



# Feasibility Study

## Youth-Friendly Health Services Palestine

Dr. Sumaya Y. Sayej

December 2018

# Acknowledgment

**This study was not possible without the joint endeavour of the United Nations Population Fund (UNFPA) and their working team represented by Mr. Anders Thomsen, UNFPA Representative in the State of Palestine, for their support and encouragement throughout the stages of the research process.**

**This project could not have been completed without considerable assistance from the professional stakeholders, young people, and service providers who generously gave their time and valuable perspectives to this study.**

**Gratitude and appreciation to the research team particularly field data collectors and the professionals who validated the questionnaire.**

## **Disclaimer:**

This publication **Feasibility Study - Youth-Friendly Health Services/Palestine** has been funded by the Italian Agency for Development Cooperation within the project **'Strengthening Reproductive Health and Rights for Palestinian Youth' - AID 11578.**

The views expressed in this publication are those of the authors and do not necessarily reflect the views or policies of the Italian Agency for Development Cooperation and the Consulate General of Italy in Jerusalem.

The Italian Agency for Development Cooperation and the Consulate General of Italy in Jerusalem are not responsible for any inaccurate or libelous information, or for the erroneous use of

# Table of content

Acknowledgment	2
ACRONYMS AND ABBREVIATIONS	6
DEFINITIONS OF THE STUDY CONCEPTS	8
EXECUTIVE SUMMARY	10
<b>Chapter I</b>	<b>35</b>
Introduction	36
1.1 Study background and significance	37
1.2 The study goal and objectives	38
<b>Chapter II</b>	<b>41</b>
Literature Review	42
2.1 The status of young people within the Palestinian context	42
2.1.1 Socio-demographic characteristics of Palestinian young people	43
2.1.2 Health and well-being of young people in Palestine	45
2.1.3 Young people's health risk behaviors	47
2.1.4 Sexual and reproductive health and rights (SRHR)	47
2.2 International and National Models of YFHS	48
2.2.1 Contexts for the provision of youth-friendly services	48
2.2.2 Effective models of service provision for young people	50
2.3 Barriers to the delivery of Youth-Friendly Health Services	52
2.4 YFHS and programmes existing in oPt	53

## Chapter III 57

### Research Methodology 58

#### 3.1 Study design 58

#### 3.2 Development of the research tools 58

3.2.1 Development of the questionnaire 58

3.2.2 The questionnaire's validity and reliability 58

3.2.3 Development of qualitative data tools 59

#### 3.3 The study settings 59

3.3.1 Participant's selection for qualitative and quantitative data 60

#### 3.4 Accessibility and ethical considerations 60

#### 3.5 Data collection procedures 60

3.5.1 The quantitative data collection 60

3.5.2 The qualitative data collection 61

#### 3.6 Data analysis procedures 61

3.6.1 Quantitative data analysis 61

3.6.2 Qualitative data analysis 61

#### 3.7 Study limitations 61

## Chapter IV 63

### Analysis and Findings 63

#### 4.1 Statistical analysis and results 63

4.1.1 Socio-demographic profile of young people 63

4.1.2 Knowledge, attitude and practices toward health and well-being 68

4.1.3 Knowledge, attitude and practices toward sexual and reproductive health issues 71

4.1.4 Attitudes and practices towards risk-taking behaviours 77

4.1.5 Knowledge, attitude and practices toward Youth Friendly Health Services-YFHS 81

#### 4.2 Qualitative Data Analysis 89

4.2.1 Interviews with representatives from academic and service institutions 89

4.2.2 Focus group discussion with health service providers 94

4.2.3 Focus group discussion with young people 96

<b>CHAPTER V</b>	<b>103</b>
<b>Conclusions and Recommendations</b>	<b>104</b>
<b>5.1 Key literature review findings</b>	<b>104</b>
<b>5.2 Recommendations</b>	<b>104</b>
5.2.1 Recommendations from academic and service professionals	104
5.2.2 Recommendations from health service providers	105
5.2.3 Recommendations from young people	105
5.2.4 The study recommendations	105
<b>REFERENCES</b>	<b>111</b>
<b>ANNEXES</b>	<b>117</b>
Annex 1	118
Annex 2	119
Annex 3.A	128
Annex 3.B	132
Annex 3.C	136

# ACRONYMS AND ABBREVIATIONS

<b>AAU-Jenin</b>	Arab American University-Jenin
<b>FP</b>	Family Planning
<b>FHS</b>	Family Health Survey
<b>GBV</b>	Gender Based Violence
<b>HIV/AIDS</b>	Human immunodeficiency virus/acquired immunodeficiency syndrome
<b>HH</b>	Household
<b>ICPD</b>	International Conference on Population and Development
<b>KAP</b>	Knowledge, Attitudes and Practices
<b>MoH</b>	Ministry of Health
<b>NIS</b>	New Israeli Shekel w
<b>NGOs</b>	Non-Governmental Organisation
<b>OPT</b>	Occupied Palestinian Territory
<b>PNA</b>	Palestinian National Authority
<b>PCBS</b>	Palestinian Central Bureau of Statistics
<b>PFPPA</b>	Palestinian Family Planning and Protection Association
<b>SRH</b>	Sexual and Reproductive Health
<b>SRHR</b>	Sexual and Reproductive Health and Rights
<b>STIs</b>	Sexually Transmitted Infections
<b>TOR</b>	Terms of Reference
<b>UNFPA</b>	United Nations Population Fund
<b>YFHS</b>	Youth-Friendly Health Services
<b>WHO</b>	World Health Organisation



# DEFINITIONS OF THE STUDY CONCEPTS

## YOUTH-FRIENDLY HEALTH SERVICES

**Youth-friendly services includes policies and attributes that attract young people to them, creating a safe and non-judgemental setting, and meeting young people's needs. These services include:**

- have expertise in providing sexual and reproductive healthcare services to young people,
- have staff who respect young people, honour their privacy and confidentiality, are non-judgmental, and allow for adequate time to interact with young people,
- have convenient hours (including welcoming drop-ins), short wait times, an accessible location, adequate space and privacy, and affordable fees,
- provide comfortable and enabling environment that are welcoming to both males and females and to youth of all sexual orientations,
- offer youth-focused group discussions, peer counsellors, information, and educational materials,
- provide integrated sexual and reproductive health services that allow young people to meet their needs for HIV, other STDs, and pregnancy prevention in one place,
- provide adolescents with information about and access to the full range of their sexual and reproductive health needs, including contraception; STIs prevention, testing, and treatment; and emerging biomedical strategies for HIV prevention,
- encourage young people to return and follow-up with medical referrals,
- solicit youth feedback on their needs and ways to improve services.

**Youth population:** The United Nations have different definitions based on age-group. The definition young people include adolescents (10-19 years) and youth (15-24 years) regardless of marital, social and economic status. In the Palestinian context, PCBS identifies the age group of (15-29) years as youth.

**Health:** A state of complete physical, mental and social well-being and not merely the absence of disease and infirmity (WHO 1948).





### **Sexual and Reproductive Health:**

Reproductive health is a “a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, reproductive health addresses the reproductive processes, functions and system at all stages of life. Reproductive health, therefore, implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this are the right of men and women to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant” (WHO, 2004).

**Risk Behaviours:** Youth Risk Behaviour Surveillance System (YRBSS) was developed in 1990 to monitor health behaviours that contribute markedly to the leading causes of death, disability, and social problems among youth and older generations. These behaviours, often established during childhood and early adolescence include: behaviours that contribute to unintentional injuries and violence; Sexual behaviours



related to unintended pregnancy and sexually transmitted infections, including HIV infection; alcohol and other drug use and tobacco use; Unhealthy dietary behaviours and inadequate physical activity (Centre for Disease Control and Prevention-CDC, 2018)

**Sexually Transmitted Infections (STIs):** Also called sexually transmitted diseases (STDs), an infectious disease that spreads from person to person during sexual contact. Sexually transmitted diseases, such as syphilis, trichomonas's, and HIV infection are caused by bacteria, parasites, and viruses (Institutes of Health, AIDS info, 2018)

**Acquired Immunodeficiency Syndrome (AIDS):** A disease of the immune system due to infection with HIV. HIV destroys the CD4 T lymphocytes (CD4 cells) of the immune system, leaving the body vulnerable to life-threatening infections and cancers. Acquired immunodeficiency syndrome (AIDS) is the most advanced stage of HIV infection. To be diagnosed with AIDS, a person with HIV must have an AIDS-defining condition or have a CD4 count less than 200 cells/mm<sup>3</sup> (Institutes of Health, AIDS info, 2018)

# EXECUTIVE SUMMARY



## Study Background

Adolescents and youth face many challenges as they navigate the complex path to adulthood. Many of these are physical: height, weight and body shape, genital, hormonal and neurological changes, occur during puberty. Coupled with rapid psychological development, increased desire for autonomy and a more mature self-understanding, these changes may lead young people to experience mental and emotional turmoil as they navigate the path of adolescence. While young people are not a homogenous group and require individualized measures to meet their needs, it is nonetheless true that many of the challenges they face are common across individuals and groups.

Adolescents and youth all around the world face similar tests and challenges. For young people in Palestine, however, many particular issues stem from the unique political situation. The serious constraints imposed by the occupation and the absence of a fully unified Palestinian central administrative control over the West Bank and Gaza Strip have, for many years, impacted the quality of health services all over the occupied Palestinian territory (oPt). Further, it has a serious impact on the mental health of the population, as demonstrated repeatedly in research focused on Palestine. This situation has been aggravated by the internal Palestinian political divide and the financial crisis of the Palestinian National Authority, leading to increased barriers to accessing health care facilities - a serious enduring and well-documented problem (WHO, Right to Health Report 2018). In short, the need for Palestinian adolescents and youth to have health services catering to their needs is well documented and immediate.

A growing number of countries are committed to developing health systems that provide special care to meet the needs of adolescents and youth. In order to support such developments, the United Nations Population Fund (UNFPA) has developed a strategy, titled **“My Body, My Rights, My World”**, which situates young people at the very center of sustainable development, by proposing a model through which young people can realize their rights, make informed and healthy choices about their bodies, set their own boundaries, and come to understand their lives and their rights in the larger context.

UNFPA in Palestine, in partnership with the Italian Agency for Development Cooperation, is focusing on strengthening reproductive health and rights for Palestinian youth. This cooperation has included the establishment of two YFHS centers, launched at the beginning of 2018 at Al-Azhar University, and in October 2018 at Al-Quds University, in collaboration with Palestinian Medical Relief Society. The purpose of this feasibility study is to assess opportunities to scale up, expand and improve such services to ensure the provision of more youth-friendly health services in preferred delivery points throughout oPt.

## The Study Design

The study design was descriptive and exploratory. It utilized both quantitative and qualitative methods in a complementary manner in order to enhance the coverage of the collected data. As part of the quantitative method, a survey was conducted which included 325 male and female students (15–29 years) with the aim of identifying their needs and priorities for YFHS, and preference of settings and approaches. The qualitative data collection included seven in-depth interviews with academic and service professionals, four focus group discussions (FGD) with service providers and eight FGDs with young people who are beneficiaries of the services provided in East Jerusalem, the West Bank and Gaza. Prior to data collection, ethical concerns were taken into account. These included issues relating to consent and confidentiality.

A descriptive analysis was subsequently done for quantitative and qualitative data (see chapter 4 - Analysis and Findings 4).

The main goal of the feasibility study is to deliver evidence-based information that will help to form a road map for the establishment of successful and sustainable YFHS-centers and to strengthen the capacity of all relevant stakeholders to meet the needs of young people. Five objectives were set and achieved through quantitative and qualitative data collection methods. Based on the study findings, a set of recommendations are put forward regarding best intervention approaches and the most effective sustainable service delivery to roll out and advocate for YFHS in East Jerusalem, West Bank and Gaza.

## Key findings of the study

### - Literature review

The primary health issues affecting Palestinian young people found in national surveys and studies<sup>1</sup> (see chapter 2 - Literature review) are summarized as:

- Low level of knowledge about sexual and reproductive health issues, particularly STIs and sexuality education.
- Low level of engagement in sports and physical activities.
- Moderate level of nutritional health problems including overweight and obesity.
- Increased drug use, alcohol drinking and addiction to those substances.
- High level of smoking tobacco and argilah.
- High levels of psychological distress and social problems related to unemployment, poverty and uncertainty for the future.
- Low level of safety and security in the oPt are limiting factors to access extracurricular activities.
- High level of physical disabilities particularly in Gaza

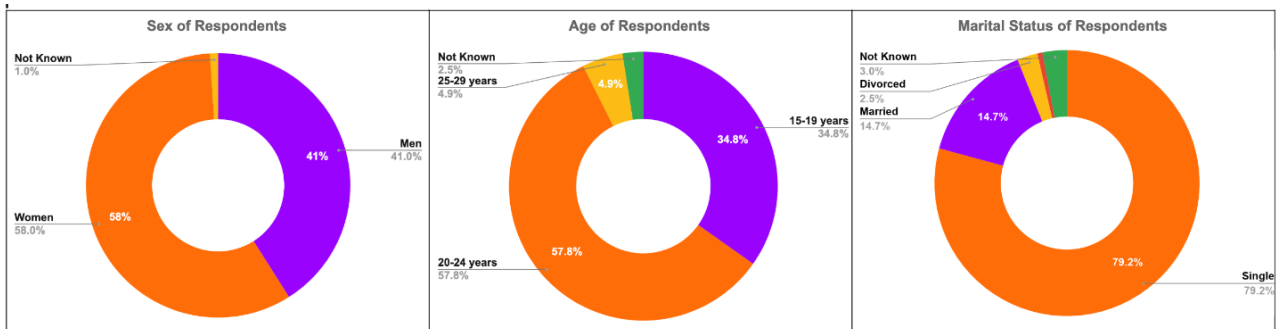
### - Key findings from the quantitative data

#### The socio-demographic profile

Of the 325 young people surveyed, 58% were female, and 41% were male (the remaining 1% is unknown). They were all students at Al-Quds University (21.5%), Hebron University (23%), Arab American University-Jenin (AAU-Jenin) (22.2%), and Al-Azhar in Gaza (31.1%). Age and marriage characteristics are indicated in Graph 1:

<sup>1</sup> Some: Abdeen, et. al., 2012; Glick et. al., 2018; PCBS 2011;2013;2015;2017;2018; UNFPA 2015;2017.

## Graph 1



**Work status and household income;** Out of the total population 37% reported having been in either part-time or full-time work; 16.6% were working at the time of the survey, although less than 2% full time. The participants' household income in NIS ranged from 400-8000/month. Some 29% of the participants' household income was less than 2000 NIS and 19% ranged 2000-4000 NIS. The Palestinian Youth Survey (2015) sets the poverty line of the reference family (five members) at 2,470 NIS and the extreme poverty line at 1,974 NIS. Compared with this formula, the poverty rate among the study participants' households 19% and extreme poverty rate 29% indicating are at a higher rate than 29.5% for the general youth survey (2015).

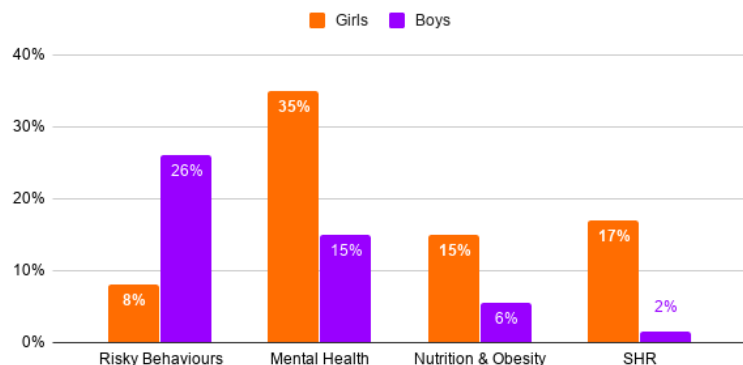
### Young people's knowledge, attitudes and practices towards health and well-being

The participants indicated a positive attitude towards their own health, with over 86% of respondents stating their felt either in 'good' or 'excellent' health.

*The participants' perception of the major health issues that young people may face;* Responses to questions around health revealed important gender differences and priorities, which may provide evidence for how best to focus health-related interventions and information for young people. Overall, male respondents emphasized risky behaviours (understood as negative coping mechanisms, such as substance abuse, violence and unsafe sex) as a major challenge, whereas female respondents were more likely to point to psychological, sexual and reproductive health-related, and nutrition/obesity-related health issues. See Graph 2 for more detail.

## Graph 2

Participants' Perception of Health Issues Faced by Young People



*Participants' practice of sports;* Around half of the participants reported practicing sports. Male respondents were more active, with around 13% reporting more than thrice-weekly practice, against just over 2% of female respondents. Just over a third of respondents reported doing sports less than three times a week, with around 22% of male respondents and around 9% of females.

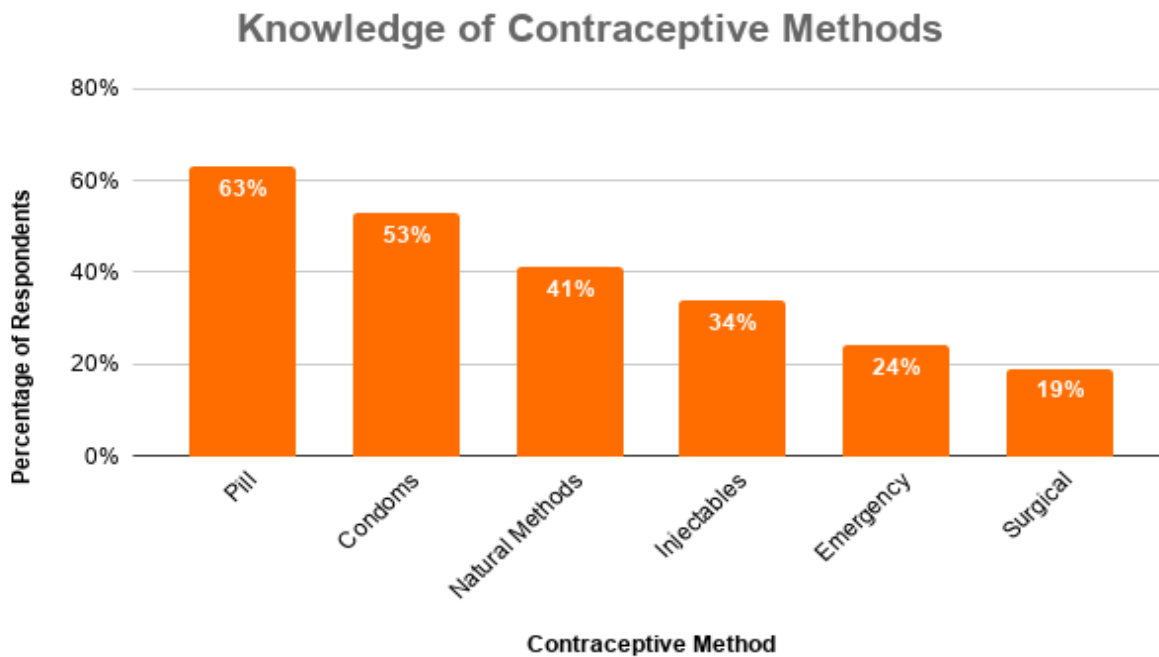
*The participants' dietary habits and nutritional problems* indicated that 50% eat three meals a day. Some 15% eat a balanced diet, 21% report regularly eating junk food (fast food) and 12% are on diet, according to their own reporting. Just over half (55.4%) reported that they do not have issues relating to overweight, underweight, obesity and anaemia. Overweight rated the highest among all surveyed, with 18.5% (5.5% males vs. 13% females) being overweight. Overall, nutrition-related issues were more frequently reported by female respondents.

### Young peoples' knowledge, attitude and practices toward sexual and reproductive health issues

The youth surveyed mentioned a few key SRH issues as being of high importance to them: in particular, these were puberty related issues (54%, most of whom were female), including menstrual pain, acne, mood changes, anxiety and depression.

*Participants' knowledge of contraceptives and FP methods;* Over 86% of respondents were aware of contraceptives, although only around 79% were able to name specific types of contraceptives. See Graph 3 for a breakdown of the contraceptive methods mentioned by the respondents (respondents were asked to mention all the methods they were aware of). In relation to condoms, a little under half of the respondents (48%) were aware that condoms prevent STIs as well as pregnancy.

**Graph 3**



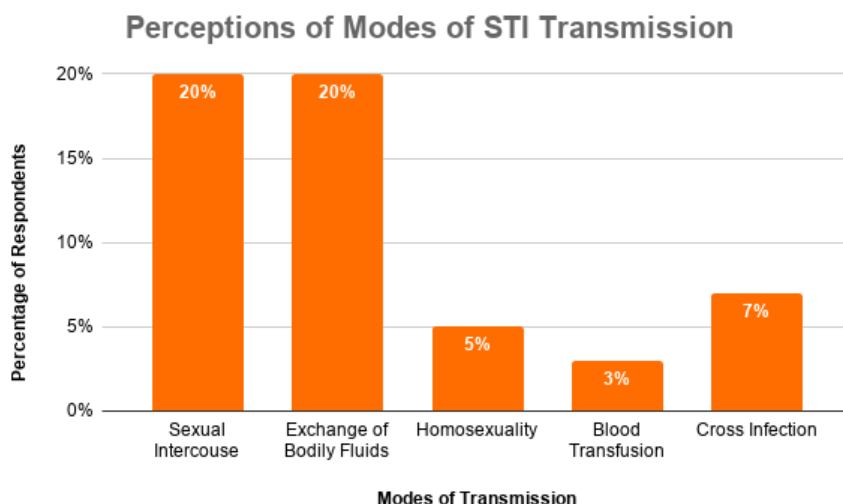
Some 52% of respondents stated that they were aware of STIs transmission modes, whereas some 43% didn't know and 5% didn't answer the question. However, when asked to explain how STIs spread, it was clear that additional information and awareness-raising may be required. As illustrated in Graph 4, some 20% of respondents stated that sexual relationships may cause STIs. Another 20% stated that the exchange of bodily fluids is to blame. Almost 5% responded 'homosexuality'<sup>2</sup>. Other answers included 'cross-infection', and 'blood transfusion'. While some respondents hence provided accurate answers, these responses indicate that access to accurate and scientific, non-biased information will be of importance in helping young people build their knowledge. Other findings in this report – regarding young people's hesitations in accessing health facilities for information, and on the main sources of information they do use – provide important insights as to how this information can be disseminated.

Furthermore, 12% of participants reported that they or any of their friends have, or have had, an STI (5.5% Hepatitis B, 3.7% Candida, 3.4% gonorrhoea, 1.5% syphilis and 1.5% HIV).

*Premarital sexual relationships and their knowledge of STIs and their transmission mode;* Some 14% of respondents answered yes when asked whether they or any of their friends had had premarital sexual relationships.

Taken together, these results indicate that if and when young people, and particularly unmarried young people, engage in sexual practices, they often lack the necessary knowledge to protect themselves. Because there may be specific socio-cultural barriers preventing unmarried young people from receiving information and services, unmarried young people are at a particular risk of STIs and/or unplanned pregnancy. Such results indicate a need to drastically improve the delivery of information on SRH through collaborative efforts of SRH service providers, school and university systems by launching projects and programs that aim to increase knowledge.

**Graph 4**



2 Although there is no link between homosexuality and STIs per se, this option was included in the research because it is a common perception that homosexuality is 'to blame' for STI transmission. This option was hence included as a way of assessing attitudes.



Furthermore, when asked about their primary sources of SRH information and counselling, only 12% responded that they would approach a health professional at the university, and another 12% from a health facility (outside the university). Just under 38.8% responded that they sought information “from the university’ as part of their study’s specialties in nursing, midwifery, medicine, and other health-related specialties, 27% from social media, and 15% from older siblings. The findings of the key informant/ focus group interviews validated some of these findings, in particular around social media. The interviews also pointed to young women, in particular, relying on advice from female friends. Given that both social media and friendly advice may be flawed, these responses underscore the need to enhance the availability of accurate, high-quality information to be available at easily accessible sources.

Social media may be put to good use in given how commonly used it is. Around 60% of respondents state that they use social media with some regularity. The survey results also show that respondents believe social media can be a useful source of information to help them “develop positive attitudes and maturity toward sexual and reproductive issues” (34%), “gain correct health information related to reproductive system and sexual behaviour” (29%), and “protect young people from unsafe sex experiences” (15%). The challenge will be to ensure accurate information reliable sources.

## **Young people attitudes and practices toward risk-taking behaviours**

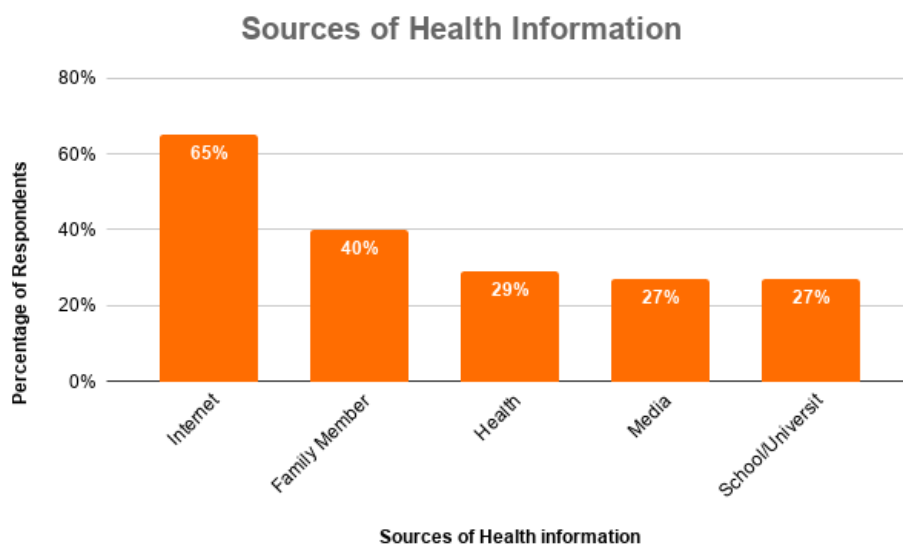
*Smoking was a habit* among 28% of the respondents. Some 16% started smoking before the age of 19 (although less than 20% of respondents answered this question). Just under 1% of respondents reported smoking hashish. *Alcohol drinking* was reported among just under 7% of the respondents, with relatively low levels of drinking reported – less than 3% reported drinking up to 2-4 times per month. *Illegal drug* use was reported by 3% of the population sample. It should be noted that this is significantly less than reported by Glick, et, al. in a 2018 study which showed 10.5% of males and 4.3% of females reported trying drugs.

*Regarding seeking help for the identified health risk behaviour problems mentioned above;* Around 36% of participants sought help for one or more than one problem; 19% for quitting smoking, 7% for stopping drug abuse, 6% for testing/treatment of STIs, and lastly 5% for help with alcohol abuse. When asked where they went for help, some 21% reported that they sought the support from a family member or friend, 10% from psychological counsellors, 7% from a private health clinic, 4% from a government health clinic, 4% sought help from pharmacy and 3% from social services. Some 4% of respondents who needed help did not know where to turn.

## Young people knowledge, attitude and practices toward youth-friendly health services (YFHS)

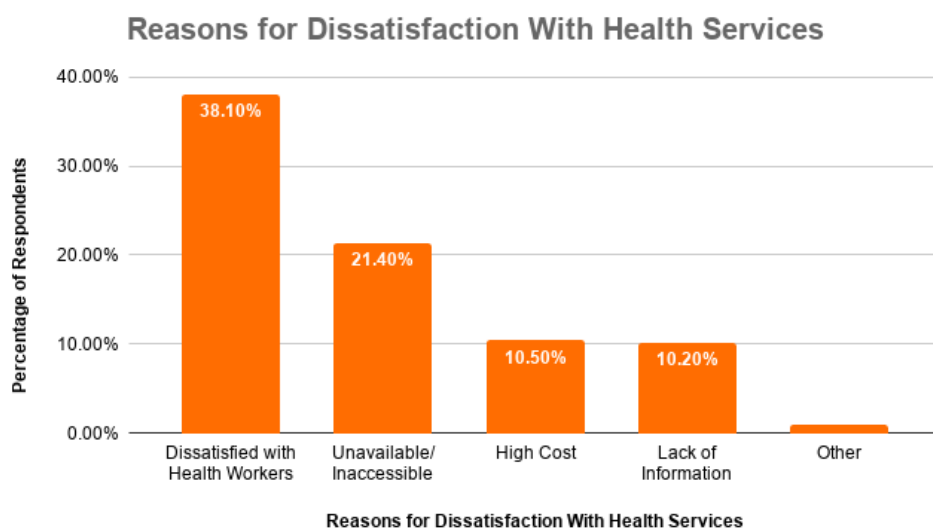
*The Participants' sources of health information in general;* As Graph 5 illustrates, a significant majority of young people reported that an important source of health information is the internet – a valuable finding when identifying avenues for creating awareness.

### Graph 5



*Participants' satisfaction with quality for services they received;* Information about the degree to which young people seek services, and the degree to which they are satisfied or dissatisfied, can be of great value to policymakers and service providers. Graph 6 below shows that the reasons for dissatisfaction with services relate to just a few key factors: i) real or perceived unavailability or inaccessibility of services (around 20% of dissatisfied clients); ii) dissatisfaction with health workers' competence, attitude or confidentiality (48%). Only a quarter of respondents stated that they do feel that existing health services cater to the needs of young people.

### Graph 6





*Reasons for not going to health centres to receive health services;* Many respondents also reported that they did not access health services, the reasons provided are indicative of areas for improvement. The different reasons can be put into sub-categories; relating to the real or perceived lack in availability and/or accessibility; hesitation to visit a health facility due to the perception that confidentiality is not guaranteed; and the issues of stigma, shame and embarrassment.

From this information about why young people do not seek health services or are dissatisfied when they do, we can conclude that better information about the availability of health services, ensuring greater confidentiality, and improving the youth-friendliness and attitudes of health service providers may be critical to enhancing young people's health-seeking behaviour.

*Participants' expectations of the services provided by YFHS centres;* When asked about their expectations from a youth-friendly health service (recipients could mention several services), issues related to SRH and gender-based violence were high on the list. Around 54% stated they expected provision of sexuality education and awareness and 29% suggested that marriage and pre-marriage counselling would be a critical service. Some 27% mentioned violence counselling. Furthermore, 27% provision of general information about SRH, and 22% highlighted provision of FP-services.

Some 34% suggested that they would expect youth-friendly services to act like a "life coach" for a healthy lifestyle (sports, nutrition, active citizenship and well-being). Over 60% of respondents expressed a preference for youth-friendly services to be provided at either private or government clinics. Another 19% highlighted youth centres, and 15% mentioned universities. Interestingly, NGO and UNRWA clinics were the least preferred options, at 7% and 5.5% respectively.

A further important finding of the study was that some 77% of young people expressed that cost would be a barrier for them at least some of the time. Only 13% of respondents were unconcerned about the cost of services.



## ▪ Key findings from the qualitative data

### - Interviews with academic and service professionals

The service institutions (PMRS, HWC) and the university representatives in West Bank and Gaza emphasized their role in appraising the young people's health and development as part of their service mission and goals and as a result, their programmes and activities are carried out accordingly. For instance, recently, two universities launched YFHS centre within their premises and one of the service institutions (PMRS) is working continuously with the model of YFHS and its protocol. In general, the service institutions, health service delivery points and the young centres at academic institutions provide the following services to varying degrees; health education and awareness programs, treatment and counselling for physical health problems, SRH, and individual counselling and PSS.

Youth's needs are significant and critical to address, and should be considered as a priority and taken seriously by decision-makers at all levels. The academic and service professionals summarized the health issues and problems that young people face as behavioural problems, violence, drug dependency and addiction, smoking tobacco, unemployment and the least to be worried about physical health problems. From a wider perspective, they emphasized the Israeli occupation, lack of efficient institutions and the societal norms regarding early marriage, marriage among relatives, and violence are factors contributing to psychological and social problems among the young and adults too.

The academics identified several barriers for young people to access health services including condensed academic schedule, students are not interested in non-academic activities, cultural constraints on allowing SRH issues to be discussed openly and limiting females from participating in youth-related

and non-academic activities. In addition, service institutions representatives indicated; lack of advocacy, lobbying and awareness-raising activities including lack of social media platforms for the available services and information and most importantly, health centers do not provide comprehensive services that meet young needs and fulfill their aspirations.

Professional stakeholders agreed that there is no national health care system specialized for youth in Palestine nor in the institutions providing health services for these youth. The youth health services for young people are spread across sectors and integrated within the larger health care system. The new school curriculum addresses youth problems and provides them with education and awareness but is not sufficient, and there are initiatives to promote the integration of SRH issues into the school curriculum. There is no or poor coordination between the different sectors in Palestine and the institutions providing youth programs. There is also insufficient data and information about youth's health problems, available services and current programmes for young people. The academic and service providers support and insist on the establishment of YFHS in any accessible place for students and other young people in the area; the academics want this center to be located in each university and the service providers wanted the center to be located within their premises.

### - Focus group discussion with health service providers

The health providers identified YFHS centre as a place that provides young people with physical, psychological, social awareness and intervention services. It should be tailored to meet the needs of young people. Most of the interviewed health care providers

were knowledgeable and use professional resources (research, reports, by working with young people, etc.) regarding young peoples' health needs, problems and priorities. They emphasized the importance and priority of SRH awareness and education sessions, concerns about risk behaviors and violence, early marriage etc. Young people seek health information mostly from the internet as their first choice followed by friends as a second choice. Some sought information from family health centres and NGO centres. Government centres are the least accessed by youth, who reported not seeking information there in order to avoid the "fear and shame".

They further described their health care centres as accessible to all, well-equipped with the necessary equipment including laboratories and drugs. The health care providers are able to function professionally and efficiently. They appraised the coordination and collaboration with other health institutions, especially regarding the referral system. However, the barriers the health care providers identified preventing young people from accessing health services are the lack of youth-sensitive services and information, lack of dedicated space, cultural constraints, shame and fear and financial cost. Barriers were also identified in providing awareness-raising activities regarding SRH, in form of social constraints to discuss openly.

Although, the health service providers reported that they have quite a good number of young people visiting their centres and mostly seeking services for SRH issues, violence, early marriage and marriage relationships. For SRH problems they reported mostly on FP issues, sexual relationships and problems, STIs and infertility. They appraised their consistent and regular awareness and education programmes launched for males and females in different sectors and communities (both young people and parents) on adolescence, early marriage, STIs, violence, antenatal, perinatal and postnatal care, breast feeding, FP and marriage counselling. As well, an important aspect of the work is the

development of young people's leadership skills, lobbying and advocacy skills as well as encouraging peer to peer education on SRH issues and social problems.

They supported the establishment of YFHS and suggested to be accessible for young people and preferred to be integrated within their health facilities and staffed by experts in young people's health. Others preferred the centres to be independent, in an accessible location within the city centre, in the villages, open in the mornings and afternoons, equipped with experts in youth health, and free of charge. All emphasized the financial cost is a barrier for the establishment of YFHS.

#### - **Focus group discussion with young people**

The participants' knowledge of the concepts of health and YFHS varied within and between the groups, depending on their age and experiences. The older age group showed more interest and understanding of the matters discussed more than the younger age group. Further, the importance of YFHS was highlighted in combination with quality of health care. The differences regarding age can be connected to the lack of education for instance in form of CSE at an early age which affects and creates a gap of knowledge crucial in the transition phase to adulthood.

The participants' responses were almost similar in identifying their health information sources; most of them considered the internet and mass media as the primary source of their information and some others considered friends and family. Regarding the internet and social media, it is considered the fastest and easiest source of information. They further elaborated; poor family dialogue on these topics and the dependence of young people on friends or social networks may lead to gaining false information and behavioural misconduct as well.

The young people discussed their needs and priorities which covered, behavioural

problems and the underlying factors; economic status and unemployability; sociocultural norms in the society contributing to stereotypes and social status including early marriage and marriage within families. Further, the participants highlighted the issue of the significant number of persons living with disabilities, especially in Gaza as a consequence from the violence from the occupation and also the phenomenon of social problems that can be seen through the prevalence of child labour, peddlers and beggars under the age of 18. SRH issues were also addressed, although resistance occurred through feeling embarrassed and ashamed.

Regarding access to health services and information most of the participants sought health services from governmental, UNRWA and/or community health centres, however emphasizing these centres not meeting their needs and do not address youth issues. They further described the health centres' infrastructure as not appropriate for the provision of youth-friendly health services and do not ensure their privacy or their right to confidentiality and respect.

Which is connected to the barriers in accessibility. The vast majority of participants agreed that there is a lack of youth health service centres and the lack of space within the available centres to meet the specific needs of young people. They reported that the health service providers in these centres are not qualified to offer youth services such as awareness and counselling on sexual and reproductive health issues, and/or on problems of nutrition for either being underweight/overweight or obesity. They added that some health service providers are reserved toward the issue of sexual and reproductive health and consider this issue as imported from the 'West' and does not meet the norms, traditions, values and religion of the Palestinian culture.

Therefore they welcomed and supported the establishment and enhancement of YFHS centres offering comprehensive services and information that are age and gender sensitive.

The youth also agreed that the centres should be within the boundaries of their residential areas. The youth suggested that these centres be equipped with recreational facilities and green spaces. Almost half of the young people preferred the service provider to be of the same sex of the beneficiary, while others do not mind this matter

## RECOMMENDATIONS

### 1. Recognize the need for dedicated policies and services for adolescents and youth as a priority area within the health and education sectors

This report adds to the body of evidence, which clearly shows that adolescents and youth have specific health needs, and that their ability to meet these needs may be inhibited unless specific actions are taken. The ultimate aim must be to establish and institutionalize YFHS as a recognized priority area within the health and education sectors. These may include actions at policy level, (such as the development of dedicated policies and strategies), at institutional level (such as the establishment of a dedicated unit on adolescent health within the Ministry of Health (MoH), and/or the formalization of working arrangements on adolescents and youth between Ministries of Health and Education). They must also include actions at the level of services, where the findings of the report can inform priority setting in terms of the priorities required for health centres to be youth-friendly in practice.

- To ensure sustainable scale-up and continuity of services, develop formal partnerships and frameworks with the Ministry of Health, which has the greatest impact on downstream health services including YFHS, if possible including a dedicated directorate at the MoH; further, formalize cooperation between MoH and the MoE to ensure enhanced delivery of evidence-based health education. Improvements of school health systems and the promotion of an integrated youth health nurse system within schools and universities may also have the potential for significant impact.
- Enhance coordination within the

sector among actors involved in the delivery of health services for adolescents and youth. The recently formed Adolescent Health Coalition may be a very effective vehicle for improved coordination not only around programming and service delivery but also around advocacy.

### 2. Enhance the availability and accessibility of health services for adolescent and young people

The survey of young people tells a clear story. Many young people are (or feel) unable or unwilling to access health services, either because they do not exist, because they are unaware of them, or because they do not trust them. It is therefore essential that efforts are made to enhance the availability and accessibility of youth-friendly health services, and to increase young people's awareness of what, where they are and how to seek help.

- Scale-up existing efforts to provide health services for adolescents and youth, taking into account lessons learned to date, as well as the findings of the research.
- Consider developing quality assessment tools including a set of minimum quality criteria for YFHS, including a focus on availability and accessibility, the competence of health service providers, satisfaction of users, and criteria such as cost, opening times, physical space and equipment/materials. The criteria should be developed and owned by the Ministry of Health and supported by partners, as a means of ensuring standardization and institutionalization of quality.



- In scaling up YFHS, take into account young people's views on their preferred type of clinic, locations and opening times.
- Ensure that services provided match the priority needs of young people as identified through the survey, and that service providers are equipped and willing to provide services which are competent and non-judgmental. Furthermore, take into account the important gender differences in the stated priorities and needs between male and female respondents, and tailor services accordingly.
- In recognition of the significant number of respondents in the survey who say they are not aware of the existence of location of health services, let alone YFHS, ensure greater dissemination of information around the availability, location and opening times of service centres, as well as of services available. Further, consider organizing introduction visits, for example of university students, where students can meet the health workers and receive an overview of which services are available. In addition, information online and on Facebook and other social media may be scaled up by YFHS.

### 3. **Ensure that YFHS centres are staffed with well-trained, competent service providers with positive attitudes to young people.**

A significant finding of the survey is that young people do not have high expectations of health providers. Their experiences are fairly negative, with almost half of dissatisfied respondents pointing to dissatisfaction with health workers. Indeed some 26% of young people who did not seek health services state that they fear judgement, a lack of confidentiality, or other factors relating to health workers' competence. Whether these perceptions are real or perceived, they point to a

significant area of improvement. Specific recommendations include:

- Ensure that staff working in YFHS are provided with dedicated training on youth health needs, which includes specific components on confidentiality and the need for judgement-free attitudes. Include requirements for such training in quality criteria for assessing YFHS, along with questions about client (both female and male) satisfaction.
- Ensure that YFHS staff include both women and men, in recognition of the shame and embarrassment that young people may feel in discussing sensitive issues with a service provider of the opposite sex.
- Recognizing that confidentiality is a major concern, and further recognizing that SRH issues, in particular, may be challenging for health workers to discuss openly, ensure the availability of reliable means of accessing information such as written materials and online resources and/or apps. Such tools can ensure that young people access correct information without having to have face-to-face conversations if they do not feel comfortable doing so.

### 4. **Redouble efforts to ensure that issues of stigma, shame and embarrassment, including that which is caused by cultural conservatism, do not become impediments to young people's access to information and services.**

Unsurprisingly, it is clear from the research that issues relating to stigma, reputation, and embarrassment are important impediments to ensuring that adolescents and youth receive and make use of high-quality information, counselling, and services. To tackle these issues, a dual approach is proposed; first, to work around

the stigma by providing young people with other, more confidential/private avenues for accessing correct information; and second, tackling the stigma head-on by seeking to speak more openly about SRH issues and needs.

- Given that a significant majority of adolescents and youth say their preferred method of accessing information is the internet, ensure that high-quality information is accessible to young people through trusted channels.
- Promote existing and new online tools and mobile phone applications (including the “Mustashari” app which is under development) to ensure young people can access reliable information confidentially.
- Ensure YFHS are well stocked with reading material which can be taken home and read in private, including entertaining materials such as comic book formats.
- In order to challenge the stigma around SRH issues, seek to promote dialogue about SRH in local and national media, on radio talk shows and on television.
- At the institutional level, work with the Ministry of Education to promote the effective delivery of Comprehensive Sexuality Education in schools, both by ensuring a holistic curriculum, and by supporting teachers to deliver the most sensitive sessions comfortably. Currently, a group of technical professionals are updating the teachers and counsellors’ guidance book on adolescent health, coordinated by Juzoor for Health & Social Development. This book will include youth-friendly material and exercises to do in classrooms. Such work may be most effective when accompanied with community/parent

outreach to ensure understanding and buy-in of the material taught.

- Establish, and scale-up, peer-to-peer education as a means of providing SRH information and outreach. This may be especially effective for young women, as they most frequently stated that they seek the advice of their friends and peers.
- Community outreach at all levels is needed to tackle the existing stigma and misconceptions connected to a number of topics such as FP, SRH, and STIs etc. With the aim to increase the accessibility, availability and acceptability of services and information.



- مستوى عالٍ من الإعاقات الجسدية بين الشباب الفلسطيني وخاصة في غزة

ملاحظة: تم تلخيص القضايا الصحية الأولية التي تؤثر على الشباب الفلسطيني من الدراسات المدرجة بالأرقام؛ 1، 9، 19، 20، 21، 23، 24، 28، 29 بصفحة المراجع.

## النتائج الرئيسية للبيانات الكمية

تم الحصول على البيانات الاجتماعية- الديموغرافية من 325 شابًا وشابة (57.5% إناث و 41.2% ذكور) طلاب من أربع جامعات فلسطينية هي؛ جامعة القدس 21.5%، جامعة الخليل 23%، الجامعة الأمريكية - جنين 22.2%، جامعة الأزهر في غزة 31.1%. تراوحت أعمارهم كالتالي؛ 58% من الفئة العمرية 20 - 24 سنة، 34.8% من الفئة العمرية 15 - 19 سنة و 5% من الفئة العمرية 25-29 سنة. وهذا يفسر العدد الكبير 92.6% منهم ملتحقين في الدراسة الجامعية الأساسية- بكالوريوس و 5.5% فقط ملتحقين في الدراسات العليا ومن كليات مختلفة

قضايا الزواج والأسرة؛ من مجموع المشاركين/ ات بالدراسة 79.2% غير متزوجين مقابل 17.8% متزوجين/ ات (12.6% - 41 إناث مقابل 5.2% - 17 ذكور) بينما 3% لم يجيبوا على هذا السؤال. أشارت النتائج إلى أن معدل زواج الشباب بين طلبة الجامعات أقل بكثير من 28% لعامة الشباب بالمقارنة مع نتائج مسح الشباب لجهاز الإحصاء الفلسطيني (2015). بالنسبة لسن الزواج؛ 9، 0% - 3 اشخاص فقط تزوجوا بعمر بين 15-17 سنة، 6، 2% تزوجوا بعمر بين 18-19 سنة، 8، 6% تزوجوا بعمر بين 20-24 سنة، و 2.1% تزوجوا بعمر بين 25-29 سنة مما يشير إلى أن الزواج المبكر قليل بين طلبة الجامعة وهذا يتناسب مع انخفاض نسبة الزواج المبكر للفتيات إلى 10.8% حسب تقرير جهاز الإحصاء الفلسطيني (2017). فهذا الانخفاض التدريجي في ظاهرة الزواج المبكر بين الفتيات الفلسطينيات يمكن أن يعكس الجهود الواسعة والشاملة التي تبذلها الحكومة والمنظمات غير الحكومية في هذا المجال. كما أشارت النتائج إلى أن الإناث

الهدف الرئيسي من دراسة الجدوى هذه هو تقديم معلومات قائمة على الأدلة والتي ستشكل خريطة طريق من أجل خدمات صحية صديقة للشباب ناجحة ومستدامة، وتعزيز القدرات لجميع أصحاب المصلحة المعنيين لتلبية احتياجات الشباب. استنادًا إلى نتائج الدراسة، تم وضع مجموعة من التوصيات لأفضل نهج للتدخلات وأفضل أماكن/ نقاط الخدمة لتنفيذها والدعوى من أجلها والاستمرارية بها في كل من القدس الشرقية والضفة الغربية وغزة. ولتحقيق هذا الهدف تم وضع خمسة أهداف قابلة للقياس وقد تحققت من خلال جمع البيانات الكمية والنوعية.

## النتائج الرئيسية للدراسة

### ملخص النتائج الرئيسية لمراجعة الأدبيات

القضايا الصحية الأولية التي تؤثر على الشباب الفلسطيني كما أشارت إليه العديد من الدراسات والمسوحات الوطنية هي:

- مستوى منخفض من المعرفة بقضايا الصحة الجنسية والإنجابية، ولا سيما الأمراض المنقولة بالاتصال الجنسي والتربية الجنسية
- مستوى منخفض لممارسة الرياضة والنشاط البدني
- مستوى معتدل للمشاكل الصحية التغذوية بما فيها زيادة الوزن والسمنة
- زيادة تعاطي المخدرات وشرب الكحول والإدمان عليها
- مستوى عالي من تدخين التبغ والرجيلة
- مستوى عالي من الضغط النفسي والمشاكل الاجتماعية بسبب البطالة والفقر وضيق الأفاق حول مستقبلهم
- انخفاض مستوى السلامة والأمان في الأراضي الفلسطينية المحتلة عوامل تحد من الوصول إلى أنشطة غير منهجية



# الملخص التنفيذي

## خلفية الدراسة

يواجه الشباب والشابات عدداً من التحديات الصحية منها التغيرات الجسدية السريعة أثناء فترة البلوغ، مثل الطول، الوزن، شكل الجسم وكذلك التغيرات الجنسية والهرمونية. بالإضافة إلى التطور النفسي، مثل الرغبة في الاستقلالية والنضج للفهم الذاتي، مما يساهم في احتمال حدوث الاضطرابات خلال فترة المراهقة. الشباب ليسوا مجموعة متجانسة والتحديات والفرص التي تؤثر على حياتهم متشابهة إلى حد كبير ولكن تتميز باختلافات فردية مهمة مستمدة من الظروف السياقية لكل فرد (الأمم المتحدة، 2007)

الحصار طويل الأمد والقيود الخطيرة التي يفرضها الاحتلال والغياب الكامل لإدارة فلسطينية مركزية وموحدة للسيطرة بالكامل على الضفة الغربية وقطاع غزة تؤثر على الصحة الجسدية والعقلية للسكان وعلى تطوير خدمات صحية عالية الجودة في جميع المناطق. وقد تفاقمت هذه الحالة بسبب الانقسام السياسي الفلسطيني الداخلي والأزمة المالية للسلطة الفلسطينية، كما أن العوائق أمام الوصول إلى مرافق الرعاية الصحية تمثل مشاكل دائمة وموثقة بشكل جيد (تقرير تحليل الحالة، منظمة الصحة العالمية 2015)

وفقاً لمنظمة الصحة العالمية (2009)، بأن هناك تزايد بعدد البلدان التي تستفيد من تجارب المنظمات غير الحكومية، والمؤسسات المهنية، ومن الشباب أنفسهم لبناء سياسات وبرامج واستراتيجيات تعالج الاحتياجات الصحية للشباب. إن استراتيجية صندوق الأمم المتحدة للسكان حول المراهقين والشباب (2013) هي تعزيز وحماية حقوق الشباب، ورؤية الى عالم يتمتع فيه البنات والأولاد بالفرص المثل لتلبية احتياجاتهم، التعبير عن أنفسهم بحرية، تحترم وجهة نظرهم، وأن يتمتعوا بعيش خال من الفقر والتمييز والعنف.

ولتأكيد العمل على هذه الاستراتيجية في فلسطين، مؤخراً دعم صندوق الأمم المتحدة للسكان، وبمساهمة من الوكالة الإيطالية للتعاون الإنمائي تمويل مركزين للخدمات الصديقة للشباب تم إطلاقهما في جامعة القدس بشهر تشرين الأول لسنة 2018 وجامعة الأزهر في غزة بداية سنة 2018 وذلك بالتعاون مع جمعية الإغاثة الطبية الفلسطينية. وسعيًا إلى توسيع نطاق هذه التجربة وتكرارها، سعى الصندوق إلى إجراء دراسة الجدوى هذه للتحقق في توفير المزيد من الخدمات الصحية الملائمة للشباب والشابات في الأراضي الفلسطينية المحتلة.

## تصميم الدراسة

تم تصميم هذه الدراسة الاستكشافية الوصفية باستخدام أساليب جمع البيانات الكمية والكيفية لتغطية مكونات البحث بشمولية. بالنسبة للبيانات الكمية، استهدفت الدراسة 325 طالب وطالبة جامعيين/ات (15- 29 سنة) لتحديد احتياجاتهم وأولوياتهم لما يسمى «الخدمات الصحية الصديقة للشباب» وتفضيلاتهم للموقع والمنهج. وشملت عملية جمع البيانات الكيفية أو النوعية 7 مقابلات معمقة مع أصحاب المصلحة في الأوساط الأكاديمية والخدمية، 4 مجموعات مناقشة مع مقدمي الخدمات و 8 مجموعات مناقشة مع الشباب/ات المستفيدين من هذه الخدمات في القدس الشرقية والضفة الغربية وقطاع غزة. قبل جمع البيانات، تم أخذ القضايا الأخلاقية في الاعتبار، وتم السعي للحصول على إذن مسبق لإجراء الدراسة وعلى أساس طوعي للمشاركة. تم إجراء التحليل الوصفي الإحصائي للبيانات الكمية واستخدام نهج التحليل الموضوعي للبيانات النوعية. تجدر الإشارة إلى أنه تم منح المشاركين الفرصة لاختيار أكثر من إجابة على العديد من الأسئلة وتمت الإشارة إليها على أنها «الردود» كما هو وارد في فصل التحليل والنتائج

الوزن الزائد كان الأعلى بين جميع المشاكل 18.5% (5.5% ذكور مقابل 13% إناث). إن نسبة الإناث كانت أعلى في جميع المشاكل المتعلقة بالصحة التغذوية وهذا يحتاج إلى اهتمام في برامج التوعية والتدخل المستقبلية

### معرفة ومواقف وممارسات الشباب/ات اتجاه صحتهم الجنسية والإنجابية والقضايا المتعلقة بها

المشاكل الصحية للمشاركين/ات المتعلقة بتغيرات البلوغ بلغت 54.2% وجدت معظمها بين الإناث، من هؤلاء؛ 26.2% أفادوا الألم خلال فترة الحيض، 25.5% أفادوا حب الشباب، تليها 24% تغيرات المزاج، 12.6% القلق والاكتئاب 11.7%.

وعي ومعرفة المشاركين/ات بقضايا الصحة الجنسية والإنجابية؛ 33.5% سمعوا عنها، و41.8% سمعوا بعض المعلومات عنها، و20.6% لم يسمعوا على الإطلاق. للتأكد من معرفتهم حول الموضوع تم إعطاء المشاركين 4 تعريفات للصحة الجنسية والإنجابية؛ وافق 41.8% على التعريف «هي حالة رفاه جسدي ونفسي واجتماعي في كل الأمور المتعلقة بالجهاز التناسلي ووظائفه وعملياته، وليس مجرد غياب المرض أو العجز». ووافق 41% على التعريف «يعني قدرة الناس على التمتع بحياة جنسية مرضية وأمنة، والقدرة على إنجاب الأطفال، والحرية في القرار لتحديد العدد والموعد لإتمام ذلك». وافق 28.3% على التعريف «يعني الحق الكامل للرجال والنساء في التمتع بصحتهم الإنجابية والجنسية والمشاركة في صنع القرار فيما يتعلق بهذه المسألة»، ووافق 21.2% على التعريف «الجميع لديه الحق في الحصول على أعلى مستوى يمكن بلوغه للصحة الجنسية والوصول إلى خدمات الصحة الجنسية والإنجابية» في حين أن 13.8% لا يعرفوا أي من التعريفات هذه. وهذا يتطلب تعزيز ونشر المعرفة حول مسائل الصحة الجنسية والإنجابية بين الجميع

وعي ومعرفة المشاركين بوسائل تنظيم الأسرة؛ 56% سمعوا عنها و30.5% سمعوا بعض المعلومات عنها مما يعني أن طلبة الجامعة على دراية بوسائل تنظيم الأسرة. علاوة على ذلك، سُئل المشاركون/ات «هل تعرف ماهي أنواع وسائل تنظيم الأسرة؟» 78.6% أجابوا نعم و 21.4% أجابوا لا. من عرف منهم أفاد؛ 62.8% عن الحبوب، 60% عن الواقي الذكري والانتوي، 41% عن الأساليب الطبيعية، 34% عن الحقن، و19% التدخل الجراحي. كذلك سُئلوا عن استخدام الواقي الذكري للحماية من الأمراض المنقولة بالاتصال الجنسي إلى جانب دوره كأحد وسائل تنظيم الأسرة؛ وافق 47.7%، و24.6% لديهم بعض المعلومات و30% لا يعرفون

العلاقات الجنسية قبل الزواج والأمراض المنقولة جنسياً. أجاب 14.2% (46 مشاركاً) بنعم للسؤال «هل تعرف إذا لديك أو لدى أحد أصدقائك علاقات جنسية قبل الزواج» رقم مذهل يمكن العثور عليه في الثقافة الفلسطينية المحافظة. أما عن معرفتهم بطرق انتقال العدوى المنقولة جنسياً، أجاب 52% بنعم مقابل 42.8% لا و5.2% لم يستجيبوا للسؤال. ومن عرف منهم أفاد عن هذه الطرق؛ 20% العلاقات الجنسية، 20% سوائل الجسم، 4.9% اللواط أو الشذوذ الجنسي، 7% عدوى أخرى بالجسم، و3.1% نقل الدم. إضافة إلى ذلك؛ أفاد 12% بأنهم أو أي من أصدقائهم عانوا أو لا زالوا يعانون من الأمراض المنقولة بالاتصال الجنسي توزعت على النحو التالي؛ 5.5% التهاب الكبد الوبائي ب، 3.7% المبيضات، 3.4% السيلان، 1.5% الزهري و1.5% فيروس نقص المناعة البشري

ولمعرفة مدى بحثهم عن التوعية والإرشاد فيما يتعلق بمسائل الصحة الجنسية والإنجابية، أفاد 39% أنهم يبحثونها من مصادر مختلفة ومنها؛ 33.8% يسعون إلى التوعية من الجامعة، 27% من وسائل الإعلام الاجتماعية، 15% من الأصدقاء الأكبر سناً، 12% من المهنيين الصحيين (المرضات والأطباء والمستشارين النفسيين المتوفرة داخل الجامعات)، 12.3% من المرافق الصحية و29% يسعى للتوعية والإرشاد من الآخرين ولكنهم لم يحددوا من هو الآخر. مع الملاحظ أن سعي الشباب/ات للبحث عن التوعية والإرشاد كان الأقل للمهنيين الصحيين والمرافق الصحية، وهذا يجب التأكيد عليه للتدخلات المستقبلية

أما بالنسبة لاستخدامهم وسائل الإعلام للحصول على المعلومات الصحية ومعلومات الصحة الجنسية والإنجابية فقد وجد منهم 48% من يبحث ولمدد متفاوتة. علاوة على ذلك، وردا على سؤال «هل تعتقد أن التثقيف والمشورة حول القضايا الجنسية والإنجابية يمكن أن تساعد الأفراد على» 33.8% وافقوا على أنها تساعد في «تطوير المواقف الإيجابية والنضج تجاه القضايا الجنسية والإنجابية»، ووافق 28.6% على أنها تساعد على «كسب المعلومات الصحية الصحيحة المتعلقة بالنظام التناسلي والسلوك الجنسي»، وافق 15.1% على أنها تساعد في «حماية الشباب من التجارب الجنسية

المتزوجات قد أنجبن أول طفل بعد عمر ١٩ عاماً وهذا يتجانس مع سنهن عند الزواج عندما وُجد 16.9% منهن تزوجن فوق سن 18 عاماً كما هو موضح أعلاه.

لا زال الزواج بين الأقارب قائماً على نطاق واسع حيث وُجد أن ثلثا المتزوجين/ات (11.1% من 17.8%) متزوجين من أقاربهم، أي أكثر من 43.3% للسكان عموماً مقارنةً بمسح صحة الأسرة (2006). كما وُجد أن متوسط حجم عائلات المشاركين/ات 6 أعضاء أعلى من 5.1 أعضاء لعموم العائلات الفلسطينية مقارنةً مع النتائج الأولية لتعداد السكان للجهاز المركزي للإحصاء الفلسطيني (2017)

حالة العمل ودخل الأسرة؛ من مجموع المشاركين/ات 37.2% منهم أفادوا بأنهم لديهم عمل. ولكن عند جمع البيانات تبين بأن 16.6% - 54 منهم يعمل و 20.6% - 67 منهم لم يعمل. من مجموعة الذين يعملوا 1.8% فقط لديهم وظيفة بدوام كامل و 14.8% - 48 يعملون بدوام جزئي وبمقارنة حالة العمل للطلبة الجامعيين فهي أقل بكثير من حالة العمل لعامة الشباب حسب نتائج المسح العام للشباب (2015) التي أشارت إلى أن 41% (33.7% ذكور و 66.7% إناث) لا يعملوا. تراوح دخل أسر المشاركين الشهري الجديد تراوح بين (400-8000). 29% كان دخلهم أقل من 2000 شيكل و 19% تراوح دخلهم بين 2000-4000 شيكل. حدد مسح الشباب الفلسطيني (2015) خط الفقر للعائلة المرجعية (خمسة أعضاء) 2,470 شيكل وخط الفقر المدقع 1,974 شيكل. بالمقارنة مع هذه المعادلة، فإن خط الفقر في هذه الدراسة 19% وخط الفقر المدقع 29% أي أعلى بكثير من 29.5% لعامة أسر الشباب كما ورد بمسح الشباب العام (2015) مما يعني أن الفقر بين أسر المشاركين عالٍ جداً

### معرفة ومواقف وممارسات الشباب اتجاه صحتهم ورفاههم

أشار المشاركون/ات إلى مواقف صحية صحيحة تجاه أنفسهم عندما أجاب 36% بأن شعورهم ممتاز و 50.5% بأن شعورهم جيد. بينما قيم 48.6% مستوى معرفتهم بالمعلومات الصحية على أنها جيدة، و 23.1% صنفوا معرفتهم على أنها ممتازة. تمكن 83.7% من تحديد تعريف المفاهيم الصحية على أنها «الحالة المثلى للرفاه العقلي والبدني والاجتماعي وليس الخلو من الأمراض» مشيراً إلى أن طلاب الجامعات لديهم معرفة بهذه القضايا.

إدراك المشاركين/ات للقضايا الصحية الرئيسية التي قد يواجهها الشباب؛ حوالي 50% (14.8% ذكور و 35% إناث) ذكروا المشاكل النفسية أو العاطفية، و 34.2% (25.9% ذكور مقابل 8.3% إناث) ذكروا مشاكل تتعلق بالسلوكيات المحفوفة بالمخاطر، و 20.3% (5.5% ذكور مقابل 14.8% إناث) ذكروا مشاكل تتعلق بالتغذية والسمنة، و 17.2% (1.53% ذكور مقابل 15.7% إناث) ذكروا مشاكل تتعلق بالصحة الإنجابية والجنسية، و 11.4% (5.2% ذكور مقابل 6.2% إناث) الأمراض المزمنة، و 1.8% (0.6% من الذكور مقابل 1.2% من الإناث) أمراض الجلد. وبشكل عام، كانت الإناث أعلى من الذكور مع وجود اختلاف ملحوظ في المشاكل النفسية/العاطفية، وقضايا الصحة الجنسية والإنجابية، ومشاكل التغذية والبدانة بينما كان الذكور أعلى بكثير في المشاكل المتعلقة بالسلوكيات الخطرة (تعاطي المخدرات والتدخين وشرب الكحول والعنف) وهذه النتائج تتوافق مع مسح الشباب في (2015) لنفس القضايا

ممارسات المشاركين/ات للرياضة البدنية: أفاد 50.2% من المشاركين/ات بأنهم يمارسون الرياضة. من ممارسي الرياضة 45.5% (34.4% ذكور مقابل 11.1% إناث) استجاب لعدد المرات لممارسة الرياضة، و 30.4% (21.6% من الذكور مقابل 8.6% إناث) يمارسوا الرياضة أقل من 3 مرات في الأسبوع و 15.2% (12.8% ذكور مقابل 2.4% إناث) يمارسوا الرياضة أكثر من 3 مرات في الأسبوع. تشير النتائج إلى أن المشاركين/ات يمارسوا الرياضة بدرجة منخفضة حيث هذه القضايا تتطابق مع مسح الشباب للجهاز المركزي للإحصاء الفلسطيني (2015)

العادات الغذائية للمشاركين/ات والمشاكل التغذوية الحاصلة لديهم: أشارت النتائج بأن 50% منهم يتناولون ثلاث وجبات في اليوم، و 14.5% يأكلوا غذاءً متوازناً، و 21.4% يتناولون الوجبات السريعة و 12.3% على النظام الغذائي لتخفيض الوزن. أما المشاكل الصحية الغذائية لديهم كانت كالتالي؛ 41.2% (16.5% ذكور مقابل 24.7% إناث) لديهم مشاكل صحية متعلقة بالتغذية. وشملت هذه المشاكل زيادة الوزن، ونقص الوزن، والسمنة، وفقر الدم. مشاكل زيادة

أما الخدمات التي تم الوصول إليها من قبل المشاركين خلال السنة الحالية؛ ذهب 28.6% منهم إلى العيادات الصحية الخاصة، 16.6% ذهبوا إلى العيادات الصحية الحكومية، 11.1% ذهبوا إلى المستشفيات، و10.8% إلى أولياء الأمور/الأصدقاء، وهذه النتائج متشابهة مع نتائج تقييم الشباب في الضفة الغربية (2011) لجميع البنود.

وقد أعرب المشاركون/ات عن رضاهم لجودة الخدمات التي تلقوها كالتالي؛ 28.3% راضون، 36% راضون إلى حد ما و8.6% غير راضين. أما أسباب عدم الرضا والرضى إلى حد ما فكانت؛ 14.3% لعدم توفر الخدمات و7.1% لصعوبة الوصول إلى الخدمة. وبنسبة أعلى بكثير 48.3% أفادوا بانعدام رضائهم تعلق بأداء وكفاءة العاملين الصحيين، من هؤلاء؛ 13.5% ادعى عدم كفاءة العاملين، 10.8% ادعى عدم اهتمام العاملين وفهمهم لاحتياجات الشباب، و10.2% ادعى عدم وجود المعلومات اللازمة لدى العاملين، 8.6% ادعى أن معاملة العاملين أو مقدمي الخدمة غير ودية و5.2% ادعى عدم وجود خصوصية وسرية. تشير هذه الأرقام إلى أن أداء وكفاءة العاملين الصحيين أمر مشكوك فيه ويحتاج إلى اهتمام أصحاب المصلحة بشأن هذه المسألة. ومع ذلك، وافق 25% على أن الخدمات الصحية الحالية تلبى احتياجات الشباب، و57.2% وافقوا إلى حد ما، و13% لم يوافقوا على ذلك.

أما أسباب عدم الذهاب إلى المراكز الصحية لتلقي الخدمات الصحية؛ 44.3% من الإجابات تتعلق بوجود الخدمات وإمكانية الوصول إليها حيث 16.3% لا يعرفونها، 14.2% أفادوا أن الخدمات غير متوفرة، 9.5% قالوا بأن الخدمات غير متاحة و4.3% لا يعرفوا إلى أين يذهبون. وهناك 26% أفادتهم تعلقت بالجودة والسرية؛ 10% زعموا خدمات منخفضة الجودة، 8.3% لا يتقنون بالمكان، 7.5% غير متأكدين من السرية. القضايا الثقافية التي تؤثر على الثقة بالنفس لدى الشباب منها 8.6% أشاروا إلى الوصمة والسمعة و4.9% أشاروا إلى أن الخوف والإحراج كانوا سببا في عدم السعي للخدمات الصحية.

بالنسبة لوجود خدمات صحية داخل الجامعات التي استهدفت، أفاد 75.4% بوجود هذه الخدمات ولكنها مختلفة وتوزعت كالتالي؛ 47.1% طبيب عام، و25.8% رعاية صحية أولية، 17.5% خدمات استشارية، 15.7% ممرضة قانونية و10.2% خدمات الاجتماعية.

وعن معرفة المشاركين/ات لمفهوم الخدمات الصحية الصديقة للشباب؛ 44% أفادوا بمعرفتهم عنها مقابل 49.5% لا يعرفون. بالنسبة لأولئك الذين قالوا نعم، تم إعطاء أربعة تعريفات للخدمات الصحية الصديقة للشباب؛ 29.5% وافق على التعريف "خدمات عالية الجودة، المعلومات والمشورة والتحويل المناسب، يمكن الوصول إليها، وبأسعار معقولة ومناسبة ومقبولة للشباب"، وافق 20.3% على التعريف "جميع الشباب لديهم إمكانية الوصول إلى المعلومات والخدمات الصحية بغض النظر عن وضعهم الاجتماعي، ونوع الجنس، والأصل الخ..." وافق 14.8% على التعريف « يتم توفير الخدمات بما يتماشى مع الحد الأدنى لمجموعة الخدمات الصحية»، وأخيراً وافق 10.2% على التعريف «يهدف إلى زيادة قبول واستخدام الخدمات الصديقة للشباب». هذه الاجابات تشير الى أن الشباب بحاجة إلى معلومات حول الخدمات الصديقة للشباب.

وبالنسبة لتوقعات المشاركين/ات للخدمات التي تقدم من قبل مراكز الخدمات الصحية الصديقة للشباب كانت التالي؛ توقع 53.8% تثقيف وتوعية جنسية، 28.9% إرشاد حول الزواج وما قبل الزواج، 27.4% استشارات حول العنف، 26.5% توقع اعطاء معلومات العامة حول الصحة الجنسية والإنجابية، 22.2% توقع خدمات تنظيم الأسرة و17% لا يعرفون. بينما وافق 34% على أنه يساعد الشباب على اتباع نمط الحياة الصحي (الرياضة والتغذية والمواطنة النشطة وغيرها ذات الصلة بالرفاهية).

تفضيل المشاركين/ات للمواقع أو المراكز لتلقي الخدمات الصحية الصديقة للشباب؛ 33.5% فضلوا أن تكون مراكز خاصة، 28% فضلوا المراكز الصحية الحكومية، 18.5% فضلوا مراكز الشباب والرياضة، 14.8% فضلوا أن يكون مركز بالجامعة، 13.8% لا يعرفون، 10.5% فضلوا مراكز الأسرة. أقل تفضيلات كانت 7.7% للمنظمات غير الحكومية و5.5% لمراكز الأونروا

غير الصحيحة» و8.3% وافقوا على أنها تساعد في «التشجيع على تحسين رغباتهم ودوافعهم الجنسية والحفاظ عليها».

### مواقف الشباب وممارساتهم تجاه السلوكيات الخطرة؛ التدخين/الكحول/والمخدرات والعنف

بلغت نسبة التدخين بين المشاركين/ات بالدراسة 28%. استجاب 17.2% منهم للسؤال «في أي عمر بدأت التدخين؟» 6.1% بدأوا التدخين بعمر 13-16 سنة و9.9% بعمر 17-19 سنة و1.2% بعمر 20-21 سنة. من بين هؤلاء المدخنين 16.6% يدخن السجائر و16.6% النرجيلة و0.9% الحشيش. كان معدل التدخين بين طلاب الجامعات أعلى من 23.5% لعامة الشباب كما جاء بمسح الشباب لعام (2015).

بلغت نسبة تعاطي الكحول بين المشاركين/ات 6.8% (22 مشارك) منهم 2.5% يشرب 2-4 مرات في الشهر، 1.8% يشرب مرة في الشهر أو أقل، 0.9% يشرب 2-4 مرات في الأسبوع. بلغ استخدام المخدرات بين المشاركين 3.1% (10 مشاركين) ولم يذكروا نوع المخدرات التي يتعاطونها. هذه النتائج أقل بكثير من نتائج دراسة غليكو آخرون بفلسطين (2018) حيث أظهرت أن 10.5% من الذكور و4.3% من الإناث أفادوا عن تعاطيهم للمخدرات.

أظهرت النتائج على أن العنف الأسري متواجد وبنسبة 21.2% (16% من الإناث مقابل 5.2% من الذكور) وأن المعتدون كما ادعى المشاركون: 5% الأخ، 4.3% الأب، 2.2% الأم، 1.8% الأخت و4.6% أفادوا عن آخرين (والتي شملت الأزواج، الحمى أو الحماه، وأكثر من شخص واحد). أما نوع الإساءة فكانت 10.2% العنف الجسدي، 15.7% إساءة المعاملة اللفظية/العاطفية و2.5% أفادوا عن الاعتداء الجنسي حيث أن هذه الأرقام أقل بكثير من مسح العنف الأسري للجهاز المركزي للإحصاء الفلسطيني (2011) والتي أشارت إلى أن 23.5% من النساء تعرضن للعنف الجسدي و11.8% تعرضن للعنف الجنسي. وعلاوة على ذلك، فإن 18.5% من أسر المشاركين/ات بالدراسة قد انتهكت من قبل القوات الإسرائيلية و/أو المستوطنين، وهذا الانتهاك أثر على الذكور أكثر منه للإناث مع الحد الأدنى من المساهمة في العنف المنزلي.

أما فيما يتعلق بالبحث عن مساعدة لمشاكل السلوكيات الصحية التي ذكرت أعلاه؛ حوالي 36% من المشاركين/ات طلبوا المساعدة لمشكلة واحدة أو لأكثر كالتالي: 19% للتدخين، 18.5% للإساءة، 7.4% لتعاطي المخدرات، 5.5% للأمراض المنقولة جنسيا، وأخيرا 4.9% للكحول. علاوة على ذلك، فقد سُئلوا «أين ذهبتم للمساعدة؟» 20.9% طلبوا المساعدة من العائلات/الأصدقاء، 9.8% طلبوا المساعدة من المستشارين النفسيين، 7.1% طلبوا المساعدة من العيادات الصحية الخاصة، 4% من العيادات الصحية الحكومية، 4.3% طلبوا المساعدة من الصيدلية، 3.7% لم يعرفوا إلى أين يذهبون و3.4% من الخدمات الاجتماعية.

### معرفة ومواقف وممارسات الشباب\ات اتجاه الخدمات الصحية الصديقة للشباب والشابات

مصادر المعلومات الصحية للمشاركين/ات بالدراسة أظهرت على أن: 65% منهم حصل على معلوماتهم الصحية من الإنترنت، 40.3% من أفراد العائلة، 28.6% من المهنيين الصحيين (مستشار نفسي، طبيب، ممرضة)، 27% من الإعلام و27% من المدرسة أو الجامعة.

الخدمات الصحية التي احتاجها المشاركون خلال السنة الحالية كانت: 51% لم يحتاجوا إلى أي من الخدمات الصحية، بينما 16.3% احتاجوا إلى خدمات صحية غذائية وهذا يتطابق مع المشاكل التغذوية التي أشار إليها المشاركون/ات سابقا والتي بلغت نسبتها 18.5% لزيادة الوزن و2.8% للسمنة، 13.8% احتاجوا إلى خدمات الصحة الجسدية، 12.3% احتاجوا خدمات جلدية، 11% استشارات نفسية و10.5% خدمات الصحة الجنسية والإنجابية وهذه النتائج تتماثل مع نتائج دراسة تقييم الشباب (2011) لجميع البنود



معلومات صحية من صديقاتهن، خاصةً فيما يتعلق بمسائل الصحة الجنسية والإنجابية. وأعرب البعض عن تقديرهم لمقدمي الخدمات الصحية والمراكز الصحية كمصدر موثوق للمعلومات حيث تتطابق هذه النتائج مع نتائج البيانات الكمية والدراسات التي تمت مراجعتها

### المعيقات التي تواجه الشباب في الوصول إلى أنشطة وخدمات الرعاية الصحية والمشاركة بها

تم تلخيص هذه من قبل أصحاب المصلحة على النحو التالي؛ الدراسة الأكاديمية المكثفة، مواقف الطلاب السلبية تجاه الأنشطة غير الأكاديمية، القيود الثقافية لمشاركة الإناث بالأنشطة غير الأكاديمية وخاصة مناقشة قضايا الصحة الجنسية والإنجابية، وقلة الاهتمام بالقضايا الصحية خاصة بين الذكور. بشكل عام، يفتقد الشباب الوعي بالخدمات المتاحة وأهميتها لصحتهم ورفاهيتهم. كما أن هناك نقص الدعوة الى وتعزيز هذه الخدمات من قبل أصحاب المصلحة. والأهم من ذلك، يعتقد الشباب/ات أن المراكز الصحية لا تقدم خدمات شاملة تلبي احتياجاتهم وتلبي طموحاتهم إلى جانب التكلفة العالية للرعاية الصحية. وفيما يتعلق بموظفي المراكز الصحية، علق الكثيرون على افتقارهم إلى التدريب والتأهيل بشأن قضايا الشباب.

### هل يحتاج الشباب الفلسطيني إلى مركز لتغطية احتياجاتهم الصحية؟

جميع أصحاب المصلحة بمن فيهم الشباب/ات يؤيدون ويصرون على إنشاء مركز الخدمات الصحية الصديقة للشباب في أي مكان سهل الوصول إليه من قبل الشباب/ات في المنطقة؛ أراد الأكاديميون أن يكون هذا المركز موجودًا في كل جامعة، وأراد مزودي الخدمات أن يكون المركز موجودًا داخل مبانيهم. معظم الشباب/ات يفضلون أن تكون هذه المراكز في أي مكان معروف، مستقل وله هوية واضحة ومهمة وأهداف، وأن لا يكون مدمج مع الخدمات الأخرى. كان هناك المزيد من التأييد لنموذج الخدمات الصحية الصديقة للشباب على ان يكون مؤهل بخبراء في صحة الشباب؛ يقدمون المشورة بخبرة وبقيادة؛ ينسقون الخدمات ويشجعون التعاون والتشبيك؛ ويقوم بمساعدة النظام الصحي السائد. كذلك شددوا على أن تكون الخدمات غير مكلفة

### توصيات الدراسة

تمت كتابة التوصيات التالية نتيجة لاستخلاص المعلومات من مصادر البيانات المختلفة، واستجابةً لأهداف الدراسة وأسئلتها

1. إقامة شراكة رسمية مع وزارة الصحة التي لديها القدرة على تحقيق أكبر تأثير على الخدمات الصحية الرئيسية بما في ذلك الخدمات الصديقة للشباب من خلال انشاء وتطوير مديرية لصحة الشباب داخل وزارة الصح
2. إقامة شراكة رسمية مع وزارة التربية والتعليم العالي والتي لها تأثير كبير على صحة الطلبة ورفاهيتهم عبر مجموعة من التدخلات ومنها تقديم التوعية والتثقيف الصحي بمجالات مختلفة ومنها الصحة الجنسية والانجابية، الغذاء الصحي، زيادة النشاط البدني من خلال تحسين خدمات الصحة المدرسية وتواجد ممرضة الصحة المدرسية داخل المدارس وتعزيز الخدمات الصحية المتاحة داخل الجامعات
3. يجب أن تعالج القضايا الاساسية والتي تم تعريفها بالدراسة بشكل شامل وبالتنسيق مع جميع أصحاب المصلحة بما في ذلك المؤسسات الحكومية وغير الحكومية آخذين بعين الاعتبار دمج برامج الرعاية الصحية الأولية أي الوقائية والرعاية الثانوية العلاجية والرعاية الثالثة أي التأهيلية لإمكانية التأثير الأكبر على صحة

تفضيل المشاركين/ات لأوقات تلقي الخدمات الصحية؛ 36.3% فضلوا أوقات الصباح، 13.8% فضلوا أوقات المساء وبنسبة أقل 10.8% فضلوا أوقات الظهر وما يقارب الثلث 32% لا يهتمهم الوقت

تفضيل المشاركين/ات لجنس مقدم الرعاية الصحية؛ 43.4% لا يهتمهم جنس مقدم الرعاية، و32% فضلوا الإناث مقابل 14.2% فضلوا الذكور، و3.1% لا يعرفون كيف يشعرون اتجاه جنس مقدمي الرعاية الصحية.

تفضيل المشاركين/ات لمكان الخدمات الصحية الصديقة للشباب؛ 71.4% فضلوا أن يكون الموقع بالقرب من مكان إقامتهم، 18.5% فضلوا أن يكون بعيداً عن مكان إقامتهم، 7.4% لم يجيبوا عن هذا السؤال و2.8% أجابوا على أماكن أخرى.

إدراك المشاركين/ات لأهمية الحفاظ على السرية؛ 57.8% أشاروا إلى أنها مهمة جداً، 25.5% مهمة أحياناً، 5.5% يعتقدون أنها غير مهمة و4.3% لا يعرفوا.

تفضيل المشاركين/ات لتوقيت منفصل بين الشباب والشابات عند تلقي الخدمات الصحية الصديقة للشباب؛ 40% فضلوا الحصول عليها بشكل منفصل عن الجنس الآخر، 38.5% لا يهتم ذلك، و3.4% لا يعرفوا

إدراك المشاركين/ات للتكلفة المالية وإمكانية الوصول إلى الخدمات الصحية؛ 36.3% اعتبروا التكلفة المالية تمثل عائقاً للوصول إلى الخدمة، 40.3% اعتبروا التكلفة المالية تشكل عائقاً في بعض الأحيان، 12.9% لم يعتبروا أن التكلفة المالية تشكل عائقاً

## النتائج الرئيسية من المشاورات مع أصحاب المصلحة الأكاديميين والمهنيين، ومقدمي الخدمات الصحية والشباب المستفيدين من الخدمات

### البرامج والأنشطة المتاحة للشباب داخل المؤسسات المستهدفة

ضمن نظام الجامعة، هناك جهود مبذولة لتطوير الطلبة بهدف تزويدهم بالمهارات الحياتية الضرورية والوعي في كل جانب من جوانب حياتهم الجامعية. من الأربع جامعات التي تم استهدافها للدراسة تم إطلاق مركزين للخدمات الصحية الصديقة للشباب في مقرهما وهما جامعاتي القدس والأزهر في غزة. شدد مقدمو الخدمات وممثلو الجامعات (الضفة الغربية وقطاع غزة) على دورهم في تعزيز صحة الشباب وتنميتهم كجزء من رسالتهم وأهداف خدماتهم حيث توجد برامج وأنشطة تتم وفقاً لذلك.

### أولويات الشباب واحتياجاتهم فيما يتعلق بالمشاكل الصحية والاجتماعية

تم تلخيص المشاكل التي تواجه الشباب من قبل جميع أصحاب المصلحة على النحو التالي: المشاكل السلوكية، العنف، المخدرات والإدمان، التدخين، البطالة وعمالة الأطفال، وأما المشاكل الصحية البدنية كانت الأقل ما يقلقهم. ارتفع معدل انتشار الإعاقات الجسدية بين الشباب الفلسطيني هو مشكلة صحية بارزة أخرى مقرونة بنقص العيادات ومراكز التأهيل لهؤلاء الأشخاص. وتتطابق هذه القضايا مع نتائج البيانات الكمية والدراسات التي تمت مراجعتها.

### مصادر المعلومات الصحية بين الشباب

كانت مصادر معلومات الشباب في الغالب من وسائل الإعلام الاجتماعية، وسعت الفتيات الأصغر سناً للحصول على





الشباب/ات ورفاههم ولتشمل أيضا أولئك الذين خارج نظام التعليم

4. معالجة الفجوة بين جميع أصحاب المصلحة في أنشطة التدخل المبكر للتدخين والكحول والمخدرات لمنع تصاعدها والحد من مخاطر ضررها على المدى الطويل.
5. العمل على تحسين التنسيق بين خدمات الصحة الجنسية والإنجابية القائمة لزيادة معرفة الشباب/ات بهذه القضايا، وخاصة الأمراض المنقولة جنسياً والتثقيف الجنسي، مخاطر الزواج المبكر وزواج الأقارب وعلى أن يشمل الأسر وصناع القرار في هذا الشأن. أيضا دمج قضايا الصحة الجنسية والإنجابية إما في إطار دراساتهم أو المناهج المدرسية أو من خلال النشاطات اللامنهجية
6. العمل على تحسين تنسيق الخدمات القائمة لربط الناس والموارد والتدريب وإشراك الشباب/ات بهذه النشاطات
7. توصي الدراسة وبدرجة عالية إنشاء المركز الصحي الصديق للشباب على أن يكون مستقل في موقع مناسب مثل الجامعة، أو بمركز صحة مجتمعي، أو أي مكان آخر سهل الوصول من قبل الشباب/ات إليه، مؤهل بالموظفين/ات الأكفاء ولهم القدرة على الاستجابة لاحتياجات الشباب.
8. لبناء وتطوير المراكز الصحية الصديقة للشباب/ات توصي الدراسة بمعايير الجودة الخاصة بها (الرجاء الرجوع لصفحة 60 للتفاصيل حولها)



# Chapter I

# Introduction

# 1. Introduction

The Middle East and North Africa (MENA) region, including the Occupied Palestinian Territory (oPt) is a 'youth bulge'. Due to an extremely high fertility rate in both the West Bank and Gaza, the youth population is expected to grow to alarming rates. The Palestinian population is young (69% are below the age of 29) and growing fast. The percentage of youth in the 15-29 age group comprises 29.2% of the total population, distributed by 36% in the 15-19 age group and 64% of the 20-29 age group. (UNFPA, 2016; 2017).

Since the 1994 International Conference on Population Development (ICPD), countries have been encouraged to adopt programmes that safeguard the youth's privacy, including confidentiality, respect and informed consent (ICPD, 1995). The services tailored to these expectations are defined as youth-friendly services (YFS) and are designed to improve care for the youth. These services include counseling, FP, Voluntary Counseling and Testing (VCT) and treatment of sexually transmitted infections (STIs). These services should be accessible, acceptable and appropriate for the youth. They should be rendered in the right place with reasonable prices, sometimes free of charge, when necessary, and delivered in the right style to be acceptable, effective, safe and affordable (WHO, 2008).

UNFPA's strategy on adolescents and youth, "My body, My life, My World" (2019) strives, for instance, to ensure access to integrated sexual and reproductive health services and information and to address the determinants of health and wellbeing. Youth sexual and reproductive health and rights need to be promoted and respected in a world to enable them to make informed choices over their own bodies while enjoying a healthy life and successful transition into adulthood (UNFPA, 2019).

Youth-friendly health services represent a strategic approach to improving young peoples' health. As a step towards achievement, two YFHS centres were launched, at Al-Quds and Al-Azhar universities. The effort is a collaboration with AICS through financial contribution and implementing partner PMRS. Furthermore, for scaling-up and replication of this experience, UNFPA sought to conduct this feasibility study to investigate the provision of more youth-friendly health services in the occupied Palestinian Territories (oPt).

## 1.1 Study background and significance

---

Worldwide, young people are making their voices heard nationally and globally. They are calling upon their governments to fulfill their commitments, particularly to respect and protect human rights. They are helping to create the intergovernmental agreements that guide the work of UN organisations including UNFPA's. They are demanding investment in, for example, their education, health, asset building and are insisting on their active participation in decisions determining their own and their nations' futures. This means that no sector or organisation can do what is needed to support young people on its own. Only by working together across sectors and in collaboration with young leaders, can the constraints on young people's progress be removed, and key obstacles effectively tackled, paving the pathway to adulthood with opportunity and support (UNFPA Strategy on Adolescents and Youth, 2013)

With many economies unable to generate sufficient jobs, and poverty forcing adolescents to leave school prematurely, young people must be given the option of accessing vocational and job training, as well as to assets, such as credit, if they are to generate livelihoods. Laws and regulations must also be enforced so that underage children are not trapped in the labor market that those at the age of work receive appropriate treatment.

Simultaneously, adolescents and youth must receive comprehensive sexuality education to develop the knowledge and skills they need to protect their health throughout their lives. Such education can be provided by schools or by non-school programmes but ideally should be combined with training on skills and opportunities for physical activity that is vital to good health.

Part of UNFPA's 5<sup>th</sup> country programme cycle (2015-2017) supported the Palestinian MoH in launching a pilot Youth Friendly Health

Services (YFHS) model in Dura/Hebron District. The YFHS model centre applied a national protocol for services and employed four relevant staff: nurse, doctor, social worker, and receptionist trained on the operationalization of the mentioned protocol. The centre had an average of 100 visits in one month from youth (aged 10 to 29) and an average of 300 adolescents and youth benefited from the services through outreach interventions implemented by the centre's staff in the schools and community centres. Furthermore, 255 cases were referred to specialized services outside of the centre.

### **The objectives of the YFHS centres are as follows:**

- Promote a healthy lifestyle and optimal health behaviours among adolescents and youth through structured health promotion interventions and counselling.
- Interact with adolescents and youth at times of concern or crisis, when they are looking for a way out of their problems.
- Establish links to other specialized services, such as counselling and recreational services, which can support young people.
- Prevent and mitigate factors leading to health problems that can affect the health and wellbeing of youth and/or result in chronic illness or disability.
- Detect cases that might lead to ill health or cause adolescents' concern.
- Refer cases that require higher level of treatment to appropriate service providers, including gender-based violence services.
- Create connections with families and influential community members (i.e. religious leader, village council leader) as core group of support and success of the centre.
- Networking with other major stakeholders (Ministry of Education, Ministry of social

Development etc.) for partnerships, referral and other purposes.

The progress reports of the MoH/Dura YFHS model centre for two consecutive years (2015 and 2016) indicated a success in demand from young people and community members with a service delivery for 5,600 young beneficiaries. Therefore, UNFPA is conducting the present feasibility study on YFHS for replication and scaling up in certain service delivery points by offering practical recommendations to achieve worthy outcomes. The service delivery points include health centres, youth centres, universities and safe places for young people. The objective is to offer services that meet their needs and identify improvement needed for YFHS in East Jerusalem, West Bank and Gaza.

Furthermore, a recent discussion held on November 8, 2018 among UNFPA, the national YFHS steering committee members' representatives of academic and service institutions, requested/identified the need to have an insight into what services are available and the quality of services offered. It was agreed that these services are sporadic, uncoordinated and insufficiently equipped to respond adequately to the needs of young people.

## 1.2 The study goal and objectives

---

The goal of this feasibility study is to deliver evidence-based information that will form a road map for a successful and sustainable YFHS delivery points and to strengthen capacities of all relevant stakeholders to meet young peoples' needs. Based on the study findings, a set of recommendations are proposed, with the aim of improving interventions and service delivery implementation, and advocating for and sustaining YFHS in East Jerusalem, West Bank and Gaza. To meet the aim, the following specific objectives were set:

### Specific objectives:

1. Identify key issues and needs of young people (15–29 years) in East Jerusalem, West Bank and Gaza for the so-called “youth-friendly health services” and their preference of setting and approach.
1. Identify the best delivery points/ places to provide and sustain YFHS in Palestine, including the humanitarian settings in Gaza.
2. Examine the feasibility of establishing a YFHS centre within the targeted locations (service providers, management focal points) and analyze their readiness to offer such services taking into consideration services' approaches, uptake, relevance, content and modality of operation.
3. Identify the perceptions of the stakeholders (service providers, management focal points in the Dura pilot model centre and PFPPA Center in Hebron) and evaluate the experiences of the beneficiaries who accessed the YFHS.

4. Formulate recommendations for consideration by stakeholders on actions to improve the health and wellbeing of young people and interventions to strengthen YFHS model services by institutionalization within these points.





# Chapter II

# Literature Review

# Literature Review

The literature review helps to guide the study and to provide the foundation for developing detailed recommendations for optimizing the health and wellbeing of young people. The state of Palestinian young people, their perceptions of health, health problems, risky behaviours and their needs is summarized and presented. As well, a review of international models and programmes for young people and the mapping of existing programmes and services are presented in order to identify best practices for the prevention and treatment of health problems and development of healthy productive young people.

## 2.1 The status of young people within the Palestinian context

Young people face a number of challenges related to their health. Rapid physical changes occur during puberty, such as height, weight and body shape, genital, hormonal and neurological changes. In addition, psychological development, such as a desire for autonomy and a more mature self-understanding, contribute to the potential for turmoil during adolescence. Young people are not a homogeneous group; the challenges and opportunities affecting their lives are broadly similar but also vary largely depending on their specific and unique contextual circumstances (United Nations, 2007).

The health situation in the oPt remains affected by the occupation since the 1967 war, which continues to permeate every aspect of its current existence and development. The territory has been split into the West Bank, East Jerusalem, and the Gaza Strip, each with its own governing body, legal system,

and unique development and human rights context. The West Bank has been divided into three distinct land areas according to their control and authority; Area A (under complete Palestinian civil and security control), Area B (under Palestinian civil and Israeli military control), and Area C (under complete Israeli military and civil control). Area C comprises approximately 60% of the West Bank (UNFPA, 2017).

Palestinians living in East Jerusalem are particularly vulnerable to a conflicted sense of identity, heightened and frequent levels of violence, unclear legal framework, and destructive coping mechanisms, such as high levels of drug abuse (UNFPA, 2017). Furthermore, the Gaza Strip has entered an extreme situation of developmental deterioration termed as 'de-development because of the siege imposed by Israel for over 10 years (Efrat, 2015).

The long-lasting siege and the serious constraints imposed by the occupation, as well as the absence of a fully unified Palestinian central administrative control over the West Bank and Gaza Strip impact the physical and mental health of the population and the development of quality health services all over oPt (WHO situation analysis reports, 2016). This situation has been aggravated by the internal Palestinian political divide, the financial crisis of the PNA and the barriers to access health care facilities are a serious enduring and well-documented problem (WHO situation reports, 2015).

During adolescence and youth-hood, individuals begin the transformation from childhood to adulthood, having to formulate their identities, beliefs, and behavior. Gender identity is extremely relevant when formulating oneself, in terms of personal understanding of what is 'normal', permissible, acceptable, desirable, etc. Palestinian young people and adolescents' growth and development have been very much influenced by two major factors: externally by the forces of occupation and exposure to high rates of violence and discrimination; and internally, by Palestinian fragmentation, loss of identity, and a patriarchal society. These factors are extremely damaging factors during the formative years of life. The gender dynamics created by a patriarchal society affect other key developmental areas, such as economic growth, civic engagement, health, and sexual education. Patriarchy affects men and women, boys and girls, in different ways, creating specific models for masculinity and femininity that pervade all other areas of life. In Palestine, gender inequality has created an oppressive environment with limited opportunities for women. Both horizontal and vertical segregation can be seen in key areas, specifically women's economic and political participation (UNFPA, 2017)

UNFPA estimated in the publication "Palestine 2030" (2016) that the population will continue to grow and duplicate in numbers considering

the young age structure and the high fertility rate due to a large number of women in reproductive ages in combination with socio-cultural norms regarding childbearing and the encouragement of getting several children. Although a rapidly increasing youth population can cause extreme stress on an already underdeveloped infrastructure (education, health, social services, urban infrastructure, housing, and access to economic opportunity), it can also contribute to demographic dividend. Young people need opportunities and access to quality education and economic opportunity, participation in public life, access to quality youth-friendly healthcare, and to be informed and choose well among these opportunities that can lead to positive growth for Palestine as a whole (World Bank, 2007; UNFPA, 2016;2017).<sup>3</sup>

## 2.1.1 Socio-demographic characteristics of Palestinian young people

Youth population; the United Nations defines various groups of young people: 'adolescents (10 – 19 years old) and youth (15-24 years old). The PCBS (2018) identified the age group of 15-29 years of age as the youth in the Palestinian society. The Palestinian society is a 'young society' where the young comprise around 30% of the total population distributed according to 36% in the 15-19 age group and 64% in the 20-29 age group, with more than half of them living in Area C close to the apartheid wall and the settlements (PCBS, 2018).

---

3 . A recent UNFPA study *Palestine 2030* has demonstrated that Palestinian youth can present a demographic threat or a great opportunity for the future. Learning that the youth population will be more than double by 2050, and increase by a million by 2030 is a daunting prospect. However, if youth were to receive quality access to education and economic opportunity; participate in public life, in the formal and informal political spheres; access to quality youth-friendly healthcare, including sexual and reproductive health; and felt themselves to be productive, valuable members of society, their potential could lead to positive growth for Palestine as a whole.

Marriage and households; the average size of Palestinian households was 5.2 people in 2015, 5.0 in the West Bank and 5.7 in the Gaza Strip (Palestinian Youth Survey, 2015). According to the data from the Population, Housing and Establishments Census (2017), there was an increase in households headed by young people (15-29 years). The rate stands at 14.9% compared to 9.2% in 2007, indicating an increase in the social and economic challenges that young people in this country face.

According to the PCBSs' youth survey (2015) on marriage findings, 28% of youth (15-29 years) are married compared to 3.9% engaged and 0.6% widowed, divorced or separated. The percentage of married youth reached 25.6% in the West Bank, compared to 31.6% in the Gaza Strip. The percentage of married males reached 15.6% compared to 40.8% females for the same age group. In contrast, early marriage among females (20-24 years) less than 18 years was 10.8% in 2017 compared to 18.1% in the 2007 census and compared to 30.5% in 1997 census for the same age group. This gradual decrease in early marriage among Palestinian females can be attributed to extensive and comprehensive efforts made by governmental institutions and NGOs.

Education; the results of the Population, Housing and Establishments Census (2017) shows that 35.3% of individuals (15-29 years) were enrolled in education, 80.7% in the age group (15-17 years), 42.4% (18-22 years), and 7.1% (23-29 years). While the percentage of enrolment among young males was 31.1% compared to 39.7% for young females. In 1997, enrolment among youth reached 28%, and increased significantly to 44.4% in 2007 (PCBS, 2018). According to the Labor Force Survey 2018, 37% of youth aged between 18-29 were enrolled in education, 45% (18-22) and 7% (23-29). 17% of youth between 18-29 had a bachelor's degree or higher in 2018, compared to 12% in 2007 (PCBS, 2019a). The dropout rate among youth was 34% in 2016 and was higher among males (PCBS, 2017).

The rate of illiteracy among individuals (15-29 years) decreased from 1.1% (1.1% in the West Bank and 1.2% in Gaza) in 2007 to about 0.7% among youth in 2019 (PCBS, 2019a).

Labour and employment; young people's participation rate in the labour force increased to 41.1% in 2017 (63.0% among males and 18.9% among females) compared to 33.8% in 2007; this increase was similar in the West Bank and Gaza during the same period. In 2018, 52% of 18-29-year-olds participated in the labor force, continuously dominated by males. On the other hand, the unemployment rate increased from 30.5% (2007) to 41% (2017) (PCBS, 2018) and 45% (among 18-29 year) in 2019 (PCBS, 2019a). Comparing West Bank and Gaza, the unemployment rate in the West Bank increased from 25.6% in 2007 to 27.2% in 2017, and it increased significantly in the Gaza Strip (from 39.8% to 61.2%) during the same period for the same age group. Addressing the reasons for unemployment, 76.4% of youth reported that the unavailability of jobs was the main reason, while 9.6% of them reported that their job did not match their qualifications and experience (PCBS, 2018).

For the working youth, 23% worked in the services sector in 2017 (16.8% males and 65.2% females) compared to 28.4% in the trade, restaurants and hotels sector (30.6% males and 13.2% females), and 19.6% in the construction sector (22.2% males and 1.4% females). Additionally, 15.1% of the employed youth work in industry (15.8% males and 10.7% females). Young women dominate the services sector, while the trade, restaurants and hotels sector is the most accommodating for male youth employment. Less than 1% of Palestinian youth work in decision-making positions as legislators and senior management employees (PCBS, 2018).

Financial status and poverty rate; more than one-fourth of Palestinian youth were considered poor in 2017. Based on PCBS national definition of poverty, the term comprises "absolute poverty" and "relative poverty", with features based on balancing

the basic needs of a household of five members including two adults and three children”<sup>4</sup>. The household poverty line stands at (2,470 NIS per month) while extreme poverty line reached (1,974 NIS per month). The poverty rate among individuals according to the monthly consumption patterns reached 29.2% in 2017 (13.9% in the West Bank and 53.0% in the Gaza Strip). The poverty rate among individuals (15-29 years) according to the monthly consumption patterns attained 29.5% (13.5% in the West Bank and 56.0% in the Gaza Strip). It was found that 16.8% of the Palestinians live in extreme poverty (5.8% in the West Bank and 33.8% in Gaza Strip), while the percentage of extreme poverty among the individuals (15-29 years) was 17.1% (6.1% in the West Bank and 35.4% in the Gaza Strip).

These living circumstances led more than one-third (37%) of young people in the Gaza Strip to think of emigration compared to 15% in the West Bank, (29% males and 18% females) desire emigrating abroad (PCBS, 2018).

## 2.1.2 Health and well-being of young people in Palestine

Regarding the priorities of Palestinian youth (15-29 years) and their wellbeing in West Bank and the Gaza Strip, 79.4% of them consider ending the occupation and building the Palestinian state the top priority, followed by 7.3% that called for improving the living standards. The same survey indicates that young people have key areas of emerging concern including mental health, sexual health, alcohol and other drugs use, nutritional problems and physical inactivity (PCBS, 2015).

A qualitative study on YFHS needs in Gaza (2015) indicates that the major health issues

<sup>4</sup> Poverty definition in this section is taken from PCBS, on International Youth Day, 122/8/018) <http://www.pcbs.gov.ps/post.aspx?lang=en&ItemID=3215> last paragraph

of young males are related to the emerging use of drugs and addictions, particularly tramadol, followed by sexual health issues, stress, isolation and uncertainty about their future. The female groups reported that the major health issues they face, related to the menstrual cycle problems (pain, acne, mood changes, etc.), as well as reproductive and sexual issues and nutritional problems either obesity or being underweight.

Mental health; chronic exposure to violence over a 50-years period of Israeli occupation has left Palestine with the highest rate of mental health disorders in the Middle East. Around 78% of Palestinians reported having experienced military raids on their homes. The prevalence of young people, genetic homogeneity and the environmental stressors of conflict over multiple generations are all contributing factors to mental health disorders (Hoyle, 2017). The Joint Health Sector Assessment Report (2014) using WHO estimates found that up to 20% suffer from psychological trauma that would need interventions while the youth survey indicates that 27.4% of Palestinians have some kind of mental health problems. A WHO unpublished report (2009) indicated that one-third of people visiting Palestinian MoH Primary Health Care centres in the Gaza Strip and the West Bank have suffered from mental health problems; a prevalence that is higher than in more stable countries

Nutritional problems; can still arise or worsen during adolescence. These problems include problems of overeating and/or consistently making poor food choices, resulting in obesity. Conversely, other adolescents develop problems with unhealthy and extremely restrictive dieting that does not meet the minimum nutritional requirements necessary for healthy growth and development.

Abdeen et. al, (2012) analyzed a cross-sectional survey for randomly selected 3617 adults aged 18-64 years to provide baseline data on the prevalence and distribution of overweight and obesity and their associations in Palestine. The results indicated the



prevalence of overweight was 35.5% among women and 40.3% in men and obesity was 31.5% in women and 17.5% in men. Adults aged 45-54 years old were significantly more likely to be obese (29.2% in men and 50.2% in women) or overweight (48.1% in men and 37.2% in women) than the younger group. The researchers conclude that obesity and overweight are enormous public health problems in Palestine. It is therefore important to carry out population-based research at the national level to investigate the social and cultural factors associated with high prevalence of overweight and obesity among Palestinian adults.

Physical activities and sports represent a minimal routine for Palestinian young people. In fact, only 24.6% (almost a quarter of youth) reported they exercised daily for at least half an hour (19.6% in the West Bank and 32.6% in the Gaza Strip). Gender variance was high with 32.0% of males exercising compared to 17.0% of females (PCBS Youth Survey, 2015). Furthermore, findings from the WHO assessment report (2016) showed that 6.3% of youth (15-29 years) reported being members of sports clubs and centres (5.7% in the West Bank compared to 7.4% in Gaza Strip).

Disability/difficulty; The same PCBS Census Report (2017) indicated that disability among young people (15-29 years) has increased from 2.8% in 2007 to 3.1% representing 40,542 individuals (18,300 in the West Bank (2.5%) and 22,242 in Gaza Strip (4.0%)). When distributed according to gender, it was among young males 4.2% compared to 2.1% among young females in 2017. Among those living with a disability, 29.4% (32.1% in the West Bank compared to 27.2% in the Gaza Strip) are not enrolled in education. According to Gaza Emergency Response Action Report (March 2015), in the Gaza Strip, there are more than 6000 people with disabilities and/or injuries, who are particularly vulnerable and require rehabilitation. Mobility disability/difficulty is the most prevalent among the youth and affects 1.3% of Palestinian youth (15-29 years), followed by sight disability/difficulty with a

percentage of 1.2% for the same age group.

Health literacy; the ability of an individual to understand health concepts is an important factor in how well an individual is able to fully participate in society. Studies have shown that people with low health literacy not only have less knowledge of illness management but have less input into their own health care decision-making, in addition to lower adherence to medication, and poorer health outcomes (Nutbeam, 2008). Low levels of health literacy are associated with lower educational attainment, lower annual income, poorer health status and fewer doctor consultations (Adams, et al., 2009)

Palestinian youth use social media to obtain information: 69.7% of youth (74.8% in the West Bank compared to 61.7% in the Gaza Strip) used a computer and used the internet, while 23.3% had a computer but did not use the internet. 74.6% of male youth and 64.5% of female youth used the internet to obtain information, including about health-related issues. Moreover, 84.8% of Palestinian youth owned a mobile phone noting that these results are for general use and not specific to health information.

In the Gaza study (2015) Palestinian young people were asked, "Where would you most likely go for advice and support?" They reported friends first, then the internet and lastly the family. Young males refer first to pharmacies to receive health service and refer less to health providers. In general, their last choice was the parents especially when the health problems related to addiction and/or sexual health issues. The young people in this same study emphasized privacy matters as reasons to avoid going to clinics or hospitals because people know each other and youth fear the stigma if they use these services. Therefore, they prefer using the internet rather than seeking help from friends, family or professionals. Many other studies indicated that young people are increasingly using the internet as a primary source for health advice and support.

## 2.1.3 Young people's health risk behaviors

The Australian Institute of Health and Welfare (2010) identified that risk factors for young people's health include personal factors such as genetics, behavioural factors such as smoking or physical inactivity, and environmental factors such as socioeconomic status. Specific risk factors that contribute to a young people's level of vulnerability and hence the likelihood of poor health and wellbeing include experience of abuse, neglect, conflict or violence within the family, use of alcohol and other drugs and unsafe sexual practices and association with risk-taking peer group

There is little systematic information about health risk behaviours among youth in Middle Eastern countries, leaving public health authorities unprepared to deal with emerging public health threats at a time of major social change. According to PCBS Youth Survey (2015), young persons (15-29 years) reported that the major health issues they faced were diseases induced by improper behaviour like smoking, and mental health problems at 50.0% and 27.4% respectively. There were no variances related to health issues between the West Bank and Gaza Strip or between males and females. For smoking, data shows that 23.5% of youth smoked, 29.5% in the West Bank and 14.0% in the Gaza Strip with a high gender variance, 40.9% of males compared to 5.4% of females.

Regarding risk behaviours among Palestinian youth, Glick, et. al. (2018) conducted a representative survey among 2500 Palestinian youth aged 15-24 years in the West Bank and East Jerusalem, permitting reliable comparison across sex and rural-urban divisions. The study found that, among youth aged 20-24 years, 22.4% of males and 11.6% of females reported having tried alcohol; 10.5% of males and 4.3% of females reported having tried drugs. The rates for experiencing sexual intercourse were low, being for unmarried males, 9.5% (20-24 years), 5-6% (18-19 years) and for females 6.9% (20-24 years) and 4.1% (18-19 years). Tobacco

use is high, even among younger youth where 45.4% of males and 21.2% of females aged 15-19 reported smoking. The results concluded that risk behaviours are higher among males, older youth and in urban areas and refugee camps.

## 2.1.4 Sexual and reproductive health and rights (SRHR)

Sexual and reproductive health and rights (SRHR) is a universal right included in the Universal Declaration of Human Rights (UDHR) and other international human rights declarations, conventions and agreements. SRHR is included in other essential human rights such as the right to life, health, education information, right to privacy, consent to marriage, free from sexual and gender-based violence, etc. It is globally recognized that realizing the rights of women and girls through gender equality and empowerment is central to sustainable development (UNFPA, 2016a; Shaw, 2009).

Access to sexual and reproductive health (SRH) was more emphasized and viewed as a fundamental basic human right since the 1994 International Conference on Population and Development. Yet across the world, adolescents' access to their sexual and reproductive health rights (SRHRs) is not respected (ICPD Taskforce, 2013). Consequently, adolescents, especially females, suffer disproportionately from poor SRH outcomes since social norms and taboos greatly hinder the provision of services to promote their SRHRs.

The conservative traditional Palestinian-Arab culture prevents the open discussion of SRHRs. Furthermore, this culture guides policies, and the legal framework governing the provision of services in oPt. As a result, the promotion and protection of young people's sexual and reproductive health rights have been neglected even though adolescents constitute approximately one-quarter of the population in Palestine (PCBS, 2013).

Juzoor's Women Health Surveillance Report (2010) reported that, despite a large number of Primary Health Centres that provide reproductive services, the data available on the barriers faced by women when accessing general health, including reproductive services, come from a research study conducted by the Palestinian Women Development Centre (PWDC) in 2010. Results showed that insufficient resources prevent women from accessing healthcare in the West Bank and Gaza Strip; 48% of them do not have access to money; 25% referred to the lack of a female health professional. Additionally, 15% explained that the distance to the health facility was an impediment, and 15% complained about the lack of transportation while 10% lacked knowledge about where to go.



## 2.2 International and National Models of YFHS

A scan of national and international models of services and programmes to improve young people's health was undertaken, including those focused on prevention and early intervention. The literature review also identified service models that have been implemented within the Palestinian health services.

### 2.2.1 Contexts for the provision of youth-friendly services

Many health initiatives for young people have not been subject to proper evaluation; therefore evidence relating to the best models of youth-friendly health provision is limited. However, data from several systematic reviews can be used to identify and describe the contexts for delivery of preferred youth-friendly health services (Tylee, et, al., 2007 and Anderson, et, al., 2010).

Evidence suggests that young people avoid using services that are not youth-specific, primarily because they are not perceived to be respectful or confidential (Jacobson, 2006). Youth-friendly health services are those that can attract young people, meet their needs and succeed in retaining them in continued care. To achieve these characteristics, however, services must have specially trained staff, be accessible and preserve privacy and confidentiality.

In their work within reproductive health services in Zimbabwe, Erulkar and colleagues (2005) reported that adolescents rated confidentiality, short waiting time, low cost and friendly staff as the most important characteristics of a health service. Their findings suggest that, even in the most resource-poor settings, clinical services are in a position to improve their level of youth friendliness. Furthermore, the ACT Healthy Young People Feasibility Study (2011)



reported that young people valued services that were helpful, welcoming, understanding, had knowledgeable staff, nonjudgmental and maintained privacy and confidentiality.

The World Health Organisation 'gold standard' of care for young people friendly services (2002) must be effective, safe, affordable and able to meet individual needs, those to which young people return and those that young people would recommend to their friends.

The WHO Adolescent Friendly Health Services: An Agenda for Change (2002), the UN World Youth Report (2007), and the WHO Making Health Services Adolescent Friendly (2012) identified and described that the framework for youth-friendly health services to include;

1. An equitable point of delivery is one with equal access to health services for all youth, not only for a specific group.
  - Policies and procedures are in place that do not restrict the provision of health services on any terms and solve issues that might hinder the equitable provision and experience of care.
  - Health-care providers and support staff treat all their patients with equal care and respect, regardless of their status.
2. An accessible point of delivery is one in which youth services are affordable and provided at times and in places that are accessible to all young people.
  - Policies and procedures are in place that ensure health services are either free or affordable to all young people.
  - Point of delivery has convenient working hours and convenient location.
  - Young people are well informed of the range of health services available and how to obtain them.
  - Community members are aware of the importance of youth access to health services and support their provision.
  - Outreach workers, selected community members and young people themselves

are involved in reaching out with health services to young people in the community.

3. An acceptable point of delivery is one in which health services are provided in ways that meet the expectations of young people.
  - Policies and procedures are in place that guarantee client confidentiality
  - Health-care providers:
    - ✓ Provide adequate information and support to enable each young person to make free and informed choices that are relevant to his or her individual needs
    - ✓ are motivated to work with young people, are non-judgmental, considerate, and easy to relate to
    - ✓ are able to devote adequate time and act in the best interests of their clients
  - Support staff to be motivated to work with young people and is non-judgmental, considerate, and easy to relate to.
  - The point of service delivery:
    - ✓ Ensures privacy (including discrete entrance)
    - ✓ Ensures consultations occur in a short waiting time, with or without an appointment, and (where necessary) swift referral
    - ✓ Lacks stigma
    - ✓ Has an appealing and clean environment
    - ✓ Has an environment that ensures physical safety
    - ✓ Provides information with a variety of methods
  - Young people are actively involved in the assessment and provision of health services

4. The appropriateness of health services for young people is best achieved if the health services provided are appropriate at their various stages of life.
  - The health services needed are provided either at the point of delivery or through referral linkages.
  - Health-care providers deal adequately with presenting issue yet strive to go beyond it, to address other issues that affect health and development of young people.
5. The effectiveness of health services for young people is best achieved if the right health services are provided in the right way and make a positive contribution to young people's health
  - Health-care providers have required competencies
  - Health-service provision is guided by technically sound protocols and guidelines
  - Points of service delivery have necessary equipment, supplies, and basic services to deliver health service
6. Gender equitable: Services are safe, affordable and accessible for young women and young men, within a context that promotes the rights of women and girls to make decisions and determine their life outcomes.

## 2.2.2 Effective models of service provision for young people

The argument for a service system that provides multiple entry points for young people to any service is strong. In short, accessing health services may not be a direct process for an individual young person; rather, they become aware of or are provided with information about broader health services indirectly (Anderson, J. and C. Lowen, 2010). Such entry points may include the internet, recreational programmes ran in youth centres, or a telephone counselling service such as a helpline (Kang, M., 2005).

Many health initiatives for young people have not been appropriately evaluated, and therefore evidence relating to the best models of youth-friendly health provision is limited. However, data from several systematic reviews can be used to identify and describe the contexts for delivery of preferred and effective youth-friendly health services (Anderson, J. and C. Lowen, 2010; Tylee, A., et al., 2007).

### **Tylee, A et al (2007) categorized the delivery of preferred youth-friendly health services models into six groups:**

1. The centre specializing in adolescents and youth health is set in a hospital. The centre is providing in-patient services in combination with the alternative for drop-in service to young people. Additionally, the centre also serves as a type of secondary or tertiary referral centre for health facilities close-by and provides professional training and a research agenda (WHO, 2002; The Lancet, 2004)
2. Community-based health facility which caters to young people within the context of health-service provision to all segments of the population. The model includes stand-alone units (generally run by NGOs, private individuals or institutions), and also units integrated in a district or municipal health system (run by the

government) (Kang, M, Bernard, D., et al., 2005; Johnson, RL, et al., 2003; Toomet, K., Part, K., and Haldre, KA.,2004).

3. School or college-based health services and centres which offers offers preventive and curative health service in or close to the school or college premises (WHO, 2002; Brindis, CD., et al., 2003).
4. Community-based centre, which is a health facility that provides other types services as well. These centres provide health information and also recreation services and help with literacy or numeracy skills. They often have links with nearby health facilities where young people are referred to (WHO, 2002; Kang, M, Bernard, D., et al., 2005; LaVake, S., 2003).
5. Pharmacies and shops selling health products, including condoms and postictal contraception, However, they do not provide health services, for example treatment of sexually transmitted infections. Social marketing programmes exist in many countries which use methods through marketing for promotion of usage of condoms and improving availability (Neukom, J., and Ashford, L., 2003).
6. Outreach information and service provision through the efforts in several countries countries to take the health information including services and products to the marginalised young people (Kang, M., et al., 2005; Burns, A. et al., 2004). The places this interaction and contact may take place is focused on where young people are present e.g. street corners, shopping malls, or bars) in combination with workplaces and schools (Wyn, J., 2000).

Furthermore, on the effectiveness of YFHS services, the International Planned Parenthood Federation (IPPF) guide “Provide: Strengthening Youth Friendly Services” (2008) pointed out whether services are provided in a clinical setting, a youth-oriented site, in

schools or in the community, there are certain essential youth-friendly characteristics for the services;

- Providers should be trained to work competently, sensitively and respectfully with adolescents and young people on their sexual and reproductive health needs.
- Services must be confidential, non-judgmental and private.
- Clinic opening hours should be convenient for adolescents and young people: such times. include late afternoons (after school), evenings and weekends.
- Services should be accessible to all adolescents and young people irrespective of their age, marital status, sexual orientation or ability to pay.
- An effective referral system should be in place.
- Opportunities should be made available for adolescents and young people to be involved in designing, implementing and evaluating the program.
- Services should seek to involve and gain the support of those important in the lives of young people and in the local community, such as partners, parents/ guardians and schools.

The IPPF’s International Medical Advisory Panel (2005) considers that sexual and reproductive rights are fundamental human rights and freedoms, included in several international agreements and treaties. Such rights must be enshrined in national legislations, constitutions and implemented on the ground. IPPF emphasizes youth friendly services requirements to be as follows:

- Are able to effectively attract adolescents, responsively meet their needs, and succeed in retaining these young clients for continuing care.

- Should offer a wide range of sexual and reproductive health services relevant to adolescents' needs. While it is not always possible, attempts should be made to identify and provide the most needed sexual and reproductive health services, including sexually transmitted infection/HIV services, at the same clinic.
- Should include sexual and reproductive health counselling, contraceptive counselling and provision (including emergency contraception), sexually transmitted infection and HIV prevention, counselling and testing, treatment and care, prenatal and post-partum care, sexual abuse counselling, relationship counselling, and safe abortion and abortion-related services (IPPF, 2005).

The IPPF most common models recommended YFHS are; the clinic-based model, youth centre model, and school-based model. Each of the models can adapt the approaches and elements of YFHS that include; community support, youth participation, youth-friendly policies and procedures, youth-friendly staff and friendly environment. However, in all cases each model must put in place a strong and effective referral system for services not available at the facility.

## 2.3 Barriers to the delivery of Youth-Friendly Health Services

---

A range of barriers hinders adolescents and youth's use of health services; such barriers are either related to young people or to service provision. Barriers to young people's access to appropriate health care include a lack of knowledge on the part of the young person, legal or cultural restrictions, physical or logistical restrictions, poor quality of clinical services, unwelcoming services, high cost of services, cultural barriers and gender barriers (WHO, 2002)

Geary, et al. (2014) in rural South Africa examined healthcare workers' perceived barriers to the provision of youth-friendly health services. The barriers to provision reported by nurses were lack of youth-friendly training among staff and lack of a dedicated space for young people. For example, four of the eight existing facilities did not appear to uphold the right of young people aged 12 years and older to access healthcare independently. Breaches in young people's confidentiality to parents were also reported.

In a study conducted to explore the congruence between the views of service providers and young people regarding access to primary health care, Bernard and colleagues (Bernard, D., et al., 2004) highlighted the differing perspectives of the two groups. Young people prioritized confidentiality, embarrassment and lack of knowledge about services, while service providers prioritized structural or systemic issues such as the need for appointments, designated opening hours and cost.

The ACT study in Australia (2011) reported that young people were concerned about confidentiality, embarrassment, lack of awareness about services and lack of service access. Structural factors (such as

cost, transport and opening hours) are also significant barriers to help-seeking where these barriers apply to young people across all socioeconomic gradients.

The Gaza study (2015) about the needs of YFHS summarized the barriers for young people to access the health services being related to cultural and social barriers; feeling of shame and fear from parents, confidentiality concerns and place reputation were the females' concerns. Shame, cost and place reputation were the males' concerns.

## 2.4 YFHS and programmes existing in oPt

Although youth concerns are already on the PNA (Palestinian National Authority) agenda (the Palestinian National Policy Agenda), it is important to add greater nuance and understanding to ensure that the young people are being targeted and supported (UNESCO, 2016; UNFPA, 2017). The range of existing young people services in oPt was identified including those proposed or under construction/development.

The National Youth Conference: "Youth at a Crossroads" held in May 2018 was organized by Juzoor Association and UNFPA and was attended by high-level representatives, both from governmental and international sectors as well as young people. During the conference, the importance of integrating SRH programmes for adolescents in schools was highlighted. It also emphasized the importance of continuing the dialogue between leaders in the education and health sectors in order to implement comprehensive programmes that would allow education systems to include curricular and non-curricular activities, which aim to introduce reproductive and sexual health for adolescents.

Through the MoH, the PNA provides health services to Palestinians under its jurisdiction

in accordance with the Constitution and the Public Health Law. Additionally, the PNA government insurance plan is the principal insurance provider in the PNA run territories. Since the ascendancy of the Hamas government in Gaza, the PNA's MOH no longer serves a governmental function in Gaza healthcare, having been replaced by Hamas. The majority of funding for MoH services emanates from foreign aid and taxes. Public sector spending represents about 32% of health care expenditure in the Palestinian territories.

The only pilot governmental YFHS was established by UNFPA's 5th country programme cycle (2015-2017), which was supported by the Palestinian MoH in close partnership with the Ministry of Education and Higher Education (MoEHE) and relevant national partners within the public health and primary health care services system. The selection of the MoH to establish these services was important in order to institutionalize and include YFHS in the national health system. Before the MoH adopted this concept, UNFPA initiated a long policy dialogue that was part of the 4th programme cycle. All these efforts led to the development of a national protocol in 2015 for YFHS model centre. The model was based on the identified package of services in the 2012 assessment that sought to respond to youth-defined needs and key priorities. Moreover, UNFPA organized a study tour to Morocco for MoH staff in order to fully comprehend and grasp the idea of a successful model for youth-friendly health services.

As the development of the protocol was fully funded, a pilot centre was launched in the Dura Health Directorate where the centre was equipped with the comprehensive package and relevant staff (nurse, doctor, social worker, and receptionist). The model's progress reports for two executive years, 2015 and 2016, indicated success in demand from young people and community members with service delivery for 5,600 young beneficiaries. Unfortunately, this centre was closed due to the end of UNFPA funding after two years of



its services and MoH authorities reiterated that financial constraints were the main reason for closure.

So far, little effort has gone into enabling primary care practitioners to deliver services that are sensitive to young people's needs, and experience is lacking in ways of reaching the adolescents most at risk (Glick, et. al. 2018). The potential of school health services, where available, to contribute effectively to health and development outcomes of school-aged children is underexplored.

NGOs in many countries take part in providing health services that are intended to respond to the needs of adolescents. These initiatives are often small in scale, limited in duration and uncertain in quality while governments provide youth-friendly services, much more needs to be done to make them widely accessible by young people regardless of their socioeconomic circumstances (Anderson, J. and C. Lowen, 2010).

Palestinian Non-Governmental Organisations (NGOs) bankrolled by private benefactors encompasses a sizable portion of the health care economy in the PNA. A World Bank survey found that 11.7% of Palestinians used NGOs most frequently for their health needs. 13.3% of households in the West Bank relied on NGOs compared to 8.1% of households in Gaza. The World Bank report explained that fewer NGOs operated in Gaza than in the West Bank and that Gaza residents were more likely to be classified as refugees and therefore had access to services provided by UNRWA. Palestinians are most likely to visit NGOs when they require mental health counselling, physical therapy and rehabilitation, and medical training and they are least likely to use NGOs for emergency care, routine check-ups, and maternity and paediatric needs.

## **NGOs having youth health programmes**

### ***Palestinian Medical Relief Society (PMRS)***

Founded in 1979 is a non-governmental health and development organisation and its ultimate goal is to ensure quality health for all based on the principles of primary health care (PHC). Since the founding of PMRS in 1979, children and youth have always comprised an essential focus and concern within PMRS primary health care programs.

Based on a comprehensive approach towards health, combining physical, mental and spiritual components, the entry point to achieving high levels of health must be by way of the family, schools, institutions and the society at large. PMRS is dedicated to empowering young people and enabling them to take on an active role in shaping public health awareness and culture. This goal is sought by PMRS through the operation of a number of community-based youth centres located throughout the oPt.

### **Youth centres have provided the platform to carry out various types of activities, including:**

1. Helping young people achieve self-realization by employing their strengths in the process of health, social change and development. The promotion of positive concepts, values and principles is envisaged to encourage healthy behaviours and habits that can lead to the nurturing of active involvement in building the desired future both the individual and the society at large.
2. Providing an environment that encourages young people to acquire necessary knowledge and life skills in a way that fosters the integration of emotional and logical intelligence
3. Empowering young people with different

cognitive disciplines and general rules that regulate social dynamics, with particular emphasis on the Palestinian society, to help them explore its dynamics and structure.

### ***Health Work Committees (HWC)***

Founded in 1985, HWC is a non-governmental health and development organisation. HWC's development programmes for the provision of health services to all segments of the Palestinian population, particularly the poor and the marginalized. HWC's development programmes include Youth Development Program; a community, cultural, and social development programme that provide services to Jerusalemite youth through "Nidal Centre" in the old city of Jerusalem. In addition, the Community Based Rehabilitation Programme (CBR) provides services to people with disabilities in twenty locations in the southern West Bank (Hebron and Bethlehem areas).

### ***The Palestinian Family Planning and Protection Associations (PFPPA)***

Since its establishment in 1964, the Palestinian Family Planning and Protection Association (PFPPA) as a member association of IPPF has worked ceaselessly to promote reproductive and sexual health and rights in the country. They have done this by enlisting the support of influential community leaders, religious leaders, professionals, media agencies and journalists, role models and community volunteers to support their work and vision.

PFPPA enlisted youth volunteers as change agents and peer educators in their community. By training local community-based organisation representatives, they have also built the skills and knowledge of community leaders to deliver positive comprehensive sexuality education (CSE)

messages in their organisations and increase awareness in their communities.

PFPPA established YFHS centre in Hebron for the last 10 years implementing the IPPF YFHS guidelines and targeting young people (15-24) years where around 3500 youth have visited the centre for two times or more in 2018. Many of these youth are leaders and peer educators within their communities as well as advocates for RSHR, gender and life skills issues (personal interview with YFHS coordinator). This centre is considered a success story that needs to be replicated in many other service delivery points.





# Chapter III

# Research Methodology

# Research Methodology

This chapter will describe the research methods utilized, construction of the study tools, sample selection, data collection and data analysis procedures, study settings, accessibility, and ethical consideration and study limitations.

## 3.1 Study design

This descriptive exploratory study utilized quantitative and qualitative methods for data collection in a complementary manner to comprehensively cover all research components. The study aims to gain information about young people's health problems and needs and their preference to receive health information and services and to examine the stakeholders' readiness for the feasibility of establishing YFHS centres within the targeted locations. The target groups are young people (15-29) years and professional stakeholders' representatives from Jerusalem, West Bank and Gaza. The UNFPA programme team and study researchers designed the study, which received approval prior to its initiation.

## 3.2 Development of the research tools

A structured questionnaire (see Annex 2) was developed for the quantitative data, and semi-structured questionnaires (see Annexes 3A, B, and C) for in-depth interviews and focus group discussions with different groups as will be outlined below.

### 3.2.1 Development of the questionnaire

The questionnaire was based on the study's objectives and concepts. The questionnaire was adapted and modified from national and international studies including the Assessment of Youth Friendly Health Services Needs in West Bank, (PCBS, 2011), the PCBS Youth Survey (2015) and ACT Healthy Young People Feasibility Study Final Report (November 2011). The questionnaire examined the young people perception, knowledge, and practices of selected issues and based on five categories: 1) Socio-demographic characteristics of young people; 2) Young people's health and well-being; 3) Sexual and reproductive health issues (SRH); 4) Risk behaviours and 5) Questions related to YFHS in terms of accessibility to and availability of health information and services and their preferences as to location, time, gender and costs (please refer to Annex 2 for the questionnaire and the informed consent attached with each questionnaire).

### 3.2.2 The questionnaire's validity and reliability

The content's validity was guaranteed when experts in research and health including the deans of the targeted universities and UNFPA revised and approved the questionnaire. In addition, in order to obtain opinions from the youth themselves, members from Y-Peer Educational Network were consolidated in the development phase.

According to feedback from everyone involved, the researcher made the changes and modifications required where rewording, adding or deleting some items as needed. Pilot testing was conducted consisting of 22 questionnaires filled by representatives of the target groups, questions, and notes made were taken into consideration. Also, the time required to complete the questionnaire was measured, which ranged from 20 to 30 minutes.

The questionnaire was tested for Cronbach coefficient alpha reliability through SPSS analysis. The tool was developed in English first, and then translated into Arabic to collect the data and ensured reliability prior to its distribution to target groups.

### 3.2.3 Development of qualitative data tools

The qualitative data questions were also based on modification and adaptation of national and international tools including the ACT Healthy Young People Feasibility Study Final Report (2011), Youth Needs Assessment for YFHS in Gaza (2015) and many other studies. The qualitative collection included two types of methodologies; 1) in-depth interviews with a long list of open-ended questions regarding youth health needs and suggested solutions from professional stakeholders' representatives of academic and service institutions. 2) open-ended questions aimed at obtaining detailed information through FG discussion with young people attending health and social service institutions and 3) similar open-ended questions aimed at obtaining detailed information through FG discussion from service providers to complement quantitative data responses.

## 3.3 The study settings

The following institutions were selected to obtain data from stakeholders and young people:

- Azhar University – Gaza (AUG): a Palestinian, public, non-profit and independent higher education institution established in 1991. The University encompasses 12 faculties, with 16,000 undergraduate students and 700 graduate students. Like most educational institutes in Gaza, the university is segregated by sex<sup>5</sup>.
- Al-Quds University- East Jerusalem is a Palestinian university with campuses in Jerusalem, Abu Dis, and al-Bireh. It is a public, non-profit and independent higher education institution founded in 1984. The University encompasses 12 faculties, with 13,000 undergraduate students and 2000 graduate students<sup>6</sup>.
- Arab American University - Jenin (north West Bank ) is a private Palestinian joint venture university based in the cities of Jenin and Ramallah. It was founded in 2000 in collaboration with California State University, and Utah State University (USU) in Logan. The University encompasses nine faculties, with 9735 undergraduate students and 375 graduate students<sup>7</sup>.
- Hebron University - south West Bank is a non-profit, public university in the city of Hebron, West Bank founded. The University encompasses nine faculties, with 10,611 undergraduate students and 379 graduate students<sup>8</sup>.
- Sharek Youth Forum focuses on the development of young people to become engaged, employable, and active citizens. Today, Sharek is a national and internationally recognized platform for youth-to-youth, youth –to-community, and youth-to-children interaction; however, they are not engaged in health services

5 Al-Azhar University, [https://en.wikipedia.org/wiki/Al-Azhar\\_University](https://en.wikipedia.org/wiki/Al-Azhar_University)

6 Al-Quds University, [https://en.wikipedia.org/wiki/Al-Quds\\_University](https://en.wikipedia.org/wiki/Al-Quds_University)

7 Arab American University, [https://en.wikipedia.org/wiki/Arab\\_American\\_University](https://en.wikipedia.org/wiki/Arab_American_University)

8 Hebron University, [https://en.wikipedia.org/wiki/Hebron\\_University](https://en.wikipedia.org/wiki/Hebron_University)

other than sometimes offering health awareness sessions sometimes<sup>9</sup>.

- Palestinian Medical Relief Society and Health Work Committees as service institutions were targeted for their health service providers and beneficiaries (please refer to 2.4 in the literature review chapter for more details about them).

### 3.3.1 Participant's selection for qualitative and quantitative data

For qualitative data, the study purposefully selected professional stakeholders of selected academic and service institutions for in-depth interviews including four universities and four NGOs. The university stakeholders were the deans or heads of public health schools, nursing schools and/or students' affairs represented by Hebron University and Arab American University of Jenin in West Bank, Al-Quds University in East Jerusalem and Al-Azhar University in Gaza.

The selected Palestinian NGOs are large organisation focusing on health and social development in general and on young people. They are: the Palestinian Medical Relief Society (PMRS), Health Work Committees (HWC), UNRWA, Sharek Youth Forum in West Bank and Gaza. Selected service providers of these institutions were targeted to have their perception of the services they provide.

The study participants included between 100 university students selected from each of the four universities mentioned above. The selection was conducted by a purposive convenient sampling approach<sup>10</sup> by selecting participants from each university campus regardless of their field of study. Another

group of young people that sought health services from the service institutions were purposefully selected to gain their perceptions of the services they received.

## 3.4 Accessibility and ethical considerations

Gaining access to professional stakeholders was sought on a voluntary basis. UNFPA facilitated the accessibility to obtain information from various target groups. A contact list was provided by UNFPA supported by a letter of endorsement for the identified academic and service stakeholders. Access to university students was granted from interviewed deans at the universities, and access to young people visiting the health service institutions was granted from their leaders emphasizing ethical considerations prior to collecting data from all targeted groups.

The data collectors went directly to young people/university students. They explained the purpose of the study and requested their participation in interviews. The university students were given an informed consent form with the questionnaire as another ethical safeguard where anonymity and confidentiality are ensured. They were also informed that the information obtained would be confidential and used only for the purpose of the research.

## 3.5 Data collection procedures

### 3.5.1 The quantitative data collection

The quantitative data collection from university students and as referred to young people was obtained after training of the data collectors and the statistician on the questionnaires. There were five data collectors; three in West Bank, one in

9 Sharek Youth Forum, <http://www.sharek.ps/>

10 *Is a type of nonprobability or non-random sampling where members of the target population that meet certain practical criteria, such as easy accessibility, geographical proximity, availability at a given time, or the willingness to participate are included for the purpose of the study. Dörnyei, Z. (2007). Research methods in applied linguistic; New York: Oxford University Press.*

Jerusalem, and one in Gaza as well as one field supervisor to double-check the data collection processes. The principal researcher of the study coordinated data collection activities with the research team to have a consensus on obtaining the data from respondents as close as possible. To this end, they explained the purpose of the data collection tools and encouraged all participants to voice their opinions and share in the study.

### 3.5.2 The qualitative data collection

The qualitative data collection included eight in-depth interviews with academic and service professionals' stakeholders, four FG discussions with service providers and eight FG discussions with young people beneficiaries from these services in the four targeted locations (four in West Bank and four in Gaza). Some of the responses were documented by using the same phrases of the participants through the text.

## 3.6 Data analysis procedures

### 3.6.1 Quantitative data analysis

After the data collection was completed, the compiled data was assembled, cleaned, and analyzed using the Statistical Package for Social Science (SPSS version 20). 350 questionnaires were collected from the students at the four targeted universities, 25 were discarded due to incompleteness. The data results were compiled into tables and their interpretation presented into narrative style in the analysis and discussion chapters.

### 3.6.2 Qualitative data analysis

A thematic analysis approach was utilized guided by the objectives and key questions of this research study. All data collected were assembled (the field notes, transcripts, personal comments) and thoroughly read

until the investigator became intimately familiar with them. This process facilitated the identification of the themes by clustering and coding the statements expressed by the respondents under each question. This process guided the researcher to describe and discuss the results explicitly and to develop recommendations. The findings were consequently compared and confronted with existing literature and other theoretical perspectives of the proposed study.

## 3.7 Study limitations

- Data collection was not an easy task and was more time-consuming than expected. Al-Azhar University expressed some reservation on the questionnaire and did not allow the data collector to go into the campus for data collection. Therefore, the data collector sat at the campus entrance to collect data from the students which may have impacted the provided answers and anonymity.
- There were no responses from UNRWA officials in West Bank although two officials were approached and asked for their contribution to the study. But in Gaza, the data collector could reach some young people who attend UNRWA services and he was able to get an FG discussion with eight young people.
- An-Najah University objected to the study because they were conducting a similar study and data collection from students was in process at the time this study was proposed. Therefore, the study researcher made some alterations as the administrative committee agreed to have the data from AAUJ students, this change delayed the data collection for this study.



# **Chapter IV**

# **Analysis and Findings**

# Analysis and Findings

## Introduction

This chapter presents the analysis and interpretation of the data results. For the quantitative data, a total of 325 questionnaires were filled in by young participants. Descriptive analysis obtained for frequencies and percentages for each item under each subcategory of the questionnaire presented into tables for discussion of the results in a clear and simple manner. For the qualitative data, thematic analysis of the data obtained from; academic and service professional stakeholders, service providers and young people receiving health services will be presented too. Both data analysis and discussion guided the researcher to develop conclusions and recommendations.

## 4.1 Statistical analysis and results from questionnaire

To achieve the first objective of the study, “identify key issues and needs of young people (15–29 years) in East Jerusalem, West Bank and Gaza for youth-friendly health services and their preference of settings and approaches. The questionnaire examined five categories; 1) Socio-demographic characteristics of young people; 2) Young people’s health and well-being; 3) Sexual and reproductive health issues (SRH); 4) Risk behaviours; and 5) Questions related to YFHS.

### 4.1.1 Socio-demographic profile of young people

The profile of the participants’ socio-demographic variables was obtained for their location, age, age at marriage and age at giving birth to first child, family type, marital status and spousal relationship, work and education, and the average income of households (NIS) per month.

**Sample distribution and participants’ gender (Table 1):** A total of 325 young people from four universities participated in the research, out of which 57.5% (187) were females and 41.2% (131) males, and 2.2% did not indicate their sex. 21.5% of the participants attended Al-Quds University, 23% Hebron University, 22.2% AAU in Jenin, and 31.1% Al-Azhar in Gaza.



**Table 1: Place of residence and gender**

Place of residence (Number of respondents Total No. 325)			Participants' gender		
	No.	%		No.	%
East Jerusalem- Al-Quds university	70	21.5	Male	131	40.3
South West Bank- Hebron University	75	23	Female	187	57.5
North West Bank -AAU in Jenin	72	22.2			
Gaza - Al-Azhar University	101	31			
Missing	7	2.1	Missing	7	2.2
<b>Total</b>	<b>325</b>	<b>100</b>	<b>Total</b>	<b>318</b>	<b>100</b>

**Participants' age and their level of university education enrolment (Table 2):**

The age of participants ranged from 15 to 29 years of age, with the majority being 20 years old. 57.8% were between 20-24 years, 34.8% 15-19 years and 5% between 25-29 years. This explains the large number of 92.6% that were enrolled in undergraduate studies from a variety of faculties and 5.5% were enrolled in graduate studies.

**Table 2: Participants' age and level of university education enrolment**

Age of participants			Level of University Education		
	No.	%		No.	%
15-19 years	113	34.8	Undergraduate Students	301	92.6
20-24 years	188	57.8	Graduate students	18	5.5
25-29 years	16	4.9			
Missing	8	2.5	Missing	6	1.8
<b>Total</b>	<b>325</b>	<b>100</b>	<b>Total</b>	<b>319</b>	<b>100</b>

**Marital status and age at marriages (Table 3):** A total of 79.2% (258) of the study participants were single and 17.8% (58) married (12.6% - 41 females and 5.2% -17 males). Out of the 17.8% who were married, 2.5% were divorced, 0.6% separated. For the age of marriage, 7.1% got married between the ages 15-19, of those 0.9% (three people) were married under the age of 18 years, 8.6% between the ages 20-24 years and 2.1% between 25-29 years. The youth marriage rate among university students was low as well as the level of early marriage which may relate to the fact of people getting married later in combination with the frequency of early marriages is reducing.

**Table 3: Marital status and age at marriage**

Marital status			Age at marriage		
	No.	%		No.	%
Single	258	79.2	15-19 years	23	7.1
Married	48	14.7	20-24 years	28	8.6
Divorced	8	2.5	25-29 years	7	2.1
Separated	2	0.6			
<b>Total married</b>	<b>58</b>	<b>17.8</b>	<b>Total responded</b>	<b>58</b>	<b>17.8</b>
Missing	10	3	Missing	267	82.1
<b>Total</b>	<b>325</b>	<b>100</b>	<b>Total</b>	<b>325</b>	<b>100</b>

**Spouse relationship and age of women at the birth of their first child (Table 4):**

Out of the 17.8% (58 participants) in the married population, 11.1% got married to a family member; 3.4% with a first cousin, 2.3% second cousin, and 5.4% to a distant relative while 7.1% married a person that is not related to them. Although the number was small, the data reflects that marriage within the family still exists. Forty-one females had children<sup>11</sup> and their age at having the first child was as follows: 2.7% were 19 years, 0.6% was lower than 18 years, 8.2% were between the ages 20-24 and 1.5% were between 25-29 years of age.

**Table 4: Spouse relationship and age of women when first child was born**

Spouse relationship			Age of women when first child was born		
	No.	%		No.	%
First cousin	11	3.4	15-19 years	9	2.7
Second Cousin	7	2.3	20-24 years	27	8.2
Distant relative	17	5.4	25-29 years	5	1.5
Unrelated	23	7.1			
<b>Total married</b>	<b>58</b>	<b>17.8</b>	<b>No. of women delivered</b>	<b>41</b>	<b>12.6</b>
Missing	267	82.1	Missing	284	87.4
<b>Total</b>	<b>325</b>	<b>100</b>	<b>Total</b>	<b>325</b>	<b>100</b>

**Family type and Number of household (HH) members (Table 5):** Around 90% of the participants' households were 'nuclear' families, 4.6% were extended families and 5% responded to the others category which included one-person family, currently living on the university campus and single-headed family. The household members of participants' families ranged from (1–18) with an average of six members per family. Around 33.3% of the households had (6-10) members with the majority of seven to eight members, 14.5% had (1-5) with the majority of five members, and 3.3% have (11-15) with a majority of 11 members.

<sup>11</sup> The question was only addressed to females as written and questioned in Arabic language  
 "كم كان عمرك عندما انجبت أول طفل"

**Table 5: Types of families and Number of household members**

Type of families			Number of HH members		
	No.	%		No.	%
Nuclear families	294	90.1	1-5	47	14.5
Extended families	15	4.6	6-10	108	33.3
Others	16	5	11-15	11	3.3
			16-18	1	0.3
			No. of responded for HH	167	51.4
			Missing	158	48.6
Total	325	100	Total	325	100

**Work status and household income (Table 6):** Out of the total population, 37.2% (121 participants) reported working, including 1.8% (6 participants) had a full-time job outside their university studies, noting that there are participants enrolled in offered part-time master programs. About 14.8% (48 participants) had part-time jobs and 20.6% (67 participants) were not working at the time of data collection. Based on the results that are focused on university students, the population was expected to have a more minimal rate of youth working. For the type of work they do, 71 participants reported their work as; 5.8% work in an office or business, 5.5% were self-employed and/or work in shops/supermarkets, 3.1% were professionals and office workers, 4.6% labourers and 2.8% worked for others such as baker, carpenter etc.

Only 59.3% (193 participants) answered the question on households' income in NIS per month that NIS ranged from 400 to 8000. Around 16% of households' income ranged from 400 to 1000, followed by 13% with a range of 1100-2000, 19.1% of households had an income range from (2100-4000), 7.4% from 4100-6000, followed by 4.6% with an income ranging from 6100-8000.

According to the national poverty concept, (based on the official definition of poverty in 1997) poverty is "absolute and relative features based on balancing the basic needs of the household of five members including two adults and three children." The poverty line of the reference family reached 2,470 NIS and the extreme poverty line reached 1,974 NIS (The Palestinian Youth Survey, 2015). The study finding indicates that the rate of poverty is higher than the general youth survey in 2015 with less income than the defined poverty line.

**Table 6: Work status, type of work, and range of HH income**

Work status			Work type			Range of HH income		
	No.	%		No.	%		No.	%
Full time	6	1.8	Self employed	18	5.5	400-1000	48	16.5
Part time	48	14.8	Labourer	15	4.6	1100-2000	42	12.9
Currently unemployed	67	20.6	Professionals	10	3.1	2100- 4000	62	19.1
			Work in office or	19	5.8	4100- 6000	24	7.4
			Others	9	2.8	6100-8000	17	5.2
<b>Total working</b>	<b>121</b>	<b>37.2</b>	<b>Total for type of work</b>	<b>71</b>	<b>21.8</b>	<b>Total responded</b>	<b>193</b>	<b>61.1</b>
Total not working	204	62.8	Students	254	78.2	Missing	132	38.9
Total	325	100	Total	325	100	Total	325	100

### 4.1.2 Knowledge, attitude and practices toward health and well-being

Participants’ feelings about their health status and their level of knowledge about health (Table 7): For the first question “How do you feel about your health status?”, more than half (50.5%) of participants felt good, 36% felt excellent, 10.4% felt fair and 1.8% felt bad indicating a healthy population as it is expected. The second question “How do you consider your level of health information?” Around half (48.6%) of the participants consider their level of health information good, 23.6% consider their level of health information excellent and 25.5% consider their level of health information fair.

**Table 7: Feelings about health status and knowledge about health**

1. How do you feel about your health status?			2. Do you consider your level of health information?		
	No.	%		No.	%
Excellent	117	36.0	Excellent	75	23.1
Good	164	50.5	Good	158	48.6
Fair	34	10.5	Fair	83	25.5
Bad	6	1.8	Bad	2	0.6
Missing	4	1.2	Missing	7	2.2
Total	325	100	Total	325	100

**Perception of the concept of health (Table 8):** The majority of the participants (83.7%) were able to identify the concept of health as “the optimal state of mental, physical and social well-being and not only being free from diseases”. This showed that they had knowledge on this matter 10.8% identified the concept of health as “having no physical diseases”, 3.4% did not know and 0.3% considered another category. The responses here complement the level of feeling healthy as indicated in the previous question.

**Table 8: Perception of the concept of health**

3.	Perception of the concept of health	No.	%
	Having no physical disease	35	10.8
	The optimal state of mental, physical and social well-being and not only being free from diseases	272	83.7
	Other	3	0.9
	Don't know	11	3.4
	Missing	4	1.2
	Total	325	100

**Participants' perception of the major health issues that young people may face (Table 9):** The participants were asked to check more than one option if applicable regarding faced health issues. Around 50% (14.8% males vs. 35% females) perceived psychological/emotional problems as a major health issues that young people may face. Furthermore, 34.2% (25.9% males vs. 8.3% females) highlighted problems related to risky behaviours, while 20.3% (5.5% males vs. 14.8% females) stressed on problems of nutrition and obesity, 17.2% (1.53% males vs. 15.7% females) mentioned reproductive and sexual health problems. On another note, 11.4% (5.2% males vs. 6.2% females) checked chronic illnesses, 8% (3% males vs. 5% females) skin diseases, 1.8% (0.6% males vs. 1.2% females) of participants did not know and 1.8% (1.2% males vs. 0.6% females) reiterated on the other category such as smoking, drug use and mood swings.

The results indicate that females rated higher than males with marked differences in psychological/emotional problems, SRH issues, problems of nutrition and obesity while males rated much higher than females on issues related to risky behaviours. The results of this study are very congruent with the youth survey (2015) results regarding their perception of the major health issues that youth may face; mental health, sexual health, alcohol and other drug use, nutritional problems and little physical activity. This means, there is a need to have comprehensive coordinated efforts to work on these problems in a preventive method and in parallel to treatment and rehabilitation of these problems.

**Table 9: Perception of the major health issues that young people may face**

4. What is your perception of the major health issues that young people may face?	Males		Females	
	No.	%	No.	%
Chronic diseases	17	5.2	20	6.2
Problems related to risky behaviours	84	25.9	27	8.3
Psychological/ Emotional problems	48	14.8	114	35
Skin diseases	10	3	16	5
Reproductive and sexual health problems	5	1.53	51	15.7
Problems of nutrition and obesity	18	5.5	48	14.8
Don't know	2	0.6	4	1.2
Others	4	1.2	2	0.6

**Participants' practices and frequency of practicing sports (Table 10):** As for their level of engagement in sports and physical activity, 50.2% (163 participants) reported that they practiced sports, while 48% (156 participants) do not. Of those practicing sports, 45.5% (34.4% males vs. 11.1% females) responded to the question regarding the frequency of their engagement in sports: 21.6% of males and 8.6% of females practiced less than three times per week, while 12.8% of males and 2.4% of females practiced more than 3 times per week. The results indicate that participants practice sports at a rate very congruent with the PCBS Youth Survey (2015) that reported a quarter of youth exercised daily and the rate of exercising females reached half of males. Promoting a healthy lifestyle for young people need continuous efforts by encouraging youth to be more involved in sports either on their own or through participation in the available youth sports clubs around their place of residence.

**Table 10: Frequency of sports practiced per week**

5. Number of times sports activities practiced per week	Males		Females	
	No.	%	No.	%
Less than 3 times	70	21.6	28	8.6
3 times or more	42	12.8	8	2.4
<b>Total number practicing sports</b>	<b>112</b>	<b>34.4</b>	<b>36</b>	<b>11</b>

Dietary habits (Table 11): Some 50% of the participants stated that they followed healthy eating habits and ate three meals a day; 21.4% reported eating junk food, 14.5% eat a balanced diet, and 12.3% are on a diet to keep in shape.

**Table 11: Dietary habits**

5.	What nutrition and dietary habits do you generally follow?	No.	%
	Eat three meals a day	158	49.7
	Eat junk food	68	21.4
	Eat balanced diet	46	14.5
	I'm on diet to keep shape	39	12.3
	Others	14	4.4
	Missing	7	2.2
	Total	325	100

**Nutritional health problems related to dietary habits (Table 12):** A total of 55.4% (180 participants) reported not having any health problems related to dietary habits and nutrition, while 41.2% (16.5% of males and 24.7% females) reported to having problems related to nutrition and dietary habits. The problems identified are: 18.5% (5.5% males vs. 13% females) overweight, 7.4% (2.7% males vs. 4.6% females) underweight, 5.2% (2.8% males vs. 2.4% females) anaemia, 2.8% (0.9% males vs. 1.9% females) obesity, 1.8% (0.6% males vs. 1.2% females) other problems, (2 reported bulimia and 2 reported glucose problems) and 5.5% didn't know. These results suggest that there is a need to promote among university students a healthy lifestyle including physical activity and nutrition education.

Table 12: Nutritional health problems related to dietary habits

6. Do you have any health problems related to dietary habits and nutrition?			If you have any health problems related to dietary habits and nutrition yes, what are they?				
	No.	%		Males		Females	
				.No	%	.No	%
Yes	134	41.2	Underweight	9	2.7	15	4.6
No	180	55.4	Overweight	18	5.5	42	13
			Obesity	3	0.9	6	1.9
			Anaemia	9	2.8	8	2.4
			Don't know	13	4	5	1.5
			Others	2	0.6	4	1.2
			Total	54	16.5	80	24.7
			Total all	134 m/f		41.2	

### 4.1.3 Knowledge, attitude and practices toward sexual and reproductive health issues

Health problems related to pubertal changes (Table 13): Some 54.2% of participants reported yes to having health problems versus 45.8% not having health problems. The participants were asked to check more than one option if applicable for their health problems; 26.2% (85 females) reported problems of pain during menstrual cycle related to pubertal changes, 25.5% reported acne, followed by 24% mood changes. To a lesser extent 12.6% reported anxiety and 11.7% reported depression where this is expected for females as normal physiological changes.

Table 13: Health problems related to pubertal changes

1.	Type of pubertal changes health problem	No.	%
	Pain during menstrual period	85	26.2
	Depression	38	11.7
	Acne	83	25.5
	Anxiety	41	12.6
	Mood changes	78	24.0

Having heard about SRH issues (Table 14): Only 33.5% (109 participants) had heard about SRH issues, 41.8% said they have some information, and 20.6% reported not having heard about SRH. Such responses indicate the gap in young people being exposed to SRH topics and discussions, and meeting their need to receive SRH health services and information.

**Table 14: Participants that heard of SRH issues**

2.	Have you heard/know about SRH health	No.	%
	Yes	109	33.5
	Some Information	136	41.8
	No	67	20.6
	Missing	13	4.0
	Total	325	100

**Participants’ knowledge for the definition of SHR (Table 15):** The participants were asked to choose to check more than one option if applicable to the definition of SRH. About 41.8% chose “Is a state of well-being physically, psychologically and socially in all matters relating to the reproductive system, its functions and processes, not merely the absence of disease or infirmity.” Some 40.6% picked “Means people’s ability to enjoy a satisfying and safe sexual life, and the ability to have children, and the freedom to decide when and how often to do so”. Further, 28.3% reported the definition “Means the full right of men and women to enjoy their reproductive and sexual health and participate in decision-making regarding this matter”, 21.2% “All have the right to the highest attainable standard of sexual health and the access to sexual and reproductive health services,” while 13.8% did not know.

**Table 15: Participants knowledge for the definition of SHR**

3.	What do we mean by sexual and reproductive health?	No.	%
	Is a state of well-being physically, psychologically and socially in all matters relating to the reproductive system, its functions and processes, not merely absence of disease or infirmity	136	41.8
	Means people’s ability to enjoy a satisfying and safe sexual life, and the ability to have children, and the freedom to decide when and how often to do so	132	40.6
	Means the full right of men and women to enjoy their reproductive and sexual health and participate in decision-making regarding this matter	92	28.3
	All have the right to the highest attainable standard of sexual health and access to sexual and reproductive health services	69	21.2
	Do not know	45	13.8

**Having heard about contraceptives (Table 16):** Some 55.7% had heard about contraceptives, 30.5% sometimes heard of them and 11.7% had not heard about them. Such responses indicate that university students are aware of contraceptives based on the majority answered “yes” and sometimes leaving small percentages not knowing about them. These results indicate more information is needed on this matter since it is very fundamental within family planning.

**Table 16: Participants that heard of contraceptives**



4.	Have you ever heard about contraceptives?	No.	%
	Yes	181	55.7
	Some information	99	30.5
	No	38	11.7
	Missing	7	2.2
	Total	325	100

**Participants' knowledge about contraceptives and its methods (Table 17):** When asked, "Do you know what the types of contraception are?", 78.6% said "yes" vs. 21.4% said "no". The participants were asked to choose more than one option if applicable on the methods of contraceptive used, 62.8% know about pills, 53% know about condoms, 41% for natural methods, 34% for injectables, and 19.4% for surgical intervention. Such responses indicate that young people have some degree of information about FP methods, but that need to be further promoted and accessible.

**Table 17: Participants' knowledge about contraceptives and its methods**

5	Contraceptive methods	No.	%
	Hormonal methods (pills or oral contraception)	204	62.8
	Hormonal methods (injectables)	111	34.2
	Mechanical methods (male and female condoms)	172	53
	Surgical intervention	63	19.4
	Natural methods	133	41
	Emergency contraceptives	77	23.7

Participants' knowledge about the usefulness of condoms (Table 18): A total of 47.7% answered "yes" to "Do you know that male condoms are used as a mean of STIs protection besides its birth control role?", 24.6% have some information and 30% did not know. The result indicates that university students are to an extent aware of male condoms use for protection from STIs, yet more information is needed on this matter.

**Table 18: Participants knowledge of the usefulness of condoms**

6	Do you know that male condoms are used as a mean of STIs protection besides its birth control role?	No.	%
	Yes	155	47.7
	Some Information	80	24.6
	No	81	24.9
	Missing	9	2.8
	Total	325	100

**Premarital sexual relationships (Table 19):** Some 14.2% (46 participants) answered

“yes” to the question “Do you know if any of your friends have or had premarital sexual relationships”, and 81.8% reported that they did not know. The number of participants reporting to about premarital sexual relationships plays an important role in a conservative culture, as in Palestine, since access to services and information is very limited and stigmatized for unmarried young people. Therefore there is an unmet need, particularly for people who are sexually active before marriage<sup>12</sup>.

**Table 19: Premarital sexual relationships**

7	Do you know if any of your friends have or had premarital sexual relationships?	No.	%
	Yes	46	14.2
	No	266	81.8
	Missing	13	4.0
	Total	325	100

**Participants’ knowledge about STIs transmission (Table 20):** A total of 52% (169 participants) answered “yes” to the question “Do you know how STIs can be transferred to others” and 42.8% said “no”. Further to this question, they were asked “How STIs can be transferred”, 41% of the total population responded to this part of the question and 59% did not respond. Of those that responded, 20% indicated that STIs are transferred through sexual relationships, 9.2% body fluids, 4.9% homosexuality<sup>13</sup>, 3.7% cross infection and 3.1% for blood transfusion. These results are alarming when 42.8% of youth do not know how STIs can be transferred to others and 14.2% of experienced premarital sexual relationships (based on the lack of access to services and information about FP). This issue requires improving access to awareness and service programs.

**Table 20: Participants knowledge about STIs transmission**

8	How STIs can be transferred	No.	%
	Homosexuality	16	4.9
	Sexual relationships	65	20.0
	Transfusion of contaminated blood	10	3.1
	Cross Infection	12	3.7
	Body fluids	30	9.2
	Total responses	133	40.9
	Missing	192	59.1
	Total	325	100

12 This question was integrated based on a detailed discussion held by the management committee of the study to explore the issue of access to services and information, since it is an essential part of SRHR. Regarding confidentiality issue, the questionnaire was anonymous and the question itself was indirect “Do you know if any of your friends has or had premarital sexual relationships”.

13 Homosexuality is perceived by young people as one of the modes of STIs transmission. It was included as an option in order to map out the knowledge and perceptions among the participants.

**Participants or their friends suffered or are still suffering from STIs (Table 21):**

Some 12% (39 participants) answered “yes” to the question “Have you or any of your friends ever suffered or are still suffering from STIs?”, while 85.5% answered “no”. Further to this question, they were asked “What type of STIs you or your friends have/had?”. Respondents were given the option to fill in more than one option, 47 responses were obtained to which 5.5% indicated Hepatitis B, 3.7% Candida, 3.4% gonorrhoea, 1.5% syphilis and 1.5% HIV.

**Table 21: Participants or their friends suffered or still suffering from STIs**

9	The type of STIs	No.	%
	Candida	12	3.7
	Hepatitis B	18	5.5
	Gonorrhoea	6	1.8
	HIV/AIDS	5	1.5
	Syphilis	5	1.5
	Others	-	-

**Participants seeking awareness and counselling regarding SRH issues (Table 22):**

The participants were asked to choose more than one option on this question if applicable. There were 231 people who chose at least one option to the question “Who did you seek awareness and counselling regarding sexual and reproductive health matters from?” and 94 participants responded that they did not seek help. For those that sought awareness and counselling, 33.8% did so from the university, 28.6% from mothers, 27% from social media, followed by 15% from older siblings, 12% from health professionals, 12.3% from a health facility, and the lowest percentage 8.3% came from fathers. The fact that health facilities and health providers received among the lower percentage among other sources used, requires attention of stakeholders to take actions and find ways and methods to reach young people and build up the trust in providing services and information of high-quality and confidential.

**Table 22: Participants seeking awareness and counselling regarding SRH issues**

10.	Who did you seek awareness and counselling regarding sexual and reproductive health matters from?	No.	%
	Mother	93	28.6
	Father	27	8.3
	Older sibling	49	15.1
	University	110	33.8
	Health professionals	39	12.0
	Health facility	40	12.3
	Social media	88	27.1
	Others	1	0.3
	Did not seek	94	28.9

**Participants' use of social media and the times used to seek health and SRH information (Table 23):** About 48% of participants answered “yes” and 49.5% answered “no” to the question “Do you use social media to have information related to health in general and SRH in specific?”. Furthermore, they were asked for the frequency of their social media use; 8% used social media from one to three hours a day, 4% for less than five hours per week, 3.7% for five hours or more per week and 31.1% sometimes they used social media. The study participants used social media less than the Palestinian general youth population when compared with 69.7% as indicated in PCBSs general youth survey (2017).

**Table 23: Participants' use of social media and frequency to access health and SRH information**

11.	Numbers of times	No.	%
	1-3 hours and more daily	26	8.0
	Less than 5 hours weekly	13	4.0
	5 hours and more weekly	12	3.7
	Used sometimes	101	31.1
	Total	152	46.8
	Missing	173	53.2
	Total	325	100.0

**Participants' perception of SRH education and counselling benefits (Table 24):** The participants were asked to choose more than one option on this question “Do you think that education and counselling about sexual and reproductive issues can help individuals to...?”. Some 33.8% chose “develop positive attitudes and maturity toward sexual and reproductive issues”, 28.6% “gain correct health information related to the reproductive system and sexual behaviour”, 15.1% “protect young people from incorrect sex experiences” and 8.3% indicated to “be encouraged to improve and sustain their sexual desires and motivation.”. This explains that university students have a certain level of knowledge on SRH issues in comparison to for example younger age groups. Further measures are needed and particularly regarding promoting and disseminating knowledge and information to all young people taking into consideration age and sex.

**Table 24: Participants perception of SRH education and counselling benefits**

12	Did you seek awareness and counselling regarding sexual and reproductive health matters to ...?	No.	%
	Gain correct health information related to reproductive system and sexual behaviour	93	28.6
	Be encouraged to improve and sustain their sexual desires and motivation	27	8.3
	Protect young people from incorrect sex experiences	49	15.1
	Develop positive attitudes and maturity toward sexual and reproductive issues	110	33.8

Within this conservative traditional Palestinian-Arab culture that prevents and limits open discussion of SRH, the university student participants, and their responses indicated they had some knowledge on some issues of SRH in comparison to others. Such clear results in the responses will allow key actors including policymakers as well as funders and health care providers to launch comprehensive SRHR programmes to promote and strengthen young people’s knowledge and practices regarding these matters. This could be integrated either within their studies or through extra-curriculum programmes or by facilitating the establishment of YFHS within their education facilities

#### 4.1.4 Attitudes and practices towards risk-taking behaviours

This section will analyze young people’s responses regarding risky behaviours, such as smoking, drinking alcohol, illegal drugs use, violence, and seeking help behaviours for these problems

##### **Smoking among participants, age of initiation and type of smoking (Table 25):**

Some 28% of the population (91 participants) were smoking, while 69.5% were not. For the smoking group, only 17.2% responded to the question “At what age did you start smoking?” of those; 6.1% started smoking between 13 and 16 years, 9.9% between 17 and 19 years, and 1.2% started smoking at 20-21 years. As for the type of smoking, although there are multi-choice responses given to participants; 16.6% reported cigarettes and hookah each and 0.9% reported hashish.

**Table 25: Smoking among participants, age of initiation and type of smoking**

1. Smoking behaviors			Age at initiation smoking			What type of smoking you practice		
	No.	%		No.	%		No.	%
Smokers	91	28.0	13-16 years	20	6.1	Cigarettes	54	16.6
Non-smokers	226	69.5	17- 19 years	32	9.9	Argilah/ hookah	54	16.6
Missing	8	2.5	20-21 years	4	1.2	Hashish	3	0.9
Total	325	100	Total responses	56	17.2			

**Alcohol drinking and frequency of drinking (Table 26):** A limit of 6.8% (22 participants) responded “yes” to drinking alcohol and 89.8% do not drink. For the drinking group, only 5.5% responded to the question “How often do you have a drink containing alcohol?”. Of those; 2.5% drank 2-4 times a month, 1.8% once a month or less, 0.9% 2-4 times a week, and one person drinks daily.

The risky behaviours among the study participants are much lower than Glick, et. al. (2018) study results where 22.4% of males and 11.6% of females aged (20-24) years

reported trying alcohol and 10.5% of males and 4.3% of females reported trying drugs. This explains that university students might be aware of the consequences of risky behaviours as they smoked less and used less alcohol and drugs in combination with socio-cultural norms and traditions existing in the Palestinian society affecting the consumption.

**Table 26: Drinking alcohol by participants and frequency of drinking**

2. Alcohol drinking			Frequency of alcohol drinking		
	No.	%		No.	%
Drink	22	6.8	Once a month or less	6	1.8
Don't drink	292	89.8	2-4 times a month	8	2.5
Missing	11	3.4	2-4 times a week	3	0.9
			Daily	1	0.3
			Total dinking	18	5.5
			Missing	307	94.5
Total	325	100	Total	325	100

**Illegal drug use and types of drugs (Table 27):** Some 3.1% of participants used illegal drugs and 92.3% have not. When asked about type of drugs, the drug users did not mention any further information.

**Table 27: Illegal drug use and types of drugs**

1. Illegal drugs use		
	No.	%
Users	10	3.1
Non-users	300	92.3
Missing	15	4.6
Total	325	100

**Domestic violence within the home environment (Table 28):** About 21.2% (69 participants) of the total that responded “yes” answered that they were abused at home (16% females vs. 5.2% males). Of those being abused, 17.8% responded to the question “Who is the abuser?”, 5% claimed that the abuser is the brother, 4.3% the father, 2.2% the mother, 1.8% the sister and 4.6% responded “others”, which included husbands, in-laws, uncles or more than one person. For the type of abuse, there were 96 responses: 10.2% reported that they were exposed to physical violence, 15.7% to verbal/emotional and 2.5% to sexual abuse. Participants’ reservation on answering this private question stems from their fear of stigmatization or shame, and also lack in knowledge about the different forms of violence.

**Table 28: Domestic violence within the home environment**

4. Participants abused at home			Who is the abuser?			5. Type of abuse		
	No.	%		No.	%		No.	%
Abused	69	21.2	Father	14	4.3	Verbal/Emotional	51	15.7
Not abused	246	75.7	Mother	7	2.2	Physical	33	10.2
Missing	10	3.1	Brother	16	4.9	Sexual	8	2.5
			Sister	6	1.8	Others	-	-
Total	325	100	Others	15	4.6			

**Exposure of participant’s households to violence from Israeli forces and/or settlers**

**(Table 28):** Some 18.5% of the participants’ responded “yes” to if their households had faced violence. Further, they were asked if any of the family members were abused during the Israeli violation; it was found that; 6.8% fathers, 6.8% brothers, 3.1% mothers, 1.5% sisters and 5.2% of the study participants reported that they had been exposed to this violation in person. Furthermore, 14.3% responded to the question “Do you believe this situation played a part in the domestic violence you experience or know of?. Of those, 2.2% believed that it did and answered “yes”, 4.3% were not sure, and 8% do not believe that Israeli violations have contributed to the domestic violence they experience or know about.

**Table 28: Exposure of households to violence from Israeli forces and/or settlers**

6. Participants HH exposed to Israeli forces			Abused family member by Israeli forces			Israeli forces affecting domestic violence		
	No.	%		No.	%		No.	%
Exposed to violence	60	18.5	Father	22	6.8	Played part	7	2.2
Not exposed	238	73.2	Mother	10	3.1	Did not play part	26	8.0
Missing	27	8.3	Brother	22	6.8	Not Sure	14	4.3
			Sister	5	1.5	Total responses	47	14.5
Total	325	100	The Participant	17	5.2	Missing	278	85.5
Total	325	100	Others	6	1.8	Total	325	100

**Seeking help for the identified health and social problems (Table 28):** A total of 36% (116 participants) have sought help for the mentioned health and social problems.19% sought help for smoking, 18.5% for abuse, 7.4% for drug abuse, 5.5% for STIs, and lastly 4.9% for alcohol



**Table 28: Seeking help for the identified health and social problems**

7. Participants seeking help			Problems they sought for		
	No.	%		No.	%
Sought help	116	35.7	Smoking	62	19.1
Didn't seek help	191	58.8	Abuse	60	18.5
Missing	18	5.5	Alcohol	16	4.9
			STIs	18	5.5
Total	325	100	Drug Use	24	7.4
			Others	3	0.9

**Sources of help for the identified participants with health and social problems**

**(Table 29):** The participants were given the choice to check more than one option if applicable to the question “Where did you go for help?”. There were 228 responses; 20.9% (68 responses) sought help from families/friends, 9.8% (32 responses) from psychological counsellors, 7.1% from private health clinics, 4% government health clinics, 4.3% pharmacy, 3.7% did not know where to go and 3.4% sought help from social services.

**Table 29: Sources of help for the identified health and social problems**

8. Where did you go for help	No.	%
Private health clinic	23	7.1
Governmental health clinic	13	4.0
Social services	11	3.4
Psychological counsellor	32	9.8
Rehabilitation centre	1	0.3
Pharmacy	14	4.3
Family/friends	68	20.9
Other places	2	0.6
Did not know where to go	12	3.7
Did not go to any place or person	52	16.0

## 4.1.5 Knowledge, attitude and practices toward Youth Friendly Health Services-YFHS

**Participants' health information source (Table 30);** The participants were given the choice to check more than one option to the question "Where do you get your health information from?". A total of 65% reported to obtaining their health information from the internet, 40.3% from a family member (father, mother, brother, sister), followed by 28.6% from health professionals (counsellor, doctor, nurse), 27% from media (newspapers, radios, TV) and 27% for school/university. The Gaza assessment study (2015) results show that the youth prioritized friends as first choice, the internet second and the family as last.

**Table 30: Participants' health information source**

1. Participants' health information source	Frequency	Percent
Internet	211	64.9
Health centres and clinics	93	28.6
Friends	102	31.4
Family (father, mother, brother, sister)	131	40.3
Magazines and books	65	20.0
Media (newspapers, radios, TV)	88	27.1
Counsellor, doctor, nurse	93	28.6
School/university	88	27.1
Others	1	0.3

**Health services needed by the participants during the current year (Table 31):** A multiple answer question was posed regarding "Have you ever needed any of the following health services during the current year?". Of the responses, 51.1% did not need any health services while 16.3% needed nutritional health services. This information is congruent with the identified 18.5% that are overweight and 2.8% obese as indicated in Table (12); 13.8% needed physical health services, 12.3% needed skin health services, 11% psychological health services and 10.5% sexual and reproductive health services.

**Table 31: Health services needed by the participants during the current year**

2. The needed health service	Frequency	Percent
Nutritional health services	53	16.3
Sexual and reproductive health services	34	10.5
Skin health services	40	12.3
Physical health services	45	13.8
Psychological health services	36	11.1
Did not need any health services	166	51.1
Others	-	-

**Health services accessed by the participants during the current year (Table 32):**

On the multiple answer question “Where did you go (place) for receiving the health services when you needed?”, the largest response of 28.6% went to private health clinics followed by 16.6% to governmental health clinics, 11.1% to hospitals, and 10.8% to parents/friends. The other responses were scattered among other services options as indicated in the table below and 21.2% did not go to any place or person to receive health service.

**Table 32: Health services accessed by the participants during the current year**

3. The place to which the participant went	Frequency	Percent
Private health clinic	93	28.6
Governmental health clinic	54	16.6
School/university services	11	3.4
Internet, books, magazines	31	9.5
School/university counsellor	21	6.5
UNRWA health clinic	17	5.2
NGOs health clinic	13	4.0
Hospital	36	11.1
Pharmacy	31	9.5
Parents/friends	35	10.8
Other places	-	-
Did not go to any place or person	69	21.2

**Participants’ satisfaction with quality for services they received (Table 33):** Around 28.3% (92 participants) were satisfied with the quality of the services they received, 36% (117 participants) were satisfied to some extent and 8.6% (28 participants) were unsatisfied.

**Table 33: Participants satisfaction with quality for services they received**

4. Are you satisfied about the quality of services you received?	Frequency	Percent
Yes	92	28.3
To some extent	117	36.0
No	28	8.6
Missing	88	27.1
<b>Total</b>	<b>325</b>	<b>100</b>

**Reasons for dissatisfaction with the quality of the received services (Table 34):** The participants were answered “Why you don’t feel satisfied or partially satisfied about the quality of services you received?”. The responses were as such: 14.3% for the unavailability of services, 13.5% for inefficient staff, complimented by 10.8% for lack of interest and understanding of youth needs, 10.5% for high cost since the largest number goes to private clinic (28.6% goes to private clinics as indicated (Table 32). Further, 10.2% reported lack of needed information, 8.6% for unfriendly service

provider, 7.1% difficulty in accessing the service and 5.2% for lack of privacy and confidentiality

**Table (34): Reasons of dissatisfaction with the quality of the services received**

5. Why do you feel not satisfied or partially satisfied about the quality of services you received?	Frequency	Percent
Inefficient staff	44	13.5
Difficulty in accessing the service	23	7.1
Lack of interest and understanding of youth needs	35	10.8
Unfriendly service provider	28	8.6
Lack of privacy and confidentiality	17	5.2
Lack of needed information	33	10.2
High cost	34	10.5
Services not available	46	14.3
Other reasons	3	0.9

**Reasons for not going to health centres to receive health services (Table 35):**

As shown in Table 32, 21.2% of the responses indicated not going to any place or person to access health services. For this reason, they were given the choice to check more than one option to this question, if applicable to the question “What are the reason(s) for not going to health centres to receive health services?”. A total of 44.3% of the responses were related to availability and accessibility where 16.3% didn’t know about the services, 14.2% claimed that services are not available, 9.5% claimed that services aren’t accessible and 4.3% did not know where to go. In addition, 25.8% of the responses were for quality and confidentiality, 10% claimed low-quality services, 8.3% did not trust the place, and 7.5% were not sure about confidentiality. Cultural issues affecting young people’s self-confidence also played a role where 8.6% claimed stigma, and reputation and 4.9% for fear and embarrassment.

**Table 35: Participants’ reasons for not going to health centres to receive health services**

6. What are the reason(s) for not going to health centres to receive health Services?	Frequency	Percent
Services aren’t available	46	14.2
Services aren’t accessible	31	9.5
Low-quality services	29	8.9
Cultural (stigma, reputation, etc.)	28	8.6
Fear and embarrassment	16	4.9
Uninsured confidentiality	24	7.4
Do not trust the place	27	8.3
Did not know where to go	14	4.3
Don’t know	53	16.3
Other reasons	1	0.3

Participants perception of the current health services meeting the youth needs (Table 36): Some 25% (81 participants) agreed that current health services meet youth needs, 57.2% (186 participants) agreed to some extent and 12.9% did not agree.

**Table 36: Participants perception of the current health services as meeting the youth needs**

7.	Do you perceive the current health services as meeting youth needs?	No.	%
	Yes	81	24.9
	To some extent	186	57.2
	No	42	12.9
	Missing	16	4.9
	Total	325	100

**Availability of health services within the participants’ schools or universities**

**(Table 37):** A total of 75.4% (245) of participants agreed that there is availability of health services within their universities, while 19.4% reported that they do not. Furthermore, the participants were given the choice to check more than one option if applicable to the question “What are these services available”. Some 47.1% (153 participants) reported the general practitioner, 25.8% (84 participants) primary health care clinic, 17.5% counselling services, 15.7% registered nurse and 10.2% social services.

**Table 37: Availability and type of health services within the participants’ universities**

8. Are there health services within the school/ university, and what are these types of services?	Frequency	Percent
Primary health care clinic	84	25.8
Counselling services	57	17.5
General practitioner	153	47.1
Social services	33	10.2
Registered nurse	51	15.7
Others	-	-

**Participants’ knowledge of and definition of YFHS (Table 38):** Some 44% (143 participants) answered “yes” and 49.5% (161 participants) answered “no” to the question “Do you know what youth-friendly health services mean?”. Furthermore, the participants were given the choice to check more than one option to the question “What does it mean to have YFHS services?”, 29.5% agreed to the first statement “High-quality services; information, counselling and referral that is relevant, accessible, affordable, appropriate and acceptable to the young people”. Furthermore, 20.3% agreed to the statement “All young people have access to health information and services regardless of their status, gender, origin, etc.”, and

14.8% agreed to the statement “The services are provided in line with the minimum health package.”. Lastly, 10.2% agreed to the statement “All young people have access to health information and services regardless of their status, gender, origin, etc.”

**Table 38: Participants’ knowledge of and definition of YFHS**

<b>9. Do you know what youth friendly health services mean? And what does it means to have YFHS</b>	<b>Frequency</b>	<b>Percent</b>
High-quality services; information, counselling and referral that is relevant, accessible, affordable, appropriate and acceptable to the young people	96	29.5
The services are provided in line with the minimum health package	48	14.8
Aims to increase acceptability and use of health services by young people	33	10.2
All young people have access to health information and services regardless of their status, gender, origin etc.	66	20.3

***Participants’ knowledge of the expected services by the YFHS centres (Table 39).***

On the question “Do you know the YFHS centre/clinic is supposed to deliver?”, participants were able to fill in more than one option. A total of 53.8% expected YFHS centre/clinic to deliver sexual education and awareness, 28.9% marriage and pre-marriage counselling, 27.4% violence counselling, 26.5% general information about SRH and 22.2% for family planning and 16.9% don’t know. 33.8% of the responses for life coaching for healthy lifestyle (sports, nutrition, active citizenship and other issues related to well-being).

**Table 39: Participants’ knowledge of the expected services at YFHS centre**

<b>10. Do you know what the YFHS centre/clinic is expected to deliver?</b>	<b>Frequency</b>	<b>Percent</b>
Marriage and pre-marriage counselling	94	28.9
Sexual education and awareness	175	53.8
Family planning	72	22.2
Violence counselling	89	27.4
General information about SRH	86	26.5
Life coach for healthy lifestyle (sports, nutrition, active citizenship and other issues related to well-being)	110	33.8
Don’t know	55	16.9

***The participants’ preferences of places or centres to receive YFHS (Table 40);*** The participants were given the choice to check more than one option if applicable to the question “What is your preferred place/centre to receive YFHS?”. Some 33.5% indicated private health centres, 28% governmental health centres, 18.5% youth and sports centres, 14.8% university centres, 13.8% reported that they didn’t know, 10.5% for family centre, 7.7% NGOs and 5.5% UNRWA centres.

**Table 40: the participants' preferences to place/centre to receive YFHS**

11. What is your preferred place /centre to receive YFHS	Frequency	Percent
Governmental health centre	91	28.0
Private health centre	109	33.5
NGOs health centre	25	7.7
UNRWA health centre	18	5.5
School / university centre	48	14.8
Youth and sports centre	60	18.5
Family centre	34	10.5
Don't know	45	13.8
Other places or centres	-	-

**Participants' time preference to receive health services (Table 41):** In responding to the question "What time do you prefer to go to the health centre to receive the services?", 36.3% preferred mornings to receive health services, 13.8% preferred the evenings, and 10.8% afternoons while 32% reported that it did not matter.

**Table 41: Participants' time preference to receive health services**

12. What time do you prefer to go to the health centre to receive the services?	Frequency	Percent
Morning	118	36.3
Afternoon	35	10.8
Evening	45	13.8
Doesn't matter	104	32.0
Missing	23	7.1
Total	325	100

**Participants' gender preference of health care providers (Table 42):** A total of 43.4% didn't mind the gender of the health care provider. However, 32% preferred females, 14.2% preferred males, and 3.1% didn't know.

**Table 42: Participants' gender preference of health care providers**

13. Do you prefer your health care provider to be?	Frequency	Per-cent
Male	46	14.2
Female	104	32.0
Doesn't matter	141	43.4
Don't know	10	3.1
Missing	24	7.4
Total	325	100



**Participants' location preference of YFHS (Table 43):** A majority of 71.4% preferred the YFHS to be offered and provided located nearby their place of residence, 18.5% preferred YFHS to be located far from their place of residence, 2.8% preferred another location and 7.4% did not answer the question.

Table 43: Participants' preference of YFHS location

14. Do you prefer the location of the YFHS to be?	Frequency	Percent
Far away from the place of residence	60	18.5
Near the place of residence	232	71.4
Another location	9	2.8
Missing	24	7.4
Total	325	100

Participants' perception of the importance of confidentiality (Table 44): When participants were asked "In your opinion, is confidentiality is important when you seek or receive your own health services?". Some 57.8% were aware of this matter and believed it is very important, 25.5% believed it is important sometimes, 5.5% believed it is not important, and 4.3% didn't know.

Table 44: Participants' perception of the importance of confidentiality

15. In your opinion is confidentiality important when you seek or receive your own health services?	Frequency	Percent
Very Important	188	57.8
Unimportant	18	5.5
Important sometimes	83	25.5
Don't Know	14	4.3
Missing	22	6.8
Total	325	100

**Participants' preference of a separate time for males and females when receiving YFHS (Table 45):** The participants were asked "Do you prefer a separate time when receiving YFHS divided between females and males?" 40% preferred a separate time to receive YFHS separate from the other sex, 38.5% indicated that it didn't matter if both sexes were received at the same time or were separated, and 3.4% didn't know.

Table 45: Participants' preference for separate time for girls and boys

16. Do you prefer a separate time when receiving YFHS divided between females and males?	Frequency	Percent
Preferred	130	40.0
Not preferred	35	10.8
Doesn't matter	125	38.5
Don't Know	11	3.4

Missing	24	7.4
Total	325	100

***The participants' perception of financial cost and accessibility to health services (Table 46):*** When asked “In your opinion, the financial costs is an obstacle to obtain health service?”, 36.3% considered financial cost an obstacle, 40.3% considered financial cost an obstacle sometimes, and 12.9% did not consider it an obstacle.

**Table 46: Financial cost and young people's accessibility to health services**

<b>17 In your opinion, the financial costs is an obstacle to obtain health service?</b>	<b>Frequency</b>	<b>Percent</b>
It's an obstacle	118	36.3
Not an obstacle	42	12.9
It's an obstacle sometimes	131	40.3
Don't Know	10	3.1
Missing	24	7.4
Total	325	100

## 4.2 Qualitative Data Analysis

---

### 4.2.1 Interviews with representatives from academic and service institutions

The interviews were conducted with professional stakeholders' representatives of academic and service institutions; four universities and three NGOs. The representatives or the interviewees as titled in this analysis offered their perspectives based on a long list of open-ended questions to have in-depth information regarding youth health needs and suggested solutions to these needs.

#### 4.2.1.1 Programmes and activities available for young people within the targeted academic and service institutions

The academics reported that there are efforts made at the universities for the development of their students by providing them with necessary life skills and awareness in every aspect of their university life. Within the university system, the department of students' affairs has some programmes and conducts non-academic activities during the year such as sports, music, and art, in addition to provision of psychological counselling, financial and social support and health awareness. Also within the different colleges, there are non-academic activities that are individual-based and fragmented initiatives that need to be organized and consistent. They reported that there are health clinics within the university system to provide primary services.

Recently, Al-Quds and Al-Azhar universities in collaboration with PMRS and UNFPA, funded by AICS have launched youth-friendly health services as a service delivery points in order to meet the YFHS protocols, to effectively attract

young people, meets their needs comfortably and responsively, and succeed in retaining young clients for continuity of care.

The academics praised the students' participation within the available programmes and activities and said that in many instances, students themselves plan and design their activities according to their needs and interests while the college's administrations support them administratively and financially to some extent.

The service institutions (PMRS, HWC) and the university representatives in West Bank and Gaza emphasized their role in appraising the young people's health and development as part of their service mission and goals and their programmes, and as a result, their activities are carried out accordingly. Sharek as a service institution is not a health organisation. They work on young people's development from different perspectives such as; promoting advocacy and volunteering activities, increasing knowledge of their rights to education and freedom as well as encouraging peer to peer involvement in these activities, etc.

In general, the service institutions, health service delivery points and the young centres at academic institutions provide the following services to varying degrees;

- Complete physical care such as diagnosis, treatment, medical consultations, and referral when necessary
- Individual counselling and psychosocial support

- Reproductive and sexual health awareness and counselling
- Conduct health awareness and health education
- Conduct first aid courses
- Support young people in their activities and aspiration
- Help students enrolled in health and medical schools to pursue their careers

#### 4.2.1.2 Professional perception of young people's health issues/needs and priorities

The institutions' representatives agreed that youth needs are significant and critical, and should be considered as a priority and taken seriously by decision-makers at all levels. Responses were categorized based on their needs and priority of concern.

1. Drug dependency, addiction and smoking tobacco are prominent behavioural problems increasing among young people; reiterating on its seriousness and consequences on the physical, psychological and social health.
2. Lack of knowledge and awareness about SRH issues including; FP, contraceptive methods and sexually transmitted illnesses (STIs). Emphasizing the societal traditions and taboos when talking about these issues particularly when that person is not married and is a female. Interviewees also raised issues of early and/or relative marriage and early childbearing.
3. Unemployment and poverty issues were of great concern among the interviewees, the high unemployment rate for the general population, and specifically among university graduates are reasons for psychological and social problems.

The issues that face young people were summarized as; behavioural problems, violence, drug dependency and addiction, tobacco smoking, unemployment, and

the least problems are the physical health problems etc. High prevalence of physical disabilities due to Israeli violence against Palestinian youth is another prominent health problem mentioned by interviewees and coincides with young people's perception on this matter.

Two interviewees said the following:

***“Israeli occupation, poverty, poor socio-economic status, lack of efficient institutions are the real causes that lead to youth problems in the Palestinian society such as early marriage, relative marriage, unemployment, violence, and addiction”.***

***“Absence of efficient institutions, poor education system, absence of developmental opportunities, restriction of movement, and the absence of proper legislations are all factors contributing to psychological and social problems among the young and the adults too.”***

#### 4.2.1.3 Professional knowledge of the barriers for young people to access non-academic activities and health care services:

The academic institutions' representatives reported the following barriers for the students to participate in non-academic activities. These barriers are similar among all university students regardless of their location and summarized as:

1. The condensed academic schedule does not leave enough time for them to participate.
2. Some students have part-time jobs.
3. Many students think that the university's methodology and activities are traditional and do not induce an innovative and inspiring environment for the students.

4. The health centres do not provide comprehensive services and information that meets their needs and fulfill their aspirations.
5. Others see a lack of seriousness or usefulness of these activities and their feeling is that the activities will not “add anything new to our knowledge”.
6. The cultural constraints on SRH and specifically for female participation in specific as stated “We live in a very conservative society; many families do not allow their daughters to participate in youth-related and non-academic activities”.
7. The shortage of financial resources to conduct youth related non-academic activities.
8. Low level of safety and security in oPt makes families more reluctant to allow/encourage their sons and daughters to participate in extra-familial activities.
7. Lack of advocacy, lobbying and awareness-raising activities including social media to promote the available services.

The hopes and aspirations of the academic interviewees for the young people related to what can be achieved within their communities suggesting the following: 1) Establishment of youth-friendly services utilizing the social media, theatre and any other creative methods that attract young people and meets their interest and hobbies. 2) Adoption of youth-friendly health services by governmental and community organisations. 3) Strong campaigns to increase the awareness of families regarding the importance of involving their children to participate in youth-related activities as these activities would enhance their skills and abilities to develop their personalities. 4) More financial support and resources should be invested in youths-related issues. 5) Freedom and the demand for freedom of expression.

**The service institutions representatives indicated the following barriers;**

1. The health centres offer general health services but they are not specialized except for Gaza PMRS clinic that includes YFHS besides primary health care.
2. Cultural constraints affect young people’s accessibility to health services particularly for females due to social stigma.
3. Lack of interest in health issues particularly by males.
4. Financial status is a major factor in young people’s movement including migration.
5. Lack of awareness among young people regarding the available services and their importance for their health and well-being.
6. Time constraints since service providers are accessible when young people are either at work or studying; this does not allow them to participate in any activities or seek the service they need.

**4.2.1.4 Professionals’ institutions provision of health information and services to young people**

At the West Bank universities, there are accessible health clinics for students that provide essential physical health services, also there is the Palestinian Red Crescent Society services (PRCs) who has an ambulance that responds to any emergency health issue that needs referral to a hospital for further or advanced treatment. Psychological counselling is provided through public health and/or nursing faculties but other problems and issues that face students are addressed on an individual basis.

The Hebron University clinic needs to be supported with more staff and equipment. They are also planning to establish a large health care centre to provide more physical,

psychological, and social health services for students.

The YFHS project was worked on by the Al-Quds and Al-Azhar universities as there are no programmes or activities that really address the problems of young people including physical, psychological, mental, professional guidance and sexual reproductive health. At Al-Azhar University, an accessible fully- functioning YFHS centre is available, with a PHC clinic equipped with a physician, nurse and psychosocial counsellor that provide essential physical health services, psychological and nutritional counselling as well as health education. However, the universities programmes are not sufficient and need to be expanded, yet services are offered free of charge, ensures privacy and confidentiality as they have a private place for those that need the service. These institutions do not offer any intervention services related to addiction.

At the NGOs –level, for PMRS, services are widespread, and health centres are fully-equipped with health providers that meet the needs of the Palestinian population at their services delivery points. PMRS centres for youth and primary health care providers for physical, mental, and psychological and SRH issues in the West Bank and Gaza and are free of charge.

HWC services are widespread health centres fully equipped with health providers that meet the needs of the Palestinian population in their services delivery points. HWC centres are primary health care providers for physical, mental, and psychological and SRH issues in the West Bank and Gaza. They have a youth health programme in East Jerusalem called “Nidal Centre”. HWC provides youth health services for minimal fees focusing on SRH and abuse issues utilizing the national referral protocol for these cases.

Both institutions offer health education and awareness programs, treatment and counselling for physical health problems, SRH, and chronic illnesses. Addiction-related

services and rehabilitative services are available at the preventive level through education and awareness and referral for specialized institutions when needed for disadvantaged young people but unfortunately, these services do not meet the needs, as stated by interviewees. Some said there is coordination and collaboration with the governmental and NGOs utilizing the national guidelines for referral, treatment and follow-up.

Sharek is not a health provider institution, as it focuses on the development of young people to become engaged, employable, and active citizens. However, they do provide health education matters utilizing the youth to youth model as part of this development

#### 4.2.1.5 Professionals' perception of what works well for young people

Youth are a group with special characteristics and must be given the priorities in provision of care especially the Palestinian youth that live in very challenging circumstances. They reiterated the need for promoting primary health care centres, university youth centres, including SRH services. They further highlighted the need to upgrade the capacities of nurses and social workers in schools, family centres, counselling centres in any healthcare institution (governmental, NGOs, UNRWA and private) so that they can help young people meet their needs and challenges.

However, all these programmes and settings provide general health services with minimum specialized services that target youth in specific. Therefore, efficient services for youth within all these programmes are needed emphasizing the SRH information, counselling regarding lifestyle, sexuality, mental health counselling and rehabilitation besides the conventional youth services focusing on physical, psychological, and social health problems. Special services for youth should be established in every system and institution.



#### 4.2.1.6 Professional knowledge of a general health system for young people and what is currently offered and what opportunities are there, if any?

The parties all agreed that there is no health care system specialized for young people in Palestine including the institutions offering health services. Youth health services for young people are across the sectors, integrated within the larger health care system without taking into consideration the specific needs. Therefore, it is necessary to restructure the health care system to integrate YFHS.

***“PMRS is developing the YFHS protocol that was initiated by the MoH in 2015 and to be distributed at national level and to be institutionalized as a tool to meet the Palestinian young people’s needs”. (PMRS representative<sup>14</sup>)***

The Palestinian government has been working on updating and revising the Palestinian curriculum for all schools taking into consideration the societal, health and political changes taking place in the entire world as well as locally. The new school curriculum is still under revision and will address youth problems and provide them with education and awareness, but the coverage will not be sufficient. Also, there are initiatives to promote the integration of SRH issues into the school curriculum by many stakeholders such as the Palestinian nongovernmental organisations (PNGO)<sup>15</sup>.

The university curricula in general provides health education for students and many guest speakers are invited to deliver lectures on many general or special topics that are of special interest to young people. The health sciences and public health schools provide academic education on health including children and young people’s health and teaching the students how to diagnose, plan,

14 Statement by the YFHS coordinator Sabreen Abdul-lah at PMRS in West Bank

15 Information gained from committee established to review curriculum.

implement, and evaluate health services for youths

All the parties agreed that health education awareness-sessions, training and campaigns in schools, colleges, sports clubs and health institutions are gradually introduced and conducted for young people. Usually these activities are not systematic and insufficient in meeting the youth’s needs and are based on funded programs. Yet, they elaborated on the widespread risky behaviours among young people and criticized the sporadic activities as said by some of the interviewees; actual services provided for youth are poor, disorganized, and only focus on treating problems after their occurrence. A preventive approach at the community level should be adopted at all Palestinian social, academic, and health institutions.

For example, awareness on smoking, alcohol and illegal drug use and the psychosocial problems resulting from risky behaviours and others as preventive measures are conducted sporadically, not consistent programmes and intervention activities have not been introduced. They further reiterated that health information, counselling and existing services and programmes are not of high quality and need to be organized and systematized.

***“My main recommendation is that the MoH establish a specialized general directorate for youth health since they constitute more than 50% of our society.”***

Some said there is coordination and cooperation among the institutions working with the youth while others opposed this view and stated that coordination and cooperation within governmental institutions and with NGOs did not exist.

***“Unfortunately, we do not have sufficient data and information about youth’s health problems, available services, and current programs, due to poor coordination between the different sectors in Palestine.”***



Therefore, there is a need for clear policies, strategies and technical plans to regulate services targeting youth between institutions so they can coordinate their efforts to develop human resources and work on a comprehensive approach to meet the youth needs and prevent risky behaviours that is spreading among them.

#### 4.2.1.7. Professionals perception for the establishment of YFHS centre to cover the needs of young people

The academic and service providers supported and insisted on the establishment of YFHS in any accessible place for students and other young people in the area; the academics wanted to set up a centre in each university and the service providers wanted the centre to be located within their premises.

They all prefer that these centres be located in a well-known place, to be independent, to have a clear identity, mission, and objectives, and not to be integrated within other services. One of the academics justified the need for YFHS:

***“We are realizing that the violence and, behavioural problems among these young people are increasing. They face a lot of life pressures and they don’t have the skills to manage and deal with these issues”.***

Another person emphasized this need when said:

***“Young people lack information and skills that they need in everyday life like communication skills, health education, and counselling in managing many problems that face them” While another person stated “establishing youths health centres is a priority in the Palestinian society”.***

## 4.2.2 Focus group discussion with health service providers

Four FG discussions with health service providers from the targeted health service organisations were conducted to complement the information obtained from stakeholders and young people and to have reliable and consistent information on the study objectives.

### 4.2.2.1 Knowledge of the concepts of YFHS and quality of health care

The health providers were able to identify YFHS as said: “YFHS provides young people with physical, psychological health, social awareness and intervention services.”. Another provider said, “YFHS should be appropriate to meet the needs of young people and address their physical and psychological health problems.”.

Some others added, YFHS should have recreational and sports activities besides health services for comprehensive care that should be accessible for all young people. On their definition of quality of care, they said to have accessible services that provide scientific information and proper health services at the proper time and to maintain the dignity and safety of the clients.

### 4.2.2.2 Sources of health information about young people’s health

The participants reported that they obtained their information from national studies, MoH and WHO reports, the health centre statistics, the community and the community-based organisations. Others reported their sources of information comes from the young people seeking health care in their facilities. They further reported that training programs, research and health education information booklets are another source of their health information.

#### 4.2.2.3 Knowledge about young people's health needs and priorities and accessibility to services and information

The participants emphasized SRH awareness and education is a priority for young people since it forms the basis for their development and transition phase from adolescence to adulthood, followed by physical and psychological needs. They reiterated their concerns about risk behaviours and violence, which is more likely to occur among this age group. Others emphasized early marriage and marriages within the family since it is a common phenomenon in the Palestinian society.

All health care providers believed that young people seek health information from the internet as their first choice followed by friends as a second choice. Some sought information from family health centres and NGO centres. Government centres are the least accessed by youth, who reported not seeking information there in order to avoid the "fear and shame".

#### 4.2.2.4 Health care providers' description of their health care centre

Participants were asked to describe their health care centre in terms of facilities and health providers. All of them emphasized that the centres are accessible to all, have adequate space, and well-equipped with the necessary equipment including laboratories and drugs. The health care providers at the centres include nurses, physician, counsellor and health educator that are able to function professionally and efficiently they possess the knowledge and skills to listen to their clients keeping privacy and confidentiality as their top priorities during their service provision. They further appraised the coordination and collaboration of their centres with other health institutions (governmental and NGOs) and emphasized their use of the national referral system when needed.

#### 4.2.2.5 Knowledge of barriers that prevent young people to access health services

Some participants reported the lack of specified youth health services at their centres in addition to a lack of spaces for them to meet their specific needs while others said there are no barriers regarding their centres. Others commented that cultural constraints, shame and fear are reasons preventing young people from accessing the services. The financial cost could be a barrier for some young people to access the service and more importantly those young people living in remote areas and Area C.

#### 4.2.2.6 Performance and evaluation of services provided to young people at their centres

Most participants reported that they have good numbers of young people visiting their centres and being accessible. When asked, "What was their priority to visit the centre?" They responded mostly for SRH issues, violence, early marriage and marriage relationships. When asked, "What are the SRH problems that young people may face?", they reported FP issues, sexual relationships and problems (rapid ejaculation, cool sexual interaction by wives, masturbation) STIs and infertility. Further, they were asked, if they launch awareness sessions regarding SRH matters for young people. All participants appraised their consistent and regular awareness and education programmes targeting both males and females, school and university students. Others target youth and community-based organisations where parents are involved. Some participants reported targeting young people working in Israel, unprivileged young people and those living in remote areas. The awareness sessions included issues of adolescence, early marriage, STIs, violence, antenatal, perinatal and postnatal care, breast-feeding, FP and marriage counselling.

Further, the participants were asked about barriers in providing SRH awareness. They reiterated the concern that there are social constraints to discuss SRH matters and sex education openly, this barrier is usually overcome when approached from a health perspective.

Reporting on the centre's activities other than service provision; the participants noted that they trained and developed more than 150 young people within their facilities on leadership and advocacy skills encouraging peer to peer education and to have a role of lobbying and advocating among their peers on SRH issues and social problems. Many of these trained youth became volunteers within these centres.

#### 4.2.2.7 Perception of young people's needs for a centre to cover their health needs

All participants supported and insisted on the establishment of YFHS in any accessible place for young people in the area; they prefer that the centre is integrated within their health facilities and staffed by experts in young people's health. Others prefer the centres to be independent, located in an accessible location within the city centre and in villages, open in the mornings and afternoons, equipped with experts in youth health and offering services free of charge. All emphasized that financial cost is a barrier for the establishment of YFHS.

#### 4.2.2.8 Health care providers' recommendations

- A comprehensive plan that includes community health organisations to improve the young people's accessibility to health information and services through health centres and mobile clinics in remote and underprivileged areas including east Jerusalem and Area C.

- A comprehensive national plan that includes governmental and NGOs for the establishment of YFHS in Palestine.
- Media campaigns at the governorates level to advocate for young people the importance of accessing health information and services in the nearby centres.

### 4.2.3 Focus group discussion with young people

Group discussions with young people and adolescents of both sexes (15-29 years) receiving health services or beneficiaries (four in West Bank and three in Gaza) were conducted to complement the responses to the questionnaire and to gain reliable and consistent information on the study objectives.

#### 4.2.3.1 Knowledge of the concepts of health, YFHS and quality of health care

The participants' knowledge of the concepts of health and YFHS varied within and between the groups, depending on their age and experiences. The older age group showed interest and understanding of the matters discussed more than the younger age group. Many participants discussed the concept of health from different perspectives. A 26-years old male defined health as "A state of peace with mind and soul and not the absence of diseases" while an 18-years old girl said "Not just to be free from mental and physical illnesses but also to find treatment and to be able to pay for this treatment."

The Y-Peer could only emphasize the importance of YFHS and encouraged institution to provide such services.

***"YFHS should be appropriate to meet***

***the needs of young people and address their physical health and psychological problems.”(22-year-old male)***

***“Health services are a necessity and should be accessible for all young people whether poor or rich.” (20-year-old female)***

Some participants described the quality of health care from different perspectives. and, as said by an 18-year-old female participant: “To have comprehensive and appropriate care that include specialty care, not expensive, available, and accessible whenever we need it”. Furthermore, a 24 year-old said “It should be cheap and appropriate to meet the needs of all young people and ensures their privacy”.

#### **4.2.3.2 Young people’s sources of health information**

The participants’ responses were almost similar in identifying their health information sources; most of them considered the internet and mass media as the primary source of their information and some others considered friends and family. Regarding the internet and social media, it is considered the fastest and easiest source of information.

***“Nowadays, technology is in everyone’s hands, and in a few minutes we can get any information”. On the contrary, an 18 years old male said, “A lot of people do not depend on media because of the power cuts for long hours” (23-year old male)***

The young females sought health information from their female friends as said by an 18 years old:

***“I ask my older girlfriends on SRH matters where these issues are sensitive and we cannot ask anyone else about it.”***

They further elaborated; poor family dialogue on these topics and the dependence of young people on friends or social networks may lead to gaining false information and behavioural misconduct as well. Other girls are open to their families but if not satisfied they go to friends. A 21-years old girl said:

***“I regularly follow Dr. Hiba Qutub programmes on TV for SRH information”<sup>16</sup>.***

Lastly, most of them appreciated health providers and health centres as a reliable source of information and encouraged each other to gain information from this source.

#### **4.2.3.3 Young people’s health and social problems; priorities and needs**

Participants’ responses were categorized by their priority of concern and needs. The majority of participants stressed that the illegal drug use phenomenon and its quick spreading among young people is a priority, reiterating on its seriousness and consequences on their physical, psychological and social health.

1. The participants stressed the behavioural problems of young people and the reasons behind these needs to be desperately addressed by health services providers. Smoking tobacco among young people is also an issue of concern.

***“The first priority is to save us from tramadol and other illegal substances in order to live in peace and tranquillity and protect us and future generations.” (24-year-old male)***

<sup>16</sup> Hiba Qutub is medical doctor specialized in sexuality according to [ar.m.wikipedia.org](http://ar.m.wikipedia.org); she appears in many Egyptian TV porgrammes to launch sexuality awareness and education and this participant is following her to have information regarding this matter.

***“What makes things worse in this regard is the lack of clinics and places of rehabilitation for the affected people.” (20-year-old)***

2. The economic status and unemployment issues were of great concern among the participants. They described bitterly the difficult economic conditions resulting from the geopolitical situation; the high unemployment rate for the general population, and specifically unemployment of university graduates, and child labour are causes of psychological and social problems.
3. There are many social issues that affect the social status of both males and females in Gaza. A 26-year-old male participant<sup>17</sup> highlighted that financial constraints leads to getting married and starting a family later in life. Another 24-year-old female commented, “Men are looking for a working woman to marry, because working women are a source of income so their chances of marriage are higher than women that do not work.”. On the other hand, participants commented on the issue of early marriage and relative marriage, its causes and consequences, the high level of divorce, as well as violence and abuse among Gaza families. They considered early marriage as one of the main reasons for divorce and recommended that decision-makers make it a priority to control this phenomenon.
4. Another phenomenon of social problems as addressed by participants is child labour, peddlers and child begging for those under the age of 18. They indicated that children are increasingly being

employed in jobs that do not match their age and they are the source of income for their dependents/families to cover their daily expenses. The begging issue was described by a 20-year-old female participant, “Wherever I go to Gaza streets I meet children and teenagers selling small things, carrying people’s goods and/or asking for money directly from people.”. They also agreed that such a phenomenon will ultimately leave negative effects on society in general and particularly on the children themselves.

5. The participants reiterated the issue of the significant number of persons living with disabilities in Gaza. A 26-year-old male participant said, “The Ministry of Development of Social Affairs in Gaza documented 50,000 permanent disability cases due to the three wars on Gaza.”. Another 21-year-old female said, “The Israelis could make Gaza a handicapped population.”. There was also an extensive discussion regarding their right to care and to have equal opportunities to live in dignity. One female participant stated, “These disabled people are like an army that needs to be cared for, rehabilitated and integrated into society so that they can live normally like other people, not as beggars in the streets as we see them.”. One young male added, “The state must provide them with education, health, psychological and social care.”. Therefore, it is normal for young people to be aware of this fact, and the care for this handicapped population should also be among young people’s priorities.
6. Lastly, the participants addressed SRH issues but were embarrassed to openly express their concerns and needs although they were of the same sex. Further, they asked for more awareness and education regarding these issues. Some females emphasized the importance of pre-marriage counselling as said, “Many girls get married and they do not know anything.”.

---

For women, early marriage refers to marrying before the age of 23, and ‘late’ if they marry after the age of 27. For men, early marriage was defined as marrying before the age of 26 and late if they married after 30 Johnson, M. D., Krahn, H. J., & Galambos, N. L. (2017). Better late than early: Marital timing and subjective well-being in midlife. *Journal of Family Psychology*, 31(5), 635-641  
<https://www.psychologytoday.com/intl/blog/media-spotlight/201708/is-there-perfect-age-getting-married>



#### 4.2.3.4 Access to health information and health services

Most of participants sought health services from governmental, UNRWA and/or community health centres emphasizing that these centres do not meet their needs and do not address youth issues. They further described the health centres' infrastructure as not appropriate for the provision of youth-friendly health services and do not ensure their privacy or their right to confidentiality and respect. One of them stated, "There is no specific place for young people to have our privacy and respect." Another participant said "It is an unpleasant environment for young people to seek help.". Few received health services from private clinics either because they needed privacy, or the required service is not available at the public centres. The NGO centres have a good share of health services for those that can pay for these services.

Regarding health centre staff, many commented on their lack of training and qualifications to address youth issues.

***"Despite the availability of some medical staff, some equipment and some medicines in health centres, we feel they do not have the experience and competence to deal with young people.". (25 year old male)***

***"There are long waiting lines to see the doctor and when you get in, the doctor only gives us a few minutes of his/her time." (Young female)***

***"Some doctors do not listen to the patient; do not examine the patient and do not give enough time to explain the problem; some of them work like a writer and the only thing they do is to write the prescription for medication.". (Young male)***

Another female participant summarized what her colleagues said, "Waiting so long, seen only for few minutes by the physician, not examined, given a prescription for a

medication which most of the time is not available in the centre pharmacy." Therefore "We go to private clinics because of the low-quality of services in government and UNRWA centres" as said by a 19-year-old female participant. Another 19-year-old male said, "Save the 50 shekels for the private doctor and buy the medicine directly from the pharmacy."

The overload of patients in the government and UNRWA health centres, the lack of space, and lack of attention by health professionals towards young people are all factors that makes them unwilling to ask for the service. In general, young people complained about medical neglect by some staff towards their feelings and complained about not giving them time to talk about their problems, these issues left young people to be uninterested in seeking care in these centres.

However, young people reported that health education and services for chronic illnesses, maternal and child care are available as well as referral services to hospitals as needed. A young female said "They referred my sister who was diagnosed with anaemia to the hospital" another participant said, "My father was diagnosed with diabetes; they referred him to a diabetic clinic and took good care of him." A third person said:

***"I swear to God, we the young people are marginalized, and no one cares for us; the health centres are concerned only about chronic illnesses and maternal and child care."***

#### 4.2.3.5 Young people's barriers to access to health care services

The vast majority of participants agreed that there is a lack of youth health service centres and the lack of space within the available centres to meet the specific needs of young people. They reported that the health service providers in these centres are not qualified

to offer youth services such as awareness and counselling on sexual and reproductive health issues, and/or on problems of nutrition for either being underweight/overweight or obesity. They added that some health service providers are reserved toward the issue of sexual and reproductive health and consider this issue as imported from the 'West' and does not meet the norms, traditions, values and religion of the Palestinian culture. Also, some young people have reservations about going to mental health centres as one girl said that "The one who seeks treatment or counselling in these centres is considered mentally ill."

The participants also agreed that private clinics need a lot of money, but they provide some privacy, especially for those with psychological and emotional problems particularly girls where such problems are considered a social stigma according to the culture of this society.

#### 4.2.3.6 Young people's perception to have a centre for their health needs

All participants supported the establishment of youth health centres with comprehensive services to cover physical health needs, psychological and social problems and to be equipped with qualified and trained medical staff to deal with young people from all aspects of their needs. The youth also agreed that the centres should be within the boundaries of their residential areas. The youth suggested that these centres be equipped with recreational facilities and green spaces. Some males suggested that they can be integrated with sport clubs while the girls opposed this suggestion.

***"In our culture the girls have a disadvantage in public sports clubs, unless these clubs are only for girls" (26-year-old female)***

Almost half of the young people preferred the service provider to be of the same sex of the beneficiary, while others do not mind this

matter. The majority suggested the possibility of integrating the YFHS with government or UNRWA primary care centres since there is medical staff that can be trained on youth issues while few suggested these centres should be integrated with other services, within universities, cultural centres or educational centres. The youth agreed that the services should be free of charge or for a minimal fee or for voluntary work.

The youth agreed that the priorities of services they need include behavioural problems namely smoking and illegal drug use, mental health and rehabilitation, reproductive and sexual health, nutritional problems, and lastly physical diseases and skin problems. However, they are aware of the political and security situation that leads to frustration, depression and ill well-being in general.

#### 4.2.3.7 Young people's perception of the barriers to the establishment of YFHS centres

The majority of youth agreed that the political situation resulting from the Palestinian division and the Israeli siege on Gaza are well-known reasons that affect the economy and hinder development in general including the establishment of youth-friendly health centres.

***"As long as the division exists, we will never get what we need." (19 year old male)***

Other reasons are the economic situation of the PNA and the extent to which decision-makers are convinced of the importance of these health centres. They asked, "Are these centres a priority for decision-makers?" Another 24-year-old young male commented, "The PNA is barely able to manage the available establishment, do you think they are able to run these proposed centres?" and "If it is established are there qualified professionals and specialized programmes in youth issues?" asked another participant.







# CHAPTER V

# Conclusions and Recommendations

# Conclusions and Recommendations

## 5.1 Key literature review findings

Palestinian young people are relatively disadvantaged politically, economically and socially, and their development and rights have been affected by two major factors: externally by the forces of occupation exposing them to high rates of violence and discrimination and internally, by Palestinian fragmentation, loss of identity, and a patriarchal society. These factors are extremely damaging during this formative stage of life.

The primary health issues affecting Palestinian young people as documented by many national surveys and studies include:

- Low level of knowledge about sexual and reproductive health issues, particularly STIs and sexuality education.
- Low level of engagement in sports and physical activities.
- Moderate level of nutritional health problems including excessive weight and obesity.
- Increased drug use, alcohol consumption and addiction to these substances.
- High levels of smoking tobacco and argileh.
- High levels of psychological distress and social problems related to unemployment, poverty and uncertainty for the future.
- Low levels of safety and security in oPt are limiting factors to access extracurricular activities.
- High levels of physical disabilities particularly in Gaza.

## 5.2 Recommendations

### 5.2.1 Recommendations from academic and service professionals

- Develop directorate for young people's health within the MoH to mainstream all institutional services including YFHS centres providing health services for Palestinian youth.
- Develop clear policies, strategies and technical plans to regulate services targeting youth between institutions so they can coordinate their efforts to develop human resources and work in a comprehensive approach to meet youth needs and promote their development.
- Establish youth-friendly services utilizing social media, theatre and any other creative methods that attracts young people and meet their interests and hobbies.
- Adopt youth-friendly health services by the governmental and community organisations.
- Conduct strong campaigns to increase the awareness of families of the importance of involving their children to participate in youth related activities as these activities will enhance their skills and ability to develop their personalities.
- Provide more financial support and resources to invest in youths-related issues.

## 5.2.2 Recommendations from health service providers

- Set up a comprehensive plan that includes community health organisations to improve the young people's accessibility to health information and services through health centres and mobile clinics in remote and unprivileged areas including east Jerusalem and Area C.
- Set up a comprehensive national plan that includes governmental and NGOs for the establishment of YFHS in Palestine.
- Conduct media campaigns at the governorates level to advocate for young people the importance of accessing health information and services in the nearby centres.

## 5.2.3 Recommendations from young people

- Provide comprehensive and integrated youth-friendly health services that include sexual and reproductive health; promote their life skills to meet their desires and aspirations; psychological counselling, social advice, nutrition awareness and rehabilitative care.
- Equip youth-friendly health services with well-trained and qualified health professionals that have experience in dealing with young people within appropriate place and space that ensures privacy and confidentiality during the provision of counselling services.
- Ensure that youth-friendly health services are independent, provides accessible location within the city center and in the villages and is open in the mornings and afternoons.
- Hire female physicians for the provision of care for young females.
- Strengthen the role of school health programmes on awareness and education regarding students' SRH, life skills, and other youth issues necessary for their development.

- Activate the role of school teachers in the Ministry of Education and private schools to address the health lessons and the reproductive system in science classes.
- Internet-based services (specific webpages) to provide advice and guidance on various health topics for youth.
- Establish a media channel for young people to address their problems and needs to provide; possible assistance on health awareness and behaviour modification as said by a 22-year-old male.
- Provide opportunities for young people to be qualified to work on initiatives that introduce youth issues utilizing different models such as conducting awareness sessions, theater and the model of the young as peer educators to be change agents.
- Involve young people in policies and decisions that concern youth and allow them to participate in all stages of service delivery.

## 5.2.4 The study recommendations

1. ***Recognize the need for dedicated policies and services for adolescents and youth as a priority area within the health and education sectors***

This report adds to the body of evidence, which clearly shows that adolescents and youth have specific health needs, and that their ability to meet these needs may be inhibited unless specific actions are taken. The ultimate aim must be to establish and institutionalize YFHS as a recognized priority area within the health and education sectors. These may include actions at policy level, (such as the development of dedicated policies and strategies), at institutional level (such as the establishment of a dedicated unit on adolescent health within the Ministry of Health (MoH), and/or the formalization of working arrangements on adolescents

and youth between Ministries of Health and Education). They must also include actions at the level of services, where the findings of the report can inform priority setting in terms of the priorities required for health centres to be youth-friendly in practice.

- To ensure sustainable scale-up and continuity of services, develop formal partnerships and frameworks with the Ministry of Health, which has the greatest impact on downstream health services including YFHS, if possible including a dedicated directorate at the MoH; further, formalize cooperation between MoH and the MoE to ensure enhanced delivery of evidence-based health education. Improvements of school health systems and the promotion of an integrated youth health nurse system within schools and universities may also have the potential for significant impact.
- Enhance coordination within the sector among actors involved in the delivery of health services for adolescents and youth. The recently formed Adolescent Health Coalition may be a very effective vehicle for improved coordination not only around programming and service delivery but also around advocacy.

2. ***Enhance the availability and accessibility of health services for adolescent and young people***

The survey of young people tells a clear story. Many young people are (or feel) unable or unwilling to access health services, either because they do not exist, because they are unaware of them, or because they do not trust them. It is therefore essential that efforts are made to enhance the availability and accessibility of youth-friendly health services, and to increase young people's awareness of what, where they are and how to seek help.

1. ***Scale-up existing efforts to provide health services for adolescents and youth, taking into account lessons learned to date, as well as the findings of the research.***

- a. Consider developing quality assessment tools including a set of minimum quality criteria for YFHS, including a focus on availability and accessibility, the competence of health service providers, satisfaction of users, and criteria such as cost, opening times, physical space and equipment/materials. The criteria should be developed and owned by the Ministry of Health and supported by partners, as a means of ensuring standardization and institutionalization of quality.
- b. In scaling up YFHS, take into account young people's views on their preferred type of clinic, locations and opening times.
- c. Ensure that services provided match the priority needs of young people as identified through the survey, and that service providers are equipped and willing to provide services which are competent and non-judgmental. Furthermore, take into account the

important gender differences in the stated priorities and needs between male and female respondents, and tailor services accordingly.

- d. In recognition of the significant number of respondents in the survey who say they are not aware of the existence of location of health services, let alone YFHS, ensure greater dissemination of information around the availability, location and opening times of service centres, as well as of services available. Further, consider organizing introduction visits, for example of university students, where students can meet the health workers and receive an overview of which services are available. In addition, information online and on Facebook and other social media may be scaled up by YFHS.

2. ***Ensure that YFHS centres are staffed with well-trained, competent service providers with positive attitudes to young people.***

A significant finding of the survey is that young people do not have high expectations of health providers. Their experiences are fairly negative, with almost half of dissatisfied respondents pointing to dissatisfaction with health workers. Indeed some 26% of young people who did not seek health services state that they fear judgement, a lack of confidentiality, or other factors relating to health workers' competence. Whether these perceptions are real or perceived, they point to a significant area of improvement. Specific recommendations include:

- Ensure that staff working in YFHS are provided with dedicated training on youth health needs, which includes specific components on confidentiality and the

need for judgement-free attitudes. Include requirements for such training in quality criteria for assessing YFHS, along with questions about client (both female and male) satisfaction.

- Ensure that YFHS staff include both women and men, in recognition of the shame and embarrassment that young people may feel in discussing sensitive issues with a service provider of the opposite sex.
- Recognizing that confidentiality is a major concern, and further recognizing that SRH issues, in particular, may be challenging for health workers to discuss openly, ensure the availability of reliable means of accessing information such as written materials and online resources and/or apps. Such tools can ensure that young people access correct information without having to have face-to-face conversations if they do not feel comfortable doing so.

3. ***Redouble efforts to ensure that issues of stigma, shame and embarrassment, including that which is caused by cultural conservatism, do not become impediments to young people's access to information and services.***

Unsurprisingly, it is clear from the research that issues relating to stigma, reputation, and embarrassment are important impediments to ensuring that adolescents and youth receive and make use of high-quality information, counselling, and services. To tackle these issues, a dual approach is proposed; first, to work around the stigma by providing young people with other, more confidential/private avenues for accessing correct information; and second, tackling the stigma head-on by seeking to speak more openly about SRH issues and needs.

- Given that a significant majority of adolescents and youth say their preferred



method of accessing information is the internet, ensure that high-quality information is accessible to young people through trusted channels.

- Promote existing and new online tools and mobile phone applications (including the “Mustashari” app which is under development) to ensure young people can access reliable information confidentially.
- Ensure YFHS are well stocked with reading material which can be taken home and read in private, including entertaining materials such as comic book formats.
- In order to challenge the stigma around SRH issues, seek to promote dialogue about SRH in local and national media, on radio talk shows and on television.
- At the institutional level, work with the Ministry of Education to promote the effective delivery of Comprehensive Sexuality Education in schools, both by ensuring a holistic curriculum, and by supporting teachers to deliver the most sensitive sessions comfortably. Currently,

a group of technical professionals are updating the teachers and counsellors’ guidance book on adolescent health, coordinated by Juzoor for Health & Social Development. This book will include youth-friendly material and exercises to do in classrooms. Such work may be most effective when accompanied with community/parent outreach to ensure understanding and buy-in of the material taught.

- Establish, and scale-up, peer-to-peer education as a means of providing SRH information and outreach. This may be especially effective for young women, as they most frequently stated that they seek the advice of their friends and peers.
- Community outreach at all levels is needed to tackle the existing stigma and misconceptions connected to a number of topics such as FP, SRH, and STIs etc. With the aim to increase the accessibility, availability and acceptability of services and information.





# References

# References



Abdeen, Z., Jildeh, C., Dkeideek, S., and Al-Sabbah, H. (2012). *Overweight and Obesity among Palestinian Adults: Analyses of the Anthropometric Data from the First National Health and Nutrition Survey (1999-2000)*.

ACT Healthy Young People Feasibility Study Final Report (November 2011). Prepared for the ACT Government Health Directorate by LeeJenn Health Consultants <http://360edge.com.au/assets/uploads/2017/01/ACT-Healthy-Young-People-Final-Report.pdf> Accessed August 2018

Adams, R.J., Appleton, S.L., Hill, C.L., Dodd, M., Findlay, C., & Wilson D.H. (2009). *Risks associated with low functional health literacy in an Australian population*. Medical Journal of Australia; 2009, 191(10), 530-534.

Anderson, J. and C. Lowen (2010), *Connecting youth with health services systematic review*. Canadian Family Physician, 56: p. 778-84.

Bernard, D., et al., (2004) *Access to primary health care for Australian adolescents: how congruent are the perspectives of health service providers and young people, and does it matter?* Australian and New Zealand Journal of Public Health, 28(5): p. 487-492.

Brindis, C.D., Klein, J., Schlitt, J., Santelli, J., Juszczak, L., and Nystrom, R.J. (2003). School-based health centers: accessibility and accountability. Journal Adolescent Health, 32(1): 98–107.

Burns, A., Ruland, C., Finger, W., Murphy-Graham, E., McCarney, R., and Schueller, J. (2004). Reaching out-of-school youth with reproductive and HIV information and services: youth issues papers. Arlington: Family Health International, YouthNet Program

International Planned Parenthood Federation (IPPF). (2005). International Medical Advisory Panel. *IMAP Statement on contraception for adolescents/young people in an era of HIV and AIDS*. Available from [https://issuu.com/ippfresources/docs/medical\\_bulletin\\_june06](https://issuu.com/ippfresources/docs/medical_bulletin_june06)

IPPF. (2008). *Provide: Strengthening youth-friendly services*. Available from [https://www.ippf.org/sites/default/files/inspire\\_provide.pdf](https://www.ippf.org/sites/default/files/inspire_provide.pdf)

Efrat, M. (2015). *Divide and Conquer: Inequality in Health*. Available from <https://reliefweb.int/sites/reliefweb.int/files/resources/256771352-Divide-Conquer-Inequality-in-Health-PHR-Israel.pdf>

Erulkar, A., C. Onoka. (2005). *What is youth-friendly? Adolescents' preferences for reproductive health services in Kenya and Zimbabwe*; African Journal of Reproductive Health, 9(3).

Geary, R., Gómez-Olivé, F., Kahn, K. Tollman, S., and Norris, A. (2014) *Barriers to and facilitators of the provision of a youth-friendly health services programme in rural South Africa*. BMC Health Service Res. 2014; 14: 259

Glick P, Al-Khammash U, Shaheen M. (2018). *Health risk behaviors of Palestinian youth: findings*

from a representative survey. *East Mediterr Health J.* 2018 May 3; 24(2):127-136. <https://www.ncbi.nlm.nih.gov/pubmed/29748941> accessed Nov. 2018

Healing the wounds (March, 2015). Handicap International Gaza Emergency Response Action Report

Health Cluster in the occupied Palestinian Territories (September, 2014) Gaza Strip, Joint health Sector Assessment Report [http://www.emro.who.int/images/stories/palestine/documents/Joint\\_Health\\_Sector\\_Assessment\\_Report\\_Gaza\\_Sept\\_2014-final.pdf](http://www.emro.who.int/images/stories/palestine/documents/Joint_Health_Sector_Assessment_Report_Gaza_Sept_2014-final.pdf) Accessed August 2018

Hoyle, C. (2017). *Mental health in Palestine among world's worst.*

<https://www.alaraby.co.uk/english/indepth/2017/5/12/mental-health-in-palestine-among-worlds-worst>

International Conference on Population and Development Taskforce. (2013). Policy Recommendations for the ICPD Beyond 2014: *Sexual and Reproductive Health and Rights for All.* <http://www.icpdtaskforce.org/pdf/Beyond2014/policy-recommendations-for-the-ICPD-beyond-2014.pdf>

Johnson, RL., Botwinick, G., Sell RL, et al. (2003). The utilization of treatment and case management services by HIV-infected youth. *Journal Adolescent Health*, 33(1): 31–38.

Juzoor, Foundation for Health and Development. (2010). *Women's Health Surveillance Report: Towards a Multidimensional Look at the Health of Palestinian Women*

Kang, M, Bernard, D., et al., (2005). *Access to health care among young people in New South Wales: Phase 2 Final Report.* NSW Centre for the Advancement of Adolescent Health: Sydney.

Kang, M. et al. (2005). *Better practice in youth health: final report on research study access to health care among young people in New South Wales: phase 2.* Sydney: New South Wales Centre for the Advancement of Adolescent Health, Children's Hospital at Westmead and Department of General Practice, University of Sydney at Westmead Hospital

LaVake, S. (2003). Applying social franchising techniques to youth reproductive health/HIV services: youth issues iapers. Arlington: Family Health International, YouthNet Program

Manenti, A., Ville de Goyet, C., Reinicke, C., Macdonald, J., & Donald, J. (2016). *Report of a Field Assessment of Health conditions in the Occupied Palestinian Territory.*

Neukom, J., and Ashford, L. (2003). Changing youth behaviour through socialmarketing-program experiences and research findings from Cameroon, Madagascar, and Rwanda. Washington: Population Services International

Nutbeam, D. (2008). *The evolving concept of health literacy.* *Social Science and Medicine*, 67(12)

Palestinian Central Bureau of Statistics (PCBS). (2013). *Annual Report; Palestine Children– Issues and Statistics :Child Statistics Series* (16) Available from [http://www.pcbs.gov.ps/Portals/\\_PCBS/Downloads/book1971.pdf](http://www.pcbs.gov.ps/Portals/_PCBS/Downloads/book1971.pdf)

PCBS. (2011). *Assessment of Youth Friendly Health Services Needs in West Bank*.

PCBS. (2018) *On the Eve of International Youth Day, 12/08/2018* <http://www.pcbs.gov.ps/post.aspx?lang=en&ItemID=3215> Accessed Sept. 2018

Palestinian Central Bureau of Statistics (PCBS). (2019a). *On the Eve of International Youth Day, 12/9/2019*.<http://www.pcbs.gov.ps/post.aspx?lang=en&ItemID=3528>

PCBS. (2015). *Palestinian Youth Survey*. Available from [http://www.pcbs.gov.ps/portals/\\_pcbs/PressRelease/Press\\_En\\_YouthSurvPal2015E.pdf](http://www.pcbs.gov.ps/portals/_pcbs/PressRelease/Press_En_YouthSurvPal2015E.pdf). Accessed August 2018

PCBS. (2018). *PCBS: The International Youth Day, 12/08/2018*. Retrieved 2019-02-08 from <http://www.pcbs.gov.ps/post.aspx?lang=en&ItemID=3215>

PCBS. (2017). *Preliminary Results of the Population, Housing and Establishments Census*. Available from [http://www.pcbs.gov.ps/portals/\\_pcbs/PressRelease/Press\\_En\\_Preliminary\\_Results\\_Report-en-with-tables.pdf](http://www.pcbs.gov.ps/portals/_pcbs/PressRelease/Press_En_Preliminary_Results_Report-en-with-tables.pdf) accessed August 2018

PCBS. (2011). *Press Release Main Findings of Violence survey in the Palestinian Society, 2011*. Available from [http://www.pcbs.gov.ps/portals/\\_pcbs/pressrelease/el3onfnewenglish.pdf](http://www.pcbs.gov.ps/portals/_pcbs/pressrelease/el3onfnewenglish.pdf)

Shaw, D. (2009). *Access to sexual and reproductive health for young people: Bridging the disconnect between rights and reality*. *International Journal of Gynecology & Obstetrics*, 106(2), 132-136.

The Lancet. (2004). *Who is responsible for adolescent health?*, 363(9426)

Toomet, K., Part, K., and Haldre, KA. (2004). *decade of youth clinics in Estonia*. *Entre nous: the European magazine for sexual and reproductive health*, 58: 5–6.

Tylee, A., et al., *Youth-friendly primary-care services: how are we doing and what more needs to be done?* *The Lancet*, 2007; 369

United Nations. (2007). *World Youth Report 2007- young people’s transition to adulthood: progress and challenges*. United Nations Department of Economic and Social Affairs.

UNAIDS and UNICEF. (2006). *HIV and AIDS Terminology Guide and Glossary for English Arabic Users*

UNESCO. (2016). *State of Palestine: 2017-22 National Policy Agenda*. Available from [https://planipolis.iiep.unesco.org/sites/planipolis/files/ressources/palestine\\_draft\\_final\\_npa.pdf](https://planipolis.iiep.unesco.org/sites/planipolis/files/ressources/palestine_draft_final_npa.pdf)

United Nations Population Fund (UNFPA). (2016a). *International Conference on Population and Development*. Available from <https://www.unfpa.org/icpd>. Accessed on October 30, 2018.

UNFPA (2016). *Palestine 2030 – Demographic change: Opportunities for development*. Available from <https://palestine.unfpa.org/en/publications/palestine-2030-demographic-change-opportunities-development>



UNFPA. (2019) Strategy for adolescents and youth – *My Body, My Life, My World*. Accessible at [https://www.unfpa.org/sites/default/files/pub-pdf/My\\_body\\_my\\_life\\_my\\_world\\_lowres\\_pages.pdf](https://www.unfpa.org/sites/default/files/pub-pdf/My_body_my_life_my_world_lowres_pages.pdf).

UNFPA. (2014). Statement by UNFPA Executive Director “Sexual and Reproductive Health is a Fundamental Human Rights”. <https://www.unfpa.org/press/sexual-and-reproductive-health-fundamental-human-right-unfpa-executive-director-addresses>

UNFPA. (2015). Youth Friendly Health Assessment in Gaza Strip. Save Youth Future Society

UNFPA. (2015). *Youth Friendly Health Services National Protocol*. Palestinian Ministry of Health

UNFPA. (2017). *Youth in Palestine. Policy and program recommendations to address demographic risks and opportunities*. Available from <https://palestine.unfpa.org/en/publications/youth-palestine-2017>

U.S. Department of Health and Human Services (HHS). (2018). *AIDSinfo Glossary of HIV/AIDS-Related Terms*. 9<sup>th</sup>. Ed. (p. 2) [https://aidsinfo.nih.gov/contentfiles/glossaryhivrelatedterms\\_english.pdf](https://aidsinfo.nih.gov/contentfiles/glossaryhivrelatedterms_english.pdf) Accessed Jan. 12<sup>th</sup>. 2019

World Bank. (2007). *World Development Report - Development and the next generation*. The World Bank: Washington, DC.

World Health Organisation (WHO). (2002). *Adolescent friendly health services: an agenda for change*. WHO: Geneva.

WHO. (2012). *Making health services adolescent friendly: Developing national quality standards for adolescent friendly health services*. Department of Maternal, Newborn, Child and Adolescent Health

WHO. (2009). *Prevalence of common mental health disorders in the PHC*. Unpublished report Gaza

WHO. (2009). *Quality Assessment Guidebook: A guide to assessing health services for adolescent clients*. Geneva, Switzerland: WHO

WHO. (2006). *Quality of Care: A process for making strategic choices for health systems*. Geneva, Switzerland: WHO.

Wyn, J, Cahill H, Holdsworth R, Rowling L, Carson S. (2000). *Mind Matters, a whole-school approach promoting mental health and wellbeing*. Aust N Z J Psychiatry; 34: 594–601.



# ANNEXES

## Annex 1

### A letter of endorsement by UNFPA



صندوق الأمم المتحدة للسكان


United Nations Population Fund

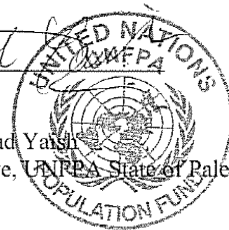
30 August 2018

#### Letter of Endorsement

This letter is to confirm that Dr Sumaya Sayej is an independent consultant contracted by UNFPA Palestine country office to conduct a feasibility study on youth-friendly health services (YFHS). The main objectives of the study are a) to assess the needs of youth in East Jerusalem, the West Bank and Gaza, b) identify delivery points to provide and sustain YFHS in Palestine and c) provide recommendations to replicate existing models. Within the scope of her work, Dr Sayej will consult with different stakeholders as well as beneficiaries to identify best practices and experiences. Your sincere cooperation to facilitate Dr Sayej's endeavors is much appreciated.

Should you have any questions, please feel free to contact me at 02 581 7167 (extension 71008).

  
Ziad Yassin  
Assistant Representative, UNFPA State of Palestine



26 Nablus Road  
Khan ElOmdan Building (former Mt. Scopus Hotel)  
Sheikh Jarrah  
P. O. Box 67149  
Jerusalem 91196

Tel: +972-2-5817167  
Fax: +972-2-5817382  
palestine.unfpa.org

# Annex 2

## Quantitative questionnaire

### Young people perception of YFHS in occupied Palestinian Territories

#### Dear participant

The aim of this questionnaire is to assess your socio-demographic characteristics and identify key issues and needs of young people (15–29 years) in East Jerusalem, West Bank and Gaza for the so called “youth friendly health services” and their preference of settings and approaches. The information obtained will form a road map for a successful and sustainable YFHS delivery points and to strengthen capacities for all relevant stakeholders to meet young people needs. Filling the questionnaire may take 10-20 minutes of your time, your participation is entirely voluntary, anonymous, and the information you give is very confidential. You may refuse to answer any question and can decide to withdraw at any time you want.

#### A. Socio-demographic data

1. **Locality:**  Jerusalem  West Bank  Gaza strip

2. **Gender:**  Male  Female

3. **Age:**  15-19 years  20-24 years  25-29Years

4. **Education status:**  undergraduate student  graduate student

#### 5. Marital status

**Are you;**  Single  Married  Divorced  Widow\widower  Separated

If married, what was your age at that time? -----

At what age you had your first child? -----

Spouse relationship:  First cousin  Second Cousin  Far relative  Unrelated

Number of household members: -----

Are there any other family members living with you?

Grandfather/ Grandmother  Uncle/Aunt  others/specify -----

#### 6. Economic status

**Do you work**  Yes  No

**If you work, is it?**  Full time job (35 hours and over/week)  part time  currently not employed

**What kind of work you do?**

- Self employed     Labourer     Work in shop, office or business     Professional  
 others\specify -----

**What is the average of your household income (NIS) per month -----?**

**B. Young people's health and well being; general knowledge and practices**

**1. How do you feel about your health status?**

- Excellent                       Good                       Fair                       Bad

**2. Do you consider your level of health information is;**

- Excellent                       Good                       Fair                       Bad

**3. What is your perception of the concept of health**

- Having no physical disease  
 The optimal state of mental, physical and social well being and not only being free from diseases  
 Other-----  
 Don't know

**4. What is your perception of the major health issues that young people may face? (You can check more than one if applicable)**

- Chronic diseases                       Skin diseases                       Others\specify-----  
 Psychological\emotional problems     Reproductive and sexual health     Don't know  
 Diseases related to risk behaviors     Problems of nutrition and obesity

**5. Do you practice sports Activity?     Yes                       No**

**If yes; how many times per week?     Less than 3                       3 and more**

**6. What dietary habits and nutrition you follow in general?**

- Eat three meals a day                       Eat junk food                       Eat balanced diet  
 I'm on diet to keep shape     others\specify-----

**7. Do you have any health problems related to dietary habits and nutrition?**

Yes       No

**If yes, what is it?**     Underweight       Overweight     Obesity

Anemia       do not know     Others\specify -----

**C. Sexual and reproductive health issues (SRH)**

**1. Do you have/had problems related to your pubertal changes?**

Yes       No

**If yes, what is it?** *(You can check more than one if applicable)*

Pain during your menstrual period     Acne       Mood changes

Depression     Anxiety     Others\specify-----

**2. Have you heard about sexual and reproductive health**

Yes       Some information       No

**3. What do we mean by sexual and reproductive health** *(You can check more than one if applicable)*

- Is a state of well-being physically, psychologically and socially in all matters relating to the reproductive system, its functions and processes, not merely absence of disease or infirmity
- means people’s ability to enjoy a satisfying and safe sexual life, and the ability to have children, and the freedom to decide when and how often to do so
- means the full right of men and women to enjoy their reproductive and sexual health and participate in decision-making regarding this matter
- all has the right to the highest attainable standard of sexual health and the access to sexual and reproductive health services
- do not know

**4. Have you ever heard about contraceptives**

Yes       Some information       No



5. **Do you know what the types of contraception are?**

- Yes  No

**If yes, what are they?** *(You can check more than one if applicable)*

- Hormonal methods (Pills or oral contraception)  
 Hormonal methods (Injectables)  
 Mechanical methods (male and female condoms)  
 Surgical intervention  
 Natural methods  
 Emergency contraceptives

6. **Do you know that male condoms are used as a mean of STIs protection beside its birth control role?**

- Yes  Some information  No

7. **Do you know if any of your friends has or had premarital sexual relationships?**

- Yes  No

8. **Do you know how STIs can be transferred to others?**

- Yes  No

If yes, how -----

9. **Did you or any of your friends have ever suffered or still suffering from STIs?**

- Yes  No

**If yes, what type of STIs?** *(You can check more than one if applicable)*

- Candida  Gonorrhoea  Syphilis  
 Hepatitis B  HIV/AIDS  Others\ specify-----

10. **Did you seek awareness and counseling regarding sexual and reproductive health matters from?** *(you can check more than one if applicable)*

- Mother  School\University  Did not seek

- Father
- Health professionals
- Social media
- Older Sibling
- Health facility
- Others

**11. Do you use the social media or to have information related to health in general and SRH in specific?**

- Yes                       No

If yes, indicate the time you use;

- 1-3 hours and more daily
- 5 hours and more weekly
- Less than 5 hours weekly
- I use it sometimes

**12. Do you think that education and counseling about sexual and reproductive issues can help individuals to:** *(you can check more than one if applicable)*

- Gain correct health information related to reproductive system and sexual behavior
- Be encouraged to improve and sustain their sexual desires and motivation
- Protect young people from incorrect sex experiences
- Develop positive attitudes and maturity toward sexual and reproductive issues
- Feel comfortable in discussing sexual issues with peers

**D. Risk behaviors**

**1. Do you smoke?**     Yes                       No

If yes, at **what age** you started smoking -----

**What type** of smoking you practice?*(You can check more than one if applicable)*

- Cigarettes     Argilah                       Hashish                       Others / specify-----

**2. Do you drink alcohol?**     Yes                       No

If yes, how often do you have a drink containing alcohol?

- Once monthly or less     2-4 times a month                       2-4 times a week                       daily

**3. Do you take any illegal drugs?**     Yes                       No

If yes, what type of drugs -----?

**4. Have you ever been in a relationship with someone who had a habit of abusing you at home?**

- Yes       No

**If yes, who is the abuser (you can check more than one if applicable)**

- Father       Mother       Brother       Sister       others /specify-----

**5. If yes, what type of abuse? (You can check more than one if applicable)**

- Verbal \Emotional       Physical       sexual       others /specify-----

**6. Have your household ever been exposed to violence from Israeli forces and/or settlers?**

- Yes       No

**If yes, who has been abused? (You can check more than one if applicable)**

- Me       Father       Mother       Brother       Sister       Others /specify-----

If yes, do you believe this situation played a part in the domestic violence you experience or know of?

- Yes       No       not sure

**7. Have you ever sought or still seeking help if you have any of the health and social problems mentioned above?**

- Yes       No

**If yes, for which problem? (You can check more than one if applicable)**

- Smoking       alcohol       drugs use  
 Abuse       STIs       others \specify-----

**8. Where did you go for help (You can check more than one if applicable)**

- Private Health Clinic       psychological counselor       Parents/ friends  
 Government Health Clinic       rehabilitation centre       Did not go to any place or person  
 Social services       Pharmacy       Other/ specify-----  
 Did not know where to go?

## E. Questions Related To YFHS

1. Usually, where do you get your health information from? (*You can check more than one if applicable*)

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Internet                 | <input type="checkbox"/> Family (father, mother, brother, sister) | <input type="checkbox"/> counselor or a doctor or nurse |
| <input type="checkbox"/> Health centre and Clinic | <input type="checkbox"/> Magazines, Books                         | <input type="checkbox"/> school / university            |
| <input type="checkbox"/> Friends                  | <input type="checkbox"/> Media (newspaper, radio, TV)             | <input type="checkbox"/> Others                         |

2. Have you ever needed any of the following health services during the current year? (*You can check more than one if applicable*)

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Nutritional Health Services | <input type="checkbox"/> Skin Health Services     | <input type="checkbox"/> Psychological Health Services |
| <input type="checkbox"/> Sexual and Reproductive     | <input type="checkbox"/> Physical Health Services |  |
| <input type="checkbox"/> Did not need                |   |  |

3. Where did you go (place) for receiving the health services when you needed (*You can check more than one if applicable*)

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Private Health Clinic        | <input type="checkbox"/> School/ University counselor      | <input type="checkbox"/> Hospital            |
| <input type="checkbox"/> Government Health Clinic     | <input type="checkbox"/> UNRWA Health clinic               | <input type="checkbox"/> Pharmacy            |
| <input type="checkbox"/> School/ University services  | <input type="checkbox"/> NGOs Health clinic                | <input type="checkbox"/> Parents/ friends    |
| <input type="checkbox"/> Internet or book or magazine | <input type="checkbox"/> Did not go to any place or person | <input type="checkbox"/> Other\ specify----- |

4. Are you satisfied about the quality of services you received

- |                              |   |                             |
|------------------------------|---|-----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> To some extent | <input type="checkbox"/> No |
|------------------------------|---|-----------------------------|

5. Why do you feel not or partially satisfied about the quality of services you received (*you can check more than one if applicable*)

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Inefficient workers                                      | <input type="checkbox"/> Not friendly Service Provider       | <input type="checkbox"/> Lack of needed information |
| <input type="checkbox"/> Difficulty in accessing the service                      | <input type="checkbox"/> Lack of privacy and confidentiality | <input checked="" type="checkbox"/> High Cost       |
| <input type="checkbox"/> Lack of interest and understanding of the needs of youth | <input type="checkbox"/> Other-----                          |   |

**6. What are the reason(s) for not going to health centres to receive health Services(*you can check more than one if applicable*);**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Not available             | <input type="checkbox"/> Cultural (stigma, reputation etc) | <input type="checkbox"/> don't trust the place |
| <input type="checkbox"/> Not accessible            | <input type="checkbox"/> Fear and embarrassment            | <input type="checkbox"/> Don't know            |
| <input type="checkbox"/> no quality service        | <input type="checkbox"/> confidentiality not ensured       | <input type="checkbox"/> Other\ specify-----   |
| <input type="checkbox"/> Did not know where to go? |  |  |

**7. Do you perceive the current health services meet youth needs?**

- Yes       To some extent       No

**8. Are there health services within the school \ University you are studying or studied at?**

- Yes       No

**If yes; what are they? (*You can check more than one if applicable*)**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Primary health care clinic | <input type="checkbox"/> general practitioner | <input type="checkbox"/> Registered nurse |
| <input type="checkbox"/> Counseling services        | <input type="checkbox"/> Social services      | <input type="checkbox"/> others -----     |

**9. Do you know what youth friendly health services mean?**

- Yes       No

**If yes, what does it mean to have YFHS (*you can check more than one if applicable*);**

- High-quality services; information, counseling and referral that is relevant, accessible, affordable, appropriate and acceptable to the young people.
- The services are provided in line with the minimum health package
- aims to increase acceptability and use of health services by young people
- All young people have access to health information and services regardless of their status, gender, origin etc...

**10. Do you know what YFHS centre/clinic is supposed to deliver? (*You can check more than one if applicable*);**

- marriage and pre-marriage counseling,
- sexual education and awareness
- family planning,

- violence counseling,
- general information on SRH,
- Life coach for healthy lifestyle (sports, nutrition, active citizenship and other factors related to wellbeing).
- Do not know

**11. What are your preferred place /centre to receive YFHS (you can check more than one if applicable);**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Government Health centre | <input type="checkbox"/> UNRWA Health centre       | <input type="checkbox"/> Family centre |
| <input type="checkbox"/> Private Health centre    | <input type="checkbox"/> School/ University centre | <input type="checkbox"/> Don't know    |
| <input type="checkbox"/> NGOs Health centre       | <input type="checkbox"/> Youth and sport centre    | <input type="checkbox"/> Others-----   |

**12. What time do you prefer to go to the health centre to receive the services?**

- Morning       Afternoon       Evening       Do not mind

**13. Do you prefer your health care provider to be?**

- Male       Female       Do not mind       Don't know

**14. Do you prefer the location of the YFHS to be?**

- Faraway from place of residence       Near to place of residence       Other-----

**15. In your opinion confidentiality is important when you seek or receive your own health services**

- Yes       No       Sometime       Don't know

**16. In your opinion the financial costs is an obstacle to obtain health service**

- Yes       No       Sometime       Don't know

**17. Do you prefer a separate time when receiving YFHS for girls and boys**

- Yes       No       Do not mind       Don't know

## Annex 3.A -

### Qualitative questions, interviews with academic and services professionals

#### المقالات المعمقة

١. ما هي البرامج والنشاطات التي تعنى بالشباب والشابات الموجودة بمؤسستكم
  - هل الشباب والشابات يشاركون ويظهروا الاهتمام بهذه البرامج والنشاطات
  - ما هي العوائق لمشاركتهم بهذه النشاطات
  - ماذا تحب أن ترى بالمجتمع ما يناسب اهتمام وهوايات الشباب
٢. برأيكم ومن تجربتكم، ما هي القضايا \ المشاكل والاحتياجات الصحية والاجتماعية التي تواجه الشباب؟ مثلاً
  - قضايا صحية (جسدية \ نفسية \ امراض مزمنة \ اعاقات الخ...)
  - قضايا اجتماعية (الزواج المبكر \ زواج الاقارب \ العمل \ التعليم \ الوضع لاقتصادي الخ...)
  - قضايا الصحة الانجابية والجنسية (الحاجة للتوعية والارشاد والخدمات؛ مثلاً التغيير الحصل عند البلوغ للاصغر سناً \ وسائل تنظيم الاسرة \ قضايا الحل والولادة \ الامراض المنقولة عن طريق الجنس الخ...؟)
  - السلوكيات الخطرة وما الذي يؤدي لتلك السلوكيات (التدخين \ شرب الكحول \ تعاطي المخدرات الخ...)
  - قضايا العنف (العنف الاسري والعنف المبني على النوع الاجتماعي \ والعنف الناتج من عنف الجيش الاسرائيلي الخ..)
3. ما الذي تقدمه مؤسستكم حالياً للشباب \ الطلبة للحصول على المعلومات والخدمات الصحية؟
  - هل لديكم برامج صحية؟ ما هي؟ وهل تحتاج هذه البرامج إلى توسيع؟
  - هل عندكم خدمات محددة مثل مركز للشباب أو مركز للرعاية الصحية الأولية أو مركز عائلة؟
  - هل هذا مركز الخدمة الصحي مجهز من ناحية الموارد البشرية (ممرض، طبيب، مرشد نفسيا اجتماعي؟) والمادية (من ناحية الاجهزة \ المختبرات \ الادوية الخ...)
  - هل عندكم خدمات العلاج، المشورة و التحويل للقضايا الصحية عامة وقضايا الصحة الانجابية والجنسية \ القضايا النفسية \ قضايا الادمان والامراض المزمنة الخ....
  - هل مركز الخدمة عندكم سهل الوصول من قبل الشباب؟ هل مساحة المكان واسعة وتؤمن الخصوصية والسرية لهم؟

- هل الخدمات مجانية
  - ماذا عن الشباب الاقل حظا للحصول على خدمات تخصصهم أي أن يكون هناك خدمات عادلة للجميع؟ (ذوي الاحتياجات الخاصة، متعاطي الكحول والمخدرات الخ...)
  - هل تتعاونوا مع المؤسسات الصحية كل حسب عملها وتخصصها من أجل التحويل \ التوعية \ العلاج والمتابعة؟
٤. ما هي العوائق الرئيسية للحصول على الرعاية الصحية من قبل الشباب ؟ ولماذا برأيكم؟
- عدم توفر الخدمة (لا يوجد مراكز خاصة تعنى بقضايا صحة الشباب والمراهقين)
  - الخدمات المتاحة لا تلبي الحد الأدنى من احتياجات الشباب والمراهقين
  - تكلفة الخدمة
  - جودة الخدمات غير مناسبة (انعدام أو قلة الخبرات والقدرات البشرية والمادية والتجهيزات الخ...)
  - السرية والخصوصية غير مضمونة
  - عدم تفهم الشباب لهذه القضايا
  - ثقافة المجتمع المحلي تؤثر على وصول الشباب لمراكز الخدمة (سمعة، وصمة عار الخ...)
  - الشباب لا يعرفوا الى أين يتوجهوا
  - الوصول إلى الخدمات الصحية والوقت المناسب؛ (عدم وجود خدمات ما بعد ساعات العمل، وقوائم انتظار طويلة خاصة بالمستشفيات ، ووقت انتظار طويل)
٥. هل يوجد نظام صحي عام للشباب وما الذي يقدمه حاليا إن وجد (الاجابة كل عن منطقتة؛ الضفة الغربية، القدس ، قطاع غزة ؟)
- ما هو هذا النظام؟
  - ما هي نقاط القوة لهذا النظام
  - ما هي نقاط الضعف
  - أين هي الفرص لتحسين هذا النظام؟
  - هل تعتبر الشراكة مع نظام الرعاية الصحية المحلي؟
  - ما هي توصياتكم
٦. برأيكم ما الذي يعمل بشكل جيد للشباب؟ (يتم تسليط الضوء على عدد من البرامج والخدمات التي تعمل بشكل جيد):
- مرافق الرعاية الصحية الأولية (وزارة الصحة \ الأونروا \ المنظمات غير الحكومية \ المستشفيات \ إلخ ...)
  - مراكز الشباب في الجامعات إن وجدت



- المرصطات والمرشدرات بالمدارس والكليات وغيرهم
- مراكز العائلة إن وجدت
- الخدماة في مجال الصة الجنسية (المعلوماة \ والإرشاد حول نمط الحياة الصحي والجنسي)
- خدماة التحويل
- وخدماة الصة النفسية والعقلية \ والتأهيل

٧. أين هي فرص الخدماة والأنظمة الاساسية لرعاية الشباب؟

- التوعية والتثقيف الصحي في المدارس والكليات
- هل يقدم المنهاج المدرسي التربية البدنية والتوعية الصحية للطلاب
- هل هناك تعليم وتدريب للتوعية والتثقيف الصحي بشكل تدريجي وممنهج؟
- هل هناك فرص في مجال الوقاية وأنشطة التدخل المبكر لمنع التدخين \ وتعاطي الكحول \ والمخدراة \ والمشاكل النفسية \ العقلية والاجتماعية الشائعة الناتجة بسببها وغيرها؟
- هل هناك فرص للتعاون بين المؤسسات لرعاية الشباب
- هل توجد معلوماة صحية عالية الجودة ومشورة صحية ومعلوماة عن الخدماة والبرامج القائمة؟

٨. هل يحتاج الشباب إلى مركز لتغطية احتياجاتهم الصحية؟ (طابع الخدماة الصحية)

- هل تؤيد إنشاء مركز لصحة الشباب؟
- أين يجب أن يكون المركز؟ وفي أي موقع؟
- هل يفضل أن يكون المكان \ بعيد عن مكان سكن الشباب أم قريب \ معروف ومشهور
- ما هي ساعات العمل المفضلة لهذا المركز
- ممن يرغب الشباب والمرهقين تلقي الخدمة من؟ أطباء \ ممرضين \ ذكور \ إناث كبار السن ام شباب مثلهم
- هل يفضل أن يكون المركز مخصص للإناث فقط؟ للذكور فقط؟ أم مختلط ولماذا
- هل يفضل أن يكون المركز مدمج مع خدماة اخرى ام منفصلة وقائمة بذاتها؟
- هل يفضل أن يكون المركز خاص \ حكومي \ تابع للانروا \ تابع لنادي او مركز ثقافي
- هل يفضل أن يكون المركز مجاني \ دفع رسوم رمزية \ تكلفة العلاج
- ما هي أنواع الخدماة التي ترغبون بتقديمها؟ وما ترتيب هذه الخدماة (نفسية \ جسدية \ جنسية \

## جلدية\ تغذية الخ) ولماذا

- هل تفضل خدمات الرعاية الصحية الاولية \أو السريرية\ عيادة خاصة \ مركز شبابي أو أي خدمة ولماذا؟
- هل تؤيد النموذج الذي يضمن خبراء في صحة الشباب لهم القدرة على النصيحة والقيادة \ تنسق للخدمات وتشجع التعاون والتواصل؛ مساعدة النظام الصحي السائد على ترجمة البحث إلى واقع عملي وتصبح «صديقة للشباب» ؛ ووضع أجندة بحث قوية للمساعدة في الاستجابة للقضايا الصحة العامة الناشئة.

9. ما هي العوائق لانشاء مراكز خاصة تعنى بقضايا صحة الشباب والمراهقين

10. ما هي توصياتكم

## Annex 3.B -

### Focus group discussions with health providers

#### المقابلة المعمقة مع مقدمي الخدمات من المراكز الصحية

1. ماذا تعني «خدمات صديقة للشباب»، «الصحة العامة»
2. ماذا يعني جودة الرعاية الصحية؟
3. ما هو مصدر معلوماتكم عن القضايا والمشاكل الصحية الخاصة بالمراهقين والشباب
4. ما هي القضايا والاحتياجات الصحية والاجتماعية التي ترون بأنها تمثل أولوية لدى الشباب والمراهقين الذين يبحثوا عن الخدمة بمراكزكم؛ مثلاً
  - قضايا صحية (جسدية \ نفسية \ امراض مزمنة \ اعاقات الخ...)
  - قضايا اجتماعية (الزواج المبكر \ زواج الاقارب \ العمل \ التعليم \ الوضع لاقتصادي الخ...)
  - قضايا الصحة الانجابية والجنسية (الحاجة للتوعية والارشاد والخدمات؛ مثلا التغيير الحصل عند البلوغ للاصغر سنا \ وسائل تنظيم الاسرة \ قضايا الحل والولادة \ الامراض المنقولة عن طريق الجنس الخ...؟)
  - السلوكيات الخطرة وما الذي يؤدي لتلك السلوكيات (التدخين \ شرب الكحول \ تعاطي المخدرات الخ...)
  - قضايا العنف (العنف الاسري والعنف المبني على النوع الاجتماعي \ والعنف الناتج من عنف الجيش الاسرائيلي الخ..)
5. برأيكم ومن خلال تجربتكم أين يذهبون وماذا يفضلون الشباب للحصول على المعلومات والخدمات الصحية؟
  - طبيب عام \ خاص \ صيدلية \ ممرض \ة
  - اصدقاء \ أهل \ الانترنت
  - مركز العائلة الصحي
  - مراكز الشباب والرعاية الصحية الأولية
  - مراكز تابعة للمنظمات الاهلية
  - مراكز تابعة لوزارة الصحة \ الحكومية
  - لا اذهب الى أي مكان

## 6. هل مركز الخدمة الصحي لديكم مجهز من ناحية الموارد البشرية والمادية؟

- ما هو الموجود بالمركز من ناحية الكوادر البشرية (ممرض، طبيب، مرشد نفسي اجتماعي مثقف صحي الخ...؟)
- ما هو الموجود بالمركز من ناحية الموارد المادية (من ناحية الاجهزة \المختبرات \ الادوية الخ...)
- هل تعتقدون أن مزودي الخدمات الصحية قادرين على توفير الخدمة من ناحية الخبرات والكفاءة والمهنية (الحفاظ على السرية والخصوصية، الاستماع اليكم، المهارة بتقديم الخدمة الخ...)
- هل المركز يقدم خدمات العلاج، المشورة و التحويل للقضايا الصحية عامة وقضايا الصحة الانجابية والجنسية \ القضايا النفسية \ قضايا الادمان والامراض المزمنة الخ....
- هل مركز الخدمة عندكم سهل الوصول اليه من قبلكم؟ هل مساحة المكان واسعة وتؤمن الخصوصية والسرية لكم؟
- هل الخدمات مجانية
- هل هناك خدمات عادلة للجميع؟ (نوي الاحتياجات الخاصة، متعاطي الكحول والمخدرات الخ...)
- هل هناك تنسيق وتعاون مع مؤسسات صحية اخرى حسب الحاجة والتخصص من أجل التحويل والمتابعة؟

## 7. ما هي العوائق الرئيسية للحصول على الرعاية الصحية من قبل الشباب ؟ ولماذا برأيكم؟

- عدم توفر الخدمة (لا يوجد مراكز خاصة تعنى بقضايا صحة الشباب والمراهقين)
- الخدمات المتاحة لا تلبى الحد الأدنى من احتياجات الشباب والمراهقين
- تكلفة الخدمة
- جودة الخدمات غير مناسبة (انعدام أو قلة الخبرات والقدرات البشرية والمادية والتجهيزات الخ....)
- السرية والخصوصية غير مضمونة
- عدم تفهم الشباب لهذه القضايا
- ثقافة المجتمع المحلي تؤثر على وصول الشباب لمراكز الخدمة (سمعة، وصمة عار الخ...)
- الشباب لا يعرفوا الى أين يتوجهوا
- الوصول إلى الخدمات الصحية والوقت المناسب؛ (عدم وجود خدمات ما بعد ساعات العمل، وقوائم انتظار طويلة خاصة بالمستشفيات ، ووقت انتظار طويل)

## 8. ما هو تقييمكم للخدمات التي تقدموها للشباب في مراكز مؤسساتكم؟

- عدد الشباب الذين ارتادوا المركز خلال السنة وفقا للجنس والعمر
- ما هي أهم القضايا التي كانت أولوية لديهم

- عدد الشباب الذين زاروا المركز بشكلمتكرر ( زيارتين فأكثر )
- هل تم تجنيد عدد من الشباب من قبل المركز كقادة او متابعين
- ما هي مشاكل الصحة الانجابية والجنسية التي تواجهونها مع الشباب والمراهقين
- ما هي محاضرات التوعية وعناوينها التي تم عقدها ومدى اقبال الشباب عليها
- من هم الشباب الأكثر عرضة للخطر وما هو عددهم ومستوى الاستجابة لديهم عند العلاج والمشورة
- هل تم شملا لاء والأمهات من خدماتكم مستفيدين، وما عددهم بالنسبة للشباب المستفيدين
- هل تم عقد عدد من اللقاءات التوعوية بالمدارس والمراكز المجتمعية خلال السنة
- هل يتم مقارنة المؤشرات التقييمية بالخطة السنوية للمركز
- ما هي العقبات التي تواجهونها وما هي اليات تجاوزها

#### 8. برأيكم، هل يحتاج الشباب إلى مركز خاص لتغطية احتياجاتهم الصحية؟ (طابع الخدمات الصحية)

- هل تؤيدوا إنشاء مركز لصحة الشباب؟
- أين يجب أن يكون المركز؟ وفي أي موقع؟
- هل تفضلوا أن يكون المكان \ بعيد عن مكان سكن الشباب أم قريب \ بمكان معروف ومشهور
- ما هي ساعات العمل المفضلة لهذا المركز
- ممن يرغب الشباب والمراهقين تلقي الخدمة من؟ أطباء \ ممرضين \ ذكور \ إناث \ كبار السن ام شباب مثلهم
- هل تفضلوا أن يكون المركز مخصص للإناث فقط؟ للذكور فقط؟ أم مختلط ولماذا؟
- هل تفضلوا أن يكون المركز مدمج مع خدمات اخرى ام منفصلة وقائمة بذاتها؟
- هل تفضلوا أن يكون المركز خاص \ حكومي \ تابع للانروا \ تابع لنادي او مركز ثقافي
- هل تفضلوا أن يكون المركز مجاني \ دفع رسوم رمزية \ تكلفة العلاج
- ما هي أنواع الخدمات التي ترغبون بتلقيها؟ وما ترتيب هذه الخدمات (نفسية \ جسدية \ جنسية \ جلدية \ تغذية الخ) ولماذا
- هل تفضلوا خدمات الرعاية الصحية الاولية \ أو السريرية \ عيادة خاصة \ مركز شبابي أو أي خدمة ولماذا؟

- هل تؤيد النموذج الذي يضمن خبراء في صحة الشباب لهم القدرة على النصيحة والقيادة، تنسق للخدمات وتشجع التعاون والتواصل؛ تساعد النظام الصحي السائد على ترجمة ما هو موجود إلى واقع عملي وتصبح «صديقة للشباب» ؛ ووضع أجندة بحث قوية للمساعدة في الاستجابة للقضايا الصحة العامة الناشئة.

9. ما هي العوائق لإنشاء مراكز خاصة تعنى بقضايا صحة الشباب والمراهقين

10. ما هي توصياتكم

## Annex 3.C -

### Focus group discussions with young people

#### المقابلات المعمقة مع الشباب والشابات متلقي الخدمات من المراكز الصحية

1. ماذا يعني «خدمات صديقة للشباب»، «الصحة العامة»
2. ماذا يعني جودة الرعاية الصحية؟
3. ما هو مصدر معلوماتكم عن القضايا والمشاكل الصحية الخاصة بالمرهقين والشباب
4. ما هي القضايا والاحتياجات الصحية والاجتماعية التي ترون بأنها تمثل أولوية لديكم كشباب ومرهقين؛ مثلاً
  - قضايا صحية (جسدية \ نفسية \ امراض مزمنة \ اعاقات الخ...)
  - قضايا اجتماعية (الزواج المبكر \ زواج الاقارب \ العمل \ التعليم \ الوضع لاقتصادي الخ...)
  - قضايا الصحة الانجابية والجنسية (الحاجة للتوعية والارشاد والخدمات؛ مثلاً التغيير الحصل عند البلوغ للاصغر سناً \ وسائل تنظيم الاسرة \ قضايا الحل والولادة \ الامراض المنقولة عن طريق الجنس الخ...؟)
  - السلوكيات الخطرة وما الذي يؤدي لتلك السلوكيات (التدخين \ شرب الكحول \ تعاطي المخدرات الخ...)
  - قضايا العنف (العنف الاسري والعنف المبني على النوع الاجتماعي \ والعنف الناتج من عنف الجيش الاسرائيلي الخ..)
5. أين تذهبون للحصول على المعلومات والخدمات الصحية؟
  - طبيب عام \ خاص \ صيدلية \ ممرض \ة
  - اصدقاء \ أهل \ الانترنت
  - مركز العائلة الصحي
  - مراكز الشباب والرعاية الصحية الأولية
  - مراكز تابعة للمنظمات الاهلية
  - مراكز تابعة لوزارة الصحة \ الحكومية

- لا اذهب الى أي مكان

6. هل مركز الخدمة الصحياً ومقدم الخدمات الذي تذهبوا اليه مجهز من ناحية الموارد البشرية والمادية؟

- ما هو الموجود بالمركز من ناحية الكوادر البشرية (ممرض، طبيب، مرشد نفسي اجتماعي مثقف صحي الخ...؟)
- ما هو الموجود بالمركز من ناحية الموارد المادية (من ناحية الاجهزة \ المختبرات \ الادوية الخ...)
- هل تعتقدون أن مزودي الخدمات الصحية قادرين على توفير الخدمة من ناحية الخبرات والكفاءة والمهنية (الحفاظ على السرية والخصوصية، الاستماع اليكم، المهارة بتقديم الخدمة الخ...)
- هل المركز يقدم خدمات العلاج، المشورة و التحويل للقضايا الصحية عامة وقضايا الصحة الانجابية والجنسية \ القضايا النفسية \ قضايا الادمان والامراض المزمنة الخ....
- هل مركز الخدمة عندكم سهل الوصول اليه من قبلكم؟ هل مساحة المكان واسعة وتؤمن الخصوصية والسرية لكم؟
- هل الخدمات مجانية
- هل هناك خدمات عادلة للجميع؟ (ذوي الاحتياجات الخاصة، متعاطي الكحول والمخدرات الخ...)
- هل يتم تحويلكم الى مؤسسات صحية اخرى حسب الحاجة والتخصص من أجل العلاج والمتابعة؟

7. ما هي العوائق الرئيسية لحصولكم (الشباب والشابات) على الرعاية الصحية؟ ولماذا برأيكم؟

- عدم توفر الخدمة (لا يوجد مراكز خاصة تعنى بقضايا صحة الشباب والمراهقين)
- الخدمات المتاحة لا تلبي الحد الأدنى من احتياجات الشباب والمراهقين
- تكلفة الخدمة
- جودة الخدمات غير مناسبة (انعدام أو قلة الخبرات والقدرات البشرية والمادية والتجهيزات الخ...)
- السرية والخصوصية غير مضمونة
- عدم تفهم الشباب لهذه القضايا
- ثقافة المجتمع المحلي تؤثر على وصول الشباب لمراكز الخدمة (سمعة، وصمة عار الخ...)
- الشباب لا يعرفوا الى أين يتوجهوا
- الوصول إلى الخدمات الصحية والوقت المناسب؛ (عدم وجود خدمات ما بعد ساعات العمل، وقوائم انتظار طويلة خاصة بالمستشفيات ، ووقت انتظار طويل)

8. برأيكم، هل يحتاج الشباب إلى مركز خاص لتغطية احتياجاتهم الصحية؟ (طابع الخدمات الصحية)

- هل تؤيدوا إنشاء مركز لصحة الشباب؟



- أين يجب أن يكون المركز؟ وفي أي موقع؟
- هل تفضلوا أن يكون المكان \ بعيد عن مكان سكن الشباب أم قريب \ بمكان معروف ومشهور
- ما هي ساعات العمل المفضلة لهذا المركز
- ممن يرغب الشباب والمراهقين تلقي الخدمة من؟ أطباء \ ممرضين \ ذكور \ إناث \ كبار السن ام شباب مثلهم
- هل تفضلوا أن يكون المركز مخصص للإناث فقط؟ للذكور فقط؟ أم مختلط ولماذا؟
- هل تفضلوا أن يكون المركز مدمج مع خدمات اخرى ام منفصلة وقائمة بذاتها؟
- هل تفضلوا أن يكون المركز خاص \ حكومي \ تابع للانروا \ تابع لنادي او مركز ثقافي
- هل تفضلوا أن يكون المركز مجاني \ دفع رسوم رمزية \ تكلفة العلاج
- ما هي أنواع الخدمات التي ترغبون بتلقيها؟ وما ترتيب هذه الخدمات (نفسية \ جسدية \ جنسية \ جلدية \ تغذية الخ) ولماذا
- هل تفضلوا خدمات الرعاية الصحية الاولية \ أو السريرية \ عيادة خاصة \ مركز شبابي أو أي خدمة ولماذا؟
- هل تؤيد النموذج الذي يضمن خبراء في صحة الشباب لهم القدرة على النصيحة والقيادة، تنسق للخدمات وتشجع التعاون والتواصل؛ تساعد النظام الصحي السائد على ترجمة ما هو موجود إلى واقع عملي وتصبح «صديقة للشباب» ؛ ووضع أجندة بحث قوية للمساعدة في الاستجابة للقضايا الصحة العامة الناشئة.

8. ما هي العوائق لانشاء مراكز خاصة تعنى بقضايا صحة الشباب والمراهقين

9. ما هي توصياتكم



