sexual act", by 3.8%,
- "Avoiding commercial sex workers", by 6.4%.

Also, the most give answer was "avoiding casual contact with an infected person" by 43.6%. This misconception also needs to be corrected in future awareness raising activities, to reduce the stigma against HIV infected people.

Table 46: Ways to avoid getting HIV

Ways to avoid getting HIV	Sex					
	Male		Female		Total	
	Yes		Yes		Yes	
	Count	Total N %	Count	Total N %	Count	Total N %
Don't know	1	4.0%	2	3.8%	3	3.8%
Avoid sex completely/abstinence	15	60.0%	18	34.0%	33	42.3%
Stay faithful to partner	3	12.0%	12	22.6%	15	19.2%
Encourage partner to stay faithful	4	16.0%	3	5.7%	7	9.0%
Avoid contaminated blood	9	36.0%	13	24.5%	22	28.2%
Use condoms for every act of sexual intercourse	0	.0%	3	5.7%	3	3.8%
Avoid sharing syringes	0	.0%	12	22.6%	12	15.4%
Avoid sharing razors and blades	10	40.0%	18	34.0%	28	35.9%

Avoid commercial sex workers	0	.0%	5	9.4%	5	6.4%
Avoid casual sex	3	12.0%	5	9.4%	8	10.3%
Avoid casual contact with infected person	11	44.0%	23	43.4%	34	43.6%
Other	1	4.0%	4	7.5%	5	6.4%

Parents and Service Providers

Sexually Transmitted Infections and their symptoms

The children's parents and the service providers were asked the same questions about STIs and HIV and AIDS. About 88.6% of the health workers, 72.2% of the other service providers (educators/animators, social workers, psychosocial counselors, head teachers, etc), and only 18.3% of the parents identified 3 or more STIs. It is noted that health workers were the most knowledgeable about STIs.

Table 47: Percentage of parents, health workers, and other service providers by number of identified STIs

		Parents	N %	Health Workers	N %	Other SP	N %
STIs identified	0	20	14.1%	0	.0%	0	.0%
	1	78	54.9%	2	5.7%	1	5.6%
	2	18	12.7%	2	5.7%	4	22.2%
	3 or more	26	18.3%	31	88.6%	13	72.2%
	Total	142	100.0%	35	100.0%	18	100.0%

The most identified STI was HIV & AIDS by 100% of the service providers and 82.3% of the parents. This was followed by:
- "syphilis", identified by 82.9% of health workers, 83.3% of other service providers, and only 15.5% of parents,
- and "gonorrhea", identified by 77.1% of health workers, 72.2% of other service providers, and only 14.8% of parents.

Table 48: Sexually Transmitted Infections identified

Infections a person can get through sexual intercourse	Yes					
	Parents	N %	Health Workers	N %	Other SP	N %
Don't know	17	12.0%	0	.0%	0	.0%
HIV & AIDS	116	82.3%	35	100.0%	18	100.0%
Gonorrhea	21	14.8%	27	77.1%	13	72.2%
Syphilis	22	15.5%	29	82.9%	15	83.3%
Chlamydia	1	.7%	12	34.3%	0	.0%
Pubic lice	0	.0%	4	11.4%	0	.0%
Thrush	0	.0%	0	.0%	2	11.1%
Genital warts	4	2.8%	7	20.0%	2	11.1%
Genital herpes	4	2.8%	9	25.7%	1	5.6%
Hepatitis B	18	12.7%	21	60.0%	9	50.0%
Hepatitis C	11	7.7%	16	45.7%	10	55.6%
Other	5	3.5%	3	8.6%	1	5.6%

Around 60.6% of parents couldn't identify any signs or symptoms that suggest that a person has an STI. On the other hand, 77.1% of health workers and 72.2% of other service providers could identify 3 or more STI symptoms.

Table 49: Percentage of parents, health workers, and other service providers by number of identified STI symptoms

		Parents	N %	Health Workers	N %	Other SP	N %
STI symptoms identified	0	86	60.6%	4	11.4%	0	.0%
	1	29	20.4%	0	.0%	2	11.1%
	2	12	8.5%	4	11.4%	3	16.7%
	3 or more	15	10.6%	27	77.1%	13	72.2%
	Total	142	100.0%	35	100.0%	18	100.0%

The most identified STI symptom by service providers was "Discharge from penis/vagina" (71.4% of health workers and 77.8% of other service providers). This was followed by "burning or itching in penis/vagina" by 65.7% of health workers and 61.1% of other service providers. Parents identified few symptoms, with "painful urination" being mentioned the most (16.2%).

Table 50: STI symptoms identified

STI symptoms	Yes					
	Parents	N %	Health Workers	N %	Other SP	N %
Don't know	53	37.3%	0	.0%	0	.0%
Discharge from penis/vagina	16	11.3%	25	71.4%	14	77.8%
Burning pain or itching in penis/vagina	22	15.5%	23	65.7%	11	61.1%
Abnormal vaginal bleeding	6	4.2%	15	42.9%	6	33.3%
Loss of weight	18	12.7%	15	42.9%	12	66.7%
Sores or warts on penis/vagina	10	7.0%	16	45.7%	5	27.8%
Abdominal pain	10	7.0%	13	37.1%	3	16.7%
Painful urination	23	16.2%	16	45.7%	10	55.6%
Swelling in groin region	1	.7%	5	14.3%	6	33.3%
Other	6	4.2%	4	11.4%	5	27.8%

HIV and AIDS

All service providers and around 90% of parents have heard of HIV and AIDS.
Out of those who heard of HIV and AIDS, 43.1% of parents, 78.8% of health workers, and 88.9% of other service providers could identify 3 or more modes of transmission of HIV.

Table 51: Percentage of parents, health workers, and other service providers, by number of identified modes of HIV transmission

		Parents	N %	Health Workers	N %	Other SP	N %
Modes of transmission of HIV	0	7	6.0%	0	.0%	0	.0%
	1	22	19.0%	0	.0%	0	.0%
	2	37	31.9%	7	21.2%	2	11.1%
	3 or more	50	43.1%	26	78.8%	16	88.9%
	Total	116	100.0%	33	100.0%	18	100.0%

The most identified modes of transmission of HIV were:

- "Sexual relations", by 88.8% of parents, 97% of health workers, and 100% of other service providers,
- "Blood transfusion", by 67.2% of parents, 90.9% of health workers, and 94.4% of other service providers.

The least identified mode of transmission was: "Mosquito or other insect bites", by 0.9% of parents, 3% of health workers, and 5.6% of other service providers.

"Other" modes of transmission mentioned by service providers included: "wounds" and "razor blades". Two service providers said that HIV could be transmitted through "bed covers" and "wearing dirty clothes". These misconceptions and others need to be corrected through training of service providers.

Also, 20.7% of parents, 42.4% of health workers, and 38.9% of other service providers though that "casual contact with an infected person" is a mode of transmission. These high percentages relate serious misconceptions that need to be corrected in future awareness raising activities, to reduce the stigma against HIV infected people.

Table 52: Modes of transmission of HIV

Modes of transmission of HIV	Yes					
	Parents	N %	Health Workers	N %	Other SP	N %
Don't know	3	2.6%	1	3.0%	0	.0%
Sexual relations	103	88.8%	32	97.0%	18	100.0%
Sharing syringes	45	38.8%	23	69.7%	15	83.3%
Unclean medical equipment	32	27.8%	20	60.6%	15	83.3%
Blood transfusion	78	67.2%	30	90.9%	17	94.4%
Mother to child	11	9.5%	20	60.6%	7	38.9%
Mosquito or other insect bites	1	.9%	1	3.0%	1	5.6%
Breast milk	1	.9%	11	33.3%	4	22.2%
Casual contact with infected person	24	20.7%	14	42.4%	7	38.9%
Other	6	5.2%	3	9.1%	3	16.7%

Also, 34.5% of parents, 87.9% of health workers, and 100% of other service providers who heard of HIV and AIDS could identify 3 or more ways to avoid getting HIV.

Table 53: Percentage of parents, health workers, and other service providers, by number of identified ways to avoid getting HIV

		Parents	N %	Health Workers	N %	Other SP	N %
Ways to avoid getting HIV	0	8	6.9%	2	6.1%	0	.0%
	1	32	27.6%	0	.0%	0	.0%
	2	36	31.0%	2	6.1%	0	.0%
	3 or more	40	34.5%	29	87.9%	18	100.0%
	Total	116	100.0%	33	100.0%	18	100.0%

The most identified ways to avoid getting HIV were:

- "Abstinence from sex", by 60.3% of parents, 81.8% of health workers, and 72.2% of other service providers,
- "Avoiding contaminated blood", by 50.9% of parents, 66.7% of health workers, and 94.4% of other service providers.

The least identified ways to avoid getting HIV was: "avoiding commercial sex workers".

Table 54: Ways to avoid getting HIV

Ways to avoid getting HIV	Yes					
	Parents	N %	Health Workers	N %	Other SP	N %
Don't know	4	3.4%	0	.0%	0	.0%
Avoid sex completely/abstinence	70	60.3%	27	81.8%	13	72.2%
Stay faithful to partner	24	20.7%	11	33.3%	6	33.3%
Encourage partner to stay faithful	3	2.6%	3	9.1%	3	16.7%
Avoid contaminated blood	59	50.9%	22	66.7%	17	94.4%
Use condoms for every act of sexual intercourse	9	7.8%	14	42.4%	6	33.3%
Avoid sharing syringes	32	27.6%	21	63.6%	17	94.4%
Avoid sharing razors and blades	31	26.7%	18	54.5%	15	83.3%
Avoid commercial sex workers	7	6.0%	2	6.1%	2	11.1%
Avoid casual sex	14	12.1%	7	21.2%	5	27.8%
Avoid casual contact with infected person	36	31.0%	10	30.3%	7	38.9%

Ways to avoid getting HIV	Yes					
	Parents	N %	Health Workers	N %	Other SP	N %
Don't know	4	3.4%	0	.0%	0	.0%
Avoid sex completely/abstinence	70	60.3%	27	81.8%	13	72.2%
Stay faithful to partner	24	20.7%	11	33.3%	6	33.3%
Encourage partner to stay faithful	3	2.6%	3	9.1%	3	16.7%
Avoid contaminated blood	59	50.9%	22	66.7%	17	94.4%
Use condoms for every act of sexual intercourse	9	7.8%	14	42.4%	6	33.3%
Avoid sharing syringes	32	27.6%	21	63.6%	17	94.4%
Avoid sharing razors and blades	31	26.7%	18	54.5%	15	83.3%
Avoid commercial sex workers	7	6.0%	2	6.1%	2	11.1%
Avoid casual sex	14	12.1%	7	21.2%	5	27.8%
Avoid casual contact with infected person	36	31.0%	10	30.3%	7	38.9%
Other	3	2.6%	0	.0%	3	16.7%

Also, 31% of parents, 30.3% of health workers, and 38.9% of other service providers though that "avoiding casual contact with an infected person" is a way to avoid getting infected with HIV. This misconception also needs to be corrected in future awareness raising activities, to reduce the stigma against HIV infected people.

Training needs

Around 79% of service providers have received training and health education sessions on HIV/AIDS. However, misconceptions still need to be addressed through a training of the service providers on STIs, HIV and AIDS.

F) SRH seeking behavior and services utilization

Children

Source of information on SRH

Children identified their "mother" as primary source of information or help in matters of sexual and reproductive health. In fact 76.7% of all children mentioned their "mother", followed by 22.5% who sought their "father" and "sister", and 20.8% who sought the "gynecologist or doctor". More girls sought their mother and sister, while more boys sought their father and doctor. "Teachers", "social workers", "counselors", and "midwives/nurses" were not mentioned by many children.

Table 55: Sources of SRH information and help

	Sex					
	Male		Female		Total	
	Yes		Yes		Yes	
	Count	N %	Count	N %	Count	N %
Don't know	5	12.8%	2	2.5%	7	5.8%
Seek no help or advice	0	.0%	1	1.2%	1	.8%
Teacher	5	12.8%	2	2.5%	7	5.8%
Mother	27	69.2%	65	80.2%	92	76.7%
Father	25	64.1%	2	2.5%	27	22.5%
Brother	4	10.3%	1	1.2%	5	4.2%
Sister	0	.0%	27	33.3%	27	22.5%
Friend	3	7.7%	14	17.3%	17	14.2%
Relative	3	7.7%	3	3.7%	6	5.0%
Gynecologist/doctor	11	28.2%	14	17.3%	25	20.8%
Nurse/midwife	0	.0%	0	.0%	0	.0%
Psychosocial counselor	0	.0%	7	8.6%	7	5.8%
Social worker	2	5.1%	2	2.5%	4	3.3%
Health center	5	12.8%	1	1.2%	6	5.0%
Youth center	0	.0%	0	.0%	0	.0%
Religious leader	0	.0%	0	.0%	0	.0%
Printed material (brochures)	0	.0%	0	.0%	0	.0%
Radio	0	.0%	0	.0%	0	.0%

TV	0	.0%	1	1.2%	1	.8%
Book	0	.0%	2	2.5%	2	1.7%
Internet	0	.0%	1	1.2%	1	.8%
Other	2	5.1%	2	2.5%	4	3.3%

Only one child stated not seeking help or advice, without giving a reason.

Asking questions about SRH topics

Around 49.6% of children had not asked their teacher about reproductive and sexual health topics. Boys (56.4%) were more likely than girls (46.1%) not to have asked their teacher about such topics. Children were also asked about the teacher's response when asked a question about SRH. About 37.4% said that the teacher answered their question (rather than scolding, refusing to answer, or referring).

Table 56: Questions to teacher about SRH topics

How did your teacher react when you asked him/her about reproductive and sexual health topics?	Sex					
	Male		Female		Total	
	Count	N %	Count	N %	Count	N %
I did not ask the teacher	22	56.4%	35	46.1%	57	49.6%
The teacher scolded me	0	.0%	5	6.6%	5	4.3%
The teacher refused to answer	2	5.1%	8	10.5%	10	8.7%
The teacher referred me to ask somebody else	0	.0%	0	.0%	0	.0%
The teacher answered my question	15	38.5%	28	36.8%	43	37.4%

In addition, 34.8% of children had not asked their parents about reproductive and sexual health topics. Boys (43.6%) were more likely than girls (30.3%) not to have asked their parents about such topics. Children were also asked about the parents' response when asked a question about SRH. About 60% said that the parents answered their question (rather than scolding, refusing to answer, or referring).

Table 57: Questions to parents about SRH topics

How did your parent/s react when you asked them about reproductive and sexual health topics?	Sex					
	Male		Female		Total	
	Count	N %	Count	N %	Count	N %
I did not ask my parents	17	43.6%	23	30.3%	40	34.8%
My parent/s scolded me	0	.0%	0	.0%	0	.0%
My parent/s refused to answer	2	5.1%	4	5.3%	6	5.2%
My parent/s referred me to ask somebody else	0	.0%	0	.0%	0	.0%
My parent/s answered my question	20	51.3%	49	64.5%	69	60.0%

Attitude towards sexual and reproductive health education

Around 22.7% of children believe that education on sexual and reproductive health should begin before the age of puberty. Girls (23.7%) were more likely than boys (20.6%) to state so.

Table 58: Attitude towards start of SRH education

In your opinion, when should education on reproductive and sexual health start?	Sex					
	Male		Female		Total	
	Count	N %	Count	N %	Count	N %
Don't know	2	5.9%	5	6.6%	7	6.4%
Before the age of puberty	7	20.6%	18	23.7%	25	22.7%
During the age of puberty	23	67.6%	36	47.4%	59	53.6%
When one is getting ready for marriage	2	5.9%	16	21.1%	18	16.4%
Other	0	.0%	1	1.3%	1	.9%

The majority of children (84.2%) support the discussion of SRH topics in classrooms and awareness sessions, with the main reason being: "improvement of youth awareness". Other children do not support the discussion of SRH topics because they do not believe there's a need for it, or think that youth might be embarrassed.

On the other hand, the large majority of parents (91.4%) believe that sexual and reproductive health rights should be included in the school program. Around 86% of

those who support the SRHR education in schools believe it should start before the age of 16, with the average age being 13.64.

Usage of SRH services by children

About 28.3% of children do not use the health centers' SRH services, with more girls (29.6%) stating so than boys (25.6%). The most mentioned services used were "education sessions" and "screening of STIs". However, these are used only by 9.2% and 8.3% of the children.

Other mentioned services include "general blood tests".

The most stated reason for not using the health center services was that children (61.8%) do not know what services are available. This high frequency demonstrates the need for making the health centers child-friendly by advertising to the children the services available to them.

Table 59: Usage of SRH services at health center

	Sex					
	Male		Female		Total	
	Yes		Yes		Yes	
	Count	N %	Count	N %	Count	N %
Don't use the health center	10	25.6%	24	29.6%	34	28.3%
Screening of STIs	2	5.1%	8	9.9%	10	8.3%
Medication for STIs	1	2.6%	2	2.5%	3	2.5%
Testing for HIV	0	.0%	1	1.2%	1	.8%
Counseling on HIV	0	.0%	0	.0%	0	.0%
Contraceptives	0	.0%	1	1.2%	1	.8%
Pregnancy testing	3	7.7%	3	3.7%	6	5.0%
Antenatal care	1	2.6%	5	6.2%	6	5.0%
Postnatal care	0	.0%	1	1.2%	1	.8%
Psychosocial counseling	2	5.1%	7	8.6%	9	7.5%
Referral to special care	5	12.8%	3	3.7%	8	6.7%
Education sessions	6	15.4%	5	6.2%	11	9.2%
Other	7	17.9%	24	29.6%	31	25.8%

Table 60: Reasons for not using SRH services at health center

	Yes	
	Count	N %
NA	8	23.5%
Don't know what services are available	21	61.8%
Too far	0	.0%
Center does not have medicine/service	0	.0%
Only for married couples	0	.0%
Too crowded	0	.0%
Long waiting hours	0	.0%
Unqualified staff	0	.0%
Staff unfriendly	2	5.9%
Not hygienic	0	.0%
Parents do not want me to go	1	2.9%
Worried about confidentiality and safety of information shared	0	.0%
Too expensive	0	.0%
Other reasons	2	5.9%

Parents and Service Providers

Source of information on SRH

Most parents (83.8%), health workers (62.9%) and other service providers (88.9%) believe that the "mother" is the primary source of information and help in matters of sexual and reproductive health. This was followed by "father", mentioned by 36.6% of parents, 51.4% of health workers, and 77.8% of other service providers.

"Friends" and "gynecologist" were also mentioned by parents and service providers. However, contrary to children's answers, 60% of health workers and 55.6% of other service providers believe that social workers are an important source of information on SRH.

Table 61: Sources of SRH information and help

	Yes					
	Parents	N %	Health workers	N %	Other SP	N %
Don't know	6	4.2%	0	.0%	0	.0%
Seek no help or advice	7	4.9%	2	5.7%	0	.0%
Teacher	9	6.3%	3	8.6%	6	33.3%
Mother	119	83.8%	22	62.9%	16	88.9%
Father	52	36.6%	18	51.4%	14	77.8%
Brother	14	9.9%	3	8.6%	0	.0%
Sister	17	12.0%	3	8.6%	2	11.1%
Friend	42	29.6%	11	31.4%	4	22.2%
Relative	10	7.0%	1	2.9%	1	5.6%
Gynecologist/doctor	10	7.0%	8	22.9%	4	22.2%
Nurse/midwife	1	.7%	7	20.0%	2	11.1%
Psychosocial counselor	10	7.0%	1	2.9%	0	.0%
Social worker	5	3.5%	21	60.0%	10	55.6%
Health center	1	.7%	3	8.6%	3	16.7%
Youth center	0	.0%	1	2.9%	0	.0%
Religious leader	0	.0%	1	2.9%	0	.0%
Printed material (brochures)	0	.0%	0	.0%	0	.0%
Radio	0	.0%	0	.0%	0	.0%
TV	1	.7%	2	5.7%	2	11.1%
Book	1	.7%	1	2.9%	3	16.7%
Internet	1	.7%	4	11.4%	5	27.8%
Other	3	2.1%	0	.0%	0	.0%

Perception about knowledge

Around 64.5% of parents consider themselves to be knowledgeable enough to provide advice on RH issues, with more female respondents (67.7%) stating so than male respondents (41.2%).

Table 62: Perception of parents' knowledge about RH

		Sex					
		Male		Female		Total	
		Count	N %	Count	N %	Count	N %
Do you consider yourself knowledgeable to provide advice on RH?	No	8	47.1%	35	28.2%	43	30.5%
	Yes	7	41.2%	84	67.7%	91	64.5%
	Don't know	2	11.8%	5	4.0%	7	5.0%

Additionally, 75% of service providers consider themselves to be knowledgeable enough to provide advice on RH issues, with more health workers (82.4%) stating so than other service providers (61.1%).

On the other hand, 66% of service providers were asked by between 1 and 10 children for SRH information in the month preceding the survey, and around 28.3% were approached by between 21 and 30 children.

Table 63: Number of children approaching service providers for SRH information in the past month

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1-10	35	66.0	66.0	66.0
	21-30	15	28.3	28.3	94.3
	31-50	3	5.7	5.7	100.0
	Total	53	100.0	100.0	

Training needs

Around 58.5% of service providers have received training in sexual and reproductive health. However, less health workers (57.1%) have received training in SRH than other service providers (61.1%).

G) Engagement, marriage, and childbirth

Children

All children interviewed were single (5 missing).

Ideal age of engagement

Around 79.6% of children thought that the ideal age for a girl to get engaged is above 18 years.

Table 64: Ideal age of girls' engagement

		Frequency	Percent	Valid Percent
Valid	<12	2	1.7	1.8
	16-18	18	15.0	15.9
	19-24	80	66.7	70.8
	25 or older	10	8.3	8.8
	Don't know	3	2.5	2.7
	Total	113	94.2	100.0
Missing	System	7	5.8	
Total		120	100.0	

When compared to the children answers about the ideal age for a boy to get engaged, more children thought it to be above 18 for boys (91.2%). Also, none thought that a boy under 12 years of age should get engaged, while this answer has been given by 1.8% of children regarding girls' engagement age. This shows that gender issues need to be tackled as they relate to engagement age.

Table 65: Ideal age of boys' engagement

		Frequency	Percent	Valid Percent
Valid	16-18	4	3.3	3.5
	19-24	60	50.0	52.6
	25 or older	44	36.7	38.6
	Don't know	6	5.0	5.3
	Total	114	95.0	100.0
Missing	System	6	5.0	
Total		120	100.0	

Idea age of marriage

Around 91.8% of children thought that the ideal age for a girl to get married is above 18 years. It is clear that there is an increase when compared to the ideal age of girls' engagement.

Table 66: Ideal age for girls' marriage

		Frequency	Percent	Valid Percent
Valid	<12	1	.8	.9
	16-18	3	2.5	2.7
	19-24	79	65.8	71.8
	25 or older	22	18.3	20.0
	Don't know	5	4.2	4.5
	Total	110	91.7	100.0
Missing	System	10	8.3	
Total		120	100.0	

When comparing girls' and boys' responses, it is noticed that girls' ideal ages for engagement and marriage were much lower in trends than boys. In fact, 21.1% of boys thought that the ideal age engagement age for girls was above 25, whereas only 2.7% of the girls stated so. Also, 30.6% of boys thought that the ideal age for girls' marriage was above 25 years, which represents twice as much as girls stating so (14.9%).

Regarding the ideal age for a boy to get married, the percentages are similar to the ideal age of girls' marriage. In fact, 91.2% of children thought that the ideal boys' marriage age was above 18 years. However, more children (54.4%) thought that boys should get married at a later age (25 or older) than girls (20%).

Table 67: Ideal age for boys' marriage

		Frequency	Percent	Valid Percent
Valid	<12	1	.8	.9
	16-18	2	1.7	1.8
	19-24	42	35.0	36.8
	25 or older	62	51.7	54.4
	Don't know	7	5.8	6.1
	Total	114	95.0	100.0
Missing	System	6	5.0	
Total		120	100.0	

Girls and boys responses were not very different regarding ideal age of boys' marriage.

Engagement, marriage, and education

About 84.2% of children believe that children under 18 who are engaged should continue their education, with considerably more girls (90.8%) in favor of continuation of education than boys (71.1%).

Table 68: Attitude on continuing education of engaged children under 18

		Sex					
		Male		Female		Total	
		Count	N %	Count	N %	Count	N %
Should children under 18 who are engaged continue their education?	No	7	18.4%	3	3.9%	10	8.8%
	Yes	27	71.1%	69	90.8%	96	84.2%
	Don't know	4	10.5%	4	5.3%	8	7.0%

These numbers decrease with regard to continuation of education of married children under 18, where 77.9% of children are in favor of continuation, with considerably more girls (86.5%) than boys (61.5%) being in favor.

Table 69: Attitude on continuing education of married children under 18

		Sex					
		Male		Female		Total	
		Count	N %	Count	N %	Count	N %
Should children under 18 who are married continue their education?	No	8	20.5%	4	5.4%	12	10.6%
	Yes	24	61.5%	64	86.5%	88	77.9%
	Don't know	7	17.9%	6	8.1%	13	11.5%

Ideal age first child-bearing

Around 74.6% of children thought that the ideal age for having a first child is above 18 years, with the majority of those stating the ideal age to be between 19 and 24 years. More boys (31.6%) than girls (25%) thought that the ideal age is above 25 years.

Table 70: Ideal age first child bearing

		Frequency	Percent	Valid Percent
Valid	12-15	2	1.7	1.8
	19-24	54	45.0	47.4
	25 or older	31	25.8	27.2
	Don't know	27	22.5	23.7
	Total	114	95.0	100.0
Missing	System	6	5.0	
Total		120	100.0	

About 60% of children think that pregnancy and child birth should be avoided during adolescence, while 16% didn't think it should be, and 24% didn't know.

Out of the 43%, only 14.9% identified 3 or more complications of delivery during adolescence; while most (44.8%) did not identify any complications, although they thought that pregnancy and child birth should be avoided during pregnancy.

Table 71: Percentage of children by number of identified pregnancy complications

		Frequency	Percent
Valid	0	30	44.8
	1	14	20.9
	2	13	19.4
	3 or more	10	14.9
	Total	67	100.0

In fact, 17.9% of those who said that pregnancy should be avoided during adolescence did not know what the complications were, and 25.3% thought that it had no negative effects.

The most identified complications were:

- "Overweight newborns", by 31.3%,

- "Maternal death", by 22.4%.

Table 72: Complications of pregnancy/child birth during adolescence

	Yes	
	Count	% out of those who think it should be avoided
Don't know	12	17.91
No negative effects	17	25.37
Maternal death	15	22.39
Premature birth	1	1.49
Overweight newborns	21	31.34
Spontaneous abortion	11	16.42
Stillbirth	7	10.45
Low birth weight	3	4.48
Bleeding	4	5.97
High level of childhood illness	12	17.91
Mental and physical disabilities in children	5	7.46
Other	14	20.90

These findings show that even among the children who believe pregnancy should be avoided during adolescence, not many know the reasons why, suggesting that a concentrated awareness effort is needed in this area.

Parents

Ideal age of engagement

Around 76.6% of parents thought that the ideal age for a girl to get engaged is above 18 years.

Table 73: Ideal ages of girls' and boys' engagement

		Ideal age of girls' engagement			Ideal age of boys' engagement		
		Frequency	Percent	Valid Percent	Frequency	Percent	Valid Percent
Valid	16-18	32	22.5	22.7	2	1.4	1.4
	19-24	100	70.4	70.9	34	23.9	24.3
	25 or older	8	5.6	5.7	103	72.5	73.6
	Don't know	1	.7	.7	1	.7	.7
	Total	141	99.3	100.0	140	98.6	100.0
Missing	System	1	.7		2	1.4	
Total		142	100.0		142	100.0	

When compared to the parents answers about the ideal age for a boy to get engaged, more parents thought it to be above 18 for boys (97.9%). Also, very few parents (1.4%) thought that a boy should get engaged between 16 and 18 years of age, while this answer has been given by 22.7% of parents regarding girls' engagement age. This shows that gender issues need to be tackled as they relate to engagement age.

When comparing the trends between male respondents and female respondents, it is noticed that female respondents tended to give a "higher" ideal age for girls engagement than male respondents. In fact, 78.1% of female respondents thought the ideal girls' engagement age is above 18, as opposed to 70.6% of male respondents.

However, when comparing ideal age of boys' engagement by gender of respondent, all (100%) male respondents thought that it's above 18 years, as opposed to 97.6% of female respondents. However, more female respondents (74.6%) believed the ideal engagement age for boys to be above 25 years than male respondents (70.6%).

Idea age of marriage

Around 91.4% of parents thought that the ideal age for a girl to get married is above 18 years. It is clear that there is an increase when compared to the ideal age of girls' engagement.

Table 74: Ideal ages of girls' and boys' marriage

		Ideal age of girls' marriage			Ideal age of boys' marriage		
		Frequency	Percent	Valid Percent	Frequency	Percent	Valid Percent
Valid	16-18	12	8.5	8.6	2	1.4	1.4
	19-24	118	83.1	84.3	20	14.1	14.3
	25 or older	10	7.0	7.1	118	83.1	84.3
	Total	140	98.6	100.0	140	98.6	100.0
Missing	System	2	1.4		2	1.4	
Total		142	100.0		142	100.0	

When compared to the parents' answers about the ideal age for a boy to get married, the percentages are a little higher for boys. In fact, 98.6% of parents thought that the ideal boys' marriage age was above 18 years. However, there's a remarkable difference noticed when comparing parents who thought that boys should get married at 25 years or older (84.3%), to parents who thought that girls should get married at 25 years or older (7.1%). It seemed by these findings that the ideal age for marriage of girls is between 19 and 24, and 25 years or above for boys, as stated by the majority of parents.

When comparing the trends between male respondents and female respondents, it is noticed that female respondents tended to give a "higher" ideal age for girls marriage than male respondents. In fact, 93.4% of female respondents thought the ideal girls' marriage age is above 18, as opposed to 76.5% of male respondents.

Also, when comparing ideal age of boys' marriage by gender of respondent, all (100%) male respondents through that it's above 18 years, as opposed to 98.3% of female respondents. However, more female respondents (85.2%) tended to mention 25 years or older as ideal age for boys marriage than male respondents (76.5%).

Engagement, marriage, and education

About 92.8% of parents believe that children under 18 who are engaged should continue their education, with more female respondents (93.4%) in favor of continuation of education than male respondents (88.2%).

Table 75: Attitude on continuing education of engaged children under 18

		Sex					
		Male		Female		Total	
		Count	N %	Count	N %	Count	N %
Should children under 18 who are engaged continue their education?	No	2	11.8%	7	5.7%	9	6.5%
	Yes	15	88.2%	114	93.4%	129	92.8%
	Don't know	0	.0%	1	.8%	1	.7%

These numbers decrease with regard to continuation of education of married children under 18, where 83.5% of parents are in favor of continuation, with more female respondents (86.3%) than male respondents (62.5%) being in favor.

Table 76: Attitude on continuing education of married children under 18

		Sex					
		Male		Female		Total	
		Count	N %	Count	N %	Count	N %
Should children under 18 who are married continue their education?	No	6	37.5%	12	10.3%	18	13.5%
	Yes	10	62.5%	101	86.3%	111	83.5%
	Don't know	0	.0%	4	3.4%	4	3.0%

Pregnancy/child birth complications

Around 75.5% of parents think that pregnancy and child birth should be avoided during adolescence, while 20.1% didn't think it should be, and 4.3% didn't know.

Out of the 75.5%, only 21.9% identified 3 or more complications of delivery during adolescence; while 35.2% could not identify any complications, although they thought that pregnancy and child birth should be avoided during pregnancy.

Table 77: Percentage of parents by number of identified pregnancy complications

		Frequency	Percent
Valid	0	37	35.2
	1	26	24.8
	2	19	18.1
	3 or more	23	21.9
	Total	105	100.0

In fact, 13.3% of those who said that pregnancy should be avoided during adolescence did not know what the complications were, and 2.8% thought that it had no negative effects.

The most identified complications were:

- "Spontaneous abortion", by 37.1%,

- "Premature birth", by 23.8%.

Other mentioned complications included physical problems, and the incapacity of an adolescent to care for a child.

Table 78: Complications of pregnancy/child birth during adolescence

	Count	% out of those who think it should be avoided
Don't know	14	13.33
No negative effects	3	2.86
Maternal death	17	16.19
Premature birth	25	23.81
Overweight newborns	3	2.86
Spontaneous abortion	39	37.14
Stillbirth	9	8.57
Low birth weight	19	18.10
Bleeding	21	20.00
High level of childhood illness	9	8.57
Mental and physical disabilities in children	17	16.19
Other	6	5.71

Service providers

Ideal age of engagement

All service providers (100%) thought that the ideal age for both girls and boys to get engaged is above 18 years. It is noticed that ideal engagement ages however are lower for girls than boys; around 80.8% thought the ideal age for girls to be between 19 and 24, while 90.4% thought the ideal age for boys to be 25 years or older.

Table 79: Ideal ages of girls' and boys' engagement

	Ideal age of girls' engagement (1 missing)		Ideal age of boys' engagement (1 missing)	
	Count	N %	Count	N %
<12	0	.0%	0	.0%
12-15	0	.0%	0	.0%
16-18	0	.0%	0	.0%
19-24	42	80.8%	5	9.6%
25 or older	10	19.2%	47	90.4%
Don't know	0	.0%	0	.0%
Total	52	100.0%	52	100.0%

Idea age of marriage

All service providers (100%) thought that the ideal age for both girls and boys to get married is above 18 years. It is noticed that ideal marriage ages however are lower for girls than boys; around 78.8% thought the ideal age for girls to be between 19 and 24, while 94.2% thought the ideal age for boys to be 25 years or older. These trends are similar to those for ideal age of engagement.

Table 80: Ideal ages of girls' and boys' marriage

	Ideal age of girls' marriage (1 missing)		Ideal age of boys' marriage (1 missing)	
	Count	N %	Count	N %
<12	0	.0%	0	.0%
12-15	0	.0%	0	.0%
16-18	0	.0%	0	.0%
19-24	41	78.8%	3	5.8%
25 or older	11	21.2%	49	94.2%
Don't know	0	.0%	0	.0%
Total	52	100.0%	52	100.0%

Engagement, marriage, and education

About 98.1% of service providers believe that children under 18 who are engaged should continue their education.

Table 81: Attitude on continuing education of engaged children under 18

		Count	N %
Should children under 18 who are engaged continue their education?	No	1	1.9%
	Yes	51	98.1%
	Don't know	0	.0%

These numbers are exactly similar with regard to continuation of education of married children under 18, where 98.1% of service providers are in favor of continuation.

Table 82: Attitude on continuing education of married children under 18

		Count	N %
Should children under 18 who are married continue their education?	No	1	1.9%
	Yes	51	98.1%
	Don't know	0	.0%

Pregnancy/child birth complications

Around 96.2% of service providers think that pregnancy and child birth should be avoided during adolescence.

Out of these, 60.4% identified 3 or more complications of delivery during adolescence; while 13.2% did not identify any of the listed complications.

Table 83: Percentage of service providers by number of identified pregnancy complications

		Frequency	Percent
Valid	0	7	13.2
	1	6	11.3
	2	8	15.1
	3 or more	32	60.4
	Total	53	100.0

The most identified complications were:

- "Premature birth", by 64%,

- "Spontaneous abortion", by 62%.

Other mentioned complications included a variety of physical and psychological problems, and the incapacity of an adolescent to care for a child.

Table 84: Complications of pregnancy/child birth during adolescence

	Count	% out of those who think it should be avoided
Don't know	0	0.00
No negative effects	0	0.00
Maternal death	28	56.00
Premature birth	32	64.00
Overweight newborns	6	12.00
Spontaneous abortion	31	62.00
Stillbirth	19	38.00
Low birth weight	21	42.00
Bleeding	14	28.00
High level of childhood illness	5	10.00
Mental and physical disabilities in children	12	24.00
Other	12	24.00

H) Violence

There were only two reported cases of abuse in oPt. One was in Arrub refugee camp, where a female parent respondent (mother) visited one of the data collectors at the UNRWA clinic and reported that the father physically and violently abused the children and her. She was given the number of the protection network coordinators in areas near her.

The other case was in Ayda and Azzah refugee camps, where a female child respondent who was sexually abused was referred by the data collector to the UNRWA clinic psychosocial counselor, and was given the number of the protection network coordinator in the area.

Furthermore, data collectors took note of abuse in some of the households in all impact areas. However, due to societal constraints no reports were made.

Children

Attitude towards violence

Children were asked some questions regarding their attitude towards violence.

Regarding violence at home, children were asked whether "it is appropriate for a husband to hit his wife or for a brother to hit his sister". Around 95.6% of children disagreed with the statement, with more girls (97.3%) disagreeing than boys (92.3%).

Table 85: Attitude towards violence at home by gender

		Sex					
		Male		Female		Total	
		Count	N %	Count	N %	Count	N %
"It is appropriate for a husband to hit his wife or for a brother to hit his sister"	Disagree	36	92.3%	73	97.3%	109	95.6%
	Agree	3	7.7%	2	2.7%	5	4.4%
	Don't know	0	.0%	0	.0%	0	.0%

There were no differences among age groups regarding the attitude of children towards violence at home.

Table 86: Attitude towards violence at home by age group

		Categorical age							
		10-12		13-15		16-18		Total	
		Count	N %	Count	N %	Count	N %	Count	N %
"It is appropriate for a husband to hit his wife or for a brother to hit his sister"	Disagree	20	95.2%	52	96.3%	27	96.4%	99	96.1%
	Agree	1	4.8%	2	3.7%	1	3.6%	4	3.9%
	Don't know	0	.0%	0	.0%	0	.0%	0	.0%

On the other hand, 94.3% of children agree with the statement: "I have the right to live without any kind of violence", with slightly more boys (97.2%) agreeing than girls (92.9%).

Table 87: Attitude towards the right to live without violence, by gender

		Sex					
		Male		Female		Total	
		Count	N %	Count	N %	Count	N %
"I have the right to live without any kind of violence"	Disagree	1	2.8%	3	4.3%	4	3.8%
	Agree	35	97.2%	65	92.9%	100	94.3%
	Don't know	0	.0%	2	2.9%	2	1.9%

There's no pattern when comparing the attitude of children towards "the right to live without violence" among age groups. It is only noticed that the age group 13-15 has the least percentage of children agreeing with the statement.

Table 88: Attitude towards the right to live without violence, by age group

		Categorical age							
		10-12		13-15		16-18		Total	
		Count	N %	Count	N %	Count	N %	Count	N %
"I have the right to live without any kind of violence"	Disagree	0	.0%	3	6.5%	1	3.4%	4	4.2%
	Agree	21	100.0%	41	89.1%	28	96.6%	90	93.8%
	Don't know	0	.0%	2	4.3%	0	.0%	2	2.1%

Furthermore, 92.1% of children agree with the statement: "I have the responsibility to make sure I don't hurt others", with slightly more boys (94.9%) agreeing than girls (90.7%).

Table 89: Attitude towards the responsibility not to hurt others, by gender

		Sex					
		Male		Female		Total	
		Count	N %	Count	N %	Count	N %
"I have the responsibility to make sure I don't hurt others"	Disagree	2	5.1%	5	6.7%	7	6.1%
	Agree	37	94.9%	68	90.7%	105	92.1%
	Don't know	0	.0%	2	2.7%	2	1.8%

There's no pattern when comparing the attitude of children towards "the responsibility not to hurt others" among age groups. It is only noticed that the age group 13-15 has the least percentage of children agreeing with the statement.

Table 90: Attitude towards the responsibility not to hurt others, by age group

		Categorical age							
		10-12		13-15		16-18		Total	
		Count	N %	Count	N %	Count	N %	Count	N %
"I have the responsibility to make sure I don't hurt others"	Disagree	1	4.8%	5	9.3%	1	3.4%	7	6.7%
	Agree	20	95.2%	47	87.0%	28	96.6%	95	91.3%
	Don't know	0	.0%	2	3.7%	0	.0%	2	1.9%

Knowledge about violence and sexual abuse

The majority of children (76.1%) said that there is violence against children aged 10-17 in their community. This shows that children are aware of violence in their community, and is indicative that violence is witnessed by the children themselves.

The large majority of children (91.7%) have identified 3 or more forms of physical abuse, with slightly more boys (94.9%) than girls (90.1%).

Table 91: Number of identified forms of physical abuse, by gender

		Sex					
		Male		Female		Total	
		Count	N %	Count	N %	Count	N %
Physical abuse forms	0	1	2.6%	5	6.2%	6	5.0%
	1	1	2.6%	0	.0%	1	.8%
	2	0	.0%	3	3.7%	3	2.5%
	3 or more	37	94.9%	73	90.1%	110	91.7%

Interestingly too, the children aged between 16 and 18 were the least to identify 3 or more forms of physical abuse. Only 79.4% of them identified 3 or more forms, as opposed to 96.3% of those aged 13-15, and 95.2% of those aged 10-12.

Table 92: Number of identified forms of physical abuse, by age group

		Categorical age							
		10-12		13-15		16-18		Total	
		Count	N %	Count	N %	Count	N %	Count	N %
Physical abuse forms	0	0	.0%	0	.0%	6	17.6%	6	5.5%
	1	1	4.8%	0	.0%	0	.0%	1	.9%
	2	0	.0%	2	3.7%	1	2.9%	3	2.8%
	3 or more	20	95.2%	52	96.3%	27	79.4%	99	90.8%

The most identified forms of physical abuse were:

- "Hitting with a hand", by 87.5%,
- "Pulling child's hair", by 96.5%.

The least identified forms were:

- "Forcing a child to stay in an uncomfortable position", by 60.8%,
- "Shaking", by 67.5%.

Table 93: Forms of physical abuse

Does physical abuse include:	No		Yes		Don't know		Total	
	Count	%	Count	%	Count	%	Count	%
Hitting with a hand	8	6.67	105	87.50	2	1.67	115	95.83
Hitting with an object	15	12.50	99	82.50	1	0.83	115	95.83
Shaking	30	25.00	81	67.50	4	3.33	115	95.83
Pulling child's hair	10	8.33	103	85.83	1	0.83	114	95.83
Burning with a match, cigarette, or hot water	11	9.17	102	85.00	2	1.67	115	95.83
Forcing a child to stay in uncomfortable position	38	31.67	73	60.83	4	3.33	115	95.83
Forcing a child to take excessive physical exercise	20	16.67	91	75.83	4	3.33	115	95.83

Similarly, the majority of children (91.7%) have identified 3 or more forms of emotional and psychological abuse, with no differences between girls and boys. Interestingly too, the children aged between 16 and 18 were the least to identify 3 or more forms of emotional abuse. Only 82.4% of them identified 3 or more forms, as opposed to 96.3% of those aged 13-15, and 90.5% of those aged 10-12.

Table 94: Number of identified forms of emotional abuse, by age group

		Categorical age							
		10-12		13-15		16-18		Total	
		Count	N %	Count	N %	Count	N %	Count	N %
Emotional or psychological abuse forms	0	1	4.8%	0	.0%	6	17.6%	7	6.4%
	1	0	.0%	0	.0%	0	.0%	0	.0%
	2	1	4.8%	2	3.7%	0	.0%	3	2.8%
	3 or more	19	90.5%	52	96.3%	28	82.4%	99	90.8%

The most identified forms were:

- "Parents abandoning their child", by 90% of children,
- "Bad name calling", by 90% of children.

Table 95: Forms of emotional and psychological abuse

Does emotional or psychological abuse include	No		Yes		Don't know		Total	
	Count	%	Count	%	Count	%	Count	%
Bad name calling	6	5.00	108	90.00	1	0.83	115	95.83
Shouting	11	9.17	103	85.83	1	0.83	115	95.83
Saying to the child that no one loves him or her	8	6.67	106	88.33	1	0.83	115	95.83
Locking a child in a space by themselves	11	9.17	103	85.83	1	0.83	115	95.83
Threatening	13	10.83	101	84.17	1	0.83	115	95.83
Parents abandoning their child	6	5.00	108	90.00	1	0.83	115	95.83
Neglecting the child's emotional needs	13	10.83	99	82.50	3	2.50	115	95.83

Finally, 83.3% of children have identified 3 or more forms of sexual abuse. This shows that the children's are less knowledgeable about sexual abuse than physical or emotional abuse, which might be explained by the "taboo" nature of the subject. Therefore, awareness raising interventions should focus more on sexual abuse than the two other subjects.

No differences were observed between girls and boys. However, it was also noticed that the children aged between 16 and 18 were the least to identify 3 or more forms of sexual abuse. Only 79.4% of them identified 3 or more forms, as opposed to 85.2% of those aged 13-15, and 85.7% of those aged 10-12. This pattern was observed regarding knowledge about the three types of abuse (physical, emotional, sexual). When comparing school enrollment of children in the age group 16-18, it is similar to those in the other age groups, and therefore this decrease in knowledge cannot be explained by the status of those children regarding school enrollment. However, it could be explained by the type of school attended, since the majority of children aged 16-18 attended public (45.5%) and semi-private (36.4%) schools, while the majority of other age groups attended UNRWA schools (79.2% of those aged 13-15, and 85.7% of those aged 10-12).

Table 96: Number of identified forms of sexual abuse, by age group

		Categorical age							
		10-12		13-15		16-18		Total	
		Count	N %	Count	N %	Count	N %	Count	N %
Sexual abuse forms	0	0	.0%	6	11.1%	6	17.6%	12	11.0%
	1	1	4.8%	2	3.7%	0	.0%	3	2.8%
	2	2	9.5%	0	.0%	1	2.9%	3	2.8%
	3 or more	18	85.7%	46	85.2%	27	79.4%	91	83.5%

The most identified forms of sexual abuse were:

- "Having sex with a child", by 85.8%,
- "Making a child touch his or her private parts or someone else's private parts", and "touching a child's private parts", by 81.7%.

Table 97: Forms of sexual abuse

Does sexual abuse include	No		Yes		Don't know		Total	
	Count	%	Count	%	Count	%	Count	%
Touching a child's private parts.	8	6.67	98	81.67	7	5.83	113	94.17
Making a child touch his or her private parts or someone else's private parts	11	9.17	98	81.67	6	5.00	115	95.83
Having sex with a child	7	5.83	103	85.83	5	4.17	115	95.83
Showing a child magazines or films which show pictures of people with little or no clothes on	14	11.67	95	79.17	6	5.00	115	95.83
Telling a child 'dirty' stories or 'dirty' jokes	13	10.83	92	76.67	6	5.00	111	92.50

Around 28% of children didn't know who the perpetrators of sexual abuse might be. Most children thought that the perpetrators are males. "Male strangers" was the most identified perpetrator, mentioned by 30% of children. Around 14.2% of children mentioned "friends" as the perpetrators, as opposed to only 9.2% who mentioned "boyfriends". This should be taken into consideration when selecting peer educators, especially in interventions related to SRH.

"Other" mentioned perpetrators were: "strangers" (without mentioning the sex), and "guys". Only one child said that the perpetrator can be a female.

On the other hand, only 10% of children have identified 3 or more protection strategies from violence. Also interestingly, more girls (28.4%) identified 2 or more protection strategies than boys (20.5%).

The most identified protection strategies were:

-"Telling a grown-up they trust", by 39.2%,

- "Running or getting away", by 29.2%.

Children mentioned "other" (15%) protection strategies, with the main one being: "hitting the perpetrator", followed by "telling the police".

Table 98: Perpetrators of sexual abuse

	Sex					
	Male		Female		Total	
	Yes		Yes		Yes	
	Count	%	Count	%	Count	%
Don't know	15	38.46	19	23.46	34	28.33
Male stranger	3	7.69	33	40.74	36	30.00
Friend	9	23.08	8	9.88	17	14.17
Boyfriend	4	10.26	7	8.64	11	9.17
Uncle	1	2.56	4	4.94	5	4.17
Brother	5	12.82	9	11.11	14	11.67
Neighbor	0	0.00	8	9.88	8	6.67
Father	3	7.69	8	9.88	11	9.17
Other	5	12.82	9	11.11	14	11.67

Table 99: Number of protection strategies identified, by gender

		Sex					
		Male		Female		Total	
		Count	N %	Count	N %	Count	N %
Protection strategies identified	0	8	20.5%	29	35.8%	37	30.8%
	1	23	59.0%	29	35.8%	52	43.3%
	2	3	7.7%	16	19.8%	19	15.8%
	3 or more	5	12.8%	7	8.6%	12	10.0%

Table 100: Violence: Protection strategies

	Yes	
	Count	%
Don't know	10	8.33
Say "No"	17	14.17
Tell a grown-up you trust	47	39.17
Run or get away	35	29.17
Yell	22	18.33
Do not take gifts in exchange of doing something you are not comfortable with	1	0.83
Learn more about violence against children through the internet, books, etc	1	0.83
Call a child helpline	3	2.50
Keep emergency numbers	3	2.50
Other	18	15.00

Knowledge about dating violence

Around 47.7% of children have heard of the term "dating violence", with more girls (54.3%) than boys (35.9%).

Table 101: Children who heard of the term "dating violence", by gender

		Sex					
		Male		Female		Total	
		Count	N %	Count	N %	Count	N %
Have you ever heard of the term "Dating Violence"?	No	25	64.1%	32	45.7%	57	52.3%
	Yes	14	35.9%	38	54.3%	52	47.7%
	Don't know	0	.0%	0	.0%	0	.0%

Also, more children in older age groups have heard of the term "dating violence" than those in the younger age groups. In fact, 48.3% of those aged 16-18 and 52% of the age group 13-15 have heard of it, as opposed to only 35% of those aged 10-12.

Table 102: Children who heard of the term "dating violence", by age group

		Categorical age							
		10-12		13-15		16-18		Total	
		Count	N %	Count	N %	Count	N %	Count	N %
Have you ever heard of the term "Dating Violence"?	No	13	65.0%	24	48.0%	15	51.7%	52	52.5%
	Yes	7	35.0%	26	52.0%	14	48.3%	47	47.5%
	Don't know	0	.0%	0	.0%	0	.0%	0	.0%

Children were the asked whether the different forms of dating violence were acceptable. They were asked whether it's acceptable that their partner:
- Yells at them,
- Forces or manipulates them in order to take money from them,
- Hits them,
- Asks them for sexual acts against their will,
- Threatens them,
- Destroys their belongings.

Around 70% of the children believed that all mentioned forms of dating violence are not acceptable. The results are shown in the table 103 below.

Table 103: Children acceptance of the different forms of dating violence

Is it acceptable that your partner	No		Yes		Don't know		Total	
	Count	N %	Count	N %	Count	N %	Count	N %
Yells at you?	92	82.9%	18	16.2%	1	.9%	111	100.0%
Forces you/manipulates you in order to take money from you?	99	87.6%	13	11.5%	1	.9%	113	100.0%
Hits you?	98	86.7%	14	12.4%	1	.9%	113	100.0%
Asks you for sexual acts against your will?	101	89.4%	11	9.7%	1	.9%	113	100.0%
Threatens you?	94	83.2%	18	15.9%	1	.9%	113	100.0%
Destroys your belongings?	96	85.0%	16	14.2%	1	.9%	113	100.0%

Children were also asked what they would do in case they were victims of any form of dating violence. Around 44.2% said that they would "break up with their partner"; while

41.7% would report it to someone they trust. Very few would report to the police (11.7%), or to an NGO (0.8%). This suggests that children need to be educated on protective mechanisms to be able to respond adequately to dating violence. Their knowledge of available support NGOs and services also needs to be raised.

Table 104: Dating violence: Protective strategies

	Sex					
	Male		Female		Total	
	Yes		Yes		Yes	
	Count	N %	Count	N %	Count	N %
Don't know	3	7.7%	3	3.7%	6	5.0%
Inform someone they trust	14	35.9%	36	44.4%	50	41.7%
Break up with their partner	16	41.0%	37	45.7%	53	44.2%
Report to the police	8	20.5%	6	7.4%	14	11.7%
Report to a specialized NGO	1	2.6%	0	.0%	1	.8%
Do nothing	0	.0%	1	1.2%	1	.8%
Other	6	15.4%	11	13.6%	17	14.2%

It is noted that more girls (45.7%) would break up with their partners than boys (41%), and more girls (44.4%) would inform someone they trust than boys (35.9%). However, more boys would report to the police than girls.

"Other" mentioned strategies included defending their selves physically by "hitting their partner", "telling the partner's parents".

Parents

Knowledge about violence and sexual abuse

The majority of parents (86.2%) said that there is violence against children aged 10-17 in their community. This shows that parents are aware of violence in their community.

Nearly all parents (95%) have identified 3 or more forms of physical abuse, with more male respondents (100%) than female respondents (94.4%).

Table 105: Number of identified forms of physical abuse, by gender

		Sex					
		Male		Female		Total	
		Count	N %	Count	N %	Count	N %
Physical abuse forms identified	0	0	.0%	5	4.0%	5	3.5%
	1	0	.0%	0	.0%	0	.0%
	2	0	.0%	2	1.6%	2	1.4%
	3 or more	17	100.0%	117	94.4%	134	95.0%

The most identified forms of physical abuse were:

- "Pulling a child's hair" and "Hitting with an object", by 88.7%,
- "Burning with a match, cigarette, or hot water", by 87.3%.

The least identified forms were: "forcing a child to stay in an uncomfortable position" by 72.5%, and "shaking" by 76%.

Table 106: Forms of physical abuse

	No		Yes		Don't know		Total	
	Count	%	Count	%	Count	%	Count	%
Hitting with a hand	28	19.72	110	77.46	1	0.70	139	97.89
Hitting with an object	13	9.15	126	88.73	0	0.00	139	97.89
Shaking	31	21.83	108	76.06	0	0.00	139	97.89
Pulling child's hair	13	9.15	126	88.73	0	0.00	139	97.89
Burning with a match, cigarette, or hot water	15	10.56	124	87.32	0	0.00	139	97.89
Forcing a child to stay in uncomfortable position,	34	23.94	103	72.54	1	0.70	138	97.18
Forcing a child to take excessive physical exercise	19	13.38	117	82.39	0	0.00	136	95.77

Similarly, 94.3% of parents have identified 3 or more forms of emotional and psychological abuse, with more male (100%) than female (93.5%) respondents.

The most identified forms were:

- "Neglecting the child's emotional needs", by 92.2%,
- "Bad name calling" and "Saying to the child that no one loves him or her", by 91.5%.

Table 107: Forms of emotional and psychological abuse

Does emotional or psychological abuse include	No		Yes		Don't know		Total	
	Count	%	Count	%	Count	%	Count	%
Bad name calling	6	4.23	130	91.55	2	1.41	138	97.18
Shouting	18	12.68	120	84.51	1	0.70	139	97.89
Saying to the child that no one loves him or her	9	6.34	130	91.55	0	0.00	139	97.89
Locking a child in a space by themselves	13	9.15	123	86.62	2	1.41	138	97.18
Threatening	30	21.13	107	75.35	2	1.41	139	97.89
Parents abandoning their child	12	8.45	126	88.73	0	0.00	138	97.18
Neglecting the child's emotional needs	8	5.63	131	92.25	0	0.00	139	97.89

Finally, 85.1% of parents have identified 3 or more forms of sexual abuse, with more male (94.1%) than female (83.8%) respondents. This decrease in knowledge as compared to physical and emotional forms of abuse might be explained by the "taboo" nature of the subject. It is suggested to concentrate awareness raising efforts on forms of sexual abuse, and create interventions to tackle the lack of communication around this issue.

The most identified forms of sexual abuse were:

- "Telling a child 'dirty' stories or 'dirty' jokes", by 86.6%,
- "Showing a child magazines or films which show pictures of people with little or no clothes on", by 85.2%.

Most parents thought that the perpetrators of sexual abuse are males. "Father" was the most identified perpetrator, mentioned by 34.5% of parents. This was followed by "male stranger" mentioned by 32.4% of parents. Brothers and uncles were also mentioned by a lot of parents, suggesting that parents mostly think that the perpetrators of sexual abuse are family members.

"Other" mentioned perpetrators were: "relatives".

Table 108: Forms of sexual abuse

Does sexual abuse include	No		Yes		Don't know		Total	
	Count	%	Count	%	Count	%	Count	%
Touching a child's private parts.	17	11.97	114	80.28	7	4.93	138	97.18
Making a child touch his or her private parts or someone else's private parts	15	10.56	118	83.10	6	4.23	139	97.89
Having sex with a child	14	9.86	120	84.51	5	3.52	139	97.89
Showing a child magazines or films which show pictures of people with little or no clothes on	14	9.86	121	85.21	4	2.82	139	97.89
Telling a child 'dirty' stories or 'dirty' jokes	12	8.45	123	86.62	4	2.82	139	97.89

Table 109: Perpetrators of sexual abuse

	Yes	
	Count	N %
Don't know	22	15.5%
Male stranger	46	32.4%
Friend	36	25.4%
Boyfriend	16	11.3%
Uncle	32	22.5%
Brother	39	27.5%
Neighbor	36	25.4%
Father	49	34.5%
Other	7	4.9%

Service providers

Response to violence in the community

The majority of service providers (92.5%) said that there is violence against children aged 10-17. This shows that they are aware of violence in their community.

Table 110: Awareness of violence against children in the community, by services provided

		Services provided					
		Health		Education, counseling, social work		Total	
		Count	N %	Count	N %	Count	N %
Is there any violence against children in this community?	No	3	8.6%	0	.0%	3	5.7%
	Yes	31	88.6%	18	100.0%	49	92.5%
	Don't know	1	2.9%	0	.0%	1	1.9%

However, health workers seemed to be less aware (88.6%) of violence than other service providers (100%). This might be due to the nature of services that allows some service providers to be involved in responding to violence more than others. Health workers might know less because they are less exposed or sought after by victims of violence, while counselors might be more acquainted with the community's social realities.

Most service providers (71.4%) (74.2% of health workers and 66.7% of other service providers) believe that violence against children occurs "at home from adults". This is followed by "between youth themselves in the neighborhood" by 65.3% of service providers. "Other" places included: "on the street".

Table 111: Places where violence occurs

Violence occurs	Services provided					
	Health		Education, counseling, social work.		Total	
	Yes		Yes		Yes	
	Count	N %	Count	N %	Count	N %
At home from adults	23	74.2%	12	66.7%	35	71.4%
At home from older siblings	11	35.5%	9	50.0%	20	40.8%
At school from teachers	13	41.9%	5	27.8%	18	36.7%
At school from older students	16	51.6%	11	61.1%	27	55.1%
Between youth themselves in the neighborhood	17	54.8%	15	83.3%	32	65.3%
Other	2	6.5%	5	27.8%	7	14.3%

Most service providers (90.4%) observe among their child patients/students signs that indicate violence. If violence is suspected as cause of the signs, most of the service providers (66%) refer the child to their supervisor. This is followed by "referring to a specialized service" and "providing counseling to the child", mentioned by 49%. Very few reported to the police (5.6%).

Around 25.7% of the health workers reported "treating the physical symptoms", suggesting that few health workers in the impact area health centers treat victims of violence. It is suggested to reinforce the health workers at the impact area health centers and equip them to be able to respond to victims of violence and be available for referral.

Table 112: Course of action if violence is suspected, by type of services provided

If you suspect violence, you	Services provided					
	Health		Education, counseling, social work		Total	
	Yes		Yes		Yes	
	Count	%	Count	%	Count	%
Do nothing	1	2.86	0	0.00	1	1.89
Treat the physical symptoms	9	25.71	1	5.56	10	18.87
Refer to a specialized service	17	48.57	9	50.00	26	49.06

Refer to supervisor	22	62.86	13	72.22	35	66.04
Report to the police	3	8.57	0	0.00	3	5.66
Discuss directly with the perpetrator	3	8.57	3	16.67	6	11.32
Provide counseling to the child	15	42.86	11	61.11	26	49.06
Providing counseling to the family	13	37.14	6	33.33	19	35.85
Other	1	2.86	4	22.22	5	9.43

On the other hand, not all the service providers' workplaces (health centers, schools, NGOs, etc) have established systems for violence response. For instance, 43.4% have treatment and follow up, while 37.7% have referral systems. These centers however seem to lack the most in investigation and appropriate judicial involvement.

Table 113: Established response systems to violence

Does your workplace have established systems for	Services provided					
	Health		Education, counseling, social work		Total	
	Yes		Yes		Yes	
	Count	%	Count	%	Count	%
Identification of violence/ sexual abuse	11	31.43	5	27.78	16	30.19
Reporting	10	28.57	7	38.89	17	32.08
Referral	10	28.57	10	55.56	20	37.74
Investigation	4	11.43	7	38.89	11	20.75
Treatment and follow up	15	42.86	8	44.44	23	43.40
Appropriate judicial involvement	6	17.14	7	38.89	13	24.53
Help lines, advice, and counseling for child victims of violence/sexual abuse	11	31.43	8	44.44	19	35.85

Furthermore, 66.6% of the service providers' workplaces do not have any programs addressing the prevention of sexual abuse. However, more health centers (68.9%) didn't have such programs than UNRWA schools (62.5%). Also, 31.2% of UNRWA schools had community education targeting prevention of sexual abuse as opposed to 17.2% of health centers. The least available intervention was "Research" (17.8%).

Table 114: Programs addressing the prevention of sexual abuse

Specific program addressing the prevention of sexual abuse	Type of facility					
	UNRWA school		Health centre/clinic		Total	
	Count	%	Count	%	Count	%
Program not available	10	62.50	20	68.97	30	66.67
Community education	5	31.25	5	17.24	10	22.22
Development of IEC material	5	31.25	4	13.79	9	20.00
Training of front line personnel	5	31.25	4	13.79	9	20.00
Advocacy for policy development and legal reform	5	31.25	4	13.79	9	20.00
Research	5	31.25	3	10.34	8	17.78

Based on the above findings, it is suggested to introduce adequate prevention and response systems to violence and sexual abuse, not only in training of the service providers, but to also with the workplaces' directors, in order to include violence prevention and response as structural components in their sustainable programs.

Knowledge about violence and sexual abuse

All service providers (100%) have identified 3 or more forms of physical abuse.

The most identified forms of physical abuse were:

- "Burning with a match, cigarette, or hot water", "Hitting with an object", and "Forcing a child to stay in uncomfortable position", by 100%.

Table 115: Forms of physical abuse

Does physical abuse include	No		Yes		Don't know		Total	
	Count	%	Count	%	Count	%	Count	%
Hitting with a hand	1	1.89	52	98.11	0	0.00	53	100.00
Hitting with an object	0	0.00	53	100.00	0	0.00	53	100.00
Shaking	1	1.89	52	98.11	0	0.00	53	100.00
Pulling child's hair	1	1.89	52	98.11	0	0.00	53	100.00
Burning with a match, cigarette, or hot water	0	0.00	53	100.00	0	0.00	53	100.00
Forcing a child to stay in uncomfortable position	0	0.00	53	100.00	0	0.00	53	100.00
Forcing a child to take excessive physical exercise	1	1.89	51	96.23	0	0.00	52	98.11

Service providers were also asked about signs of physical abuse. About 83% of service providers identified 3 or more signs as per the SCS guidelines.

Table 116: Number of signs of physical abuse identified by type of services provided

		Services provided					
		Health		Education, counseling, social work		Total	
		Count	N %	Count	N %	Count	N %
Signs of physical abuse	0	1	2.9%	0	.0%	1	1.9%
	1	3	8.6%	0	.0%	3	5.7%
	2	5	14.3%	0	.0%	5	9.4%
	3 or more	26	74.3%	18	100.0%	44	83.0%
	Total	35	100.0%	18	100.0%	53	100.0%

Contrary to expectations, less health workers (74.3%) identified 3 or more signs than "other service providers" (100%) working in education, counseling, and social work. This is perhaps due to victims not being referred or treated by health workers. It is therefore recommended to focus more on health workers in awareness raising efforts regarding identification of physical abuse signs.

The most identified signs of physical abuse were:

- "Unexplained recurrent injuries", by 84.9%,
- "Injuries which have not received medical attention", by 58.5%.

Table 117: Signs of physical abuse

Signs of physical abuse	services provided					
	Health		Education, counseling, social work		Total	
	Yes		Yes		Yes	
	Count	N %	Count	N %	Count	N %
Unexplained recurrent injuries	31	58.5%	14	26.4%	45	84.9%
Improbable excuses or refusal to explain injuries	9	17.0%	11	20.8%	20	37.7%
Injuries which have not received medical attention	20	37.7%	11	20.8%	31	58.5%

Injuries which occur to the body in places which are not normally exposed to falls, rough games etc	18	34.0%	10	18.9%	28	52.8%
Fear of physical contact, shrinking back if touched	8	15.1%	4	7.5%	12	22.6%
Wearing clothes to cover injuries, even in hot weather	10	18.9%	5	9.4%	15	28.3%
Fear of returning home or of parents being contacted	7	13.2%	5	9.4%	12	22.6%
Showing wariness or distrust of adults	12	22.6%	7	13.2%	19	35.8%
Self-destructive tendencies	6	11.3%	7	13.2%	13	24.5%
Being very passive and complaint	12	22.6%	5	9.4%	17	32.1%
Aggression towards others	11	20.8%	8	15.1%	19	35.8%
Chronic running away	8	15.1%	11	20.8%	19	35.8%
Other	0	.0%	2	3.8%	2	3.8%

Similarly, 96.2% of service providers have identified 3 or more forms of sexual abuse, with more health workers (97.1%) than "other service providers" (94.4%).

The most identified form of sexual abuse was: "Touching a child's private parts", by 98.1%. However, all forms were identified by over 90% of service providers.

Table 118: Number of forms of sexual abuse by type of services provided

		Services provided					
		Health		Education, counseling, social work.		Total	
		Count	N %	Count	N %	Count	N %
Forms of sexual abuse	0	1	2.9%	0	.0%	1	1.9%
	1	0	.0%	0	.0%	0	.0%
	2	0	.0%	1	5.6%	1	1.9%
	3 or more	34	97.1%	17	94.4%	51	96.2%
	Total	35	100.0%	18	100.0%	53	100.0%

Table 119: Forms of sexual abuse

Does sexual abuse include	No		Yes		Don't know		Total	
	Count	%	Count	%	Count	%	Count	%
Touching a child's private parts	1	1.89	52	98.11	0	0.00	53	100.00
Making a child touch his or her private parts or someone else's private parts	1	1.89	51	96.23	0	0.00	52	98.11
Having sex with a child	1	1.89	51	96.23	0	0.00	52	98.11
Showing a child magazines or films which show pictures of people with little or no clothes on	1	1.89	51	96.23	0	0.00	52	98.11
Telling a child 'dirty' stories or 'dirty' jokes	3	5.66	48	90.57	0	0.00	51	96.23

Table 120: Number of signs of sexual abuse identified by type of services provided

		Services provided					
		Health		Education, counseling, social work		Total	
		Count	N %	Count	N %	Count	N %
Signs of sexual abuse	0	5	14.3%	0	.0%	5	9.4%
	1	3	8.6%	0	.0%	3	5.7%
	2	1	2.9%	1	5.6%	2	3.8%
	3 or more	26	74.3%	17	94.4%	43	81.1%
	Total	35	100.0%	18	100.0%	53	100.0%

Service providers were also asked about signs of sexual abuse. Only 81.1% of service providers identified 3 or more signs as per the SCS guidelines.

Contrary to expectations, less health workers (74.3%) identified 3 or more signs than "other service providers" (94.4%) working in education, counseling, and social work. This is perhaps due to victims not being referred or treated by health workers. It is therefore recommended to focus more on health workers in awareness raising efforts regarding identification of sexual abuse signs.

The most identified signs of sexual abuse were:
-"Being isolated and withdrawn", by 64.1%,
- "Depression, self-mutilation, suicide attempts", by 62.2%,
- "Medical problems", by 60.4%.

Table 121: Signs of sexual abuse

Signs of sexual abuse	Yes	
	Count	%
Being overly affectionate or knowledgeable in a sexual way inappropriate to the child's age	11	20.75
Medical problems, such as chronic itching, pain in the genitals, venereal diseases	32	60.38
Personality changes, such as becoming insecure or clingy	25	47.17
Regressing to younger behavior patterns	9	16.98
Sudden loss of appetite or compulsive eating	14	26.42
Being isolated or withdrawn	34	64.15
Inability to concentrate	27	50.94
Lack of trust or fear of someone they know well, such as not wanting to be alone	28	52.83
Being worried about clothing being removed	14	26.42
Bedwetting, nightmares, day mares	15	28.30
Suddenly drawing sexually explicit pictures	7	13.21
Depression, self-mutilation, suicide attempts	33	62.26
Trying to be 'ultra-good' or perfect, overreacting to criticism	6	11.32
Other	7	13.21

Most service providers thought that the perpetrators of sexual abuse are males. "Father" was the most identified perpetrator, mentioned by 73.6% of service providers. This was followed by "brother" which was mentioned by 71.7%, and "uncle" by 58.5%, suggesting that service providers believe most sexual abuse is perpetrated by close male family members.

Table 122: Perpetrators of sexual abuse

The perpetrators may be	Services provided					
	Health		Education, counseling, social work.		Total	
	Yes		Yes		Yes	
	Count	%	Count	%	Count	%
Don't know	0	0.00	0	0.00	0	0.00
Male stranger	12	34.29	9	50.00	21	39.62
Friend	14	40.00	5	27.78	19	35.85
Boyfriend	12	34.29	11	61.11	23	43.40
Uncle	23	65.71	8	44.44	31	58.49
Brother	26	74.29	12	66.67	38	71.70
Neighbor	15	42.86	6	33.33	21	39.62
Father	28	80.00	11	61.11	39	73.58
Other	2	5.71	6	33.33	8	15.09

Training needs

Furthermore, 80.8% of the service providers feel that they have a responsibility to address violence in the community, which represents a good indication of their motivation to be involved in response mechanisms. However, only 44.2% of the service providers feel they have enough knowledge and skills to deal with children who have been sexually abused. In fact, 41.5% have received training on dealing with children who have been subject to violence or sexual abuse. Furthermore, 50.9% have received training regarding communication with children and their families, and facilitating children participation.

However, and although the service providers lack in knowledge, skills, and training in adequate response to children victims of sexual abuse, 80.8% of them feel confident in supporting children who have been sexually abused. It is recommended therefore to channel the service providers' motivation into good practices, and train them based on standard guidelines and procedures.

CONCLUSIONS AND RECOMMENDATIONS

This section will give recommendations for the project activities based on the KAP survey results detailed in the report, in relation to each section.

General recommendations related to survey management:

- It is recommended to allocate more time for such surveys, especially when considering:

  1. The wide variety of indicators that need to be covered;
  2. The multiple targeted populations (children, parents, and different types of service providers);
  3. The geographical locations (Lebanon and oPt), and the time required to remotely and *adequately* supervise data collection and the quality of gathered data in another country;
  4. The change of plans perceived at the beginning of the survey, which required re-investment in gathering of new information upon which to plan the survey.

  This was explicitly demonstrated with the excessive delays occurring throughout the survey steps.

- Regarding the two indicators that were suppressed from the survey:
  - Indicator 1: Number of service providers responding to signs of violence in an appropriate way;
  - Indicator 2: Percentage of improvement of number of criteria for adolescent friendly services;

  it is recommended to develop a list of criteria based on which the response of service providers as well as the services provided for children can be measured against and monitored throughout the project. The list of criteria could be developed based on:

  - Technical guidelines;
  - Qualitative research involving the children themselves in describing what child-friendly SRH services mean to them. This could also include qualitative perspectives of children survivors of violence about the quality of services received (through focus groups, and in-depth interviews)-to improve the quality of services for survivors of violence and sexual abuse.

- Regarding the section on "media habits" that was suppressed from the survey tools, it is suggested to use the section for conducting a smaller scale survey of the children media habits prior to campaign planning, in order to ensure better reach.
- It is also recommended to conduct qualitative research prior to development of material in order to explore misconceptions and attitudes. This will serve as complementary information to the survey results.

Education

Since all children can read, printed material can be used as an education and communication mean in future project activities. However, since very few children reported printed material to be a source of information, it is not highly recommended to use it as the main educational medium, but to include it as a support to education activities such as peer education, and other participatory education sessions. Furthermore, a mechanism of monitoring needs to be put in place in order to ensure that printed material is being used properly. Also, since almost all children read Arabic, it is preferred to produce printed material in that language.

The fact that the majority of children (95.7%) are enrolled in schools suggests that almost all children in the impact area can be reached through school activities. The majority can be reached through UNRWA schools, followed by public schools, semi-private schools, and finally private schools.

Also, children can be reached through non-formal education, since 42.6% of them are enrolled. The most effective form to reach the children through is private language courses, followed by religious education. SCS can liaise with the language education and religious institutions in the impact area in view of introducing some of the SRH topics within their sessions.
The children can also be reached through youth groups, especially those aged between 10 and 12 years.

Personal Hygiene

The prevalence of good hygienic behavior is very low. Only 37% of children bathe at least once a day. However, most parents (90.8%) have reported that their children wash their genitals at least once a day, which is relatively high, but cannot be checked for accuracy.

The girls' knowledge about causes for infection/irritation of the genitals is relatively fair, with 52% identifying at least 3 causes. Also, 76.3% of girls knew that the tampon/pad should be changed many times during the day during menstruation.

It is recommended to provide extensive education about appropriate amount of bathing and washing genitals, as well as infections of the genitals and menstrual hygiene, to boys and girls separately, since there were found to be differences among their practices. It is also recommended to provide education for mothers on personal hygiene of their children and skills to educate them, since they are the main source of information mentioned by children regardless

of gender. Education can also target teachers, sisters, and fathers who were ranked as second, third and fourth sources of information on personal hygiene.

However, it is not recommended to provide peer education as an education method for personal hygiene topics, since children do not seem to seek the information from their "friends" on these issues. In fact, only 7.5% of children mentioned "friends" as their source of information, perhaps due to shyness about the nature of the issue, or not perceiving the source to provide credible information. Furthermore, media channels were not mentioned as a prominent source and may not be very effective in reaching the children in future activities. Printed materials were mentioned by only 4.2% of the children as sources of information, suggesting either of the following:

- The lack of availability of printed materials tackling personal hygiene issues for adolescents;
- The printed materials are not accessible to the children;
- The printed materials are not attractive or child-friendly.

It is recommended therefore to produce child-friendly material around personal hygiene issues and ensure their accessibility to the children.

Changes during puberty

Children

Knowledge about physical changes occurring in puberty was fair among children. More girls (49.4%) identified 3 or more physical changes (occurring in girls) than boys (41%) (occurring in boys). Therefore, education sessions need to target boys and girls separately since differences were found between their levels of knowledge. Education should focus on the least identified changes.

Knowledge about worries and problems faced during puberty was very low for both genders. Only 20% identified 3 or more worries/problems. It is recommended to provide education for children on worries and problems faced during puberty, as well as skills to face these problems such as communication skills, anger management, self esteem, etc. These sessions could include the parents of the children in order to improve communication between the two, since the answers both children and parents gave revealed "conflict with parents" to be a serious problem faced. This would also improve better communication about SRH issues between the two, which is needed for project activities since the parents are key sources of information for children regarding all SRH topics.

Parents and service providers

Parents identified less physical changes in both boys and girls than service providers. About 45% of parents, 94.3% of health workers, and 100% of other service providers identified 3 or more physical changes in girls during puberty. The percentages decreased when identifying changes in

boys; around 39.4% of parents, 94.3% of health workers, and 88.9% of other service providers identified 3 or more physical changes in boys during puberty.

The parents and service providers knowledge regarding worries faced by adolescents was very low in comparison with knowledge about physical changes. Only 10.6% of parents, 44.4% of other service providers, and 54.3% of the health workers identified 3 or more worries or problems faced during puberty.

The large majority of health workers (91.4%) and other service providers (94.4%) recognized that children aged 10-17 face SRH risks, as opposed to only 40.8% of parents. However, Few parents (8.6%), 28.1% of the health workers, and 35.3% of the other service providers identified 3 or more SRH risks faced by children.

These results suggest creating a common knowledge base by educating service providers and parents on:

- Changes occurring in puberty, with concentration on physical changes occurring in boys;
- Worries/problems faced during puberty, with concentration on the psychosocial problems faced by adolescents;
- SRH risks faced by adolescents.

It is also recommended to provide these caregivers with the necessary skills that will enable them to answer the children needs during adolescence and puberty; these include: communication skills, counseling skills, referral to appropriate services, etc.

STIs, HIV and AIDS

Children

The knowledge level of children about STIs is very low. Only 3.3% could identify 3 or more STIs. Only 2.5% could identify 3 or more STI symptoms.

Around 72% of children have heard of HIV and AIDS. Only 32.1 % of those could identify 3 or more modes of transmission of HIV, and only 25.6% could identify 3 or more ways to avoid getting HIV. 42.3% believed that “casual contact with an infected person” is a mode of transmission and 43.6% believed that “avoiding casual contact with an infected person” is a way to avoid getting infected with HIV.

It was noticed that knowledge levels between girls and boys were different, and knowledge about HIV and AIDS increased with older age.

It is recommended to provide education on STIs and HIV & AIDS, with separate tailored sessions for girls and boys, and more focus on younger age groups. Correcting misconceptions about HIV & AIDS should be one of the objectives of the education interventions, to reduce the

stigma against HIV infected people. The sessions also need to focus on the least identified answers.

There's also a need to review the schools' curriculum contents regarding SRH in general and STIs, HIV & AIDS in particular, with the help of the teachers and schools administration. Lesson plans could be included though the schools and used within the curriculum.

Parents and service providers

About 88.6 % of health workers, 72.2% of other service providers, and only 18.3% of the parents identified 3 or more STIs. Around 77.1% of health workers, and 72.2% of other service providers, and only 10.6% of parents could identify 3 or more STI symptoms.

All service providers and 90% of parents have heard of HIV and AIDS. Out of these, 43.1% of parents, 78.8% of health workers, and 88.9% of other service providers could identify 3 or more modes of transmission of HIV. 34.5% of parents, 87.9% of health workers, and 100% of other service providers identified 3 or more ways to avoid getting HIV. Also, 20.7% of parents, 42.4% of health workers, and 38.9% of other service providers though that "casual contact with an infected person" is a mode of transmission, and 31% of parents, 30.3% of health workers, and 38.9% of other service providers though that "avoiding casual contact with an infected person" is a way to avoid getting infected with HIV.

Around 79% of service providers have received training and health education sessions on HIV/AIDS.

These results suggest providing training and education for parents and service providers on STIs, HIV, and AIDS, with focus on the least identified answers and special focus on correcting misconceptions related to casual contact with HIV-infected people, in order to reduce the stigma around them.

SRH seeking behavior and services utilization

Children

Most children (76.7%) identified their "mother" as primary source of information or help in matters of sexual and reproductive health. This was followed by "father", "sister", and "gynecologist or doctor". Unlike the subject of personal hygiene, there was a gender difference when seeking information about SRH; more girls sought their mother, while more boys sought their father. "Teachers", "social workers", "counselors", and "midwives/nurses" were not mentioned by many children.

It is therefore recommended to convey educational messages through the parents, as well as prepare the parents by educating them on SRH issues and ways to communicate about these topics with their children. Since "gynecologists and doctors" were considered as a prominent

source of information and help, it is also recommended to train them in providing youth-appropriate advice and counseling. It would also be beneficial to start introducing the service providers that were less sought after as "child-friendly" and approachable sources of information, through organization of interactive education sessions on SRH.

It is worth to be noted that friends and the media were not mentioned as eminent sources of information on SRH. It is therefore recommended to use the strongest and most mentioned channels.

On the other hand, more children (65.2%) have asked their parents about SRH topics than those their teachers (50.4%). However, out of those who asked, most got an answer to their question, instead of being scolded, refused, or referred. Thus, interventions in this area need to focus both on getting more children to ask their parents and teachers, and preparing the parents and teachers to be able to respond.

The majority of children (84.2%) support the discussion of SRH topics in classrooms, but only 22.7% felt that it should take place before puberty. Most parents on the other hand believe that sexual and reproductive health rights should be included in the school program, and most think education on SRHR should start before the age of 16. These findings can be used in advocacy efforts with the schools in order to include SRHR topics within the curriculum.
About 28.3% of children do not use the SRH services at the health centers for the main reason of "not knowing what services are available". Thus, it is suggested to sensitize the children in the impact area about the child-friendly services available at the health centers by advertising them. It is also recommended to implement educational interventions with the aim of increasing their knowledge about their sexual and reproductive health rights, to ensure that they can claim their right to SRH.

Parents and service providers

Although 64.5% of parents and 75% of service providers consider themselves to be knowledgeable enough to provide advice on RH issues, the majority of service providers (66%) were asked by only 1-10 children for SRH information in the month preceding the survey. This confirms the previous findings about who the children consider to be their source of information.

As noted earlier, interventions should target both children to consult more with the service providers, and service providers to recognize SRH as a right for children, and be able to respond to the children needs. Also, it is advisable to take into consideration that less health workers have received training in SRH than the other service providers.

Engagement, marriage, and childbirth

The attitude of children, parents, service providers towards ideal engagement and marriage ages for boys and girls was relatively favorable, since most of them believed that these should be above 18 years. However, ideal engagement and marriage ages were always perceived to be

lower for girls than for boys. Furthermore, differences were observed between female and male respondents' attitudes. This shows that gender issues need to be tackled as they relate to engagement and marriage ages.

Most children, parents, and service providers were in favor of continuation of education even after engagement or marriage. However, very few children and parents could identify the complications of childbirth during adolescence. Thus, education interventions are needed to raise the awareness of children and parents on the complications of childbirth during adolescence, as well as to reinforce their favorable attitudes by raising awareness on the consequences of early engagement and marriage.

Violence

Children

The majority of children had disapproving attitudes towards violence, with some differences between boys and girls, and within age groups. It is therefore suggested to target girls and boys with tailored interventions aiming to educate them on their rights regarding protection from violence so that they recognize when their rights are being violated and know how to protect themselves.

The large majority of children had relatively high levels of knowledge regarding forms of physical, emotional, and sexual abuse, with less knowledge about sexual abuse, perhaps due to lack of communication about this "taboo" subject. It is therefore recommended to reinforce their knowledge through education activities, and plan interventions with the objective of improving communication around the subject of sexual abuse.

Most of the children thought the perpetrators of sexual abuse were males, and especially strangers. Friends were mentioned in a higher percentage than boyfriends. This needs be taken into consideration when selecting peer educators, especially in interventions related to SRH. It is also recommended to educate children on the possible gender and identity of perpetrators. Since very few children could identify protection strategies if attacked, it is also recommended to provide them with the needed protection skills.

Only 47.7% have heard of the term "dating violence", and their level of knowledge was not very high regarding their response in case they were exposed to it. This suggests that children need to be educated on protective mechanisms to be able to respond adequately to dating violence. Their knowledge of available support NGOs and services also needs to be raised.

Parents

The large majority of parents had relatively high levels of knowledge regarding forms of physical, emotional, and sexual abuse, with lower levels of knowledge about the latter. Most of them however thought the perpetrators of sexual abuse were males.

It is recommended to focus educational interventions on the least identified forms of violence, as well as non-violent discipline, and consequences of violence on the child. It is also beneficial to include parents in the interventions targeting increasing communication and awareness about sexual abuse.

Service providers

Not all service providers' workplaces have established systems for response to violence. It is suggested to reinforce the health workers at the impact area centers and equip them to be able to respond to victims of violence and be available for referral. It is also suggested to strengthen and create a coordination and referral mechanism among the available services in the community, as well as train the service providers on their specific roles and responsibilities within these structures. Training of service providers should include confidentiality, safety, and child protection principles.

Furthermore, 66.6% of the service providers' workplaces do not have any programs addressing the prevention of sexual abuse. The least available intervention was "research", which suggests that future project interventions with the field partners need to include research activities on sexual abuse. Prevention programs need to be introduced as well in UNRWA health centers and at the schools attended by the children in the impact area.

The service providers' knowledge about forms of physical and sexual abuse was high. However, their knowledge on signs of physical and sexual abuse was not as high. It is therefore recommended to train the service providers on the SCS guidelines in order to help them identify signs of abuse and respond effectively.

It is also recommended to train the service providers in dealing with children who have been subject to violence or sexual abuse, and in providing youth-appropriate advice and counseling.

Educational interventions

All educational interventions need to:

- Start with qualitative research to complement the results of the KAP;

- Develop tailored programs for the different needs and levels of knowledge observed between boys and girls, and male respondents and female respondents;

- Develop tailored programs for the different age groups based on noted differences in knowledge and attitudes;

- Focus on the least identified answers and correct the misconceptions, as per the results of the KAP;

- Use print material as "support" and not as a sole activity;

- Engage the main sources of information for each topic as mentioned by children.

It is also recommended to create information points since they are presently not available. These should target adolescents with youth-friendly information at reachable and accessible locations, such as youth clubs, NGO centers, and schools. Mechanisms should be put in place in order to monitor their usage and evaluate their effectiveness.

APPENDIX I:
SCS KAP INDICATORS

Protective skills

- Knowledge on changes during adolescence
- Knowledge and practices on personal hygiene
- Attitudes towards age of marriage, engagement, child bearing
- Knowledge on sexually transmitted diseases, such as HIV/AIDS
- Knowledge on violence and child sexual abuse
- Knowledge on healthy relationships and dating violence
- # Questions by adolescents related to sexual education

Protective mechanisms:

- School dropout rates
- Health center use by adolescents
- Knowledge and practices of health workers regarding adolescent health and GBV
- Knowledge and practices of teachers/social workers regarding adolescent health and GBV
- # Service providers reporting on signs of violence
- # Service providers responding to signs of violence in an appropriate way
- # Reporting and follow up of adolescent protection issues through community based protection mechanisms
- # of criteria for adolescent friendly services
- # Adolescents and children visiting the information points

APPENDIX II:

OPT QUESTIONNAIRES – ENGLISH VERSIONS

ACCESS TO EDUCATION AND HEALTH SERVICES
BASELINE FORM: Health Services Providers KAP.

Informed Consent

Hello. My name is _____, and I work with Save the Children, …. to improve our understanding of the situation of youth in your community. We are conducting a survey and would appreciate your participation. I would like to observe your work with children 10-18 years of age and ask you some questions about yourself. This information will help to plan a program that improves utilization of education and health services. We usually need 20-30 minutes to complete the survey, and your part is voluntary so you can choose not to answer some individual questions. However, we hope that you will participate in this survey since your views about how you work with youth are important.

At this time, do you want to ask me anything about the survey?

Do you agree? Yes No

RESPONDENT AGREES TO BE INTERVIEWED [YES] [NO]

Interview number: _____

Name of impact area: |_|
oPt: 1= Al-Arroub, 2= Aqabet Jaber, 3= Ayda & Al-Azzeh, 4= Ein El-Sultan, 5=Dura

Name of the interviewer:_____

Name of respondent: _____

Name of facility (health clinic/center): _____

Visits register

No. of visit	Date of interview			Status of interview	*Time interview*	
	Day	Month	Year		Began	Ended
1						
2						
3						

4						
5						

Codes for status of visit:
1= Not at center/school **3**= Interview not completed
2= Refusal **4**= Interview completed

If refusal, reason:_____

If interview not completed, reason:_____

Section 1: General characteristics

1. Services provided: |_| 1=Health, 2=Education, counseling, social work.

2. Position of person interviewed/observed: |_|

Group 1: Health workers	Group 2: Education, counseling, social workers
1=Senior medical officer, 2=Senior staff nurse, 3= Senior practical nurse, 4=Midwife,	5=Teacher, 6= Head teacher, 7=Psychosocial counselor 8= Social worker, 9= Educator/animator,
10= Other, (specify):_____	

3. Sex: |_| 1=Male, 2=Female

4. Age: |_| 1= <20 years,
2= 20-29 years,
3= 30-40 years,
4= >40 years

5. How many years have you been treating children aged 10 to 17? |_||_|

Section 2: Changes during puberty

6. What physical changes in the body occur in girls during puberty? (Unprompted multiple response)	a. Breasts start to grow __ b. Hair growth (genital/underarms) __ c. Height and weight increase d. Menstruation starts __

	e. Oily skin, pimples__ f. Do not know __ g. Other __ (specify) _____
7. What physical changes in the body occur in boys during puberty? (Unprompted multiple response)	a. Hair growth (face, arms, legs, pubic) __ b. Voice changes (hoarse voice) __ c. Height and weight increase __ d. Body becomes more muscled/strong e. Oily skin, pimples __ f. Changes in sex organs __ g. Do not know__ h. Other__ (specify)_____
8. What problems or worries does a person face during puberty? (Multiple response)	a. No problems or worries__ If no problems, skip to Q115 b. Abdominal cramps___ c. Nocturnal emissions___ d. Feeling fatigued / tired ___ e. Eating too much __ f. Get sad / depressed __ g. Irritability / Anger __ h. Cannot concentrate on work / study__ i. Timidity/shyness j. Do not know__ k. Other__ (specify)_____
9. Do adolescents face reproductive health risks?	1=yes 2=no, skip to Q.12, mark N/A in Q11 3=don't know, skip to Q.12, mark N/A in Q11
10. If yes, what are they?	a. N/A b. Unintended, too-early pregnancy c. STIs, including HIV d. Unsafe abortion e. Sexual violence and exploitation. f. Don't know g. Other, specify:_____
11. When a child/adolescent aged 10-17 has a reproductive health problem or question, where should he/she seek	a. Seek no help or advice b. Teacher __ c. Mother __

help or advice? **Remember, reproductive health problems are problems associated with the reproductive health organs, such as pregnancy, contraceptive concerns, HIV/AIDS, STIs, abortion, etc.** **(Do not read out; Probe by asking, "Anyplace else?" and mark all that apply)**	d. Father e. Brother or sister __ f. Friend __ g. Relative __ h. Gynecologist/doctor i. Nurse/midwife j. Psychosocial counselor k. Social worker l. Health center m. Youth center __ n. Printed material (brochures) __ o. Radio __ p. TV__ q. Book r. Internet s. Don't remember __ t. Don't know u. Other (specify)_____
12. Do you consider yourself knowledgeable enough to provide advice on sexual and reproductive health issues to youth aged 10-17? |_|	1=Yes 2=No
Section 3:STIs and HIV/AIDS	
13. Do you know any infections a person can get through sexual intercourse? If yes, which one do you know? (Do not read out. Probe by asking, "What others?" and circle all that applies)	1. HIV/AIDS 2. Gonorrhea 3. Syphilis 4. Genital warts 5. Genital herpes 6. Hepatitis B 7. Other (specify):_____ 8. Don't know
14. What signs or symptoms suggest that a person has a sexually transmitted infection (STI)? (Do not read out. Probe by asking, What others?" and circle all that	1. Discharge from penis/vagina 2. Burning pain or itching in penis/vagina 3. Abnormal vaginal bleeding 4. Loss of weight 5. Sores or warts on penis/vagina

applies.)	6. Painful urination 7. Swelling in groin region 9. Other (specify):_____ 8. Don't know
If the respondent named AIDS as sexually transmitted infection in Q59, circle answer 1. Without asking him Q61. If the respondent didn't name AIDS in Q59, ask him Q61. 15. Have you heard of an illness/disease called AIDS? |_|	1. Yes 2. No If no skip to Q111
16. Please name all the ways in which you believe a person can get AIDS. (Do not read out. Probe by asking, "Anything else?"And circle all that apply)	1. Sexual relations 2. Sharing syringes/unclean medical equipment 3. Blood transfusions 4. Mother to child during birth 5. Mosquito or other insect bites 6. Through breast milk 7. Casual contact with infected person (e.g., sharing food, cup or glass; handshake, cough or sneeze) 8. Other (specify):_____ 9. Don't know
17. What can a person do to avoid getting infected with HIV/AIDS? (Unprompted Multiple Responses)	1. Avoid sex completely/abstinence 2. Stay faithful to partner 3. Encourage partner to stay faithful 4. Avoid contaminated blood (unscreened blood transfusions) 5. Use condoms for every act of sexual intercourse 6. Avoid sharing syringes 7. Avoid sharing razors and blades 8. Avoid commercial sex workers 9. Avoid casual sex 10. Avoid Casual contact with infected person (e.g., sharing food, cup or glass; handshake, cough or sneeze)__ 10. Other (specify):_____ 11. Don't know
Section 4: Engagement & Marriage	
18. In your opinion what is the best age for a girl to get engaged? |_|	1=Less than 12 years 2=12-14 years

	3=15-18 years 4=19-20 years 5=21-22 years 6=23-24 years 7=25 or older 99=I don't know
19. In your opinion what is the best age for a boy to get engaged? |_|	1=Less than 12 years 2=12-14 years 3=15-18 years 4=19-20 years 5=21-22 years 6=23-24 years 7=25 or older 99=I don't know
20. In your opinion what is the best age for a girl to get married? |_|	1=Less than 12 years 2=12-14 years 3=15-18 years 4=19-20 years 5=21-22 years 6=23-24 years 7=25 or older 99=I don't know
21. In your opinion what is the best age for a boy to get married? |_|	1=Less than 12 years 2=12-14 years 3=15-18 years 4=19-20 years 5=21-22 years 6=23-24 years 7=25 or older 99=I don't know
22. Are there any reasons why pregnancy/child birth should be avoided when a person is in his/her adolescence? |_|	1=Yes 2=No (If no, go to Q30, but fill N/A in Q29) 3=Don't know (go to Q30, but fill N/A in Q29)
23. What do you think are the complications with early pregnancy/delivery? (Unprompted Multiple Response)	a. Not applicable (N/A) b. Maternal death c. Premature birth d. Overweight newborns e. Spontaneous abortion f. Stillbirth g. Low birth weight h. Bleeding i. High level of childhood illness

	j. Mental and physical disabilities in children k. No negative effects l. Don't know m. Other,(Specify)_____ _____

Section 5: Violence

A. Child Needs, Care and Protection

24. In your opinion, what should children 10-17 years be protected from?

Children should be protected from:	**Very Important**	**Somewhat important**	**Not important**
a. Be protected from disease	_|	_|	_|
b. Be protected from extreme heat and cold	_|	_|	_|
c. Be protected from conflict and violence inside the home	_|	_|	_|
d. Be protected from violence outside the home	_|	_|	_|
e. Be protected from poverty	_|	_|	_|
f. Be protected from unsafe and inadequate home/shelter	_|	_|	_|
g. Be protected from accidents	_|	_|	_|
h. Be protected from risky sexual behavior	_|	_|	_|
i. Be protected from sexual abuse	_|	_|	_|
j. Be protected from substance abuse	_|	_|	_|
k. Be protected from being exploited by others	_|	_|	_|
i.Others [Specify]:_____	_|	_|	_|

25. In your opinion, what are the needs of children aged 10-17? And how important are these needs in your opinion?

Children's need for:	**Very Important**	**Somewhat important**	**Not important**
a. Sufficient healthy nutritious food	_|	_|	_|
b. Stimulating environment/education/apprenticeships	_|	_|	_|
c. Healthy environment (clean water, air,)	_|	_|	_|
d. A safe and secure environment	_|	_|	_|
e. Access to health services/vaccinations	_|	_|	_|
f. Physical care (cleaning/hygiene)	_|	_|	_|
g. Adequate rest	_|	_|	_|
h. Opportunities for leisure/sports/social activities	_|	_|	_|
i. Friends of same age			
j. Adult role models			
k. Work opportunities			
O. Others [Specify]:_____			

Violence:

26. What are violent behaviors against children 10-17?
a. Physical
b. Psychological
c. Social
d. Economical
e. Other, specify:_____

27. Is there violence against children 10-17 years in this community?
|_| 1=Yes, 2=No

28. If yes where do think this violence is?
    1. Not applicable?
    2. At home from adults |_|
    3. At home from older siblings |_|
    4. At school from teachers |_|
    5. At school from older students |_|
    6. Between youth themselves in the neighborhood |_|
    7. Other |_| (specify) _____

29. Do you observe among your child patients symptoms that indicate violence? |_| 1=Yes, 2=No

30. If yes, what symptoms have you observed:
    1. Bruises |_|
    2. Broken bones |_|
    3. Blue eyes |_|
    4. Internal bleeding |_|
    5. Cuts |_|
    6. Food/drink deprivation |_|
    7. Exposure to heat or cold |_|
    8. Exploitation/hard work |_|
    9. Bruises as a result of sexual abuse |_|
    10. Other |_| (specify):_____

31. If you suspect violence as the cause of the symptoms, what do you do?
    1. Nothing, treat symptom |_|
    2. Ask what the reason is from child |_|
    3. As what the reason is from caretaker with child |_|
    4. If violence is at home, ask father to come to the clinic |_|
    5. If violence is at school, ask caregiver to discuss with teacher |_|
    6. Other |_| (specify) _____

32. Do you report signs of violence?
    1=yes
    2=no, skip to Q35, mark N/A in Q 34

33. If yes, to who?
    1.

34. Do you feel that health providers have a responsibility to address violence in the community?
|_| 1=Yes, 2=No

Sexual abuse

35. Do you feel you have enough knowledge and skills to deal with children who have been sexually abused?
    1=yes
    2=no
    3= Don't know

36. What are factors that make children vulnerable to sexual abuse?
    1. Gender
    2. Unaccompanied children
    3. Children in foster care, adopted children, stepchildren
    4. Physically or mentally handicapped children
    5. History of past abuse
    6. Poverty
    7. War/armed conflict
    8. Psychological or cognitive vulnerability
    9. Single parent homes/broken homes
    10. Social isolation (e.g. lacking an emotional support network)
    11. Parent with mental illness, or alcohol or drug dependency
    12. Don' know
    13. Other, specify:_____

37. What are physical indicators of child sexual abuse?
    1. Unexplained genital injury
    2. Recurrent vulvovaginitis (an inflammation of the vagina.It can result in discharge, itching and pain,and is often associated with an irritation or infection of the vulva. It is usually due to infection)
    3. Vaginal or penile discharge
    4. Bedwetting and fecal soiling beyond the usual age
    5. Anal complaints (e.g. fissures, pain, bleeding)
    6. Pain on urination
    7. Urinary tract infection
    8. STI

9. Pregnancy
10. Presence of sperm
11. Don' know
12. Other, specify:_____

38. What are behavioral indicators of child sexual abuse?

1. Regression in behaviour, school performance or development
2. Acute traumatic response such as clingy behaviour and
3. Irritability in young children
4. Sleep disturbances
5. Eating disorders
6. Problems at school
7. Social problems
8. Depression
9. Poor self-esteem
10. Inappropriate sexualized behaviours
11. Don' know
12. Other, specify:_____

39. What are consequences of child sexual abuse on the child?
    1. Gastrointestinal disorders (e.g. irritable bowel syndrome, non-ulcer dyspepsia, chronic abdominal pain);
    2. Depressive symptoms;
    3. Anxiety;
    4. Low self-esteem;
    5. Symptoms associated with PTSD such as re-experiencing, avoidance/
    6. numbing, hyperarousal;
    7. Increased or inappropriate sexual behaviour;
    8. Loss of social competence;
    9. Cognitive impairment;
    10. Body image concerns;
    11. Substance abuse
    12. Don' know
    13. Other, specify:_____
    (other: STI, death, pregnancy, unsafe abortion, disability, etc…)

40. Do you feel confident in supporting with children who have been sexually abused?
    1=yes
    2=no
    3= Don't know

41. Have you received any training on guidelines of dealing with children who have been sexually abused?
    1=yes

2=no
3= Don't know

42. Have you received any training regarding communication with children and their families, and facilitating children participation?
1=yes
2=no
3= Don't know

Thank the health worker for his/her cooperation

INCLUSIVE EDUCATION

BASELINE FORM: Parents Knowledge, Attitude and Practice (KAP) Survey

Informed Consent

Hello. My name is _____, and I am working with Save the Children and … to improve our understanding of the situation of children's education in your community. We are conducting a survey and would appreciate your participation. I would like to ask you/your child about your/his/her education, your/her/his family and your/his/her home. This information will help to plan a program that improves the inclusion of all children in education. Al your answers will be kept strictly confidential and will only be used for the purpose of this research. You will have the opportunity to obtain the results of the research you are taking part, if you wish. The survey usually takes 45 to 60 minutes to complete. Participation in this survey is voluntary and you/your child can choose not to answer any individual questions. However, we hope that you will/you will allow your child to participate in this survey since your/his/her views are important. If you have any questions regarding this research you may contact: _____ (name and contact of senior SC staff member in the governorate).

At this time, do you want to ask me anything about the survey?

I have read and understood the information above and give my voluntary consent to participate in this research. I understand that I can withdraw my consent at any time.

Signature of one of the Parents: _____ Date: _____

Cluster number: _____ Interview number: _____

Name of impact area: |_|
oPt: 1= Al-Arroub, 2= Aqabet Jaber, 3= Ayda & Al-Azzeh, 4= Ein El-Sultan, 5=Dura

Name of the interviewer:_____

Visits register

No. of visit	**Date of interview**			**Status of interview**	***Time interview***	
	Day	Month	Year		**Began**	**Ended**
1						
2						
3						
4						

5						

Codes for status of visit:
1= Not at home at 5th call **3=** Not at home at visit (opt)/haven't showed up to center
2= Refusal at call **4**=Refusal at visit

5= Interview not completed
6=Interview completed

If refusal, reason:_____

If interview not completed, reason:_____

Full name of child:_____

Full name of parent:_____

Address of household:

Area: Al-Arroub |_| Aqabet Jaber |_| Ayda & Al-Azzeh |_| Ein El-Sultan |_| Dura |_|
Street: _____

Section 1: General characteristics **I would now like to ask you some questions about your family and your home.**	
1. Relationship of respondent to child |_|	1. Biological Mother 2. Biological Father 3. Older Sister/Brother 4. Grandparent 5. Aunt/Uncle 6. Other [specify]_____
2. Sex of respondent	1. Male 2. Female
3. Year of birth	_____
4. Family status	1. Single 2. Engaged 3. Married 4. Widow 5. Divorced 6. Separated

5. How many people live in your household?	____ (enter number of people)
6. Housing: |_|	1. Rented 2. Owned 3. Shared with another family 4. Free of charge 5. Other, specify:_____
7. How many rooms, excluding the kitchen and bathrooms?	____ (number of rooms)
8. What level of education did you complete? |_| **(choose one)**	0. Not applicable 1. Illiterate 2. Reads and writes 3. Below secondary level 4. Completed secondary level 5. Completed higher education: University, Masters, Doctorate 6. Completed professional/technical level 7. Informal education (including religious studies) 8. Do not know 9. Other (specify):_____
9. Activity status? |_| **(choose one)**	0. Not applicable 1. Working 2. Not working 3. Full time house wife 4. Housewife with a part time job 5. Retired

Section 2: Education	
10. Does (name) attend school?	1. Yes If Yes, skip to Q12 2. No
11. Did (name) ever attend school?	1.Yes 2. No
Not attending school/stopped school These questions are for parents of a child who either dropped out or never attended school. Check Q9, if the child answered "No", go to Q11. If the parent answered "Yes", then skip this section and go to	

Q12	
12. Why does (name) not attend/stopped school? (Unprompted multiple response.) Do not read possible response, but always ask "Anything else."	a. School is too far ___ b. Not enough books and/ or supplies_____ c. Not enough qualified female teachers____ d. Not enough teachers (all teachers)____ e. He/she wanted to stop as school was boring___ f. He/she needs to stay home and help with chores ___ g. He needs to help his father ___ h. Cost of attending school is too high ____ i. Boys are given priority to attend school ___ j. Formal school education is not as important for girls as it is for boys ___ k. She/he became too old ___ l. She/he is not clever __ m. She/he got engaged or married ___ n. He/she needs to earn money ___ o. School space is inadequate (overcrowding, cold, hot, etc.) ___ p. He/she had learned enough____ q. School is mixed and not appropriate for girls ___ r. Other (specify) _____
All children	
13. Has (name) ever attended any other forms of education, either now or in the past? |__|	1. Yes 2. No If no, skip to Q44
14. If yes, which other forms of education did/does (name) attend? (Read Multiple response) 1=Yes 2=No	a. Youth club __ b. Private school support __ c. Remedial classes __ d. Technical/vocational training e. Religious education __ f. Lectures on health, literacy, etc. __ g. Other __ h. (specify)_____
Section 3: Changes during puberty	
15. What physical changes in the body occur in girls during puberty?	h. Breasts start to grow __ i. Hair growth (genital/underarms) __ j. Height and weight increase

(Unprompted multiple response)	k. Menstruation starts __ l. Oily skin, pimples__ m. Do not know __ n. Other __ (specify) _____
16. What physical changes in the body occur in boys during puberty? (Unprompted multiple response)	i. Hair growth (face, arms, legs, pubic) __ j. Voice changes (hoarse voice) __ k. Height and weight increase __ l. Body becomes more muscled/strong m. Oily skin, pimples __ n. Changes in sex organs __ o. Do not know__ p. Other__ (specify)_____
17. What problems or worries does a person face during puberty? (Multiple response)	l. No problems or worries__ If no problems, skip to Q115 m. Abdominal cramps___ n. Nocturnal emissions___ o. Feeling fatigued / tired ___ p. Eating too much __ q. Get sad / depressed __ r. Irritability / Anger __ s. Cannot concentrate on work / study__ t. Timidity/shyness u. Do not know__ v. Other__ (specify)_____
18. Do adolescents face reproductive health risks?	1=yes 2=no, skip to Q.21, mark N/A in Q20 3=don't know, skip to Q.21, mark N/A in Q20
19. If yes, what are they?	h. N/A i. Unintended, too-early pregnancy j. STIs, including HIV k. Unsafe abortion l. Sexual violence and exploitation. m. Don't know n. Other, specify:_____
20. When a child/adolescent aged 10-17 has a reproductive health problem or	o. Seek no help or advice p. Teacher __

question, where should he/she seek help or advice? **Remember, reproductive health problems are problems associated with the reproductive health organs, such as pregnancy, contraceptive concerns, HIV/AIDS, STIs, abortion, etc.** **(Do not read out; Probe by asking, "Anyplace else?" and mark all that apply)**	q. Mother __ r. Father s. Brother or sister __ t. Friend __ u. Relative __ v. Gynecologist/doctor w. Nurse/midwife x. Psychosocial counselor y. Social worker z. Health center aa. Youth center __ bb. Printed material (brochures) __ cc. Radio __ dd. TV__ ee. Book ff. Internet gg. Don't remember __ hh. Don't know ii. Other (specify)_____
21. Do you consider yourself knowledgeable enough to provide advice on sexual and reproductive health issues to youth aged 10-17? |_|	1=Yes 2=No
Section 4:STIs and HIV/AIDS	
22. Do you know any infections a person can get through sexual intercourse? If yes, which one do you know? (Do not read out. Probe by asking, "What others?" and circle all that applies)	10. HIV/AIDS 11. Gonorrhea 12. Syphilis 13. Genital warts 14. Genital herpes 15. Hepatitis B 16. Other (specify):_____ 17. Don't know
23. What signs or symptoms suggest that a person has a sexually transmitted infection (STI)?	9. Discharge from penis/vagina 10. Burning pain or itching in penis/vagina 11. Abnormal vaginal bleeding 12. Loss of weight

(Do not read out. Probe by asking, What others?" and circle all that applies.)	13. Sores or warts on penis/vagina 14. Painful urination 15. Swelling in groin region 18. Other (specify):_____ 16. Don't know
If the respondent named AIDS as sexually transmitted infection in Q59, circle answer 1. Without asking him Q61. If the respondent didn't name AIDS in Q59, ask him Q61. 24. Have you heard of an illness/disease called AIDS? |_|	3. Yes 4. No If no skip to Q111
25. Please name all the ways in which you believe a person can get AIDS. (Do not read out. Probe by asking, "Anything else?"And circle all that apply)	11. Sexual relations 12. Sharing syringes 13. Unclean medical equipment 14. Blood transfusions 15. Mother to child during birth 16. Mosquito or other insect bites 17. Through breast milk 18. Casual contact with infected person (e.g., sharing food, cup or glass; handshake, cough or sneeze) 19. Other (specify):_____ 20. Don't know
26. What can a person do to avoid getting infected with HIV/AIDS? (Unprompted Multiple Responses)	12. Avoid sex completely/abstinence 13. Stay faithful to partner 14. Encourage partner to stay faithful 15. Avoid contaminated blood (unscreened blood transfusions) 16. Use condoms for every act of sexual intercourse 17. Avoid sharing syringes 18. Avoid sharing razors and blades 19. Avoid commercial sex workers 20. Avoid casual sex 21. Avoid Casual contact with infected person (e.g., sharing food, cup or glass; handshake, cough or sneeze)__ 21. Other (specify):_____ 22. Don't know

Section 5: Engagement & Marriage	
27. In your opinion what is the best age for a girl to get engaged? |_|	1=Less than 12 years 2=12-14 years 3=15-18 years 4=19-20 years 5=21-22 years 6=23-24 years 7=25 or older 99=I don't know
28. In your opinion what is the best age for a boy to get engaged? |_|	1=Less than 12 years 2=12-14 years 3=15-18 years 4=19-20 years 5=21-22 years 6=23-24 years 7=25 or older 99=I don't know
29. In your opinion what is the best age for a girl to get married? |_|	1=Less than 12 years 2=12-14 years 3=15-18 years 4=19-20 years 5=21-22 years 6=23-24 years 7=25 or older 99=I don't know
30. In your opinion what is the best age for a boy to get married? |_|	1=Less than 12 years 2=12-14 years 3=15-18 years 4=19-20 years 5=21-22 years 6=23-24 years 7=25 or older 99=I don't know
31. Are there any reasons why pregnancy/child birth should be avoided when a person is in his/her adolescence? |_|	1=Yes 2=No (If no, go to Q30, but fill N/A in Q29) 3=Don't know (go to Q30, but fill N/A in Q29)
32. What do you think are the complications with early pregnancy/delivery? (Unprompted Multiple Response)	n. Not applicable (N/A) o. Maternal death p. Premature birth q. Overweight newborns r. Spontaneous abortion

	s. Stillbirth t. Low birth weight u. Bleeding v. High level of childhood illness w. Mental and physical disabilities in children x. No negative effects y. Don't know z. Other,(Specify)_____ _____

Section 6: Violence

Punishment / Violence

33. Now I will read some statements. Can you please indicate whether you agree or disagree with the statement	**Agree**	**Disagree**
a. A teacher needs to use physical punishment (hitting/hurting a child) to teach a child the correct behavior	|__|	|__|
b. A teacher needs to use humiliating punishment (calling child names/stupid, making the child feel small) to teach a child correct behavior	|__|	|__|
c. Parents need to use physical punishment (hitting/hurting a child) to teach a child the correct behavior	|__|	|__|
d. Parents need to use humiliating punishments (calling child names/stupid, making the child feel small) to teach a child correct behavior	|__|	|__|

34. Adults use different ways to teach children good behavior and to address behavior problems. I will read various methods used and I want you to tell me if you or anyone else in your household has used this method with (*NAME*) in the **past one month**. If you or anyone else have used this method, please tell us who implemented it

1=Yes 2=No

a. Took away privileges, forbade something *(NAME)* liked or did not allow him/her to leave house. ____	*Implementer:* _____
b. Explained why something (the behavior) was wrong and told him/her to do something else ___	*Implementer:* _____
c. Shouted, yelled/screamed at him/her ___	*Implementer:* _____
d. Called him/her stupid, lazy or other bad names ___	*Implementer:* _____
e. Shook him/her (with rigor/force) ___	*Implementer:* _____
f. Spanked, hit or slapped him/her with hand ___	*Implementer:* _____
g. Spanked, hit or slapped him/her with object ___	*Implementer:* _____
h. Threatened him/her ___	*Implementer:* _____
i. Locked the child into a space by himself/herself ___	*Implementer:* _____

j. Others [Specify]:_____	*Implementer:* _____

35. When the adults in the house get into arguments with one another does the child witness these arguments?	1. Always 2. Most of the time 3. Sometimes 2. Never If never, skip to Q and mark N/A in Q33 and Q34
36. Do these arguments often contain physical aggression (hitting, slapping, pushing, etc)? |__|	1. N/A 2. Yes 3. No
37. Do these arguments often contain verbal aggression (yelling/shouting, name calling, etc) |___|	1. N/A 2. Yes 3. No

PLEASE THANK THE PARENT FOR HELPING WITH THE SURVEY

ACCESS TO EDUCATION AND HEALTH SERVICES
BASELINE FORM: Education Services Providers KAP.

Informed Consent

Hello. My name is _____, and I work with Save the Children, … to improve our understanding of the situation of youth in your community. We are conducting a survey and would appreciate your participation. I would like to observe your work with children 10-18 years of age and ask you some questions about yourself. This information will help to plan a program that improves utilization of education and health services. We usually need 20-30 minutes to complete the survey, and your part is voluntary so you can choose not to answer some individual questions. However, we hope that you will participate in this survey since your views about how you work with youth are important.

At this time, do you want to ask me anything about the survey?

Do you agree? Yes No

RESPONDENT AGREES TO BE INTERVIEWED [YES] [NO]

Interview number: _____

Name of impact area: |_|
oPt: 1= Al-Arroub, 2= Aqabet Jaber, 3= Ayda & Al-Azzeh, 4= Ein El-Sultan, 5=Dura

Name of the interviewer:_____

Name of respondent: _____

Type of facility: |_|
1= Public school 2=Private school 3=Semi-private school 4=UNRWA school
5=NGO 6=Health center/clinic

Name of school/NGO/health facility:
_____

Visits register

No. of visit	Date of interview			Status of interview	*Time interview*	
	Day	Month	Year		**Began**	**Ended**
1						
2						

3						
4						
5						

Codes for status of visit:
1= Not at center/school **3**= Interview not completed
2= Refusal **4**= Interview completed

If refusal, reason:_____

If interview not completed, reason:_____

Section 1: General characteristics

1. Services provided: |_| 1=Health, 2=Education, counseling, social work.

2. Position of person interviewed/observed: |_|

Group 1: Health workers 1=Senior medical officer, 2=Senior staff nurse, 3= Senior practical nurse, 4=Midwife,	Group 2: Education, counseling, social workers 5=Teacher, 6= Head teacher, 7=Psychosocial counselor 8= Social worker, 9= Educator/animator,
10= Other, (specify): _____	

3. Sex: |_| 1=Male, 2=Female

4. Age: |_| 1= <20 years,
2= 20-29 years,
3= 30-40 years,
4= >40 years

5. How many years have you been teaching / counseling/ providing services to children aged 10 to 17? |_||_|

Section 2: Changes during puberty

6. What physical changes in the body occur in girls during puberty? (Unprompted multiple response)	o. Breasts start to grow __ p. Hair growth (genital/underarms) __ q. Height and weight increase r. Menstruation starts __

	s. Oily skin, pimples__ t. Do not know __ u. Other __ (specify) _____
7. What physical changes in the body occur in boys during puberty? (Unprompted multiple response)	q. Hair growth (face, arms, legs, pubic) __ r. Voice changes (hoarse voice) __ s. Height and weight increase __ t. Body becomes more muscled/strong u. Oily skin, pimples __ v. Changes in sex organs __ w. Do not know__ x. Other__ (specify)_____
8. What problems or worries does a person face during puberty? (Multiple response)	w. No problems or worries__ If no problems, skip to Q115 x. Abdominal cramps___ y. Nocturnal emissions___ z. Feeling fatigued / tired ___ aa. Eating too much __ bb. Get sad / depressed __ cc. Irritability / Anger __ dd. Cannot concentrate on work / study__ ee. Timidity/shyness ff. Do not know__ gg. Other__ (specify)_____
9. Do adolescents face reproductive health risks?	1=yes 2=no, skip to Q.12, mark N/A in Q11 3=don't know, skip to Q.12, mark N/A in Q11
10. If yes, what are they?	jj. N/A kk. Unintended, too-early pregnancy ll. STIs, including HIV mm. Unsafe abortion nn. Sexual violence and exploitation. oo. Don't know pp. Other, specify:_____
11. When a child/adolescent aged 10-17 has a reproductive health problem or question, where should he/she seek	qq. Seek no help or advice rr. Teacher __ ss. Mother __

help or advice? **Remember, reproductive health problems are problems associated with the reproductive health organs, such as pregnancy, contraceptive concerns, HIV/AIDS, STIs, abortion, etc.** **(Do not read out; Probe by asking, "Anyplace else?" and mark all that apply)**	tt. Father uu. Brother or sister __ vv. Friend __ ww. Relative __ xx. Gynecologist/doctor yy. Nurse/midwife zz. Psychosocial counselor aaa. Social worker bbb. Health center ccc. Youth center __ ddd. Printed material (brochures) __ eee. Radio __ fff. TV__ ggg. Book hhh. Internet iii. Don't remember __ jjj. Don't know kkk. Other (specify)_____
12. Do you consider yourself knowledgeable enough to provide advice on sexual and reproductive health issues to youth aged 10-17? |_|	1=Yes 2=No
Section 3:STIs and HIV/AIDS	
13. Do you know any infections a person can get through sexual intercourse? If yes, which one do you know? (Do not read out. Probe by asking, "What others?" and circle all that applies)	19. HIV/AIDS 20. Gonorrhea 21. Syphilis 22. Genital warts 23. Genital herpes 24. Hepatitis B 25. Other (specify):_____ 26. Don't know
14. What signs or symptoms suggest that a person has a sexually transmitted infection (STI)? (Do not read out. Probe by asking, What others?" and circle all that	17. Discharge from penis/vagina 18. Burning pain or itching in penis/vagina 19. Abnormal vaginal bleeding 20. Loss of weight 21. Sores or warts on penis/vagina

applies.)	22. Painful urination 23. Swelling in groin region 27. Other (specify):_____ 24. Don't know
If the respondent named AIDS as sexually transmitted infection in Q59, circle answer 1. Without asking him Q61. If the respondent didn't name AIDS in Q59, ask him Q61. 15. Have you heard of an illness/disease called AIDS? |_|	5. Yes 6. No If no skip to Q111
16. Please name all the ways in which you believe a person can get AIDS. (Do not read out. Probe by asking, "Anything else?"And circle all that apply)	22. Sexual relations 23. Sharing syringes/unclean medical equipment 24. Blood transfusions 25. Mother to child during birth 26. Mosquito or other insect bites 27. Through breast milk 28. Casual contact with infected person (e.g., sharing food, cup or glass; handshake, cough or sneeze) 29. Other (specify):_____ 30. Don't know
17. What can a person do to avoid getting infected with HIV/AIDS? (Unprompted Multiple Responses)	23. Avoid sex completely/abstinence 24. Stay faithful to partner 25. Encourage partner to stay faithful 26. Avoid contaminated blood (unscreened blood transfusions) 27. Use condoms for every act of sexual intercourse 28. Avoid sharing syringes 29. Avoid sharing razors and blades 30. Avoid commercial sex workers 31. Avoid casual sex 32. Avoid Casual contact with infected person (e.g., sharing food, cup or glass; handshake, cough or sneeze)__ 31. Other (specify):_____ 33. Don't know
Section 4: Engagement & Marriage	
18. In your opinion what is the best age for a girl to get engaged? |_|	1=Less than 12 years 2=12-14 years

	3=15-18 years 4=19-20 years 5=21-22 years 6=23-24 years 7=25 or older 99=I don't know
19. In your opinion what is the best age for a boy to get engaged? |_|	1=Less than 12 years 2=12-14 years 3=15-18 years 4=19-20 years 5=21-22 years 6=23-24 years 7=25 or older 99=I don't know
20. Do you think that children who are engaged should continue their education? |_|	1=Yes 2=No 3= Not applicable
21. In your opinion what is the best age for a girl to get married? |_|	1=Less than 12 years 2=12-14 years 3=15-18 years 4=19-20 years 5=21-22 years 6=23-24 years 7=25 or older 99=I don't know
22. In your opinion what is the best age for a boy to get married? |_|	1=Less than 12 years 2=12-14 years 3=15-18 years 4=19-20 years 5=21-22 years 6=23-24 years 7=25 or older 99=I don't know
23. Do you think that children who are married should continue their education? |_|	1=Yes 2=No 3=Not Applicable
24. Are there any reasons why pregnancy/child birth should be avoided when a person is in his/her adolescence? |_|	1=Yes 2=No (If no, go to Q30, but fill N/A in Q29) 3=Don't know (go to Q30, but fill N/A in Q29)
25. What do you think are the complications with early pregnancy/delivery? (Unprompted Multiple Response)	aa. Not applicable (N/A) bb. Maternal death cc. Premature birth dd. Overweight newborns

	ee. Spontaneous abortion ff. Stillbirth gg. Low birth weight hh. Bleeding ii. High level of childhood illness jj. Mental and physical disabilities in children kk. No negative effects ll. Don't know mm. Other,(Specify)_____ _____

Section 5: Violence

A. Child Needs, Care and Protection

26. In your opinion, what should children 10-17 years be protected from?

Children should be protected from:	**Very Important**	**Somewhat important**	**Not important**
l. Be protected from disease	_|	_|	_|
m. Be protected from extreme heat and cold	_|	_|	_|
n. Be protected from conflict and violence inside the home	_|	_|	_|
o. Be protected from violence outside the home	_|	_|	_|
p. Be protected from poverty	_|	_|	_|
q. Be protected from unsafe and inadequate home/shelter	_|	_|	_|
r. Be protected from accidents	_|	_|	_|
s. Be protected from risky sexual behavior	_|	_|	_|
t. Be protected from sexual abuse	_|	_|	_|
u. Be protected from substance abuse	_|	_|	_|
v. Be protected from being exploited by others	_|	_|	_|
ii.Others [Specify]:_____	_|	_|	_|

27. In your opinion, what are the needs of children aged 10-17? And how important are these needs in your opinion?

Children's need for:	**Very Important**	**Somewhat important**	**Not important**
l. Sufficient healthy nutritious food	_|	_|	_|
m. Stimulating environment/education/apprenticeships	_|	_|	_|
n. Healthy environment (clean water, air,)	_|	_|	_|
o. A safe and secure environment	_|	_|	_|
p. Access to health services/vaccinations	_|	_|	_|
q. Physical care (cleaning/hygiene)	_|	_|	_|
r. Adequate rest	_|	_|	_|

s. Opportunities for leisure/sports/social activities t. Friends of same age u. Adult role models v. Work opportunities O. Others [Specify]:_____	|_|	|_|	|_|

28. Only for teachers:
For other service providers, mark (1.) Not Applicable.
What do you do when a child does not behave well in class?

1. Not applicable |_|
2. Take them to see the school management |_|
3. Give the child additional work |_|
4. Send the child to the corner |_|
5. Send the child back home |_|
6. Shout at the child |_|
7. Hit the child on the hand |_|
8. Hit the child on another part of the body |_|
9. Other |_| (specify)_____

29. What are violent behaviors against children 10-17?

f. Physical
g. Psychological
h. Social
i. Economical
j. Other, specify:_____

30. Is there violence against children 10-17 years in this community? |_| 1=Yes, 2=No

31. If yes, where do think this violence is?

1. At home from adults |_|
2. At home from older siblings |_|
3. At school from teachers |_|
4. At school from older students |_|
5. Between youth themselves in the neighborhood |_|
6. Other |_| (specify) _____

32. Do you observe among your students/clients, children with symptoms that indicate violence? |_| 1=Yes, 2=No

33. If yes, what symptoms have you observed:

1. Bruises |_|
2. Broken bones |_|

3. Blue eyes |_|
4. Internal bleeding |_|
5. Cuts |_|
6. Food/drink deprivation |_|
7. Exposure to heat or cold |_|
8. Exploitation/hard work |_|
9. Bruises as a result of sexual abuse |_|
10. Other |_| (specify):_____

34. If you suspect violence as the cause of the symptoms, what do you do?
    1. Nothing, treat symptom |_|
    2. Ask what the reason is from child |_|
    3. If violence is at home, ask father to come to the school/center |_|
    4. If violence is at school, discuss with other teachers |_|
    5. Other |_| (specify) _____

35. Do you report signs of violence?
    1=yes
    2=no, skip to Q35, mark N/A in Q 34

36. If yes, to who?
    1.

37. For teachers:

Do you feel that teachers have a responsibility to address violence in the community?
|_| 1=Yes, 2=No
For social workers:

For social workers/educators

Do you feel that social workers/educators have a responsibility to address violence in the community?
|_| 1=Yes, 2=No

For psychosocial counselors:

Do you feel that psychosocial counselors have a responsibility to address violence in the community?
|_| 1=Yes, 2=No

<u>Sexual abuse</u>

38. Do you feel you have enough knowledge and skills to deal with children who have been sexually abused?
    1=yes
    2=no
    3= Don't know

39. What are factors that make children vulnerable to sexual abuse?
    14. Gender
    15. Unaccompanied children
    16. Children in foster care, adopted children, stepchildren
    17. Physically or mentally handicapped children
    18. History of past abuse
    19. Poverty
    20. War/armed conflict
    21. Psychological or cognitive vulnerability
    22. Single parent homes/broken homes
    23. Social isolation (e.g. lacking an emotional support network)
    24. Parent with mental illness, or alcohol or drug dependency
    25. Don' know
    26. Other, specify:_____

40. What are physical indicators of child sexual abuse?
    13. Unexplained genital injury
    14. Recurrent vulvovaginitis (an inflammation of the vagina.It can result in discharge, itching and pain,and is often associated with an irritation or infection of the vulva. It is usually due to infection)
    15. Vaginal or penile discharge
    16. Bedwetting and fecal soiling beyond the usual age
    17. Anal complaints (e.g. fissures, pain, bleeding)
    18. Pain on urination
    19. Urinary tract infection
    20. STI
    21. Pregnancy
    22. Presence of sperm
    23. Don' know
    24. Other, specify:_____

41. What are behavioral indicators of child sexual abuse?

    13. Regression in behaviour, school performance or development
    14. Acute traumatic response such as clingy behaviour and
    15. Irritability in young children
    16. Sleep disturbances
    17. Eating disorders
    18. Problems at school
    19. Social problems
    20. Depression
    21. Poor self-esteem
    22. Inappropriate sexualized behaviours
    23. Don' know
    24. Other, specify:_____

42. What are consequences of child sexual abuse on the child?
    14. Gastrointestinal disorders (e.g. irritable bowel syndrome, non-ulcer dyspepsia, chronic abdominal pain);
    15. Depressive symptoms;
    16. Anxiety;
    17. Low self-esteem;
    18. Symptoms associated with PTSD such as re-experiencing, avoidance/
    19. numbing, hyperarousal;
    20. Increased or inappropriate sexual behaviour;
    21. Loss of social competence;
    22. Cognitive impairment;
    23. Body image concerns;
    24. Substance abuse
    25. Don' know
    26. Other, specify:_____
        (other: STI, death, pregnancy, unsafe abortion, disability, etc…)

43. Do you feel confident in supporting with children who have been sexually abused?
    1=yes
    2=no
    3= Don't know

44. Have you received any training on guidelines of dealing with children who have been sexually abused?
    1=yes
    2=no
    3= Don't know

45. Have you received any training regarding communication with children and their families, and facilitating children participation?
    1=yes
    2=no
    3= Don't know

Thank the service provider for his/her cooperation