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Impact evaluation of project: Protecting Adolescents from Gender based Violence through the Promotion of their Sexual and Reproductive Health Rights /Palestine.

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Impact evaluation of project: Protecting Adolescents from Gender based Violence through the Promotion of their Sexual and Reproductive Health Rights /Palestine.

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Thesis Approval

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Dedication

This thesis is dedicated to my family, my parents, my husband and children, without their love, patience, understanding, and support nothing would be done.

Rasha Hamoudeh

Declaration:

I Certify that this thesis submitted for the degree of Master, is the result of my own research, except where otherwise acknowledged, and that study has not been submitted for a higher degree to any other university or institution.

Signed …….

Rasha Mohammad Mahmoud Hamoudeh

Date: 17/12/2016

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Abstract

Background Adolescence is a period of transition from childhood to adulthood, and the age when most people start to explore their sexuality. This natural sexual behavior puts these young at risk of being affected by undesirable sexual and reproductive health concerns. Several initiatives have been taken by non-governmental organizations to recognize adolescents' reproductive health needs and targeted children protection in many regions. This study looked into one of the projects that concerns sexual and reproductive health of adolescents.

The project was aim to improve knowledge, attitudes and practices of adolescents towards puberty, personal hygiene, early marriage, violence, reproductive health, HIV (AIDS) and other sexual transmitted disease.

Methods The aim of this study was to evaluate the impact of the project (Protecting Adolescents from Gender based Violence through the Promotion of their Sexual and Reproductive Health Rights) by evaluating the changes in knowledge, attitudes and behaviors of the children and adolescents in the following areas: puberty, personal hygiene, early marriage, violence, reproductive health, HIV (AIDS) and other sexual transmitted disease.

A quantitative case control study was used. The study started in January 2014. Data collection was completed in April 2015. The study was conducted in three camps schools of (Arroub, Aida and Ein Sultan camps). The total Study sample included 210 children that aged between 14-18 years and from the targeted school camp and volunteered to participate, 70 children assigned to the case group that participated in the project " **Protecting Adolescents from Gender based Violence through the Promotion of their Sexual and Reproductive Health Rights** /Palestine, in 2010. And 140 children assigned to the control group that didn't participate in the project. The data collection tools were structured self-administrated questionnaire for case and control groups. KAP survey was used to measure the impact of the project activities. The data were analyzed using the statistical package for the social science (SPSS) 19.0 version, the level of significance $\alpha=0.05$ ($p<0.05$) for statistical analysis.

Findings The study results showed that there were statistically significant differences at the level of α=0.05 in knowledge, attitudes and practices of children and adolescents in the following areas: puberty, personal hygiene, early marriage, violence, reproductive health, HIV (AIDS) and other sexual transmitted disease.

Conclusion This study indicates that the intervention program was effective in changing knowledge, attitudes and practices in children and adolescents. It was clear that the project has been able to bring in a remarkable change to the most of the case group; the improvement in the case group compared with children in the control group in the following area: puberty, personal hygiene, early marriage, violence, reproductive health, HIV (AIDS) and other sexual transmitted disease. The impact evaluation of the project" Protecting Adolescents from Gender based Violence through the Promotion of their Sexual and Reproductive Health Rights' in (Arroub, Aida and Ein Sultan camps) was very effective. Significant progress was achieved. The interventional projects concerns children and adolescent are recommended to be used to change the sexual and reproductive health outcomes.

العنوان : تقييم أثر المشروع: حماية المراهقين من العنف القائم على النوع الاجتماعي من خلال تعزيز حقوقهم في الصحةالجنسيةوالإنجابية / فلسطين.

اعداد :رشا محمد محمود حمودة

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الملخص

الخلفية: المراهقة هي فترة انتقالية من مرحلة الطفولة إلى مرحلة البلوغ، والسن التي يبدأ فيها معظم الناس لاستكشاف حياتهم الجنسية. يضع هذا السلوك الجنسي الطبيعي هؤلاء الشباب عرضة لخطر التأثر بالمخاوف الصحة الجنسية والإنجابية غير مرغوب فيها. اتخذت عدة مبادرات من قبل المنظمات غير الحكومية على الاعتراف باحتياجات الصحة الإنجابية للمراهقين وحماية الأطفال المستهدفين في العديد من المناطق. وقد بحثت هذه الدراسة في واحدة من المشاريع التي تتعلق بالصحة الجنسية والإنجابية للمراهقين.

وكان هذا المشروع يهدف إلى تحسين معارف ومواقف وممارسات المراهقين نحو البلوغ، النظافة الشخصية، والزواج المبكر، والعنف، والصحة الإنجابية، وفيروس نقص المناعة البشرية (الإيدز) وغيرها من الأمراض التي تنتقل بالاتصال الجنسي.

المنهجية: الهدف من هذه الدراسة هو تقييم أثر المشروع (حماية المراهقين من العنف القائم على النوع الاجتماعي من خلال تعزيزحقوقهم في الصحة الجنسية و الإنجابية) من خلال تقييم التغيرات في المعرفة والمواقف والسلوكيات من الأطفال والمراهقين في المجالات التالية: البلوغ، النظافة الشخصية، والزواج المبكر، والعنف، والصحة الإنجابية، وفيروس نقص المناعة البشرية (الإيدز) وغيرها من الأمراض التي تنتقل بالاتصال الجنسي.

اعتمدت الدراسة طريقه البحث الكمي (دراسة الحالات والشواهد)(التدخل و المقارنة). بدأت الدراسة في يناير كانون الثاني عام 2014. واكتمل جمع البيانات في أبريل عام 2015. وقد أجريت الدراسة في ثلاثة مدارس مخيمات (العروب، عايدة ومخيم عين السلطان). وتضمنت مجموع عينة الدراسة 210 أطفال التي تتراوح أعمارهم بين 14-18 عاما، 70 طفلا لمجموعة التدخل التي شاركت في مشروع "حماية المراهقين من العنف القائم على النوع الاجتماعي من خلال تعزيزحقوقهم في الصحة الجنسية و الإنجابية / فلسطين، في عام 2010. و 140طفلا لمجموعة المقارنة التي لم تشارك في المشروع. وقد تم جمع البيانات من المجموعتين بواسطة استبيان يتم الاجابة عليه بشكل شخصي. واستخدمت الدراسة KAP لقياس أثر أنشطة المشروع. وقد تم تحليل البيانات باستخدام الحزمة الإحصائية للعلوم الاجتماعية SPSS الإصدار19.0، ومستوى الدلالة0.05 = α ,0.05>p) للتحليل الإحصائي.

النتائج: أظهرت نتائج الدراسة أن هناك فروقا ذات دلالة إحصائية عند مستوى $\alpha = 0.05$ في المعرفة والمواقف والممارسات من الأطفال والمراهقين في المجالات التالية: البلوغ، النظافة الشخصية، والزواج المبكر، والعنف، والصحة الإنجابية، وفيروس نقص المناعة البشرية (الإيدز) وغيرها من الأمراض التي تنتقل بالاتصال الجنسي.

الخاتمة: تشير هذه الدراسة إلى أن برنامج التدخل الفعال في تغيير المعارف والمواقف والممارسات في الأطفال والمراهقين. ومن الواضح أن المشروع قد تمكن من جلب تغييرا ملحوظا على معظم أفراد مجموعة التدخل؛ التحسن في مجموعة التدخل بالمقارنة مع الأطفال في مجموعة المقارنة في المناطق التالية: البلوغ، النظافة الشخصية، والزواج المبكر، والعنف، والصحة الإنجابية، وفيروس نقص المناعة البشرية (الإيدز) وغيرها من الأمراض التي تنتقل بالاتصال الجنسي. كان تقييم أثر المشروع "حماية المراهقين من العنف القائم على النوع الاجتماعي من خلال تعزيز حقوقهم في الصحة الجنسية و الإنجابية" في (مخيمات العروب، عايدة وعين السلطان) جيد جدا. وعليه يوصي هذا البحث بضرورة تبني المشاريع التي تعنى بالاهتمام بالأطفال والمراهقين من أجل تحسين النتائج الصحية الجنسية والإنجابيةعلى المستوى الوطني.

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Chapter one
Introduction

1.1 Background:

The term “Adolescent” is defined by WHO as being between the age of 10-19 years old, whereas the term “Youth” as being between the age 15-24 years old (WHO, 1993). Additionally, the Convention on the Rights of Children defines “a child” as a human being aged below 18 years. It is understood that adolescent is the period of transition from childhood to adulthood. It is known to be a crucial period since the adult health status is closely associated with the experiences witnessed during adolescence (Geneva, WHO, 2002). The definitions of child, adolescent, and youth are varying noticeably from one national to another.

It is worth mentioning that an interest in children rights at the international level has emerged from the international human rights. It is noticeable that care in international rights of children began to be formally organized and declared since 1923, when a statement of children rights became known and declared as Geneva Declaration (1), containing five basic principles for the protection of childhood.

In 1924, in its fifth session, the United Nations has approved Geneva Declaration, and urged the Member States to respect its principles as: "Men and women all over the country recognize that humanity should provide to the child the best they have, assert their duties, independent from everything else, such as sex, nationality, religion" (Geneva Declaration, 1924). This Declaration remained the same until 1948, when the United Nations approved the establishment of an extended Declaration composed of ten basic items ratified by its General Assembly on November 20, 1959. Not to mention that it has seriously prepared for the

endorsement of Child Rights Convention adopted by the United Nations General Assembly unanimously on November 20, 1989.

The Child Rights Convention (CRC) was adopted on an International level in 1989. The Convention states that "the child should be fully prepared, to live an individual life in society, bring him up in the spirit of high ideals declared in United Nations Charter". In the same Convention, the term “Child” was defined as a group of individuals belonging to the age group 0-18 years, regardless to what stage he/she belongs. The stages are namely: early childhood, childhood, adolescence and young people. According to this Convention, a child can be defined as every human being below the age of eighteen, which is the age of maturity pursuant to the applicable law (Convention of Child Rights, 1989).

Whereas adolescence can be defined as the period of transition from childhood to adulthood, and the age at which most people begin to explore their sexuality. Undoubtedly, the natural sexual behavior of the young puts them at risk of being affected by undesirable sexual and reproductive health concerns. Throughout the world, nearly one among five girls becomes a mother before turning to 18 (Christiansen, Gibbs, and Chandra-Mouli, 2013).

In 1994, the International Conference on Population and Development (ICPD), and the Fourth World Conference on Women (Beijing, 1995), have given special attention to the special needs of adolescents in respect of sexuality and reproductive health. According to the said conferences, sexuality and reproductive health are recognized as human rights. ICPD aimed at improving sexuality and reproductive health as well as promoting the satisfaction of sexuality and reproductive health rights.

Indeed, sexuality, reproductive health, and well-being are important elements in young people’s life. Throughout adolescence, young people are able to explore, experience, and express their sexuality in healthy, pleasurable, and safe ways. To maintain sexual health, it is required to set up a positive approach to human sexuality and an understanding of the complex factors that shape human sexual behaviors. As these factors determine whether understanding sexuality will lead to positive sexual health and well-being, or to negative sexual behaviors

that put young people at risk, e.g. catching the infection of HIV/AIDS, or sexually transmitted infections (STIs), or unwanted pregnancies, or unsafe abortion, or infertility and gender-based violence.

In spite of the great international attention focused on child rights, most importantly, child care and protection, reality may neglect these international conventions and conferences, since many children are exposed to daily violence on the social and economical levels, as well as due to the various political backgrounds. According to UNICEF, around 500 million - 1.5 billion children are annually exposed to violence (UNICEF, 2009), which implies the fact that violence against children is a global pandemic and phenomenon.

It is important that health program managers, policy-makers, care providers and other non-governmental organizations understand and promote the potentially positive role of sexuality in people's lives in order to establish a health system that can promote sexually healthy societies.

It is worth noting that several initiatives in many regions have been taken by non-governmental organizations for the purpose of recognizing adolescents' reproductive health needs aimed at children protection. For example, in Palestine the Swedish Child Protection Organization, in collaboration with Juzoor Organization for Health & Community Development, has implemented a children protection project, under the financing of the European Union, in December 2010, titled "Investing in People: Good Health for All, for Capacity Development, Introducing Reproductive, Sexual Health, and Public Rights". The Project started in 2010, and ended on 2012, it covered 284 children, aimed at emphasizing the rights of children and adults in respect of sexual and reproductive health.

The project sought to improve knowledge, attitudes, and practices of adolescents, parents and service providers, in five areas (Arroub, Aqabet Jabber, Aida & Izza, Ein Sultan and Dura). Furthermore, Juzoor has implemented a program in cooperation with the United Nations Relief and Works Agency(UNRWA) , not to mention that it has invested in the fields of development, production and implementation of three key modules related to Children and

Adolescents Sexual and Reproductive Health Rights (SRHR), providing that these modules were developed for service providers.

Moreover, Juzoor has provided intensive training on each module to trainers. Service providers were responsible for training children, adolescents, parents, and other care givers. Under this program, 7 training courses were carried out on the modules for service providers. In return, these training courses made available more than 200 workshops/sessions to the target groups using these modules and based on relevant topics and exercises during the project period.

This research is aimed at evaluating the impact of this project on children's knowledge, attitudes and practices towards puberty, personal hygiene, early marriage, violence, reproductive health, HIV (AIDS) and other sexual transmitted diseases.

The project is evaluated by measuring its progress, its extent of meeting and fulfilling the needs established for, its effectiveness, as well as its impact and sustainability in order to review the achievements of the project compared to what was planned for (PCM, 2004). The impact of the project shall reflect the extent of dissemination of benefits received by target groups within the community or region, in addition to the project's contribution in developing the Sector of Health. Accordingly, the impact of the project measures the extent of achieving the overall objective of the project on the long term.

1.2 Problem Statement:

The process of impact evaluation is defined as the systematic identification of effects, whether positive or negative, intended or not towards individual households, institutions, or the environment caused by a given development activity such as a program or a project (Paul J. Gertler, 2011). This research is aimed at evaluating the long term impact of the project titled (Protecting Adolescents from Gender-based Violence through the Promotion of their Sexual and Reproductive Health Rights) on the knowledge, attitudes, and practices of children and adolescents knowledge, in the following fields: puberty, personal hygiene, early marriage, violence, reproductive health, HIV (AIDS) and other sexual transmitted diseases.

After making researches in literature, it is found that a few studies have evaluated the impact of projects on a long term. Despite the fact that there are many projects handling child protection and rights in Palestine, no studies, to the researcher's knowledge, tackled the long-term impact of projects concerning child rights. Therefore, this study may be considered as a motive for engaging in the field of addressing and examining the impact of projects, including the effectiveness thereunder and the limitations imposed on achieving the best results for the targeted groups, children in particular. Further, the study could also be deemed as a motive to find the best ways for achieving actual changes for children who will be the leaders of the future. .

1.3 Justification of the Study:

The Project, (Protecting Adolescents from Gender-based Violence through the Promotion of their Sexual and Reproductive Health Rights), was carried out on a large scale by Juzoor, in the selected areas in both south and middle of Palestine. The Project was carried out in response of the significant global and local attention concentrated on the issue of widespread and systematic sexual and gender-based violence. This study evaluated the impact of the Project interventions on the targeted population (children and adolescents), and the targeted area (Arroub, Aida, and Ein Sultan). The results of this study can be used in planning for the coming phases or projects to continue receiving support and/or funding from donors. Moreover, these results may be used by program developers and policy makers at the Ministry of Health and the Ministry of Education, to develop appropriate strategies aimed at improving adolescents' knowledge, attitudes and practices by using an Educational program that emphasizes the values of physical education and healthy lifestyle choices.

The study is significant for being conducted by a non governmental organization project (Juzoor). It is important and vital due to the efforts exerted towards the development of the Palestinian community in respect of the political and economical situation. The study highlights the role of non-governmental organizations in the development and upbringing of

the Palestinian society. These organizations can be defined as non-profit, aimed at providing many services and diverse needs to the society.

The World Bank has defined the term "non-governmental organizations" as: private organizations engaged in activities aimed at eliminating suffering, defending the interests of poor, protecting the environment and achieving the development of society. On the Palestinian level, the non-governmental organizations constitute an important part of the Palestinian social framework, and a key component of the organizational structure in the Palestinian development process (WorldBank, 2002).

1.4 Purpose and Objectives of the Study:

The Study Purpose:

The purpose of this study was to evaluate the impact of the project (Protecting Adolescents from Gender-based Violence through the Promotion of their Sexual and Reproductive Health Rights) by evaluating the changes in knowledge, attitudes and practices of the children and adolescents in the following fields: puberty, personal hygiene, early marriage, violence, reproductive health, HIV (AIDS) and other sexual transmitted diseases.

The Study Objectives:

1. Evaluate the knowledge of children concerning puberty, personal hygiene, early marriage, violence, reproductive health, HIV (AIDS) and other sexual transmitted diseases.
2. Assess children's attitudes towards reproductive health/ sex education, HIV (AIDS) and other sexual transmitted diseases as well as early marriage.
3. Assess children's practices towards violence and early marriage.

1.6 Difficulties and Limitations:

1- Difficult access to the records of children involved in the program for several reasons:

- The time period between the program and the study is long; therefore, it was difficult to reach the required data related to the project such as the service providers' names, the children names.
- The constant changes and movements of UNRWA team and its work places which made it difficult to reach the persons who handled children directly during the program.
- The absence of an archive system in the five regions (Arroub, Aqabet Jabber, Aida & Izza, Ein Sultan and Dura), which made it difficult to the researcher to access the information of the children involved in the program.

2- Difficulty to reach the project areas under the current restrictions imposed by the Israeli occupation, not to mention the long distance between camps and schools which made it difficult to meet students and ask them to fill out the questionnaires. Therefore, an agreement was held with school counselors to meet students during school hours and to facilitate access to them as groups.

3- Difficulty in collecting data from children who left schools for several reasons such as work, early marriage or changing the place of residence.

Chapter two
Literature Review

2.1 Introduction

This chapter is an overview of the study concepts including puberty, personal hygiene, early marriage, violence, reproductive health, HIV (AIDS) and other sexual transmitted diseases.

Moreover, it presents an overview of children and adolescents' knowledge, attitude, and behaviors in the following area: violence, reproductive health, personal hygiene, early marriage, HIV (AIDS) and other sexually transmitted diseases.

Additionally, previous studies are related to puberty, personal hygiene, early marriage, violence, reproductive health, HIV (AIDS) and other sexual transmitted diseases are discussed.
Table (2.1) summarizes some studies that were conducted in relation to puberty, personal hygiene, early marriage, violence, reproductive health, HIV (AIDS) and other sexually transmitted diseases.

2.2 Theoretical Overview

2.2.1. Early Marriage:

Throughout the world, marriage is regarded as the moment of celebration and the milestone in the life of the involved couples. It is one of the most important social phenomena distinguishing a community from the others, and one culture from another. Further, marriage is considered as an important social institution with rules, laws and values differing from one community to another.

Darwish defines marriage as a covenant between one man and one woman. In their eagerness to achieve their goals (Darwish, 2013), it is a contract where both male and female satisfy their physical, biological, social, psychological, and spiritual needs.

Early marriage is defined as a formal marriage or informal union before the age 18 between boys and girls. The practice when one or both spouses are below the age of 18 is known as child marriage. This marriage is widely spread and can lead to a lifetime of disadvantage and deprivation (IPPF, 2006).

> "Below the age 18, the girl is still considered a child under the Convention on the Rights of the Child. Following marriage a girl is expected to set aside her childhood and assume the role of a woman, proceeds immediately upon a life that includes sex, motherhood and all the household duties traditionally expected of a wife. Although early marriage extends to boys as well, the number of girls involved is far greater" (UNICEF, 2006, p44).

Undoubtedly, early marriage deprives children from their childhood, disrupts their education, increases risk of exposure to violence and abuse, and threatens their health. Accordingly, marriage will not achieve its goals, not to mention the other factors including economic factors, structural factors, and social factors.

The phenomenon of early marriage has remained widespread in Palestine despite the rise of the median age of first marriage. In 2012, the median age of first marriage in respect of men in Palestine amounted to 24.5 compared to 23.0 in 1997. Whereas in respect of females, in 2012, the median age amounted to 20.1 compared to 18.0 in 1997 (Palestinian Central Bureau Of Statistics, 2013).

2.2.2. Personal Hygiene:

Hygiene is not only concerned with cleanliness, but involves also the conditions, activities and practices of protecting health and preventing diseases. Importantly, personal hygiene creates a kind of sanitary barrier and helps to prevent infectious diseases. It is largely a matter of human behaviors, and it is determined by social traditions, customs and culture (Deodhar, 2003).

Moreover, the health of a household is determined by the behaviors, habits and practices of personal hygiene members. Hygiene practices are active efforts exerted by individuals and families, and it is best instilled early during childhood.
There are various conditions, habits, behaviors and practices influencing the personal hygiene including knowledge on health, cleanliness habits, family traditions, cultural and social values, and the influence of friends, teachers and relatives, etc.

"A personal hygiene consists of health consciousness, cleanliness, hand washing, safe drinking water, sanitary disposal of waste, freedom from addiction to tobacco and/or alcohol" (Deodhar, 2003, pS48).

2.2.3. Puberty Characteristics:

WHO identifies adolescence as "the period in human growth and development that occurs after childhood and before adulthood, from ages 10 to19" (WHO, 2001).

"Adolescence is a transition stage in the life style, linking childhood to the adulthood during which physical, mental and social development takes place" (V.R.S., 2012,p293). Puberty is a normal physiological event for adolescents, it is a stage in which adolescents cross the line between childhood and adulthood (Golchin et al, 2012).
During puberty, a set of changes occurs to adolescents on various levels, including physical, psychological and social aspects (Oswalt, 2010).

Although the different societies, social, cultural and religious factors have an important influence on puberty, adolescents have physiological similarities in puberty characteristics.

The period of puberty is one of the most critical periods in life. From the physiological aspect, stress during puberty and early adolescence may affect brain development and lead vulnerable individuals to develop psychological illness of different kinds (Cameron, 2004). On the other hand, enhancement to social learning of environment can prevent many of the psychological problems (Patton & Viner, 2007).

There are key characteristics of the pubertal time, namely: weight, height, genital stage, breast stage and pubic hair stage, testis volume and menarche (Alan et al, 2002). Not to mention, voice change in respect of boys is considered one of the key characteristics of the pubertal timing (Carolyn et al, 2012).

2.2.4. Reproductive Health and Sexually Transmitted Diseases:

It is worth mentioning that the International Technical Guidance, released by UNESCO, in December 2009, is aimed at providing an evidence-based and rights-based platform that offers children and adolescents vital knowledge on relationships, sexuality, reproduction, and HIV/AIDS, within a structured teaching and learning process during the compulsory school years (UNESCO, 2009).

Reproductive health is defined as a state of physical, mental, and social well-being in regards to all matters related to the reproductive system, and at all stages of life (WHO, 2002).

Additionally, Sexually Transmitted Infections (STIs) are infections with significant probability of transmission by means of sexual contact through vaginal, oral and anal sex. These infections may lead to serious complications such as infertility, ectopic pregnancy, cervical cancer, fetal wastage, and even death (Kunzang Norbu, 2013).

Sexually transmitted diseases (STDs) are a common source of morbidity for adolescents and young adults. STDs caused by Chlamydia trachomatis and Neisseria gonorrhoeae are infertility and pelvic inflammatory diseases. Trichomonas vaginalis lead to chronic purulent vaginal discharge, vulvovaginal irritation, dysuria, dyspareunia, and leads to pregnancy complications. These STDs, including others, increase the risk of acquiring human immunodeficiency virus HIV (Crosby & Danner, 2008). This virus infects the lymphocytes and leaves the human body unable to fight the opportunistic infections and cancers which take the advantage of the weakened immune system (Sule & Abdullah, 2014).

Getting infected with HIV virus, which is not controlled or treated yet, is almost dangerous and fatal. The four major routes of transmission of this virus are: contaminated blood transfer, unsafe sex, contaminated needles, and vertical transfer from mother to child(Sule & Abdullah, 2014).

The acronym "AIDS" stands for Acquired Immune Deficiency Syndrome and it is caused by HIV virus. Since no cure has been discovered for this disease, it is important to examine all various strategies used to control it in order to minimize the disease prevalence (Sule & Abdullah, 2014).

2.2.5. Violence against Children and Adolescent:

Violence against children is widely spread. It is not limited to a specific country or society; it takes place across all social, ethnic and cultural groups, at every socioeconomic level, within all religions and at all levels of education (UN, 1995).

There are several definitions of violence against children. Most importantly, WHO defines it as the intentional use of physical force or power, threatened or actual, against a child, by an individual or a group of people, that either results in, or has a high likelihood of resulting in actual or potential harm to the child's health, survival, development or dignity (WHO, 2002).

Whereas in the Convention on the Rights of the Child, violence against children is defined as the same definition of the UN: all forms of physical or mental violence, injury and abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse (UN, 2006).

It is worth noting that the term "Child Maltreatment" is the abuse and neglect towards children under the age 18. It includes all types of physical and/or emotional ill-treatment, sexual abuse, negligence and commercial or other exploitation, which results in actual or potential harm to the child's health, survival, development or dignity within the context of a relationship of responsibility, trust or power. Exposure to intimate partner violence is sometimes included as a form of child maltreatment (WHO, 2014).

The Child Abuse Prevention and Treatment Act issued in 1974 indicate that child abuse or neglect is limited to children under the age 18, being harmed or placed in situations of significant risk by their parents or others in charge for their welfare (CAPTA, 2014).

Violence may take several forms. First, Physical violence, that refers to the action of causing pain and temporary or permanent problems with physical functioning to a child. For example, hitting or trying to hit a child with an object, battering, or using or threatening to use a gun or a knife, biting, kicking with the fist, burning with a cigarette, pulling hair and strangling, which are all forms of physical abuse. These actions might cause bruises, burns, permanent pain, head injuries, fractures, internal injuries or slashes, or psychological trauma, even death (Twaite & Rodriguez-Srednicki, 2004).

Second, "Psychological Violence" which is defined as verbal or nonverbal behavior of threatening a child in a frightening manner, or ridiculing, humiliating, belittling, or isolating them. This type of violence will result in many negative consequences including cause the child to suffer from loss of appetite, or feelings of guilt, soiling or bed-wetting themselves, feeling low self-esteem, or the inability to trust other people, not to mention depression and aggressive (Basile et al, 2007).

> Third, "Sexual Violence", that refers to the physical force that is mainly directed towards the child's genitals and sexual characteristics. The term "Sexual Violence" is defined as: "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work" (WHO, 2002, pp.149)

> The term "Child Neglect" refers to the inadequate care of a child's basic needs, either the physical or emotional. Child neglect may vary in type, severity and length. "Neglect refers to the failure of a parent to provide for the development of the child, where the parent is in a position to do in one or more of the following areas: health, education, emotional development, nutrition, shelter and safe living conditions. Neglect is thus distinguished from circumstances of poverty in

that neglect can occur only in cases where reasonable resources are available to the family or caregiver" (WHO, 2002, p.60).

2.3 Review of Previous Studies

There are several studies conducted in the field of health education in connection to specific reproductive health aspects including sexual transmitted diseases and HIV, puberty, violence, early marriage and personal hygiene, as well as the effect of the same on children and adolescents' knowledge, attitudes and practices.

Padhyegurjar, Padhyegurjar & Adsul (2012) conducted an interventional follow-up study on student of nine standard schools. The sample of the study was a total of 375 students (222 males, 156 females). A pre-test was conducted to assess the students' knowledge; afterwards health education sessions on reproductive health were conducted with these students.

The first post-intervention evaluation was carried out immediately after holding the health education sessions. The second post-test was administered within six months, and the third post-test was administered one year after the health education session in order to observe the impact of intervention on knowledge and attitude.

Based on the results of the study, sex education should be incorporated in school curriculum, because it was found that young people are poorly informed on issues of sexuality and reproductive health. I was also found that the role of parents and teachers in addressing reproductive and sexual health issued was below the expected, while it should be great in the socio-cultural and personality development of adolescents.

The study recommended that interventions, health education sessions and educational programs can increase awareness on reproductive health. However, in the absence of appropriate health services, this awareness may not always translate into appropriate help by adolescents.

Moreover, the study found that students are likely to lose information on certain aspects as time progresses. Therefore, it recommended incorporating such information on a graded program starting from the seventh grade up to higher grades in order to maintain sustained levels of knowledge.

The study has also recommended that doctors, parents and teachers should be trained and encouraged to speak to adolescents about the issues they face while growing up so that the entire program becomes sustainable.

Gao et al (2012) discussed the effectiveness of school-based education on the HIV/AIDS knowledge, attitude, and behavior among secondary school students. His study was divided into two stages, the baseline research and the intervention research. He used a self administrated questionnaire prior and post to the intervention.

The questionnaire was completed by 1500 students; and only 1468 students were successfully followed up after the HIV/AIDS educational intervention. This intervention consisted of two sections, a 30-minute lecture and a 15-minute promotional video, highlighting the topic of HIV/AIDS.

The questionnaire was based on the adolescent knowledge scale of HIV/AIDS set by Zimet (1998), and the request placed by the United Nation General Assembly, in its special session, concerning the knowledge of young people about HIV/AIDS prevention.

After intervention, students showed an increased rate of awareness. Older students showed more understanding of the content of educational material, because they had learnt some relevant knowledge in their biology class or other relevant curricula.

Moreover, the study findings showed that television/broadcast was the principal source of knowledge on HIV/AIDS, as well as the Internet. The findings also showed that schools and parents were not the main source of knowledge on HIV/AIDS, which indicates that teachers

are not sufficiently conscious about HIV prevention; and parents face difficulty in speaking openly to their children on the prevention of HIV/AIDS.

The study recommended that educational programs about HIV/AIDS prevention will effective and beneficial for older students. And that HIV/AIDS education will be successful if carried out using continuous and long term strategies.

Moreover, decision makers, schools headmasters, as well as teachers should be aware that school education is an effective solution to prevent the spread of HIV/AIDS. Relevant curricula should be developed every semester and the education materials for each age group should be recognized.

In his study, Kabir et al (2015) has evaluated the changes in the knowledge of female unmarried adolescents on the selected reproductive health issues under the Project "Demand-Based Reproductive Health Commodity Project" (DBRHCP) intervention. The study was implemented in two areas: the rural sub-district Nabiganj area, and an urban slum in Dhaka city, both known as low-performing areas with low RH indicators. The study was conducted among female unmarried adolescents aged between 12–19. The sample of the study was amounted to 800 per site.

At the beginning of the project, an assessment for needs was carried out to set up the intervention strategies. The project applied the Behavior Change Communication (BCC) intervention for female unmarried adolescents. Under the BCC intervention, activities, video shows, and peer promoters were formed by the Community Support Groups (CSGs).

The structured questionnaire was taken from previous studies carried out by the International Centre for Diarrhoeal Disease Research, Bangladesh (icddr,b). These previous studies have also explored RH related knowledge among female unmarried adolescents. The questionnaire included items of knowledge assessment and menstruation perception of families, as well as perceptions of mode of transmission of HIV/AIDS including the source of information, the knowledge of STIs and reported STI symptoms, and the utilization of health care facilities. It

is worth mentioning that STI-related symptoms include burning during urination, genital ulcer/sores, and excessive bleeding.

Moreover, pre-post interventions studies were also carried out. However, only quantitative analysis was conducted for this study. The researchers found that adolescents' knowledge is increased in some areas, as measures are taken during menstruation, semi-permanent FP methods, HIV/AIDS and healthcare facilities.

The study showed that the intervention has increased the reproductive health related knowledge as reported in the study. This intervention can be used to develop appropriate strategies aimed at improving adolescents' RH-related knowledge, and service delivery.

Moreover, the study implied that the use of both, the quantitative and qualitative methods, would have enriched the understanding of female unmarried adolescents of reproductive health issues and increased their knowledge and perceptions.

Anwar et al (2010) discussed the awareness of school students concerning sexually transmitted infections (STIs) and their sexual behavior in Pulau Pinang, Malaysia.

The researchers aimed to produce baseline information about school students' awareness and perception about sexually transmitted infections (STIs), and their effectiveness to help establish control and education programs.

Another cross-sectional, descriptive study was carried out. In this study, 1139 students (474 males, 665 females) from governmental schools have participated. Governmental schools were selected because the majority of private schools are either representatives of Chinese population or Indian population. Students were asked to fill a questionnaire then fold them to maintain confidentiality.

In the previously indicated study, Anwar et al (2010) found that the students who claimed to be sexually active were less knowledgeable. Further, it was found that sexual activity was

significantly associated to gender, and that males were more sexually active than females. AIDS was found to be the most commonly known STIs among students who claimed to have heard of STIs.

The study found that the majority of students who claimed to have sexual experience had their sexual debut at the ages 15-19 years. When compared sexual debut between males and females, no significant difference was detected among different ethnic groups, religions, educational levels, course streams and socioeconomic classes. It was also found that sexual experience was significantly associated with gender, and that more male participants claimed to have multiple partners in comparison to females.

The study showed that knowledge on sexual health and STIs is insufficient among young people of Pulau Pinang. Although considerable percentage of them were involved in risky sexual behaviors which may adversely affect the prevalence of STIs and AIDS among the population. The researchers concluded that arranging public talks and seminars focusing on STIs prevention education are highly required to enhance student awareness.

Several studies related to puberty and changes among adolescents were carried out:

Golchin et al (2012) investigated Iranian adolescent girls' experiences regarding puberty in an effort to acquire basic information needed to implement suitable interventions aimed at improving their health status.

Further, a qualitative study was conducted, with a sample of 38 girls between the ages 12 to 20 years old, from the city of Sari. These girls who have experienced at least 3 menstrual cycles, have participated in a focus group discussion and individual in-depth interviews which took place in venues convenient for them (schools, universities or their homes).

All interviews were transcribed verbatim. The narratives were identified by interview transcripts, and categories were set after coding. Interview transcriptions, codes, and

categories were reviewed several times. Finally, the meaningful themes have emerged after making a comparison of the different individual opinions and experiences concerning puberty.

Seven main themes were extracted from these interviews, namely: menarche as the most unpleasant event in puberty, nervousness and shame regarding body changes, psychological changes, and discord with parents, sexual orientation, scholastic dysfunction and religious considerations.

Moreover, this study focused on anxiety and shame towards physical appearance and psychological changes during puberty as a concern by its participants. The study found that adolescent girls often do not receive accurate information about menstrual health because of culturally specific practices that lead to incorrect and unhealthy behaviors.

Golchin et al (2012) concluded that for the majority of the participants, puberty was an unpleasant experience. Most of them needed education on how to address issues concerning puberty. The study recommended that the society, families and of course the adolescents themselves are all responsible for working together to create an atmosphere in which correct information concerning puberty and the associated issues can be accessible.

Opare-Addo et al (2012) discussed the Menarche and pubertal development among school girls in Kumasi, Ghana, in order to determine menarcheal and pubertal ages as well as the possible factors of the current pubertal trends.

Another cross-sectional study was carried out. The study involved 720 girls aged 7-17, starting from the 4^{th} grade until the 10^{th} grade, in Kumasi schools. Using the method of cluster sampling, two types of schools were selected; urban and rural, by simple random sampling. All information was obtained by self-reporting. And an extensive questionnaire data was made, including Tanner Stage Self-Assessment, and the physical measurements carefully taken by trained personnel.

The researchers found that the mean age of menarche among Kumasi school girls was 12.4 ± 1.2 years old, and the median age of entering menarche for all girls (probit analysis), was estimated to be 12.89 ± 1.93 years old. Moreover, they found that predicting factors for earlier menarche were attended in schools, in addition to the BMI and the age of mothers at the birth of child. The study concluded that the decline in menarcheal age in Ghana may be largely tied to the changes in lifestyle as development and urbanization are spreading as economies grow, affluence, diet and lifestyle choices change.

Additionally, the study found that girls from poor socioeconomic status (SES) are more likely to experience later menarche. Although high SES is sometimes referred to better nutrition and awareness of physical activity; and accordingly later menarcheal age, it could also be referred to luxury and little physical activity.

The study showed that rural girls, who generally have lower BMI, are more physically active and have later age of menarche compared to their urban counterparts. This suggests that there is a role for the change from physically active to less physically active lifestyles in the observed changes in menarche age among Kumasi girls.

Opare-Addo et al (2012) encouraged policy-makers in Ghana to reconsider the school curricula due to its importance in underscoring the values of physical education and healthy lifestyle choices.

Ahmadi et al (2009) discussed the experience of puberty by adolescent boys in order to understand the views and experiences of puberty phenomenon among adolescent boys and their parents in an Iranian cultural context.

A qualitative study was carried out. It was an attempt to interpret puberty phenomenon in a more deeply manner to help interpret people's natural life conditions, and their understanding of this phenomenon. Samples were selected by the purposeful sampling method. The sample included 16 adolescent boys (aged 13–17), providing that they have experienced puberty, or at least some of the physical development signs, in addition to 12 of the parents, who had at least

one adolescent boy, and who are willing to participate in the study to discuss their experiences and deep feelings concerning puberty of their children.

Data was collected by using deep, open and semi-structured interviews, which were transcribed verbatim and analyzed. All interviews included the respondent's age, educational level, job, and parents' age besides the questions on puberty.

Ahmadi et al (2009) found that adolescent boys, as well as parents' views and experiences on this revolved around four main themes, namely: Shame and embarrassment when describing puberty changes, Anxiety and fear of physical and mental changes occurring during puberty, Transition and normality of puberty, and the Necessity of education and development of knowledge about puberty and sexual orientation.

Several studies related to violence against children were carried out, including:

The study of Sundaram (2013) which discussed how young people define violence, how they accept the different forms of violence, and the reason of accepting some forms of violence in comparison to others.

The study comprised of seventy student aged 14–16, from six secondary schools across the north of England. In each school, focus group discussions were conducted in the form of mixed-sex and single-sex focus groups to explore young people's views on interpersonal violence and to uncover the ways in which they understand, rationalize and even justify violence.

The sample of the study addressed various types of violence, including, the emotional, physical and sexual violence. Each focus group commenced with a brainstorm on the words, behaviors and participants in connection to violence. The study related materials were placed in the middle of table so all participants could view them. Each photograph, statement or vignette was presented with a simple probe or prompt.

Sundaram (2013) found that violence could be interpreted in a range of behaviors, including but not limited to, pushing, shouting, screaming, swearing, augmenting, name-calling, and being jealousy. In addition, violence could be in the form of more extreme forms of violence, such as murder, shooting, fist-fighting, punching, child abusing, rape and kidnapping.

The study found that understandings of violence did not vary according to the ethnic or socio-economic composition of the participant. In other words, there are no gender differences in terms of identifying violence.

The study showed that violence carried out by men at a low-level (e.g. gentle pushing, hair-pulling and scratching), or emotional violence (e.g. name-calling and verbal abuse) are frequently carried out against women. Men's violence against women was thus viewed as less acceptable since they have the potential to cause more harm and damage to women in comparison to the violence carried out by women against men.

According to this study, men's violence is described as harmful and severe, usually in the form of high-impact physical violence. Whereas women's violence was characterized differently than men's, it is mostly in the form of emotional or verbal aggression, including bullying, isolation and 'bitchiness' e.g. put-downs, gossiping and spreading rumors.

The study of Herrman & Silverstein (2012) discussed the thoughts of young women on violence and violence prevention. A qualitative, focus group was conducted, and a sample of 32 young women aged 12-18 were included, providing that they were incarcerated, or involved with the judicial system, or affiliated with services designated for at-risk youth, and/or self-identified as living in poverty or disadvantaged neighborhoods.

Researchers of this study found that young women had little hope in preventing or stopping violence abolishment. Seven predominant themes were generated from the study: Violence is learned, perpetuated from childhood, and based on past experiences; it is a learnt behavior from home, from peers, from the environment, or from media and social marketing.

Moreover, the study concluded that violence is contagious. In other words, violence experiences, whether by witnessing or being victims, were all related in terms of the transfer method of violence to others, it is unstoppable. The most poignant theme that emerged from the data collected under this study was that girls usually submit to the inevitability and unrelenting nature of violence. They even reported that they have little hope to reduce or prevent violence, and that people attempting to prevent or allay violence usually get hurt in the process. Participants stated that violence causes "depression," "suicide," "meanness," "anger," and "being careless to oneself."

Violence could take the form of belonging to a larger group, as is the case in gangs and peers. The influence of gangs, and peers was noted to be highly associated with the social nature of violence. Additionally, violence associated with gang membership appeared to be well known by participants, whether being perpetrators or victimized, in order to stay an active member in the gang. This form of violence was used as a protective mechanism against serious violence in areas of high rate of crimes.

The study also found that violence might lead to other crimes. For example, the desperation and hopelessness associated with poverty may lead to illicit forms of earning money, such as drug trafficking, prostitution, and robbery, all of which may naturally progress to violence and fighting. Under this study, girls addressed lots of words when discussing violence such as drugs, guns, rape, assault, robbery, murder, and domestics.

The study suggested that violence can be stopped, and that violence prevention must begin with the individuals themselves. People need to see the reason for, and feel the need to, change their personal behavior before communities can address violence prevention. The individual force behind violence appeared to be more important than the community's will. As stated, "Prevention has to start within individuals themselves".

The study of Herrman & Silverstein (2012) focused on the importance of early intervention and commencing violence prevention with young children rather than waiting until middle or

high school. Strategies under this study included classes about relationships, positive people in their world, positive media portrayals, and recreational activities.

Moreover, the study of Pomeroy et al (2011) compared the impact of peer theater education, traditional peer education, and a comparison group on the in-depth attitudes and knowledge concerning Interpersonal Violence (IPV) among social work students in an introductory social work course.

A pre- post intervention analysis was carried out. This analysis included 63 university students from two sections of undergraduate introductory social work courses, with no differences concerning any of the demographic background variables at the baseline.

The study used the mixed-methods design, by using a nonequivalent comparison group design to compare three groups (Peer Theater, peer education, and a comparison group) and qualitative measurement (focus group).

Participants from the two undergraduate social work courses who met on the same days were assigned to the two intervention conditions (Peer Theater, peer education), by providing each participant with a color-coded card and a corresponding location where the student was asked to show up for subsequent class sessions related to the study. Students who attended this course on a different day served as the comparison group.

During the first class session, participants were asked to complete an informed consent and a brief anonymous questionnaire containing basic demographic and background variables, and then participate in a pre-intervention focus group. The intervention was provided at the second class session, and a post-intervention focus group was conducted at the final class session of the study.

At the pre-intervention baseline, Pomeroy et al (2011) found that students lack awareness concerning violent relationships and that they demonstrated some understanding of violent relationships dynamics on campus. After the intervention, the comparison group results were

similar to the pre-intervention statements, the peer education statements reflected increased knowledge acquisition, and the peer theater statements suggested integration of knowledge, awareness, and practical application.

It was concluded that Peer Theater may be a viable method for educating social work students about interpersonal violence, to better recognize interpersonal violence situations and to gain clarity regarding the less obvious forms of such violence.

In the peer education group, students demonstrated increased factual knowledge, whereas in the peer theater group, students seemed to develop a more practical understanding and awareness of the real-life dynamics of violent relationships, sexual assault, and stalking.

The study of Rates et al (2015) described and analyzed reports of violence against young children aged 0 -9 years old, issued by the Public Health Services in Brazil, in terms of violence types, and suggested protective actions for victims.

This study addressed a descriptive analytical study on 17900 cases of violence against children reported and captured by the Violence and Accident Surveillance System (Viva-SINAN), starting from 1st of January, until 31st December 2011, based on the data collected on "Domestic, sexual and/ or other forms of violence".

Under this study, the following variables were selected for assessment: (1) demographic characteristics of victims/assisted individuals (gender, age, ethnicity/ skin color, presence of disabilities or disorders, area of residence); (2) event characteristics (whether it occurred at home, repeat violence, nature of the injury, affected body part); (3) type of violence; (4) perpetrator's characteristics (relationship to victim, suspected alcohol intake); and (5) progression and follow-up.

Furthermore, the study of Rates et al (2014) found that the most incidents cases of domestic violence were perpetrated against girls by the children's parents. Violence was characterized by repeated occurrences, and one-fourth of the perpetrators were reported as having used

alcohol. According to this study, neglect was the type of violence most often reported, followed by physical, sexual and psychological violence. The odds of physical violence and neglect were higher among boys, whereas the odds of sexual and psychological violence were higher among girls. Moreover, and based on the study, the head and neck were the most body areas affected, followed by the chest, abdomen, and pelvic.

The researchers concluded that health plays an important role in developing inter-sectoral policies and networks (including judiciary, education, health and social work, among others) to potentiate and increase protective actions aimed at promoting quality of life among individuals.

Several studies related to early marriage were carried out, including:

The study of Nasrullah et al (2014) carried out to assess knowledge and attitude on child marriage practiced by women in urban slums of Lahore, Pakistan, by using a qualitative method.

Under the study, open-ended interviews were conducted with 19 women aged 15-49 years old, providing that they were married before the age of 18 years old, for a time period of at least 5 years, and had at least one child birth. All the interviews were tape-recorded, transcript and then inserted to Microsoft Excel.

Nasrullah et al (2014) found that the majority of the participants were not aware of the negative health outcomes of child marriage and were satisfied with their life; they even believe that their parents made the right decision.

Only a quarter of the participants believed that negative outcomes of child marriages were confined to medical grounds and negatively affect the social relations. They reported a number of health problems, which included frequent pains, disturbed menstrual cycle, abortion, difficulty in child birth and physical weakness including other social problems.

The study concluded that the strong influence of culture and community perceptions, varying interpretation of religion, and protecting family honor are some of the reasons of the continuation of child marriage.

The researchers concluded that raising awareness on the negative health outcomes of child marriage shall be carried out by the government, local and international NGOs, by implementing and enforcing strict laws against child marriage practice, promoting civil, sexual and reproductive health rights for women, and providing economic opportunities for girls and their families, such as microfinance schemes that can help eliminate child marriage practice.

There is also the study of Marshan et al (2013) which is conducted to give a clearer picture of child marriage in Indonesia, especially in respect of women perspectives, and to identify the prevalence determinant factors of child marriage.

The National Socioeconomic Survey (SUSENAS) provided by the Center Board of Statistic (BPS) in 2010 was used as a source of data for the research. From this Survey, researchers extracted variables that were used in child marriage analysis. Moreover, data on women aged 20-24 years old, married or in union before the age of 18, and still living with their parents (468,770 women) were also analyzed.

Marshan et al (2013) found that the determinants factors of child marriage in Indonesia are influenced by three aspects, namely: the condition of individuals, households, and society. In terms of the condition of households, the household heads profile and their physical characteristics are included. The household condition or characteristics seem to be the major determinant of early marriage decision. Undoubtedly, the individual characteristics appear to be important in terms of taking the decision of early marriage. The study also addressed some preventive and protective action strategies taken by individuals who perceive child marriage as “their problem”.

Researchers concluded that an action must be taken by the government to provide a strong social and economic foundation. This can be done through a larger package of social and

economic policies that promote marital, educational aspirations, and needs of low-income families. This action should focus on how to create enabling environments that develop alternatives to child marriage.

In his study, Hammann (2014) discussed the effects of child marriages in Bangladesh, to indicate to which extent socioeconomic factors influence early marriage and childbearing.

In the study, data from the Demographic and Health Surveys (DHS) of Bangladesh of 2011 were used. The survey is designed in a way to provide representative results for both urban and rural areas by using a questionnaire. The sample included married women aged 12-49 years old. Three age groups were created in order to delineate the immaturity of entering into marriage. These women were married before the age of 13 (child), or married from 14-18 (adolescent), or married above the age18 (woman).

Hammann (2014) found that over years of observation, the age of marriage is increasing. The determinants of child marriages are wealth status, education, religion and place of residence. In terms of wealth status, it increases the probability of a woman getting married, both as a 'child' and as a 'woman'. Children from 'richest' households are less likely to die, in comparison to children born in the 'poorest' households. As for education, it determined at what age young women will enter the life of marriage. The study showed that children are **stunted** in the rural areas of Bangladesh; while more children die in urban areas. The proportion of children who are **stunted** is lower in terms of children whose mothers receive access to maternal care and could reduce the occurrence of **stunting** and mortality in infants.

The researcher concluded that there is a possibility to improve the access to education, and that more strategic targeting should be implemented with a stronger orientation towards the poorest households in Bangladesh.

Several studies related to Personal Hygiene were conducted, including:

Singh et al (2014) discussed the Knowledge and Practices on Personal Hygiene of Adolescents in India where adolescents constitute about one fifth of the population. The study was aimed at ascertaining the level of knowledge on personal hygiene, to identify the practices of personal hygiene among adolescents in rural and urban area and to identify the gap between knowledge and practices of personal hygiene.

The researcher conducted a descriptive study in which 240 students (120 from rural area and 120 from urban areas) have participated. Students aged 10-19 years old, and data was collected by face to face interviews**.**

Singh et al (2014) found that the majority of respondents have knowledge of hygiene practices but are not aware of how to practice it. The study showed that there were differences in the habits of urban and rural adolescents even though they were of the same age group. Moreover, the study found that there is a poor menstrual hygiene commonly seen among adolescent girls, because they were not properly guided on how to manage their periods.

The researcher concluded that adolescents from both urban and rural area have to be educated on different unhygienic problems and habits according to their own context. Additionally, educational strategies need to be implemented and promoted by further research scholars among urban and rural adolescents.

There is also the study of Rani et al (2014) which is aimed at assessing the morbidity pattern and to find out the status of personal hygiene among primary school children in the rural area of Uttar Pradesh.

A cross-sectional study was carried out in the rural area of Manipuri District, Uttar Pradesh. A randomly sample of 171 children (85girls, 86 boys) was selected, aged 5-13 years old.

Health appraisal on children was carried out to find out the presence of morbidities in school premises under natural light. They used predesigned, pretested structured questionnaire to

collect data. General information was collected including the name, age, father's name, sex, class, caste, father's occupation and parent's education. Status of personal hygiene in children was assessed using parameters of examination of hair, hands, nails, clothes, and ear.

Rani et al (2014) found that the percentage of anemia was higher among children born from illiterate mothers which may refer to their lack of knowledge on iron-rich food. Moreover, the higher dental problems were noticed in rural areas where children had low level of awareness about oral hygiene. Good personal hygiene forms part of primary health prevention strategy and this has been found to be effective by reducing morbidity and mortality among children. Rani et al (2014) concluded that parents and teachers need to emphasize to their children the importance of personal hygiene as a way to promote health.

Miko et al (2013) conducted a study to characterize the personal and environmental hygiene habits among college students, define the determinants of hygiene, and assess the relationship between reported hygiene behaviors, environmental contamination, and health status. A Quantitative study was done in which 501 students completed a standardized hygiene questionnaire

Miko et al (2013) found that the vast majority of study participants believed that hand washing is important for infection prevention, and that improved hygiene behaviors are effective in reducing the incidence of certain infections such as viral upper respiratory infection and gastroenteritis.

The study concluded that cleanliness itself is considered a meaningful marker of safe hygiene practices, and that environmental contamination appears to be unrelated to reported household hygiene and risk of clinical infection. Most college students have a clear understanding of hygiene benefits and significantly believe in its ability to prevent infection and promote health. The researchers concluded that this population may be well suited for hygiene interventions with sustained impact on adult life.

2.4 Summary

This chapter has explored a wide variety of studies as well as articles and master thesis. According to these studies, intervention project can change the knowledge, attitude, and practices of child and adolescents in the following areas: violence, reproductive health, personal hygiene, early marriage, HIV (AIDS) and other sexual transmitted diseases. Moreover, most of these studies concluded that the need for an educational program that can increase awareness on violence, reproductive health, personal hygiene, early marriage, HIV (AIDS) and other sexual transmitted diseases is highly required. Probably because the educational intervention will increases knowledge significantly and changes the attitude as well as lead to positive practices. The chapter of literature review is aimed at supporting the main question raised by this research which is to develop appropriate strategies for improving adolescents' knowledge, practices and attitudes.

Chapter Three
Conceptual Framework:

3.1 Conceptual Framework:

Conceptual framework is based on the project's components which include (the age of children (14-17), (18-20)), gender (male, female), targeted population (adolescent), violence, HIV(AIDS)& other STI's, marriage and engagement, changes during puberty, personal hygiene.

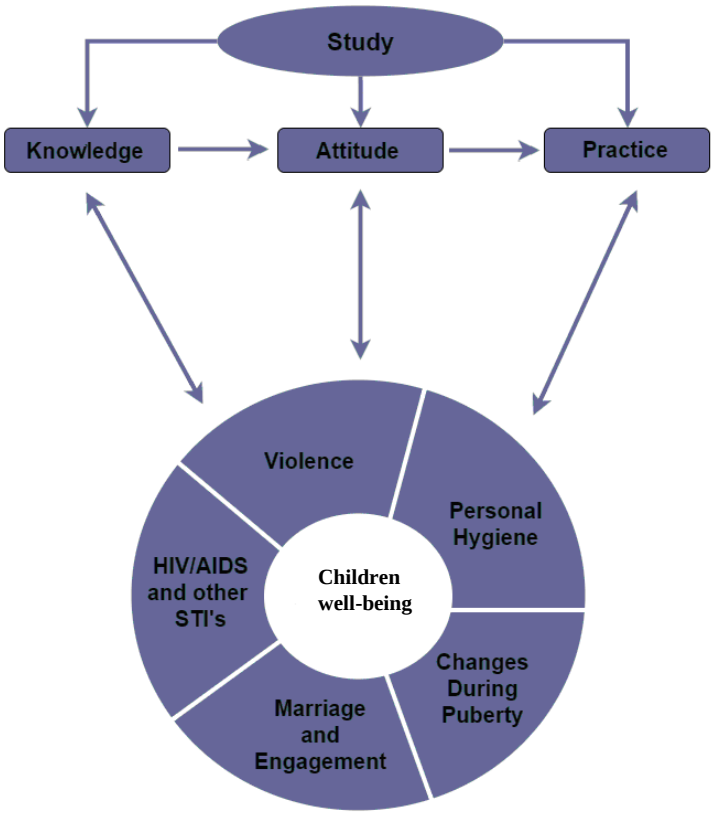

Figure (3.1): The conceptual framework of the study; components that affect the protection of adolescent from gender-based violence.

3.2 Conceptual Definitions:

The following are the conceptual definitions of the study variables:

Impact Evaluation IE:

The World Bank Poverty Net Web site defines IE as an evaluation that "Changes in the well-being of individuals, households, communities or firms that can be attributed to a particular project, program or policy, aimed at providing feedback to help improve the design of programs and policies"(The World Bank, 2014).

Gender-based violence (GBV):

Gender-based violence is a term used to describe any harmful act that is perpetrated against a person's will, and that is based on socially ascribed differences between males and females. While men and boys can be victims/survivors of some types of GBV (particularly sexual violence) around the world, GBV has a greater impact on women and girls. (Global Protection Cluster, 2016).

Violence:

Violence is defined in many ways, importantly "the intentional use of physical force or power, threatened or actual, against another person or against oneself or a group of people that result in or has a high likelihood of resulting in injury, death, psychological harm, mal development or deprivation" (WHO, 2002).

Sexually transmitted infections (STI's) :

Sexually transmitted infections (STIs) are the "infections that are spread primarily through person-to-person sexual contact. There are more than 30 different sexually transmissible bacteria, viruses and parasites" (WHO, 2014).

The Human Immune Deficiency Virus (HIV):

> "A retrovirus that infects cells of the immune system, destroying or impairing their function. As the infection progresses, the immune system becomes weaker, and the person becomes more susceptible to infections. The most advanced stage of HIV infection is acquired immunodeficiency

> syndrome (AIDS). It can take 10-15 years for an HIV-infected person to develop AIDS; antiretroviral drugs can slow down the process even further ,HIV is transmitted through unprotected sexual intercourse (anal or vaginal), transfusion of contaminated blood, sharing of contaminated needles, and between a mother and her infant during pregnancy, childbirth and breastfeeding"(WHO,2014) .

Early Marriage:

This harmful practice is most commonly known in poor communities, where they are deprived of education and meaningful work. These communities are becoming more vulnerable to health risks associated with early sexual activity and childbearing, leading to high rates of maternal mortality and children, as well as sexually transmitted diseases, including HIV. Moreover, they are more likely to be victims of domestic violence, sexual abuse and social isolation (Hammann et al, 2014).

Child Marriage

"a formal marriage or informal union before age 18 is a reality for both boys and girls, although girls are disproportionately the most affected" (UNICEF, 2014).

Changes during Puberty Definition:

Changes occur when children reach the age of puberty. Represented in certain hormones produces by the body, such as estrogen and testosterone which cause physical changes. However, because of the difference between testosterone and estrogen, variable related to testosterone appear more among boys, whereas variables related to estrogen appear more among girls. These changes include: Growth in: size, weight and sex.

Female changes include: breast development, body hair growth (underarm and pubic hair), period starting, body growth, increasing weight, length of the legs and shoulders width.

Male changes include: growth of testicles & scrotal sac, growth of head, hands, feet, arms, legs and shoulders, voice change, body hair growth(facial, underarm and pubic hair (brown, 2013).

Personal Hygiene:

"It is the basic concept of cleaning, grooming and it is the first step to good health. Besides that it is consider as one of the most important part of our daily lives at home and at workplace which help us to protect ourselves and keep us with good health". (Rasool, 2012, pp1).

Personal hygiene includes different habits, i.e., washing hands and brushing teeth which protects our bodies from bacteria, viruses and fungal. These habits will help us protect our mental health and activity. Not to mention that good personal hygiene will make us feel good about ourselves.

> "Personal hygiene involves those practices performed by an individual to care for one's bodily health and well being, through cleanliness. Motivations for personal hygiene practice include reduction of personal illness, healing from personal illness, optimal health and sense of well being, social acceptance and prevention of spread of illness to others" (Wikipedia, 2014).

For purposes of the study, KAP questioner was used in the project and will be used to assess the impact.

The "KAP Survey" stands for Knowledge, Attitude and Practices.

K: Knowledge is a set of understandings, and the knowledge of "science". It also represents one's capacity for imagining, and one's way of perceiving.

A: Attitude is defined as a way of being, a position. These are leanings or "tendencies to….".This is an intermediate variable between the situation and the response to this situation. It helps explain that among the possible practices for a subject submitted to a stimulus, that subject adopts one practice and not another.

P: Practices or behavior's are the observable actions of an individual in response to a stimulus. This is something that deals with the concrete, and with actions. (Spring-nutrition, 2011).

3.3 Operational Definitions

Dependent variables:

- KAP: **K**nowledge, **A**ttitude and **P**ractices.

Knowledge: section 3(Q3), Section 4 (Q 1,2,3), Section 5(Q 1,2,3,4,5) , Section 6 (Q 7), Section 7(Q 9) , Section 8 (Q 5,6,7,9)

Attitude: section 6 (Q2,3,4,5,6,8) , Section 7(Q 2,3,4,5,6,7,8,10), Section 8(Q 1,3,4,8)

Practices: section 3(Q 1,2), Section 6(Q 1) , Section 8(Q 2).

Independent variables:

These include socio demographic variables:

Section one in survey:
-Gender: male or female
-Age: From 14-18 years old.
-Nationality: Palestinian or other nationaliy.
-Family situation: refugees or not
-Marital status/living condition (for parents): divorced, married …etc.

Section two in survey:
Educational level: Primary school or secondary school

Section seven (marriage or engagement):
(Q1): Social status (Single, Engaged, Married).

Chapter Four

Methodology

4.1. Introduction

This chapter describes the research methodology used in the study including; study design, study setting, study sample size, study period, sample inclusion criteria, sampling method, research tool, data collecting and data analysis . Moreover it addresses the ethical consideration.

4.2.Study Design

This study used a quantitative case control study, two-group, a case group (participated group) and control group (non-participated group) in order to evaluate the effectiveness of the project **"Protecting Adolescents from Gender-based Violence through the Promotion of their Sexual and Reproductive Health Rights** /Palestine".

Under the study, a comparison between case and control group focusing on the knowledge, attitude and practice in the following areas: violence, reproductive health, personal hygiene, early marriage, HIV (AIDS) and other sexually transmitted diseases, was conducted. The researcher used a questionnaire that was constructed and used by the same project in 2010.

4.3.Study Settings

The study was conducted in three camps schools, namely: (Arroub, Aida and Ein Sultan camps). These camps were selected because there were readily accessible to the researcher. Aqabet Jabber and Dura camps were excluded due to the difficulty of accessing them as well as the lack of children who participated in the project in 2010.

Below a description for each camp:

Arroub camp:

Established in 1949 in the "Valley of frost" area, 15 km to the south of the city of Bethlehem, to the left of the main street (Bethlehem - Hebron), 35 km to the south of Jerusalem. Arroub camp bordered from north by the village of Beit Fajar, and Ain Al-Aroub; and from the east by the lands of Seir, and Al Sheoukh; and to the south the territory of the town of Halhul; and to the west of Beit Ummar (Palestinian Central Bureau of Statistics, 2013).

In 1949, the area of the camp was about 258 dunums, however; it reduced to 238 dunums. The camp population amounted to 6775, according to the statistics made in 1995, whereas it was amounted to 9527, according to the estimates made in the year 2013. The origins of the camp inhabitants descended from 33 villages belonging to the Ramlet, Hebron and Gaza (Palestinian Central Bureau of Statistics, 2013).

Aida camp:

This camp was established in 1948 in the western area between Bethlehem and Beit Jala, to the western of the main road (Hebron - Jerusalem), with an area of 60 dunums, however; the area increased to reach 115 dunums. The camp's population amounted to 3059, according to the estimates of 2013 (Palestinian Central Bureau of Statistics, 2013).

The camp included refugees from 17 villages in the western regions of Jerusalem and Hebron, including: Walaja, and Khirbet alomor, Cabu, and Ajjur, and Allar, Deir Aban, and Maleiha, and Ras Abu Ammar, and Bet natef (Palestinian Central Bureau of Statistics, 2013).

Ein Sultan camp:

This camp was constructed adjacent to the city of Jericho from the west, in 1948, above an area of 708 dunams, down Mount Krontol (Mount of Temptation) chartered by UNRWA to the Jordanian government, located 1 km away from the city of Jericho (Palestinian Central Bureau of Statistics, 2013).

When founded, the population of the camp amounted to 35,000, most of which are refugees who have emigrated in 1948 from parts of Ramle and Led and Hebron families, and the population of Deouk who transferred by Jericho Municipality (Palestinian Central Bureau of Statistics, 2013).

After the aggression of June 1967; most of the population fled to the East Bank; bringing the number only about 2800 people; most of the camp houses became empty after their owners left; this provided a justification to the Israeli occupation authorities to demolish in 11/13/1985 (Palestinian Central Bureau of Statistics, 2013).

According to the "Palestinian Central Bureau of Statistics" in 2013, the population was estimated to 3688 (Palestinian Central Bureau of Statistics, 2013).

4.4.Study Sample Inclusion

Inclusion criteria:

- Children who participated in the project in 2010, aged between 14-18 years, and from the camps.
- Children who have compatible characteristics with the case group and who have not participated in the project in 2010, aged between 14-18 years, and from the camps.

4.5.Study Sample Size

Study population included all children that participated in Juzoor project in 2010 aged between 14-18 years. Two hundred and eighty four participated in the project in 2010. Two hundred and ten children met the selection criteria, from the targeted school camps: Arroub camp, Aida camp, and Ein Sultan camp and volunteered to participate in this study, 70 children were randomly assigned to the case group that participated in the project "**Protecting Adolescents from Gender based Violence through the Promotion of their Sexual and Reproductive Health Rights** /Palestine", in 2010. And 140 children randomly assigned to the control group that didn't participate in the project as shown in table (4.1) below.

The sample size was determined based on the number of children who participated in the project, and was accessible to them either by the coordinators of UNRWA in the camps or by instructor's camp schools or by children who have reached them. Total children who were able to access are 70 out of 284 children participated in the project in 2010. Two children did not participate in the project were selected randomly in exchange for every child participated in the project with the same ages and characteristics from the same school. The number of students who did not participate is 140 children.

Table (4.1): Distribution of study population into case and control groups

Camps	Case group	Control group	Total
Arroub camp	49	98	147
Aida camp	6	12	18
Ein Sultan camp	15	30	45
Total	70	140	210

4.6. Research Instrument

A structured questionnaire which developed by the project Juzoor in 2010 was used for case and control groups (please Refer to annex 2). KAP survey was used to measure the impact of the project activities. The data was collected by a self administration questionnaire from the selected sample; the case group is the group that received the project intervention (participated group) and the control group is the group that did not receive the intervention (the non participated group).

This study Consisted the following parts (see attached copy in Annex 2):

- Section one, Question 1-6: Socio demographic information about the children age, gender, place of residence, living condition (social status of parents), situation, nationality, Membership in the youth centers.
- Section two, Question 1-6: includes the education information.
- Section three, Question 1-3: includes personal hygiene information.
- Section four, Question 1-3: includes the characteristics during puberty information.
- Section five, Question 1-5: includes sexual transmitted disease information.
- Section six, Question 1-8: includes the information of reproductive health.
- Section seven, Question 1-10: includes Information about engagement and marriage.
- Section nine, Question 1-9: includes information about violence.

4.7. Validity and reliability

Validity of the questionnaire for use with children was assured by Juzoor experts. Questionnaire used in this study was used in the project in 2010 by Juzoor.

Reliability; internal consistency was examined by Juzoor.

4.8. Pilot Testing

Pilot testing is the instrument used to identify difficulties in understanding. It was also used to check the data collected, complete time, and administer the scale for clarity and children willingness to complete it.

A pilot study was conducted in Aroup camp school. Ten children who met the inclusion criteria were selected randomly to pilot testing; five children from the case group and five children from the control group were also selected. All the children were selected for the pilot study after obtaining their consent to participate. The results of the pilot study were excluded from the actual study.

The findings of the pilot study showed that time required for completing the questionnaire ranged from 20-30 minutes with an average of 25 minutes.

4.9. Data Collection

The study obtained approval from Al-Quds University to use higher studies from the Council conducted in January 2014. Data collection was completed in April 2015. Data collection was arranged through self-administrated questionnaire that was distributed and collected among students, after school hours, by the researcher and the school instructor.

4.10. Data Analysis

Data was entered and analyzed using the statistical software package SPSS version 19.and the level of significance (α) was set at 0.05. The differences between the case and the control group were compared using Chi-square. The data analysis included the descriptive characteristics of, the participating and the non-participating groups, as well as the frequency and percentage of each variable in each section of the study.

Regarding the descriptive characteristics section (the first and the second sections), and in order to look for differences between both groups, variables for both groups including (Gender, Age, Nationality, Family status, Marital status (for parents), living condition and the level of education), were all analyzed.

In the other sections, variables were analyzed based on the study objectives. The third section was about personal hygiene, whereas the fourth section was about the characteristics during puberty. The fifth section was about the sexual transmitted diseases. The sixth was about reproductive health. The seventh section was about engagement and marriage, and the last section was about violence.

4.11. Permission and Ethical Consideration

- Permission was taken from the Graduate Research Committee at Al-Quds University.
- The consent included confirmation on participation, with a clear statement about confidentiality, and no name required. Every participant knew that participation was optional and that they have the right to refuse it (please Refer to annex 1).
- Data collection tool did not include the participants' names. A separate sheet of database was kept for names only. Each participant was assigned a number used throughout the study.
- Permission from Juzoor was taken to use their tools and data.
- Permission from the United Nations Relief and Works Agency(UNRWA) was taken to enter their school camps.

4.12. Summary

The study is a quantitative case control study to evaluate the impact effect of the project "**Protecting Adolescents from Gender based Violence through the Promotion of their Sexual and Reproductive Health Rights** /Palestine, implemented by Juzoor organization in 2010. The study is aimed at assessing children's knowledge, attitudes, and practices in the following areas: violence, reproductive health, personal hygiene, early marriage, HIV (AIDS) and other sexually transmitted diseases. The researcher used a questionnaire that was constructed and used by the project.

Self -administrated questionnaire were distributed and collected from the students after school hours by the researcher and the school instructor. In the study, 210 children have participated, 70 from the case group and 140 children were from the control group. A comparison was done between both groups. A pilot study was excluded from the study.

The data analysis was processed through SPSS statistical package testing. This research was done taking into consideration the ethical rules and obligations.

Chapter five

Results

5.1 **Introduction**:

This chapter consists of eight sections. The first describes the demographic characteristics of the study population including age, gender, place of residence, living condition (social status of parents), situation, nationality, membership at youth centers, whereas the second describes the educational information. As for the third section, it describes the personal hygiene information, whereas the fourth describes the characteristics of puberty. Further, the fifth section describes the information on sexual transmitted diseases, whereas the sixth describes the information of reproductive health. Additionally, the seventh section describes the information about engagement and marriage, and finally, the eighth and last section describes the information about violence.

5.2 Results

This section presents the data collected from the questionnaire (which includes the eight sections of data stated above), as well as the results of that data.

5.2.1 Socio-Demographic Characteristics:

The total number of respondents of this study is amounted to 210 children (70 of them have participated in the Juzoor Project in 2010 (the case group), whereas 140 of them did not participate in the project (the control group). Every child from the case group is compared

with two children from the control group, in order to find whether they have compatible characteristics in common such as age, grade, gender, and region.

Table (5.1.a): Socio -Demographic characteristics of the groups.

	Case group		Control group		
	Frequency	%	Frequency	%	Significant level
Place of Residence					
Arroub	49	70.00%	98	70.00%	$x^2=0$ P=1.000
Aida	6	8.60%	12	8.60%	
Ein Sultan	15	21.40%	30	21.40%	
Age*					
14.1-15	6	8.60%	12	8.60%	$x^2=0$ P=1.000
15.1-16	18	25.70%	36	25.70%	
16.1-17	26	37.10%	52	37.10%	
17.1-18	20	28.60%	40	28.60%	
Have you participated in the past three weeks in a field study on the topics of reproductive or sexual health?					
No	56	80.00%	112	80.00%	$x^2=0$ P=1.000
Yes	14	20.00%	28	20.00%	
Gender					
Male	33	47.10%	66	47.10%	$x^2=0$ P=1.000
Female	37	52.90%	74	52.90%	
Nationality					
Palestinian	70	100.00%	140	100.00%	$x^2=0$ P=1.000
Non-Holder of Identity	0	0.00%	0	0.00%	
Status					
Refugee	66	94.30%	137	97.86%	$x^2=1.8473$ P=0.174099
Non-Refugee	4	5.70%	3	2.14%	

Table (5.1.b): Socio -Demographic characteristics of the groups.

	Case group		Control group		
	Frequency	%	Frequency	%	Significant level
Living Condition (Social Status of Parents)					
Parents Live Together	66	94.30%	122	87.15%	x^2=6.016 P=0.19796
Parents Separated	0	0.00%	5	3.60%	
Father is Dead	3	4.30%	6	4.30%	
Mother is dead	0	0.00%	6	4.25%	
Parents are dead	1	1.40%	1	0.70%	
Are you a member at a youth club?					
No	39	55.70%	84	60.00%	x^2=0.3532 P=0.552286
Yes	31	44.30%	56	40.00%	

*Average age = 16.6 years old.

Table (5.1) shows that no significant differences are found between case and control groups concerning demographic data at α=0.05. This indicates that both groups had similarities in relation to the demographic characteristics of participants.

Table (5.2): Gender & Age Groups Distribution:

Gender		14.1-15		15.1-16		16.1-17		17.1-18		
		Frequency	%	Frequency	%	Frequency	%	Frequency	%	Significant level
Male	Case group (n=33)	6	8.6%	8	11.4%	11	15.7%	8	11.4%	x^2=0 P=1.000
	Control group (n=66)	12	8.6%	16	11.4%	22	15.7%	16	11.4%	
Female	Case group (n=37)	0	0.0%	10	14.3%	15	21.4%	12	17.1%	x^2=0 P=1.000
	Control group (n=74)	0	0.0%	20	14.3%	30	21.4%	24	17.1%	

Table (5.2) shows that there are no significant differences found between the case and control groups regarding gender and age at α=0.05. This means that both groups had similarities in relation to these characteristics of participants.

5.2.2 Education:

This section covers the data about education in the case group and control group. we presented here that questions related to educational level.

Table (5.3.a): Education Results: Differences between case and control groups.

	Case group		Control group		
	Frequency	%	Frequency	%	SIGNIFICANT LEVEL
Can you read?					
No	0	0.00%	4	2.90%	x^2=2.0388 P=0.153327
Yes	70	100.00%	136	97.10%	
Language					
Arabic	32	45.70%	74	52.90%	x^2=2.0388 P=0.15332
English	0	0.00%	0	0.00%	
Arabic& English	38	54.30%	66	47.10%	
Are you attending school at the present time?					
No	4	5.70%	8	5.70%	x^2=0 P=1.000
Yes	66	94.30%	132	94.30%	
Is the school you are attending:					
Governmental	60	85.70%	120	85.70%	x^2=0 P=1.000
UNRWA	6	8.57%	12	8.57%	

Table (5.3.b): Education Results: Differences between case and control groups.

	Case group		Control group		
	Frequency	%	Frequency	%	SIGNIFICANT LEVEL
Are you attending any level of education at the present time?					
No	3	4.30%	3	2.10%	x^2=3.5742 P=0.466679
Youth center	25	35.70%	30	21.40%	
Languages courses	6	8.60%	17	12.10%	
School Enrollment	3	4.30%	2	1.40%	
Professional \technical training	1	1.40%	2	1.40%	

Table (5.3) shows that there are no significant differences between case and control groups regarding the educational level at α=0.05. This means that both groups had similarities in relation to the educational level of participants.

5.2.3 Personal Hygiene:

This section shows how children expressed their practices of personal hygiene; the data obtained indicates that most children from the case group answered having the highest changes of hygiene practices compared with the control group.

Table (5.4): Personal Hygiene Practices.

	Case group		Control group		
	Frequency	%	Frequency	%	Significant level
How often do you take a shower?					
Once or more a day	42	60%	14	10%	x^2=71.1265 P<0.0001
Day after a day(4th day of the week)	18	25.70%	34	24.30%	
Twice a week	10	14.30%	61	43.60%	
Once or less a week	0	0%	31	22.10%	
What is the source of your information on personal hygiene practices?					
Family	60	85.70%	69	49.30%	x^2=25.973 P<0.0001
Health sector	14	20.00%	14	10.00%	x^2= 4.019 P=0.0450
Society	18	25.70%	6	4.30%	x^2= 21.005 P<0.0001
School	27	38.60%	34	24.30%	x^2= 4.606 P=0.0319
Social Media	16	22.90%	22	15.70%	x^2= 1.624 P=0.2025

As illustrated in table (5.4), the data of the question "How many times do you take a shower?" shows that there is a significant differences between the case and control groups at α=0.05(P <0.05).

About 10% of the control group answered that they have shower once or more per day, compared with 60% of the case group. Apparently, there seems to be variation in the percentages of answers, no one answered once or less per week in the case group compared with 22.1% of the control group.

Table (5.4) shows the source of information concerning personal hygiene between the case and control groups; i.e. family; health sector; society; school or the social media. Significant differences among participants in the case group were reported at $\alpha=0.05$ ($p<0.05$). As for the source "social media", no difference is seen between both groups.

Female Section

Within the entire sample of the study, females constitute 52.9%, 37 females in the case group, and 74 females in the control group.

Table (5.5): Female Results: Changing Sanitary Pads during the Menstrual Cycle.

	Case group		Control group		
	Frequency	%	Frequency	%	Significant level
How many times do you change your sanitary pads during the menstrual cycle?					
daily	0	0%	20		$x^2=12.1978$ P=0.000478
Several times a day	37	100%	54		

Among the female answers, changing sanitary pads during the menstrual cycle several times per day is significantly reported by the case group compared to the control group.

As illustrated in table (5.5), the percentage of changing sanitary pads reached up to 100% as reported by females in the case group, compared to 73% are reported by females in the control group.

5.2.4 Changes during Puberty:

This section presents the results of the female and male knowledge on their physical changes during puberty. At first, a question was asked for females only, and then another question for males.

Table (5.6): Female's knowledge about changes happens during puberty.

	Case group		Control group		
	Frequency	%	Frequency	%	Significant level
Breasts Growth	35	94.60%	52	70.20%	x^2=8.757 P=0.0034
The Appearance of Hair in the Pubic Area and Underarms	34	91.90%	23	31.10%	x^2=36.172 P<0.0001
Increasing in Length	28	75.70%	27	36.50%	x^2=15.026 P=0.0001
Increasing Muscle Growth	12	32.40%	15	20.30%	x^2=1.944 P=0.1633
Growth of the Pelvis and Hips Bones	27	73%	31	41.90%	x^2=9.477 P=0.0021
Menstrual Cycle	35	94.60%	56	75.70%	x^2=5.916 P=0.0156
Oily Skin \ Acne	31	83.80%	26	35.10%	x^2=23.206 P<0.0001
Increasing Sweating	19	51.40%	22	29.70%	x^2=4.942 P=0.0262

Table (5.6) shows that there are significant differences between the female answers in the case group and their answers in the control groups concerning their knowledge of changes during puberty at α=0.05(P <0.05); i.e. breast growth; appearance of hair in the pubic area and underarms; increasing in length; growth of the pelvis and hips bones; menstrual cycle; oily skin \ acne and increasing sweating. As for the muscles growth, no differences are seen in the answers of females from the case and control groups.

Table (5.7): Knowledge of changes happens during puberty.

	Case group		Control group		
	Frequency	%	Frequency	%	Significant level
Hair Growth (face, hands, legs, pubic area	28	84.80%	42	63.60%	x^2=4.722 P=0.0298
Sound change (become rough)	30	90.90%	38	57.60%	x^2=11.231 P=0.0008
Increasing in height and weight	22	66.70%	28	42.40%	x^2=5.229 P=0.0222
Increase muscles / physical force Growth	21	63.60%	22	33.30%	x^2=8.139 P=0.0043
Widening shoulders	17	51.50%	22	33.30%	x^2=3.022 P=0.0821
Change in the genitals	21	63.60%	19	28.80%	x^2=10.953 P=0.0009
Oily skin \ acne	20	60.60%	16	24.80%	x^2=12.010 P=0.0005
Increasing sweating	26	78.80%	13	19.70%	x^2=31.858 P<0.0001

Table (5.7) below shows the significant differences in the male answers from the case and control groups concerning their knowledge of changes during puberty at α=0.05(P <0.05); i.e. hair growth (face, hands, legs, pubic area); sound change; increasing in height and weight; increase muscle / physical force growth; change in the genitals; oily skin \ acne; increasing sweating. No differences in the male answers are noticed concerning increasing shoulder width.

Table (5.8): Knowledge of problems faced adolescent during puberty.

	Case group		Control group		
	Frequency	%	Frequency	%	Significant level
Abdominal cramps	6	8.60%	22	15.70%	x^2=2.026 P=0.1546
Night secretion	21	30.00%	28	20.00%	x^2=2.596 P=0.1071
Feeling tired \ inactivity	29	41.40%	24	17.10%	x^2=14.549 P=0.0001
Excessive eating	20	28.60%	24	17.10%	x^2=3.711 P=0.0541
Depression \ sorrow	43	61.40%	10	7.10%	x^2=72.649 P<0.0001
Nervous and anger	45	64.30%	34	24.30%	x^2=31.661 P<0.0001
Lack of focus in the study	30	42.90%	26	18.60%	x^2=14.013 P=0.0002
Shame	19	27.10%	20	14.30%	x^2=5.033 P=0.0249

The results show that knowledge of problems faced during puberty is significantly high in the case group rather that the control group. As illustrated in table (5.8) above, there are significant differences between the answers of the case group and the answers of the control group concerning the knowledge of changes during puberty at α=0.05(P <0.05); i.e. Feeling tired \ inactivity ; Depression \ sorrow; Nervous and anger ; Lack of focus in study and Shame. As for abdominal cramps, night secretion, and excessive easting, no differences in answers are seen between the case and the control groups.

5.2.5 Sexual Transmitted Diseases:

This section presents the data on the knowledge of sexual transmitted diseases reported by the answers of case and control groups.

Table (5.9): Knowledge of sexual transmitted diseases.

	Case group		Control group		
	Frequency	%	Frequency	%	Significant level
Don't know	0	0.00%	20	14.30%	x^2=11.012 P=0.0009
HIV and AIDS	67	95.70%	90	64.30%	x^2=24.272 P<0.0001
Gonorrhea	23	32.90%	22	15.70%	x^2=8.159 P=0.0043
Syphilis	11	15.70%	6	4.30%	x^2=8.109 P=0.0044
Chlamydia	15	21.40%	6	4.30%	x^2=15.090 P=0.0001
Pubic lice	50	71.40%	8	5.70%	x^2=100.327 P<0.0001
Thrush	10	14.30%	2	1.40%	x^2=14.379 P=0.0001
Genital Warts	11	15.70%	4	2.90%	x^2=11.438 P=0.0007
Genital herpes	15	21.40%	8	5.70%	x^2=11.756 P=0.0006
Hepatitis B	53	75.70%	38	27.10%	x^2=44.331 P<0.0001
Hepatitis C	45	64.30%	34	24.30%	x^2=31.661 P<0.0001

As illustrated in table (5.9), knowledge level about sexual transmitted diseases are significantly differences between case and control group.

Table (5.10): Knowledge about signs and symptoms of infected with sexually transmitted diseases.

	Case group		Control group		
	Frequency	%	Frequency	%	Significant level
Don't know	0	0.00%	78	55.70%	x^2=61.725 P<0.0001
Discharge from the penis / vagina	33	47.10%	28	20.00%	x^2=16.555 P<0.0001
Burning or itching of the penis / vagina	31	44.30%	21	15%	x^2=21.399 P<0.0001
Abnormal vaginal bleeding	23	32.90%	21	15%	x^2=8.980 P=0.0027
Loss of weight	26	37.10%	25	17.90%	x^2=9.308 P=0.0023
Ulcers or blisters in the penis / vagina	20	28.60%	11	7.90%	x^2=15.782 P=0.0001
Abdominal pain	28	40.00%	12	8.60%	x^2=29.675 P<0.0001
Pain when urinating	28	40.00%	28	20.00%	x^2=9.5 P=0.0021
Swelling in thigh	8	11.40%	8	5.70%	x^2=2.149 P=0.1427

Table (5.10) shows the differences of knowledge on signs and symptoms of persons infected with sexually transmitted diseases between the case and control groups; i.e. Discharge from the penis / vagina; Burning or itching of the penis / vagina; Abnormal vaginal bleeding; Lose weight; Ulcers or blisters in the penis / vagina; Abdominal pain and Pain when urinating. Results show that knowledge of signs and symptoms are significantly changes among the case group compared with the control group. No major difference between both groups is noticed in regard to swelling thigh as a sign of infection with sexually transmitted diseases. As illustrated in table (5.10), 55.7%of control group do not have knowledge on the signs and symptoms of infection with sexually transmitted diseases.

Table (5.11): Knowledge of HIV/AIDS.

	Case group		Control group		
	Frequency	%	Frequency	%	Significant level
Have you ever heard of HIV (AIDS)?					
Yes	70	100%	120	85.70%	x^2=11.0526 P=0.0009
No	0	0.00%	20	14.30%	

Table (5.11) shows the percentage of knowledge about HIV/AIDS. Results show significant differences between answers of the case and control groups at α=0.05 ($p<0.05$).

Table (5.12): Knowledge about transmitting HIV disease (AIDS).

	Case group		Control group		
	Frequency	%	Frequency	%	Significant level
Unsafe sexual relationship	64	91.40%	48	40%	x^2=48.009 P<0.0001
Sharing contaminated needles	62	88.60%	44	36.70%	x^2=48.035 P<0.0001
Non-sterile medical devices	53	75.70%	42	35%	x^2=29.140 P<0.0001
Transfer contaminated blood	63	90.00%	41	34.20%	x^2=55.273 P<0.0001
From a pregnant mother to fetus	36	51.40%	24	20%	x^2=20.072 P<0.0001
Mosquitoes or other	53	75.70%	8	6.70%	x^2=96.030 P<0.0001
Through breast feeding	30	42.90%	6	5%	x^2=41.107 P<0.0001
Dealing with infected persons (food, cups, shaking hands, sneezing, cough …)	18	25.70%	12	10%	x^2=8.155 P=0.0043

As shown i n table (5.12), when asked on the knowledge of the ways of getting or transmitting HIV/AIDS, differences are significantly differences at $\alpha=0.05$ ($p<0.05$) in the case group compared to the control group.

Table (5.13): Knowledge about avoiding infected with HIV disease.

	Case group		Control group		
	Frequency	%	Frequency	%	Significant level
Avoid sexual contact	64	91.40%	20	16.70%	$x^2=99.489$ P<0.0001
Avoid contaminated blood	61	87.10%	26	21.70%	$x^2=75.776$ P<0.0001
Use condom before each sexual contact	52	74.30%	10	8.30%	$x^2=87.164$ P<0.0001
Avoid contaminated needles	44	62.90%	31	25.80%	$x^2=25.337$ P<0.0001
Avoid sharing shaving blades	55	78.60%	30	25%	$x^2=51.103$ P<0.0001
Avoid dealing with infected persons (food, cups, shaking hands, sneezing, cough …)	10	14.30%	66	55%	$x^2=30.352$ P<0.0001

As shown in table (5.13) above, knowledge level shows that there are differences between the answers of control group and case group on how to avoid infected with HIV disease are significantly changes at $\alpha=0.05$ ($p<0.05$) in the case group compared to the control group.

5.2.6 Reproductive Health.

This section demonstrates the knowledge of reproductive health as reported by the case and control groups.

Table (5.14): Source of knowledge's about reproductive health issues.

	Case group		Control group		
	Frequency	%	Frequency	%	Significant level
Don't ask	4	5.70%	62	44.30%	x^2= 32.107 P<0.0001
Family	61	87.10%	42	30%	x^2= 60.594 P<0.0001
Health sector	44	62.90%	14	10.00%	x^2= 64.994 P<0.0001
Society	19	27.10%	20	14.30%	x^2= 5.033 P=0.0249
School	51	72.90%	44	31.40%	x^2= 32.289 P<o.ooo1
Social Media	15	21.40%	50	35.70%	x^2= 4.445 P=0.0350

As illustrated in table (5.14), when respondents were asked the question "Who helped you in facing a problem or answering a question about reproductive health?" results show significant differences between the case and the control groups at α=0.05 ($p<0.05$).

Table (5.15): The reasons for don't asking for help regarding the reproductive health issues.

	Case group		Control group		
	Frequency	%	Frequency	%	Significant level
Shyness	3	75%	44	71%	x^2= 0.0298 P=0.862941
Confidentiality	1	25%	18	29%	

Table (5.15) shows that 4 children from the case group do not ask for help, in comparison to 62 children from the control group. No significant differences in the answers about reasons are

noticed between both groups. For example, 75% from the case group compared to 71% from the control group answered with shyness; 25% from the case group compared with 29% from the control group answered with confidentiality.

Table (5.16): Teachers and parents in a reply to questions related to reproductive health.

	Case group		Control group		
	Frequency	%	Frequency	%	Significant level
How was the response of your parents when you asked them about topics related to reproductive health?					
They answered with open-mindedness	44	62.90%	18	12.90%	x^2= 55.756 P<0.0001
Reprove	8	11.40%	16	11.40%	x^2= 0000 P=1.000
Refused to answer	0	0.00%	8	5.70%	x^2= 4.128 P=0.0422
Asked me to ask the question to someone else	0	0.00%	2	1.40%	x^2= 0.985 P=.3211
How was the response of your teacher when you asked him/her about topics related to reproductive health?					
They answered with open-mindedness	35	50%	22	15.70%	x^2= 27.637 P<0.0001
Reprove	0	0.00%	2	1.40%	x^2= 0.985 P=.3211
Refused to answer	4	5.70%	4	2.90%	x^2= 0.988 P=0.3203
Asked me to ask the question to someone else	0	0.00%	1	0.70%	x^2= 0.490 P= 0.4839

As illustrated in table (5.16) above, results show that 62.9% of the case group answered with "Open-Mindedness" when asked about the response of parents if asked about any issues related to reproductive health, in comparison to 12.9% of the control group. Further, the results show that 50% of case group answered with "Open-Mindedness" as well in terms of

the response of teachers when asked about reproductive health, compared to 15.7% of the control group.

Furthermore, table (5.16) shows significant differences in the response of parents between the two groups; i.e. the answers “they answered with all open-mindedness” and “refused to answer” are significantly changes. Moreover, the results show that there is no major difference in the answer “they asked me to ask someone else” and the answer “Reprove” between both groups.

Results show that there is great difference in the answer “teacher answered with open-mindedness” between both groups; i.e. the percentage of this answer is significantly changes. No major difference in regard to the answer “teacher asked me to ask someone else” or the answer “teacher refused to answer” or “Reprove” are seen between both groups.

Table (5.17): The proper age for the sexual and reproductive health educations.

When do you think that education should begin on reproductive / sexual health	Case group		Control group		
	Frequency	%	Frequency	%	Significant level
Before puberty	27	38.60%	29	20.70%	x^2= 35.7589 P<0.0001
Upon reaching puberty	35	50%	35	25%	
Before marriage	8	11.40%	76	54.30%	

Table (5.17) above shows that 50% of the case group compared with 25% of the control group has reported to start education on reproductive health upon reaching the period of puberty. Furthermore, the above table shows that there is a significant difference between the case group and the control group at $\alpha=0.05$ ($p<0.05$).

Table (5.18): Discussion the reproductive/sexual health topics in school lessons or center sessions.

	Case group		Control group		
	Frequency	%	Frequency	%	Significant level
Yes, in order to raise the awareness of young people	50	71.40%	16	11.40%	x^2=86.1215 P<0.0001
No, topics that cause shyness	11	15.70%	23	16.40%	
No, no need for it	5	7.10%	25	17.90%	
No, parents would not approve	2	2.90%	40	28.60%	
No, it encourages young people to sexual relations	2	2.90%	36	25.70%	

Table (5.18) above, shows a significant differences at ($p<0.05$), that 71.4% of the case group support discussing reproductive health topics during school or workshops in centers, compared to 11.4% only of the control group. Further, results show that 28.6% of the control group answered with "no, parents would not approve" and 25.7% f the same group answered with "No, it encourages young people to sexual relations".

Table (5.19.a): Knowledge's about services that provided at the health centers/UNRWA Clinics.

	Case group		Control group		
	Frequency	%	Frequency	%	Significant level
Don't go to health centers	32	45.70%	50	35.70%	x^2= 1.952 P=0.1624
Examination of the sexually transmitted diseases	11	15.70%	23	16.40%	x^2= 0.017 P=0.8969
Treatment of sexually transmitted diseases	7	10.00%	14	10%	x^2= 0000 P=1.000
Examination to detect HIV	10	14.30%	15	10.70%	x^2= 0.574 P=0.4486
Guidance before and after HIV examination	4	5.70%	3	2.10%	x^2= 1.886 P=0.1696
Contraception / Birth Control	6	8.60%	11	7.90%	x^2= 0.030 P=0.8615
Pregnancy tests	6	8.60%	22	15.70%	x^2= 2.026 P=0.1546

Table (5.19.b): Knowledge's about services that provided at the health centers/UNRWA Clinics.

	Case group		Control group		
	Frequency	%	Frequency	%	Significant level
Pregnant women care	7	10.00%	18	12.90%	x^2= 0.372 P=0.5421
Care for women giving birth	5	7.10%	6	4.30%	x^2= 0.734 P-0.3915
Psychosocial – sexual guidance	19	27.10%	14	9.30%	x^2= 11.396 P=0.0007
Referral of specialized services or tests not available in the center	7	10.00%	3	2.10%	x^2= 6.428 P=0.0112
Educational seminars	9	12.90%	30	21.40%	x^2= 2.219 P=0.1363

Table (5.19) above shows that there are no significant differences between both groups concerning the knowledge of health center services; i.e. examination of sexually transmitted diseases; treatment of sexually transmitted diseases; examination to detect HIV; guidance before and after HIV examination; contraception / birth control; pregnancy tests; pregnant women care; the care for women giving birth; educational seminars, do not show great differences between both groups.

However; results show that there are significant differences between both groups concerning their answers related to psychosocial-sexual guidance and referral of specialized services or tests not available in the center.

Moreover, the results in the table above also show that 45.7% of case group compared to 35.7% of the control group do not go to health centers when facing sexual/reproductive health issues.

Table (5.20): Reason for answer "Do not go to health center".

	Case group		Control group		
	Frequency	%	Frequency	%	Significant level
Do not know what are the services provided by these centers	5	7.10%	19	13.60%	x^2= 5.8682 P=0.217
The center is too far	4	5.70%	3	2.10%	
No medicines/Services in the center are available	4	5.70%	4	2.90%	
The center is for married couples only	1	1.40%	2	1.40%	
Always crowded	5	7.10%	3	2.10%	
Waiting for long time	6	8.60%	4	2.90%	
Non-qualified staff	0	0.00%	4	2.90%	
Non-friendly staff	2	2.90%	4	2.90%	
My family does not want me to go	2	2.90%	1	0.70%	
Afraid of the lack of Confidentiality	5	7.10%	6	4.30%	

Table (5.20) below shows the reason why 15.7% of the case group compared with 16.4% of the control group answered that they do not go to health centers, and why 8.6% of the case group compared with 15.7% of the control group answered with "Pregnant women care".

Table (5.20) above show that 8.6% of the case group does not go to the health center because they always wait for a long time. Further, 7.1% of the case group does not go to health centers because they are afraid of the lack of confidentiality, in addition to 7.1% of the same group who do not go to health centers because they don't know the services provided there, and 7.1% because the center is always crowded. As for the control group, show that 2.9% of this group does not go to health centers because they are waiting for a long time, and 4.3% because they are afraid of the lack of confidentiality, in addition to 13.6% because they do not know the services provided in centers and 2.1% because the center is always crowded. Results show that there are no significant differences between the case group and the control group.

5.2.7 Marriage and Engagement.

This section shows the results of the attitudes of case and control groups towards marriage and engagement.

Table (5.21): Social status.

	Case group		Control group		
	Frequency	%	Frequency	%	Significant level
Single	**69**	**98.60%**	**130**	**92.90%**	x^2= 3.223 P=0.1996
Engaged	**1**	**1.40%**	**7**	**5%**	
Married	**0**	**0.00%**	**3**	**2.10%**	

As illustrated in table (5.21) below, there are no significant differences in the social status in the case group compared to the control group.

Table (5.22): Proper age for engagement.

	Case group		Control group		
	Frequency	%	Frequency	%	Significant level
What do you think is the best age for engagement for female?					
16-18 yrs	10	14.30%	57	40.70%	x^2= 15.0042 P=0.0006
19-24 yrs	50	71.40%	69	49.30%	
Above 25	10	14.30%	14	10%	
What do you think is the best age for engagement for male?					
16-18 yrs	3	4.30%	43	30.70%	x^2= 21.2788 P<0.0001
19-24 yrs	39	55.70%	67	47.90%	
Above 25	28	40.00%	30	21.40%	

Table (5.22) shows the proper age for engagement for male and female as reported by the case and control groups. The majority of participants answered that (19-24 yrs) is the proper age for engagement. 71.4% of the case group answered concerning females, whereas 55.7% of the same group answered concerning males. As for the control group, 49.3% answered concerning females, and 47.9% answered concerning males. It is noticeable that the proper age for engagement for males and females is significantly differences ($p<0.005$) in groups.

Table (5.23): Do engaged children under the age 18 complete their studies or not.

	Case group		Control group		
	Frequency	%	Frequency	%	Significant level
Yes	67	95.7%	101	72.1%	x^2= 16.2054 P<0.0001
No	3	4.3%	39	27.9%	

The results in table (5.23) above show that 4.3% of the case group answered "NO" compared to 27.9% of the control group. However; 95.7% of case group and 72.1% of control group believe that these children shall complete their studies even if engaged under 18. There are significant differences between the answers of case and control groups ($p<0.05$).

Table (5.24): Proper age for marriage.

	Case group		Control group		
	Frequency	%	Frequency	%	Significant level
What do you think is the best age for marriage for females?					
16-18 yrs	3	4.3%	37	26.4%	x^2= 22.0456 P<0.0001
19-24 yrs	47	67.1%	89	63.6%	
Above 25	20	28.6%	14	10%	
What do you think is the best age for a marriage for males?					
16-18 yrs	0	0.0%	17	12.1%	x^2= 12.623 P=0.0018
19-24 yrs	27	38.6%	64	45.7%	
Above 25	43	61.4%	59	42.1%	

Table (5.24) shows the proper age for marriage for males and females in both, the case and control groups. The majority of both groups answered with the age (19-24) yrs concerning females marriage, 67.1% of the case group, compared to 63.6% of the control group. Further, the results in this table also show that 61.4% of the case group answered with the age (above

25 yrs) as the appropriate age for males' marriage, compared with 42.1% of the control group. Results show that there are significant differences between the answers of the case and control groups ($p<0.05$).

Table (5.25): Do married children under the age 18 complete their studies or not. .

	Case group		Control group		
	Frequency	%	Frequency	%	Significant level
Do you think children under the age of 18 years, who are married, must complete their studies?					
Yes	65	92.9%	72	51.4%	x^2= 35.3185 P<0.0001
No	5	7.1%	68	48.6%	

Table (5.25) above shows that 7.1% of the case group answered with "NO" compared to 92.9% who have answered with "Yes". As for the control group, 51.4% agree that these children shall complete their study, whereas 48.6% do not agree with this. Results show that there are significant differences between the answers of the case and control groups ($p<0.05$).

Table (5.26): Proper age for the first pregnancy.

	Case group		Control group		
	Frequency	%	Frequency	%	Significant level
What do you think is the best age for the first pregnancy?					
16-18 yrs	1	1.4%	31	22.1%	x^2= 16.5883 P<0.0001
19-24 yrs	32	45.7%	59	42.2%	
Above 25	37	50.0%	50	35.7%	

Table (5.26) above, show the results of the most proper age for the first pregnancy. Results show that 50.0% of the case group answered with "above 25", compared to 35.7% of the control group who answered with the same age. Additionally, results show that 45.7% of the

case group answered with the age (19-24) compared to 42.2% of the control group who answered with the same age. Further, 1.4% of the case group answered with 16-18 yrs old, compared with 22.1% of the control group who answered with the same age. Results show that there are significant differences between the answers of the case and control groups ($p<0.05$).

Table (5.27): Reasons, why pregnancy should be avoided during puberty.

	Case group		Control group		
	Frequency	%	Frequency	%	Significant level
Are there any reasons why pregnancy should be avoided during puberty?					
Yes	61	87.1%	82	58.6%	$x^2= 17.5347$ P<0.0001
No	9	12.9%	58	41.4%	

As illustrated in table (5.27), 82.9% of the case group answered YES, and 8.6% of the same group answered NO. Compared with 45.7% of the control group answered YES and 30% answered they don't know whereas 24.3% answered NO. Results show that there are significant differences between the answers of the case and control groups ($p<0.05$).

Table (5.28): Complications that happen during pregnancy/giving birth during puberty.

	Case group		Control group		
	Frequency	%	Frequency	%	Significant level
Mother's death	43	61.4%	20	14.3%	x^2= 49.063 P<0.0001
Premature birth	38	54.3%	17	12.1%	x^2= 42.811 P<0.0001
Increased weight at birth	5	7.1%	4	2.9%	x^2= 1.991 P=0.1582
Sudden abortion	37	52.9%	19	13.6%	x^2= 36.653 P<0.0001
Stillbirth	30	42.9%	10	7.1%	x^2= 38.626 P<0.0001
Low weight at birth	23	32.9%	10	7.1%	x^2= 23.359 P<0.0001
Bleeding	33	47.1%	18	12.9%	x^2= 29.531 P<0.0001
Increased probability of childhood diseases	28	40.0%	10	7.1%	x^2= 33.962 P<0.0001
Mental or physical disability	27	38.6%	9	6.4%	x^2= 33.917 P<0.0001

Table (5.28) shows the differences in knowledge level concerning problems faced during pregnancy at puberty between both groups; Mother's death; Premature birth; Sudden abortion; Stillbirth; Low weight at birth; Bleeding; Increased probability of childhood diseases and Mental or physical disability. These answers are significantly changes in the case group compared with the control group. Further, results show that there is no major difference in regards to the answer; Increased weight at birth noticed between both groups.

5.2.8 Violence.

This section presents the knowledge about violence of both, the case and control groups.

Table (5.29): Husband can beat his wife or brother can beat his sister.

	Case group		Control group		
	Frequency	%	Frequency	%	Significant level
Do you agree or not to the following statement? "It is appropriate that the husband beats his wife or the brother beats his sister"					
No	70	100%	92	65.7%	x^2= 31.1111 P<0.0001
Yes	0	0.0%	48	34.3%	

As illustrated in table (5.29), 65.7% of the control groups answered that they do not agree that the husband can beat his wife or that the brother can beat his sister, compared to 100% of the case group who answered with the same question with "No". As illustrated in table (5.29) there are significant differences between the answers of the case and control groups ($p<0.05$).

Table (5.30): Children are exposed to violence in the communities.

	Case group		Control group		
	Frequency	%	Frequency	%	Significant level
Are children aged 10-17 yrs old exposed to violence in your community?					
No	13	18.6%	40	28.6%	x^2= 2.4733 P=0.1158
Yes	57	81.4%	100	71.4%	

Table (5.30) above, shows that 81.4% of the case group answered children in their communities are exposed to violence compared to 71.4% of the control group who answered with the same. The majority of the two groups show that children are indeed exposed to

violence in their communities. Results show that there are no significant differences between both groups.

Table (5.31): “I have the right to have a life from any violence”.

	Case group		Control group		
	Frequency	%	Frequency	%	Significant level
Do you agree with the following statement? "I have the right to have a life from any form of violence					
No	0	0.0%	8	5.7%	x^2= 4.1584 P=0.0414
Yes	70	100%	132	94.3%	

As illustrated in table (5.31), 100% of the case group agrees with the statement compared to 94.3% of the control group who also agree with the same statement. Results show that there are significant differences between both group at $\alpha=0.05$ ($p<0.05$).

Table (5.32):“It is my responsibility not to abuse others”

	Case group		Control group		
	Frequency	%	Frequency	%	Significant level
Do you agree with the following statement? "It is my responsibility not to abuse others					
No	2	2.9%	28	20.0%	x^2= 11.082 P<0.0001
Yes	68	97.1%	112	80.0%	

As illustrated in table (5.32) above, 97.1% of the case group agrees with the statement, compared to 80.0% of the control group. The majority of both groups agree with the statement. Results show that there are significant differences between both group at $\alpha=0.05$ ($p<0.05$).

Table (5.33): Physical violence manifestations.

	Case group		Control group		
	Frequency	%	Frequency	%	Significant level
Beating by hand	67	95.7%	80	57.1%	x^2=32.932 P<0.0001
Beating tools	63	90.0%	85	60.7%	x^2= 19.159 P<0.0001
Shaking	50	71.4%	40	28.6%	x^2=34.739 P<0.0001
Pulling hair	56	80.0%	50	35.7%	x^2= 36.462 P<0.0001
Burning with cigarette or hot water	54	78.3%	60	42.9%	x^2= 23.488 P<0.0001
Forcing a child to stay in an uncomfortable position (to stand in the corner)	41	58.6%	20	14.3%	x^2= 44.207 P<0.0001
Forcing a child to do intensive physical exercises	40	57.1%	29	20.7%	x^2= 27.904 P<0.0001

Table (5.33) above shows the results of both groups concerning physical violence manifestations. Results show that 95.7% of the case group answered beating by hand, compared to 90.0% of the same group answered beating by a tool, whereas 60.7% of the control group answered beating by a tool, compared to 42.9% of the same group answered by burning. Results show that there are significant differences between both group at α=0.05 ($p<0.05$).

Table (5.34): Mental violence manifestations.

	Case group		Control group		
	Frequency	%	Frequency	%	Significant level
Insulting children and calling them with abusive titles	59	84.3%	75	53.7%	x^2=18.852 P<0.0001
Screaming at children	61	87.1%	71	50.7%	x^2=26.351 P<0.0001
Telling children that no one loves them	52	74.3%	73	52.1%	x^2=9.499 P=0.0021
Lock up a child alone	51	72.9%	50	35.7%	x^2=25.746 P<0.0001
Threatening children	57	81.4%	61	43.6%	x^2=26.959 P<0.0001
Abandoning children	49	70.0%	67	47.9%	x^2=9.175 P=0.0025
Neglecting children emotionally	51	72.9%	45	32.1%	x^2=31.156 P<0.0001

Table (5.34) above presents the results of both groups concerning mental violence manifestations. The results show that 84.3% of the case group answered with insulting children and calling them with abusive titles, compared to 87.1% of the same group answered with screaming at children. As for the control group, results show that 53.7% answered with insulting children and calling them with abusive titles, compared to 50.7% of the same group answered with screaming at children and 52.1% answered with telling children that no one loves them. Results show that there are significant differences between both group at α=0.05 ($p<0.05$).

Table (5.35): Sexual violence manifestations.

	Case group		Control group		
	Frequency	%	Frequency	%	Significant level
Touching intimate parts of children	66	94.3%	83	59.3%	x^2=27.613 P<0.0001
Forcing a child to touch the intimate parts or intimate private parts of others	62	88.6%	80	57.1%	x^2=21.041 P<0.0001
Having sex with a child	68	97.1%	95	67.9%	x^2=22.806 P<0.0001
Looking at pictorial magazines or movies include images of people naked or semi-naked	46	65.7%	43	30.7%	x^2=23.301 P<0.0001
Tell children unethical stories or jokes	37	52.9%	40	28.7%	x^2=11.699 P<0.0001

Table (5.35) above shows the results of both groups concerning sexual violence manifestations. Both groups do know the sexual violence manifestation. Still both groups are need for more information. Results show that there are significant differences between both group at α=0.05 ($p<0.05$).

Table (5.36): Sexual perpetrators.

	Case group		Control group		
	Frequency	%	Frequency	%	Significant level
Male stranger	57	81.4%	76	54.3%	x^2=6.944 P=0.0084
Friend	38	54.3%	28	20.0%	x^2=14.688 P=0.0001
Uncle	31	44.3%	18	12.9%	x^2=25.352 P<0.0001
Brother	30	42.9%	14	10.0%	x^2=30.338 P<0.0001
Neighbor	37	52.9%	20	14.3%	x^2=34.974 P<0.0001
Father	29	41.4%	14	10.0%	x^2=28.132 P<0.0001

As shown in Table (5.36). Regarding sexual perpetrators, with differences between both groups, both group considered male stranger is the main perpetrator, 81.4% of case group and 54.3% of control group. Regarding father, 41.4% of case group and 10% of control group consider father as a sexual perpetrator. There are significant differences between both group at α=0.05 ($p<0.05$).

Table (5.37): What they can do to protect yourself from violence.

	Case group		Control group		
	Frequency	%	Frequency	%	Significant level
To say "NO"	39	55.70%	70	50%	x^2=0.604 P=0.4369
Tell someone I trust	44	62.90%	54	38.60%	x^2=11.018 P=0.0009
Run or save myself	44	62.90%	53	37.90%	x^2=11.677 P=0.0006
Shout	37	52.90%	49	35%	x^2=6.153 P=0.0131
Do not take gifts to do something wrong in return	37	52.90%	60	42.90%	x^2=1.868 P=0.1717
Find out more about violence against children through the Internet, books, etc	34	48.60%	20	14.30%	x^2=28.591 P<0.0001
Ask for a telephone number concerned with helping and saving children	33	47.10%	18	12.90%	x^2=29.531 P<0.0001
Keep emergency telephone numbers	35	50.00%	13	9.30%	x^2=43.619 P=0.0001

Table (5.37) above, present the differences in protection methods from violence between both groups. All answers stated above are significantly differences in the case group compared with the control group. No significant differences in regards to the answer; Do not take gifts to do something wrong in return and to say "No" for violence are seen between both groups, which is the most method needed by children to protect themselves.

5.3. Summary.

A total of 210 children have participated in this study. 70 children of them have participated in the project" Protecting Adolescents from Gender based Violence through the Promotion of their Sexual and Reproductive Health Rights project /Palestine" implemented by Juzoor in 2010. These children are identified as the case group. In addition, 140 children have not participated in the Juzoor project; these are identified as the control group. No differences in socio-demographic characteristics between both groups are noticed.

Each group consists of 47.1% males compared with 52.9% females. Further, 100% of the children are interviewed under the Palestinian Nationality and 94.3% of them are refugees, whereas 37.2% of children are members at youth clubs.

This chapter focuses on the results of the questionnaire between both groups for KAP (Knowledge, Attitude, Practice) of the education, personal hygiene, the characteristics during puberty, sexual transmitted diseases, reproductive health, engagement and marriage, and violence. The findings indicate significant differences in the case group and the control group.

The results of this chapter need to be taken into consideration to support planning, implementing, monitoring, and improving of the future interventions. It is clear that the project was able to bring a remarkable change to the targeted group. The next chapter will discuss these results through comparison between group results, presenting conclusion and recommendation.

Chapter six
Discussion, conclusion and recommendations

6.1 Introduction

This study was conducted to evaluate the impact of the project (Protecting Adolescents from Gender based Violence through the Promotion of their Sexual and Reproductive Health Rights) on differences in knowledge, attitudes and practices of children and adolescents in the following areas: puberty, personal hygiene, early marriage, violence, reproductive health, HIV (AIDS) and other sexual transmitted disease.
This study took place in 3 camps schools in Palestine (Arroub, Aida and Ein Sultan camps).
The study was quantitative case control design with case and control groups.
In this chapter results are discussed. Comparing between case group and control group was done to look for the changes in outcome that are directly attributable to the program effectiveness and their sustainability.
This chapter is divided into three sections. The first section in this chapter shed lights on the most important finding that agreement with the conceptual framework components.
The following sections are study conclusion and recommendations.

6.2. Summary of the study findings

A total of 210 children were part of this study, 70 children were identified as members of the case group, and 140 children were identified as members of the control group, no significant differences in the socio demographic characteristics between the both groups was identified.
The impact evaluation of the project" Protecting Adolescents from Gender based Violence through the Promotion of their Sexual and Reproductive Health Rights' in (Arroub, Aida and

Ein Sultan camps) was very effective. Significant differences was achieved. It was noticed that several children knowledge, attitude and practices have been changed.
Analyzing the changes in knowledge, attitudes and practices pertaining to project objectives, it is clear that the project has been able to bring in remarkable differences to the most of the case group.

6.3. Discussions:

6.3.1. Personal hygiene

In both group results shows a significant differences in personal hygiene knowledge. Differences regarding personal hygiene practices are also significant.
This study shows that case group is more knowledgeable level compared with control group. Case group being more awareness about menstrual period and how many times they must changes their sanitary pads. Control group are poor awareness level about menstrual hygiene maybe because they were not properly guided on how to manage their period, or they haven't knowledge about hygiene practices or they don't know how to practice it.

Significant differences among case group were reported regarding personal hygiene practices. Case group are more awareness about personal hygiene practices, according bathing, 60% of case group take one ore more shower a day, compare with 10% of control group because control group has low level of awareness about their body hygiene or because their own context and habits.

Significant differences among case group were reported regarding personal hygiene practices when we asked about the source of information about personal hygiene (family; health sector; society; school and the media) compared with control group. It is interesting to observe the main role of family especially mothers in the provision of information about personal hygiene with 85.7% in case group comparing with 49.3% of control group. That because mothers are the first line of contact between children and environment, or because mothers present in

house more time than fathers who spend more hours at work outside home, mother is the first resort for children.

Comparing these results with results from other studies we can notice that improving hygiene practices are effective in reducing hygiene problems, cleanliness is considered a marker of safe hygiene practices and the need for interventions that increase the knowledge level of personal hygiene (Miko et al, 2013). Need parents and teachers to emphasize to their children the importance of personal hygiene (Rani et al, 2014). Needs for educational strategies to be implemented and promoted by further research scholars about personal hygiene (Singh et al, 2014).

6.3.2. Changes during puberty:

Knowledge's about changes during puberty are significantly difference in case group and control group. This study shows that case group, who participated in the project in 2010 and received the intervention, are more knowledgeable and mention more puberty manifestation and more puberty problems faced by adolescent during puberty compared with the control group. This study indicates that the project have a role in the change of case group knowledge.

Case group mentioned more puberty manifestation and more puberty problems faced by adolescent during puberty than control group because most of control group cant addresses issues concern puberty due to their culture or religious considerations or because most of them consider puberty as an unpleasant experience, nervousness and sham regarding body changes, or because they don't receive accurate information about puberty.

Comparing these results with other studies we can notice that knowledge level in group that received intervention is higher than that didn't receive the intervention (Golchin et al, 2012). Adolescent need more education and development of knowledge about puberty and puberty manifestation (Ahmadi et al, 2009). Society, families are responsible for working together to create an atmosphere that correct information concerning puberty and the associated issues (Golchin et al, 2012).

6.3.3. The sexual transmitted disease and HIV:

Within the area of sexually- transmitted infections and HIV, the project has achieved significant difference in children knowledge's in both groups.
The differences in knowledge about signs and symptoms of infected person with sexually transmitted disease between the two groups are significantly differences in the case group compared with the control group. Also, It is remarkable to note that case group can identify HIV and the methods of transmission and prevention. Compared with control group, significant differences are between both group results. This is another significant difference of the project being able to provide structured knowledge about STIs and HIV mode of transmission and hence prevention. Children showed an increase rate of awareness because of the intervention that received by children in the project in 2010.

The result is congruent with Gao et al (2012) about HIV/AIDS that found that Educational intervention increased the student knowledge significantly and changes their attitude positively. Educational programs about HIV/AIDS prevention will effective and beneficial for children if carried out using continuous and long term strategies.

6.3.4. Reproductive health:

Children knowledge, attitudes and practices on reproductive health is a significant difference in both groups. Case group has reported more services that health centers (UNRWA) provides for the community. Also, it is more awareness about the right age that education in the field of reproductive health must start. Case group support starting education in the field of reproductive health at school, university and health center groups, when control group support starting education when preparing for marriage.

Comparing these results with results from other studies we notice that case group was more conscious about the reproductive health importance because of the interventions that received in the project in 2010. Also, other studies support that interventions, health education sessions

and programs increase the children awareness of reproductive health issues, they also recommended that doctors, parents and teachers should be trained and encouraged to speak to children about reproductive heath issues while they growing up on a graded program to maintain sustained level of knowledge because children are likely to lose information as time progresses(Padhyegurjar et al,2012).

6.3.5. Marriage and engagement:

Within the area of marriage and engagement the project has achieving significant differences in children attitude and behavior.

This section shows the results about attitude towards marriage and engagement in case and control groups. Discussed the results about the proper age for adolescent engagement, marriage and the first pregnancy shows significant differences in case group and control group.

Case group shows more awareness about the proper age for engagement, marriage and the first pregnancy. Control group are poor awareness because they aren't aware of the negative health out comes of children marriage or because children believe that their parents made the right decision, or because the influence of their culture and community perceptions or because the wealth status.

Knowledge about child pregnancy complications is significant difference in both groups. Case group are able to mention three or more complications of child pregnancy more than control group.

Comparing these results with results from other studies we can notice that an action must be taken to provide a strong social and economic foundation to make policies that can promote the marital and the educational level (Marshan et al, 2013). The need to improve the access to education, and the need for more intervention to increase children knowledge's and attitudes. (Marshan et al, 2013).

6.3.6. Violence:

Knowledge's about violence are significant difference in both groups. Case group were mentioned more sexual, physical and mental violence manifestation than control group. This result suggests the role of the intervention on case group awareness about violence forms, manifestations and also violence protection method.

Comparing these results with results from other studies we notice that children education on attitudes and knowledge's concerning violence increase their knowledge about violence situations and forms. (Pomeroy et al, 2011).

Children's attitude toward violence there are significant difference in both groups. Group issue is more awareness about their rights to live free from violence, how to recognize the violence and how to reject the different forms of violence (Sundaram, 2013).

Children practices toward violence are significant difference in both groups. Case group can interpreted violence in a range of practices: pushing, shouting, screaming...etc. this study found that understanding level of violence are different according to the children participation in the project(Herman & Silverstein, 2012).

6.4. Conclusions:

This study confirms that after measuring differences in knowledge, attitudes and practices related to the objectives of the project, it is clear that the project has been able to bring a significant change to the participants.

The high enrolment in schools form the appropriate basis for focusing on these setting as an entry point for SRHR(Sexual and Reproductive Health Right) education and services and this needs to be connected to a wider institutional and social construct to ensure protection and sustainability. This suggests the need for early educational sessions among children and their families to accept SRHR education in schools. Another important issue is to involving parents,

teachers and services provider in developing the material that will achieve the purpose of the educational project.

Having touched on different topics and indicators that have been asked about, this study shows that there are parts need more attention and must be under control because of their sensitive role and their influences on children such as media. Media can help children if they were under the control of specialists and parents.

There are a lot of questions that have a compatible answer from both groups, especially questions that address violence in society and the rejection of various manifestations of violence. This is due to the awareness level of students in general about their rights away from joining the program or not, so information must be consistent with the degree of awareness of students

6.5. Recommendation:

1. Recommendation for families, schools and community:

- Encouraging children to read, due to the children's ability to read; print media can be used as mean of education and communication in the future activities of the project.

- Ensure including children in all schools they have correct answers to all the questions they think about, especially around sexual and reproductive health.

- Since the answers about personal hygiene and puberty cannot be tested and verified as they remain subject to children answers. It is recommended to provide teachings about the importance of personal hygiene and changes during puberty, and it is recommended to encourage mothers to join the education program about the importance of these subjects because children consider her as the first and primary source of information.

- The school has a role to playing in assisting and observing children during school hours. There is need for school to raise children’s awareness about violence,

reproductive health and children's rights and to encourage communication between teachers and student about these subjects.

- Schools should raise the children's knowledge about non-profit and supporting institutions that provide services for community especially children.

2. Recommendation for health centers and providers:

- Health centers and service providers who provide information for children through educational courses , should encourage parents to participate in these courses to improve communication between parents and children especially in the topics related to reproductive health and sexuality.
- Health center should collaborated with teachers and parents to provide them with any assistance regarding topics related to reproductive health and sexuality in general, HIV and sexually transmitted diseases, in particular
- Provide health educational promotion sessions about children rights, sexual health, and early marriage involving parents and children together.
- Provide information's about the services that health centers provides to the community.

3. Policy and management:

Recommendation for policy maker and managers:

- Considering violence and early marriage as priority public problems, integrating them into the national strategy for children rights.
- Improve partnership and cross sectoral collaboration between the government and the different organizations to achieve the children and the community benefits.
- Share results with policy makers, negotiate on how to activate and enhance the role of health centers that are part of the system as well as those who part of other organization.

4. Need for continued research:

- Long terms follow up and impact evaluation studies must be done conducted to ensure effectiveness and sustainability of educational program and projects.

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Annexes:

Annex (1)

دراسة ميدانية حول حقوق الأطفال والمراهقين المتعلقة بصحتهم الانجابية والجنسية
مسح لمعارف ومواقف وممارسات الفتيات والفتيان استمارة

موافقة مبنية على المعرفة

تقوم طالبة دراسات عليا في جامعه القدس ,كليه الصحه العامه, باجراء بحث حول الصحة الجنسية و الإنجابية للأطفال الذين يعيشون في هذه المنطقة. وسيتمّ إجراء مقابلات مع الأطفال .

لهذا السبب، نرغب في إشراك ابنتك / ابنك في مقابلة تعتمد على إستمارة تمّ إعدادها لجمع المعلومات حول المعارف والمواقف والسلوكيات في مجال الصحة الإنجابية ، والعنف ، وآليات الحماية /التكيّف. وتستغرق المقابلة حوالي ال45 دقيقة.

المعلومات التي ستشاركوننا بها ستقدم في تقرير البحث النهائي. لكن الأسماء / الهوية وأيّة معلومات أخرى خاصة لن يتم الكشف عنها، وستعامل بسرّية تامة. كما أن المشاركة في هذا البحث هو طوعي، وتستطيع أن تختار عدم الإجابة على اي من الأسئلة.

وسوف تساعد هذه المعلومات للتخطيط لبرنامج يحسّن مستوى معرفة الشباب حول قضايا الصحة. وسيكون بامكانك الحصول على نتائج هذا البحث الذي تشارك فيه ان كنت ترغب في ذلك.

ابنك في المقابلة./إننا نطلب موافقتك بوسيلة هذه الرسالة على مشاركة ابنتك

في حال وافقت، الرجاء التوقيع هنا أدناه.

توقيع الوالد : _____
توقيع الطفل/المراهق: _____

المكان والتاريخ : _____

Annex (2)

الاستبانة

المركز:●
العروب●
عايدة والعزّة ●
عين السلطان ●

هل شاركت خلال الأسابيع الثلاثة الماضية بدراسة ميدانية حول مواضيع الصحة الانجابية والجنسية؟
0. لا
1. نعم

القسم الأول: خصائص عامــة	
1. الجنس	1. ذكر 2. أنثى
2. سنة الولادة	____
3. الجنسية **(اجابة واحدة فقط)**	1. لبناني 2. فلسطيني 3. عراقي 4. سوداني 5. كردي 6. أرمني 7. سوري 8. مصري 9. مكتوم القيد (غير حائز على هوية) 10. غيره، حدد: _____
4. الوضع	1. لاجئ 2. غير لاجئ
5. وضع الاسرة \ الحالة الإجتماعية للأهل **(اجابة واحدة فقط)**	1. الأب والأم موجودان في أسرة واحدة 2. الأب والأم منفصلان 3. الأب متوفٍ 4. الأم متوفاة 5. الأب والأم متوفيين 6. الأب متزوج من أخرى 7. الأم متزوجة من آخر 8. غيره، حدد: _____
6. هل انت عضو في نادٍ شبابيٍّ؟	1. لا 2. نعم

القسم الثاني: التعليم	
1. هل تستطيع القراءة ؟ (كتاب اطفال مثلا)	0. لا **انتقل للسؤال" 3"** 1. نعم
2. بأية لغات ؟	a. عربي

	b. انكليزي c. فرنسي d. عربي+انكليزي e. غيره، حدد: _____
3. هل انت ملتحق بالمدرسة حالياً ؟	0. لا 1. نعم
4. هل المدرسة التي تذهب اليها:	1. حكومية 2. خاصة 3. مدرسة تابعة للاونروا (وكالة الأمم المتحدة لإغاثة وتشغيل اللاجئين الفلسطينيين في الشرق الأدنى)
5. هل أنت ملتحق بأي من أشكال التعليم التالية حالياً ؟ **(إجابات متعددة)**	1. لا 2. نادٍ شبابيً (*من ضمنها محاضرات حول الصحة*) 3. دروس خاصة في اللغات 4. الاستلحاق الدراسي (*من ضمنها محو الأمية*) 5. التدريب المهني\التقني 6. غيره، (حدد) _____
القسم الثالث: النظافة الشخصية **الآن سوف أسالك بعض الأسئلة المتعلقة بنظافتك الشخصية**	
1. كم مرة تستحم/تستحمين؟ **(اجابة واحدة فقط)**	1. مرة في اليوم أو أكثر 2. يوم بعد يوم (4 مرّات في الاسبوع) 3. مرّتين في الاسبوع 4. مرّة في الاسبوع أو أقلّ
2. من أين تستحصل على معلومات حول النظافة الشخصية؟ **(إجابات متعددة)**	a. أستاذ b. الأم c. الأب d. الأخ e. الأخت f. صديق g. قريب h. طبيب i. ممرض/قابلة قانونية j. مرشد نفس/إجتماعي k. مساعدة إجتماعية l. مركز صحي m. مركز شبابي n. منشورات ومطويات o. الراديو p. التلفزيون q. كتب r. إنترنت
قسم خاص بالفتيات	
3. كم مرة يجب أن تبدل الفتاة الفوطة الصحية خلال الدورة الشهرية؟ **(اجابة واحدة فقط)**	1. يومياً 2. عدة مرّات خلال النهار
القسم الرابع: التغيرات المصاحبة لمرحلة البلوغ (مرحلة المراهقة)	
1. **سؤال موجّه للفتيات فقط:** ما هي التغيرات البدنية/الفيزيولوجية التي تحدث أثناء البلوغ عند الفتيات ؟	a. نمو الثديين b. ظهور الشعر في منطقة العانة وتحت الابطين c. زيادة في الطول

(إجابات متعددة	d. زيادة نمو العضلات e. نمو عظام الحوض واستدارة الوركين f. بدء الحيض \ الدورة الشهرية g. البشرة الدهنية\ حب الشباب h. زيادة التعرق
2. **سؤال موجّه للفتيان فقط:** ما هي التغيرات البدنية/الفيزيولوجية التي تحدث أثناء البلوغ عند الفتيان ؟ **(إجابات متعددة)**	a. نمو الشعر (الوجه، الأيدي،الأرجل، منطقة العانة) b. تغيّر الصوت (يصبح خشنا) c. زيادة في الطول والوزن d. زيادة نمو العضلات /القوة الجسدية e. اتساع الكتفين f. . تغيير في الأعضاء التناسلية g. البشرة الدهنية\ حب الشباب h. زيادة افراز غدد العرق
3. ما المشاكل أو الهموم التي يواجها المراهق أثناء البلوغ؟ **(إجابات متعددة)**	a. تقلصات بالبطن b. إفرزات ليلية c. الشعور بالتعب\الخمول d. الإفراط بالأكل e. الإكتئاب\الحزن f. عصبية وغضب g. عدم التركيز في الدراسة h. الخجل
القسم الخامس: الإلتهابات المنقولة جنسيّا وفيروس نقص المناعة المكتسب ومرض الإيدز (أو السيدا)	
1. هل تعرف إلتهابات يمكن أن تنتقل للشخص عبر علاقة جنسية؟ في حال نعم أي منها تعرف؟ **(إجابات متعددة)**	a. لا b. فيروس نقص المناعة المكتسب ومرض الإيدز (أو السيدا) c. السيلان d. الزهري e. الكلاميديا f. قمل العانة g. مرض القلاع h. الثآليل التناسلية i. الهربس التناسلي j. إلتهاب الكبد الوبائي B k. إلتهاب الكبد الوبائي C

2. أية عوارض أو علامات قد تدل على أن شخص ما يعاني من إلتهابات متناقلة جنسياً؟ **(إجابات متعددة)**	a. لا أعرف b. إفرازات من العضو الذكري/المهبل c. تحرق أو حكة في العضو الذكري/المهبل d. نزيف مهبلي غير طبيعي e. خسارة الوزن f. قروح أو بثور في العضو الذكري/المهبل g. ألم في البطن h. ألم عند التبول i. تورم في منطقة الفخذ
3. هل سبق وأن سمعت بفيروس نقص المناعة المكتسب ومرض الإيدز (أو السيدا)؟	0. لا ، **انتقل للقسم السادس** 1. نعم
4. من فضلك، عدد كافة السبل/الطرق التي تعتقد يمكنها أن تعرّض الشخص لفيروس السيدا؟ **(إجابات متعددة)**	a. العلاقة الجنسية غير المأمونة b. مشاركة الإبر الملوثة c. أدوات طبية غير معقمة d. نقل دم ملوث e. من الأم الحامل لجنينها f. البعوض أو غيرها g. من خلال الإرضاع عبر الثدي h. الإحتكاك بالأشخاص المصابين (مشاركة الطعام، الأكواب، المصافحة، العطس، السعال...)
5. ماذا يمكن للشخص أن يفعل للوقاية من إلتقاط عدوى السيدا؟ **(إجابات متعددة)**	a. تفادي العلاقات الجنسية بصورة مطلقة b. تشجيع الشريك على الإخلاص c. تفادي الدم الملوث d. إستعمال الواقي الذكري عند كل علاقة جنسية e. تفادي إستعمال الحقن غير المعقمة f. تفادي مشاركة شفرات وريش الحلاقة g. تفادي الإحتكاك بشخص مصاب (مشاركة الطعام، الأكواب، المصافحة، العطس، السعال...)
القسم السادس: المعلومات المتعلقة بالصحة الانجابية والجنسية	
1. في حال واجهت مشكلة أو كان لديك سؤال متعلق بصحتك الانجابية\الجنسية، الى من تذهب للمساعدة؟ تذكر ان مشاكل الصحة الانجابية هي مشاكل ممكن ان تكون متعلقة بالاعضاء التناسلية، الحمل غير المرغوب به، الايدز والحماية من الأمراض المنقولة جنسياً، الإجهاض، الخ..	a. لا أبحث عن النصيحة أو المساعدة b. أستاذ c. الأم d. الأب e. الأخ f. الأخت g. صديق h. قريب i. طبيب l. مساعدة إجتماعية m. مركز صحي n. مركز شبابي o. منشورات ومطويات p. الراديو q. التلفزيون r. كتب s. إنترنت

(إجابات متعددة)	j. ممرض/قابلة قانونية (داية) k. مرشد نفس/إجتماعي
2. اذا كانت الاجابة هي (b) في السؤال 1، لم لا؟	a. الاحراج b. قلق حول خرق السرية
3. كيف كان تجاوب المدرّس/ة عندما سألته/ها عن مواضيع متعلقة بالصحة الانجابية / التربية الجنسية؟ **(إجابة واحدة)**	1. وبّخني 2. رفض(ت) الإجابة 3. طلب(ت) منّي طرح السؤال على شخص آخر 4. أجابني بكل رحابة صدر
4. كيف كان تجاوب أحد والديك عندما سألته/ها عن مواضيع متعلقة بالصحة الانجابية / التربية الجنسية؟ **(إجابة واحدة)**	1. وبّخني 2. رفض(ت) الإجابة 3. طلب(ت) منّي طرح السؤال على شخص آخر 4. أجابني بكل رحابة صدر
5. برأيك متى يجب أن تبدأ التربية حول الصحة الانجابية / الجنسية؟ **(إجابة واحدة)**	1. قبل سن البلوغ 2. عند سن البلوغ 3. عند التحضير للزواج
6. هل تؤيد ان تتم مناقشة مواضيع الصحة الانجابية / التربية الجنسية خلال الحصص المدرسية وحلقات التوعية في المراكز؟لماذا؟	a. لا، خجل الشباب b. لا، لا حاجة لذلك c. لا، لن يوافق الأهل d. لا، ذلك يشجع الشباب على العلاقات الجنسية e. نعم، ترفع من وعي الشباب
7. ما هي الخدمات التي تستخدمها في المركز الصحي / عيادة الاونروا عندما تواجه مشكلة متعلقة بصحتك الانجابية\الجنسية؟ **(إجابات متعددة)**	a. لا ألجأ الى مراكز صحيّة b. فحص للإلتهابات المنقولة جنسيّاً c. علاج للإلتهابات المنقولة جنسيّاً d. فحص لكشف فيروس نقص المناعة المكتسب e. إرشاد قبل و بعد فحص فيروس نقص المناعة المكتسب f. وسائل منع الحمل / تنظيم الاسرة g. فحوصات حمل h. رعاية الحوامل i. رعاية الواضعات j. إرشاد نفسي اجتماعي جنسي k. الاحالة لخدمات متخصصة أو فحوصات غير متوفرة في المركز l. حلقات تثقيفية
8. إذا كانت الإجابة " لا ألجأ الى	a. لا أعرف ما هي الخدمات التي توفرها هذه المراكز

مراكز صحيّة"، لم لا؟ **(إجابات متعددة)**	b. المركز بعيد جداً c. لا يوجد في المركز أدوية/خدمات d. المركز فقط للمتزوجين e. المركز مكتظ دائماً f. ساعات إنتظار طويلة g. فريق عمل غير مؤهل h. فريق عمل غير ودود i. غير نظيف أو صحي j. لا يريد أهلي أن أذهب k. أخاف من عدم السرية l. أكلاف عالية
القسم السابع: الخطبة والزواج	
1. هل أنت:	1. أعزب 2. خاطب 3. متزوج
2. برأيك ما هو أفضل سن للخطبة بالنسبة للفتيات؟ **(إجابة واحدة)**	1. 16–18 سنة 2. 19– 24 سنة 3. 25 سنة وأكثر
3. برأيك ما هو أفضل سن للخطبة بالنسبة للفتيان؟ **(إجابة واحدة)**	1. 16–18 سنة 2. 19– 24 سنة 3. 25 سنة وأكثر
4. هل تعتقد أن الأطفال الذين عمرهم تحت ال18 سنة، والذين هم مخطوبين يجب عليهم أن يستكملوا دراستهم ؟ **(إجابة واحدة)**	1. لا 2. نعم
5. برأيك ما هو أفضل سن لزواج الفتيات؟ **(إجابة واحدة)**	1. 16–18 سنة 2. 19– 24 سنة 3. 25 سنة وأكثر
6. برأيك ما هو أفضل سن لزواج الفتيان؟ **(إجابة واحدة)**	1. 16–18 سنة 2. 19– 24 سنة 3. 25 سنة وأكثر
7. هل تعتقد أن الأطفال الذين عمرهم تحت ال18 سنة، والذين هم متزوجين يجب عليهم أن يستكملوا دراستهم ؟ **(إجابة واحدة)**	1. لا 2. نعم

8. برأيك، ما هو العمر الأمثل للحمل الأول؟ **(إجابة واحدة)**	1. 16–18 سنة 2. 19– 24 سنة 3. 25 سنة وأكثر
9. هل هناك أي أسباب تستدعي الإبتعاد عن /تجنّب الحمل عندما يكون الشخص في سن المراهقه؟	1. لا ، **إنتقل للقسم الثامن** 2. نعم
10. برأيك، ما هي التعقيدات التي قد تنتج خلال الحمل/الولادة خلال المراهقة؟ **(إجابات متعددة)**	a. وفاة الأم b. ولادة مبكرة c. زيادة وزن المولود d. إجهاض فجائي e. ولادة جنين ميت f. مولود بوزن منخفض g. نزيف h. زيادة إحتمال أمراض الطفولة i. إعاقة عقلية أو جسدية
القسم الثامن: العنف	
أ- العنف في البيت	
1. هل توافق أم لا على العبارة التالية؟ "إنه من الملائم أن يقوم الزوج بضرب زوجته أو الأخ أن يقوم بضرب أخته"	1. لا أوافق 2. أوافق
ب- المعارف المتعلقة بالعنف والاستغلال الجنسي	
2. هل يتعرض الأطفال 10-17 سنة للعنف في مجتمعك؟	0. لا 1. نعم
3. هل توافق على العبارة التالية؟ " من حقي أن أعيش حياة خالية من أي شكل من أشكال العنف"	0. لا أوافق 1. أوافق
4. هل توافق على العبارة التالية؟ " مسؤوليتي أن لا أقوم بالإساءة للآخرين"	0. لا أوافق 1. أوافق
5. هل يشمل العنف الجسدي ما يلي: **(إجابات متعددة)**	a. الضرب باليد b. الضرب بأداة c. الهز d. شد الشعر e. حرق بالسيجارة أو بالكبريت أو المياه الساخنة f. إكراه الطفل غلى البقاء في وضعية غير مريحة (كالوقوف في الزاوية) g. إجبار الطفل على القيام بتمارين جسدية مكثفة

6. هل يشمل العنف النفسي/المعنوي ما يلي: **(إجابات متعددة)**	a. تحقير الطفل ونعته بصفات مسيئة b. الصراخ بوجه الطفل c. القول للطفل أن لا أحد يحبه d. حجز الطفل وحده e. التهديد f. تخلي الأهل عن الطفل g. إهمال الطفل عاطفياً
7. هل يتضمن العنف الجنسي ما يلي: **(إجابات متعددة)**	a. لمس الأجزاء الحميمة الخاصة بالطفل b. جعل الطفل يلمس أجزائه الحميمة أو أجزاء حميمة خاصة بآخرين c. ممارسة الجنس مع الطفل d. إطلاع الطفل على مجلة مصورة أو أفلام تتضمن صور لأشخاص شبه عراة أو عراة e. إخبار الطفل قصص أو نكات غير أخلاقية
8. من هو برأيك المتحرش/المعتدي الجنسي؟ **(إجابات متعددة)**	a. ذكر غريب b. صديق c. العم d. الأخ e. الجار f. الاب
9. ماذا تستطيع أن تفعل لحماية نفسك من العنف؟ **(إجابات متعددة)**	a. أن أقول "لا" b. أن أخبر شخص أثق به c. أركض أو أنجي بنفسي d. أصرخ e. لا آخذ هدايا بمقابل القيام بأمر خاطئ f. أكتشف المزيد عن العنف ضد الأطفال من خلال الانترنت أو الكتب، الخ g. أطلب رقم تلفون المساعدة الخاص بالأطفال h. أحتفظ بأرقام تلفون الطوارئ

Annex (3)

بسم الله الرحمن الرحيم

حضرة الدكتور أميه خماش المحترم:
وكالة الغوث: لمدير عام الخدمات الصحية
تحيه طيبه وبعد:
انا الطالبه رشا محمد حمودة,برنامج ماجستير سياسات واداره صحية /كلية الصحة العامة/ جامعة القدس ,اقوم ببحث رسالة الماجستير بعنوان :
"Impact evaluation of project :**Protecting Adolescents from Gender based Violence through the Promotion of their Sexual and Reproductive Health Rights project** /Palestine."

اطلب من حضرتكم الموافقه على دخولي الى مخيمات الوكالة لتعبئه الاستبيان الخاص برسالتي ومساعدتي في الوصول الى الاشخاص المعنيين ، وانا اتعهد بتزويدكم بنتائج الرسالة فور الانتهاء منها.

مع فائق الاحترام
رشا حمودة

Annex (4)

بسم الله الرحمن الرحيم

Al-Quds University
Jerusalem
School of Public Health

جامعة القدس
القدس
كلية الصحة العامة

التاريخ: 2014/9/17
الرقم: ك ص ع/536/2014

حضرة الدكتور أمية خماش المحترم
مدير عام الخدمات الصحية/ وكالة الغوث

الموضوع: مساعدة الطالبة رشا محمد حمودة

تحية طيبة وبعد،،

تقوم الطلبة رشا حمودة برنامج ماجستير السياسات والإدارة الصحية/ كلية الصحة العامة/ جامعة القدس بحث رسالة الماجستير بعنوان:

Impact evaluation of project: Protecting adolescents from gender based violence through the promotion of their sexual and reproductive health rights.

وهي بحاجة إلى تعبئة استبانة الدراسة في مخيمات الوكالة. لذا نرجو من حضرتكم تسهيل مهمة الطالبة لكي تستطيع إنهاء متطلبات الرسالة.

شاكرين لكم حسن تعاونكم،،

د. معتصم حمدان
عميد كلية الصحة العامة

نسخة: الملف

Jerusalem
P.O.Box 51000
Telefax +970-2-2799234
Email: sphealth@admin.alquds.edu

فرع القدس / تلفاكس 02-2799234
ص.ب. 51000 القدس
البريد الالكتروني: sphealth@admin.alquds.edu

Annex (5)

بسم الله الرحمن الرحيم

Al-Quds University
Jerusalem
School of Public Health

جامعة القدس
القدس
كلية الصحة العامة

التاريخ: 2014/9/24
الرقم: ك ص ع/87/2014

حضرة الدكتور أمية خماش المحترم
مدير عام الخدمات الصحية/ وكالة الغوث

الموضوع: مساعدة الطالبة رشا محمد حمودة

تحية طيبة وبعد،،

بعد مراجعة مشروع البحث :
"Impact evaluation of project: Protecting adolescents from gender based violence through the promotion of their sexual and reproductive health rights".

تشهد كلية الصحة العامة/ جامعة القدس بأن المشروع قد تم مراجعتة والموافقة عليه من قبل لجنة الدراسات العليا

وعلى الطالبة رشا محمد حمودة الألتزام بجميع الأسس الأخلاقية والمنهجية التي تم الموافقة عليها.

علما بأنه سيتم مشاركتكم بنتائج البحث بعد الأنتهاء منه.

شاكرين لكم حسن تعاونكم،،

د. د. أسمى الامام
قائم بأعمال عميد كلية الصحة العامة

نسخة: الملف

Jerusalem
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Annex (6)

From: KHAMMASH, Umaiyeh <U.KHAMMASH@UNRWA.ORG>
To: rasha hammodeh
Sent: 10/08/14 at 10:22 PM
Subject: approval request

Approved

Annex (7)

To Juzoor for health and social development:

I am a master student at AL-Quds University in the faculty of public health; my thesis will be in health policy and management. I want to conduct an impact evaluation research on a project was carried out by your institution “Protecting Adolescents from Gender based Violence through the Promotion of their Sexual and Reproductive Health Rights /Palestine”.
I am contacting you for permission to make an impact evaluation on your project, and to use your tool in my research questionnaire, and sharing data which needed to complete my research.

Best regards;

Rasha Hamoudeh.

Annex (8)

From: Dana Nusseibeh <dnusseibeh@juzoor.org>
To: rasha hammodeh
Sent: 03/03/14 at 3:18 AM
Subject: approval request

Dear Rasha
We have no problem if you want to use the questionnaire we used in our project, but you have to adapt it because it was used regionally which means there are questions that for other countries and does not apply to our community
Thank you

Dana Nusseibeh
Juzoor for Health & Social Development
Program Coordinator
Jawwal: 0592969664
Tel: +970-22414488