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Child Abuse and Neglect:
Training Needs Assessment of UNRWA Health and Social Care Professionals

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I. Abbreviations

CAN	Child abuse and neglect
CRC	Convention on the Rights of the Child
HSCP	Health and social care professionals
D	Physicians
ICPH	Institute of Community and Public Health
N	Nurses
MW	Midwives
MOSA	Ministry of Social Affairs
PC	Psychosocial counsellors
TBA	Traditional Birth Attendants
SW	Social Workers
SHC	Special hardship cases
UNRWA	United Nations Relief and Works Agency for Palestine Refugees in the Near East

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IV. Executive Summary

The chief objective of this study was to examine the perceived training needs and demands of UNRWA's health and social care professionals in child abuse and neglect; these included physicians, nurses, midwives, psychosocial counsellors and social workers. Eighty-four health and social care professionals were interviewed across 6 selected UNRWA refugee clinics/camps: Kalandia, Jalazone, Shufat, al-Zawyeh, Fawwar and Tulkarm camps. Of these 84 participants, 73 responded that they had seen child abuse and neglect cases in the clinics and/or refugee camps, and many had seen more than one type of abuse. However, the most common type of abuse seen by all respondents (67) was neglect. The majority of participants (60) reported that counselling or consultation with the child and/or family was their main method of managing child abuse and neglect cases.

Of the health and social care providers interviewed, almost all reported observing significant enough cases of child abuse and neglect to warrant further attention by UNRWA in effective and transparent system building. Most participants expressed a genuine need for further training, especially in the areas of defining child abuse and neglect and the problems specific to the Palestinian community; understanding and addressing children's needs; developing a more effective system of management, reporting and referral; more effective cooperation and linkages among the different providers and organizations dealing with child abuse and neglect cases; and the protection of UNRWA staff and child victims by UNRWA.

The information revealed in this research indicates that a major determinant in the occurrence of child abuse and neglect is violence under Israeli military occupation. Participants recognized that this violation of family and community could lead to child abuse and neglect. The lack of freedom of movement, poverty and the ensuing unemployment are key issues which were identified, which signifies that broader contextual understanding is essential to future trainings.

The initial results of this study indicate that more attention should be paid to the educational and communication needs of nurses, midwives and traditional birth attendants. It is surprising that the initial findings of this report indicate that this group have so far been afforded the least attention. These particular caretakers have the strongest links to family and community, specifically to women, who are the primary caretakers in the family, and who trust and confide in them.

Effective management of child abuse and neglect necessitates the involvement of many professionals at different levels. Consequently, future training activities, management and report system building efforts, need to take into consideration inter and intra-sectoral collaboration. Initially baseline training in child abuse and neglect is to be provided for all, then specialty training in relation to job function. These are to be followed by periodic discussions of cases among all parties involved, in addition to information updates. Undeniably, children do not live in sectors, they live in communities. Therefore, collaboration of providers across all sectors is essential to effectively identify and manage circumstances where a child is at risk of abuse or exploitation.

ملخص البحث

يهدف البحث إلى دراسة الاحتياجات والمتطلبات التدريبية لمهنيي الرعاية الصحية والاجتماعية في الأونروا في مجال حماية الطفل. تشمل هذه الدراسة الأطباء والممرضات والقابلات والمرشدين النفسيين والعاملين الاجتماعيين. لقد أجريت المقابلات مع 84 من الأخصائيين في الرعاية الصحية والاجتماعية موزعين على ستة مخيمات منتفاة للاجئين : قلنديا والجلـزون و شعفاط و الزاوية والفوار وطولكرم . غالبية (73) ممن أجريت معهم المقابلات ذكروا بأنهم شاهدوا حالات إساءة معاملـة الأطفال وإهمالهم في العيادات أو في المخيمات. وقد شاهد كثيرون منهم أكثر من نوع واحد من سوء المعاملة، ومـع ذلـك فإن النوع الأكثر شيوعا وفقاً لـ67 من المقابلين كان الإهمال. وقد أفاد غالبية المشاركين (60) بأن المـشورة أو الإرشـاد للأطفال والأسرة هي الوسيلة الأساسية التي استخدموها للتعامل مع حالات إساءة معاملة الأطفال وإهمالهم.

وقد ذكر مقدمو الرعاية الصحية والاجتماعية في هذه المخيمات إن معظمهم قد شاهدوا بما فيه الكفاية من حـالات إسـاءة معاملة الأطفال وإهمالهم مما يستدعي مزيد من الاهتمام من الأونروا في بناء نظام ذي شفافية وفعالية عالية للتعامل مع هذه الحالات. وقد أعرب معظم المشاركين عن حاجتهم الحقيقية لمزيد من التدريب ولا سيما في مجالات مفهوم إساءة معاملـة الأطفال وإهمالهم والمشاكل الخاصة بالمجتمع الفلسطيني بالإضافة إلى فهم ومعالجة احتياجات الأطفال وتطوير نظام أكثـر فعالية للتبليغ والإحالة مع إيجاد تعاون وتشبيك بين مختلف مقدمي الخدمات و المنظمات التي تتعامل مـع هـذة الحـالات. والأهم من ذالك حماية الموظفين والضحايا من الأطفال من قبل الأونروا.

في الواقع ، إن المعلومات التي كشفت عنها الدراسة تشير إلى أن التأثير الرئيسي في حدوث إساءة معاملة الأطفال وإهمالهم هو العنف الناجم عن الاحتلال العسكري الإسرائيلي. المشاركون قدروا أن هذا العنف مـن الاحـتلال الموجـه للأسـرة والمجتمع يمكن أن يؤدي إلى إساءة معاملة الأطفال وإهمالهم ، كمثال عدم وجود حرية التنقل والفقر والبطالة والتي هي من أهم القضايا الرئيسية في هذا المضمار. ولهذا لا بد من إيجاد مفهوم أوسع نطاقا لإساءة معاملة الأطفـال وإهمـالهم داخـل المجتمع الفلسطيني من أجل التحضير لتدريبات مستقبلية لمهنيي الرعاية الصحية والاجتماعية.

إن النتائج الأولية لهذه الدراسة تشير إلى الحاجة إلى إبلاء المزيد من الاهتمام لاحتياجات الممرضات والقابلات والقـابلات التقليديات في مجال حماية الطفل حيث أن نتائج هذا التقرير تشير إلى أنه تم منح القليل من هذا الاهتمام لهـذة المجموعـة حتى الآن مع أن الممرضات والقابلات تحديداً لديهم علاقات قوية مع الأسرة والمجتمع لا سيما مع المرأة التي هي الراعية الأولى في الأسرة والتي تثق بهن وتشاركهن أسرارها.

إساءة معاملة الأطفال وإهمالهم تهم جميع المختصين. وبناء على ذلك فإن أنشطة التدريب المستقبلية والجهود المبذولة لبنـاء نظام للتعامل مع هذه الحالات يتطلب ضرورة الأخذ في الاعتبار التعاون المشترك فيما بين القطاعات المختلفـة والتـدريب الخاص لكلّ موظف وفق وظيفته المحددة، بالإضافة إلى مناقشه دورية بين جميع الأطراف المعنية لنقاش الحالات وتحديث المعلومات أولاً بأول.

ومما لا يمكن إنكاره أن الأطفال لا يعيشون في قطاعات بل يعيشون في المجتمعات المحلية ولهذا فإن تعاون جميع مقـدمي الخدمات في جميع القطاعات على نحو فعال أمر ضروري لتحديد الظروف التي قد يكون فيهـا الطفـل عرضـة لخطـر الاعتداء أو الاستغلال من أجل التعامل معها.

V. Background

The United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA), was established by the UN General Assembly in 1949. It was created to respond to the humanitarian needs of the Palestinians who, dispossessed and dispersed, became refugees in the Gaza Strip, the West Bank, Jordan, Lebanon and Syria as a result of the 1948 Arab Israeli war. Today UNRWA is the main provider of basic services to over 4.6 million registered Palestine refugees in the Middle East.

UNRWA's mission is *"To help Palestine refugees achieve their full potential in human development terms under the difficult circumstances in which they live."* Promoting Palestinian interests as individuals with rights and entitlements under international law and ensuring their well-being and long-term human development is the fundamental basis for all their activities. The Agency's identity remains that of a public service organization providing essential services to Palestinian refugees, and is presently involved in the direct delivery of education, health, relief and social services, infrastructure and microfinance. UNRWA has also supplied emergency food aid, medical care, shelter and protection to refugees caught in outbreaks of conflict.

The Geneva recommendations are an important source of general guidance for the Agency's work (UNRWA, 2005). According to their Medium Term Plan 2005-2009 ***"There is a pressing need to raise the standard of UNRWA services to levels that compare favourably with host authority services and fulfill international benchmarks. Raising standards would mean delivering high quality services that effectively and efficiently fulfill refugee needs and are accessible to all refugees on an equitable basis. This would require a systematic reliance on assessed needs as the basis for planning, budgeting and evaluation, as well as adherence to relevant international instruments pertaining to human rights and sustainable development"*** (UNRWA, 2005)**.**

It was recommended during the Geneva Conference (2004), **"Meeting the Humanitarian Needs of the Palestinian Refugees in the Near East: Building Partnerships in Support of UNRWA – Working Group on 'Promoting the Well-being of the Palestine Refugee Child,'** that UNRWA and its partners undertake a systematic review of protection requirements to strengthen the protection of Palestine refugee children, using the Convention on the Rights of the Child (CRC) as a point of departure.

Though the Geneva recommendations are an important source of general guidance for the Agency's work, UNRWA is contending with high population growth rates among Palestine refugees, worsening socio-economic conditions in the region, several years of (inflation adjusted) negative growth in its General Fund budget and in some fields, military blockades and restrictions on movement and access to labour markets (UNRWA, 2005). As such, it has been reiterated in UNRWA's Medium Term Plan 2005-2009, that one of the main challenges indentified was that "*There is a lack of accurate, current information on Palestine refugee living conditions and refugee assets, and.the Agency has insufficient capacity for research, data collection, analyses and data management*" (UNRWA, 2005).

In the context child maltreatment in Palestine, violence of a public or private nature not directly related, although arguably indirectly related to Israeli military violence, including violence in the home, violence in school, or other institutions, is much less documented and understood. While there may be a lack of quantitative data on the current exposure of children to public and private violence not directly related to Israeli military violence, as UNICEF stated, *"…the absence of data does not mean the absence of a problem"(*UNICEF, 2000).

It is important therefore to review the way in which UNRWA's services currently operate and identify performance improvements, so as to enhance their quality and impact, as put forth in the Agency's strategic priorities for 2008-09 (UNRWA, 2007).

VI. Introduction

The conception of this study was based on the findings of the 2007 ICPH/Birzeit study "**Child Abuse and Neglect in the West Bank: Training, Perception and Management of Cases among Palestinian Physicians".** This previous study identified a priority need for training of health professionals on recognition of signs of abuse and neglect in order to enhance their ability to identify and administer to the needs of maltreated children. Subsequent to the initial findings, the current pilot study aimed to examine the perceived training needs and demands of UNRWA's health and social care professionals (HSCPs). These HSCPs included physicians, nurses, midwives, psychosocial counsellors and social workers in six refugee clinics/camps located in Ramallah, Jerusalem, Hebron and Tulkarm. Specifically, the core objectives were:

- To assess the perception of UNRWA health and social care professionals on the content and effectiveness of previous child abuse and neglect training.

- To assess how the UNRWA health and social care professionals manage and report child abuse and neglect cases.

- To assess the perception of UNRWA health and social care professionals on their training needs on child abuse and neglect (CAN).

Past studies have suggested that physicians underreport suspected child maltreatment cases, possibly because of a lack of knowledge on this subject. To remedy and improve this situation, it was suggested that all organizations providing health care services should give child protection training to their staff (RCPCH, 2006) and follow-up on the implementation of their training. Though literature pertaining to specific training needs of health and social care professionals on child abuse and neglect is scarce, one article *(Flaherty et al*, 2004) commented that there are no studies that describe the frequency with which primary care paediatric providers report suspected abuse. In their study, it was found that one of the most common reasons providers indicated for not reporting suspected abuse, was the belief that they could work with the family without outside intervention (Flaherty et al, 2004).

Studying reported cases is usually less resource-demanding, and it is easier to relate the findings to issues of service delivery and service quality (Van Voorhis & Gilbert, 1998). Many argue that the reported cases are only the "tip of the iceberg" of the real phenomena (Ben-Arieh, Zionit, & Binstock-Rivlin, 2000). Others argue that the reported cases include reports that were proved false, and thus overestimate the phenomena (Gilbert, 1997; Tomison, 1995).

In either argument, studies of the frequency of child maltreatment have proven to be an important contribution to the design of policies and to the delivery of services to children at risk. This is especially relevant as the studies present not only the overall rates of maltreatment but also its "geography", that is, the distribution across regions, communities, cultures, and populations of child maltreatment within a given society (National Committee for Prevention of Child Abuse, 1992; National Research Council, 1993; Swanson, 2000).

Looking specifically at the abuse and neglect of children with disabilities, a study conducted by Orelove et al. (2000), examined the role of training inadequacies in maltreatment of children with disabilities and, conversely, how the training of staff might be an effective measure in prevention and intervention efforts. The study targeted three key groups: parents, educators, and investigators, who were asked about their knowledge level, experience with, and training interests on maltreatment. The results showed that a majority of respondents were willing to attend training, and all three groups ranked the recognition of maltreatment of children with disabilities as a top training priority, and those flaws in the systems that respond to maltreatment of children with disabilities are also included in the list of causal factors of this phenomenon.

Recently, a needs assessment survey was carried out by the Sharek Youth Forum to evaluate refugee youth's perception with regards to their human rights in the refugee camps, as well as the economic, social and political situation generally faced by the refugee youth. The finding showed that children perceived themselves as the main victims of human rights abuse in the camp, and the top four potential abusers included, in the order identified: Israeli authorities, Palestinian authorities, refugee camp committees, and family and friends (Sharek, 2008). Though they were named as potential abusers, the family was also seen to be the main protector of children's rights. Main findings in relation to specific human rights were: lack of financial resources, presence of violence within school environment (right to education); lack of sufficient number of medical personnel in UNRWA health clinic, lack of specialized medical centres economically accessible to refugees (right to adequate healthcare); normalization of violence, psychological violence suffered more than physical violence (right to personal security and not to be subjected to violence). Perpetrators of violence are likely to be family members or residents of the refugee camps.

Health professionals are often the first to encounter child victims of family violence, and although training curricula do exist, they are not consistently offered to those who care for victims of family violence. Physicians play a major role in identifying children who may have been abused or neglected, as they are usually the only professionals who have direct contact with children and their families, and have the opportunity of raising questions while conducting physical examinations.

We hope that this study will prove to be a valuable document in addressing the reality of child abuse and neglect issues confronted by UNRWA health and social care professionals. It can be used as a platform for UNRWA to focus appropriate resources, time and effort towards targeted solutions. The results of the training needs analysis will highlight the gaps in training and information that is needed for policy making and future trainings.

VII. Methodology

1. Project Conceptualization

Originally, the intent of the current study was to investigate the extent to which physician's follow-up and refer child abuse and neglect cases to psychosocial counsellors within the UNRWA clinics, as a follow-up to the 2007 research study conducted by the Institute of Community and Public Health/Birzeit University **"Child Abuse and Neglect in the West Bank: Training, Perception and Management of Cases among Palestinian Physicians".** The results from the 2007 study showed that physicians working in UNRWA reported the highest rate of referring cases to psychosocial counsellors, particularly psychological abuse cases (92%). The initial study also showed that the highest percentage of physicians trained in child abuse and neglect were found working with UNRWA (20%). However, upon further investigation and discussions with a focus group composed of some of the psychosocial counsellors from Ramallah and Jerusalem, it was discovered that none of the counsellors had received referrals from physicians other than bedwetting cases. In fact, most of their referrals actually came from either the school counsellors, or from mothers.

Additional discussions with the counsellors, revealed that there was insufficient communication and cooperation among health professionals, and that physicians did not have a clear understanding of child abuse and neglect or the role of psychosocial counsellors and what they did. Based on this information, and in consultation with UNRWA Chief Field Health Program Officer in the West Bank, Dr Umaiyeh Khammash, it was decided that a pilot project would be launched in selected refugee camps to assess how health and social care professionals identify, manage and refer/report child abuse and neglect cases, their perceived training needs, and subsequent to this assessment, determine what further training may be required.

2. Sampling methods

This project was initially planned as a pilot study, limited to four camps, two in Ramallah and two in Jerusalem. With approval from the UNRWA Chief Field Health Program Officer in the West Bank, the following clinics/camps were chosen to participate in the pilot study: Kalandia, Jalazone, Shufat, and al-Zawyeh clinic. However, it was later decided that there was a need to expand the project to include 2 more camps in different regions. This decision was made first because of the enthusiastic response from the participants, and second because of certain information obtained during the initial interviews, which indicated the need for the diversification of regions. Therefore two camps were added to the study, one in Tulkarm (Tulkarm Camp) and one in Hebron (Fawwar Camp). This would represent more diversified opinions and experiences from the health professionals relating to child abuse and neglect cases. Permission was granted from the UNRWA regional health and social affairs officers, before beginning the study in each of the camps.
Originally, the intention was to interview only four different stakeholder groups;

- Physicians
- Nurses
- Midwives including Traditional Birth Attendants (TBAs)
- Psychosocial Counsellors

However, based upon the information obtained during first few interviews, it became evident that social workers were also an important target group, as they work directly with families in their homes, and thus it was decided to add social workers to the list of study participants.

3. Data collection methods

This is primarily a qualitative study, and information was obtained through in-depth interviews; although through this process some quantitative data was also collected. The number of interviews conducted ranged between 2-6 per day, depending on the amount of information provided by the participant. Questionnaires used contained both close ended and open-ended questions. The questionnaire was loosely based on the 1995 Institute of Community and Public Health/Birzeit University study **"Needs Assessment Study of Primary Health Care Centres,"** and the 2007 study **"Child Abuse and Neglect in the West Bank: Training, Perception and Management of Cases among Palestinian Physicians."** While the structure of the questionnaires did vary somewhat according to the different professional groups, generally the interviews were divided into the following:

- Demographic Profile and Education
- Work Profile, specifically duties relating to children
- Training and Experience
- Identification of child abuse and neglect cases
- Management and Reporting of child abuse and neglect cases
- Training Needs
- Additional Comments

A field test pilot was conducted in Amari camp to assess the coherence of the questionnaires and the relevance of the questions to current local reality, and amendments were made accordingly.

4. Data analysis methods

Most interviews were tape recorded and transcribed for analysis, whereby consent was obtained from each of the participants. Given the size of the dataset, the SPSS software was used to enable effective data management, study frequency and association between variables for closed-ended questions.

Though there are different categorizations of professionals within the UNRWA system, all health and social care professionals were listed under their general category of work. For example, the category of social workers includes emergency relief, special hardship cases/social affairs, disability social workers, etc.

Open-ended questions were qualitatively analysed and coded according to thematic occurrences. These key thematic ideas presented a range of study participant perception, descriptive information about participants who offer comments and quotes that illustrate the chosen themes. These themes are interpretations of that data collected. Under the qualitative coding, all physicians were coded as "D"; all nurses as "N"; all midwives as "MW"; all psychosocial counsellors as "P"; and all social workers as "SW".

Traditional birth attendants (TBA) were also interviewed as they are in contact with mothers and their newborns, and routinely make home visits. Yet as there were only 2 TBAs interviewed, they were listed under the category of midwives for the purpose of analysis. However, whenever a specific question did not apply to TBAs, they were excluded from this category.

5. Difficulties and Limitations

There was some difficulty in coordination with the different schedules of the health and social staff, and several trips (between 3-5) had to be made to each of the camps. This took up more time than had initially been allocated.

Field-work revealed different types of social workers in camps, including emergency social workers. This was not evident early in the pilot study. The number of social workers also varied from camp to camp. This led to prolongation of the time allotted to field work.

As child maltreatment is a very sensitive issue within the Palestinian community, some participants were somewhat hesitant initially with having an international person conducting interviews, but eventually they became comfortable and were quite open with their responses.

Responses are qualitative and not representative in nature, and therefore should be interpreted with caution, although they do reveal some important aspects of the problem of child abuse and neglect.

VIII. Results

1. Demographic variables

Among the eighty four participants, there were **13 physicians; 29 nurses, 10 midwives, 4 psychosocial counsellors** and **28 social workers**. The overwhelming majority of the participants (70.2%) were females as shown in Table 1.

Table 1: **Gender representation**

	Number	Percent
Male	25	29.8
Female	59	70.2
Total	84	100.0

Though most of the professional groups had received a basic degree (i.e. Diploma or Bachelor), one of the midwives/traditional birth attendant reported having only completed her 10th grade year, and only 1 doctor of the 84 participants had obtained a PhD degree.

The number of participants varied from one camp to another and also by regional area. As is shown in Table 2 (please see below), the Middle area which includes Kalandia camp, Jalazone camp, Shufat camp, and Al-Zawyeh clinic had the largest number of participants (56). Also one doctor reported working in more than one region, i.e. Al-Zawyeh clinic, Amari camp, and Khamathta clinic.

Table 2: Health and social care professionals by regional area

HSCPs / Region	D	N	MW	PC	SW	Total
North (Tulkarm)	2	4	2	1	6	15
Middle (Kalandia, Jalazone, Shufat, Al-Zawyeh)	8	22	7	2	17	56
South (Fawwar Camp-Hebron)	2	3	1	1	5	12
Middle + South (Al-Zawyeh, Amari, Khamathta clinic)	1	----	----	----	----	1
Total	13	29	10	4	28	84

2. Workload

All health care professionals work 6 days per week, whereas social workers reported working between 2-5 days a week in their respective refugee camps. When questioned, approximately one third of participants (35) responded that their work load was 'just right', and 63% of respondents felt that they were understaffed. Of those who reported understaffing, 21 were nurses, who commented that understaffing affected their ability to detect if a child has been neglected or abused. Lack of time was mentioned repeatedly by the nurses, explaining that they have for the most part only 1-2 minutes to spend with each patient, allowing them enough time to treat the medical problem, but not enough time to discover its root cause.

In its annual health report, UNRWA reported that its staff-to-population ratios in 2007 continued to be very low compared to national and regional standards (UNRWA Annual Report of the Department of Health 2007). Coupled with high utilization rates, the low staff and population ratios continued to be the reason for the heavy workloads at UNRWA's primary health care facilities (UNRWA Annual Report of the Department of Health 2007). One of the major objectives of the Medium Term Plan was to reduce excessive workloads by recruiting additional staff and improving access to basic health services through the expansion and upgrading of primary health care facilities (UNRWA Annual report of the Department of Health 2007). However achieving these goals is dependent on the level of future funding the Agency's receives.

3. Identification

Table 3 outlines four types of child abuse and neglect reported by the health and social care professionals, namely: physical abuse; neglect; psychological abuse; and sexual abuse. The majority of participants 73 (87%) responded that they had seen child abuse and neglect cases in the clinics and/or refugee camps, and many had seen more than one type of abuse. For example, although 1 doctor reported seeing all four types of child abuse and neglect, 6 other doctors reported that the types of cases they see reflect a combination of physical abuse, psychological abuse and neglect. Similarly, the same combination of abuse was reported as the most frequent and common type encountered by the HSCPs from the refugee camps in all 3 regions, North/Middle/South.

Table 3: Number of social health care professionals who have seen CAN cases by type

Type of CAN / HSCPs	Physical	Neglect	Psychological	Sexual	All Types	Total # of HSCPs interviewed
Physicians	**11**	**9**	**11**	**3**	**1**	**13**
Nurses	**16**	**22**	**15**	**3**	**3**	**29**
Midwives	**5**	**7**	**6**	**0**	**0**	**10**
Psychosocial counselors	**4**	**3**	**4**	**4**	**3**	**4**
Social workers	**19**	**26**	**25**	**4**	**4**	**28**
Total	**55**	**67**	**61**	**14**	**11**	**84**

The social workers provided the most examples of cases seen, followed by the nurses, physicians, psychosocial counsellors, and midwives. A number of participants reported seeing all of the four afore-mentioned types of CAN. The responses varied for each participant, but the most common type of case seen by all the social health care professionals, was neglect. Neglect was observed by more than three quarters of the health and social care professionals.

Participants were then asked to elaborate on these initial responses and explain in terms of physical and behavioural indicators, how they were able to identify cases as child abuse and neglect. The following sections depict some of the most common, as well as rare cases/examples observed by the HSCPs.

3.1 Physical abuse

3.1.1 Physical Indicators

The most common example of physical indicator reported by all the participants was bruises/cuts/burns on the face or body. Two doctors mentioned even seeing ecchymosis[1] on the face, while one doctor reported stool and urinal incontinence. One nurse revealed that a girl who had been badly beaten came to the clinic with oedema[2].
School violence, specifically violence among children, was observed to be a clear indicator of physical abuse.

[1] Ecchymosis: the escape of blood into the tissues from ruptured blood vessels marked by a livid black-and-blue or purple spot or area. *MedlinePlus*
[2] Oedema: presence of abnormally large amounts of fluid in the intercellular tissue spaces of the body usually applied to demonstrable accumulations of excessive fluid in the subcutaneous tissues—swelling and blue bruises. *Online Medical Dictionary*

Example 1
A nurse reported that a boy threw a chemical on another's boy's face and eyes. It was not clear what the chemical was or where the boy had obtained it, although there was some speculation that it was something left over by Israeli soldiers.

Two of the participants commented that teachers were emotionally abusing the students because they are not allowed to physically punish them, or that perhaps it was a reflection of personal problems. Though there were very few reported incidents of teachers beating students, one prominent example stands out.

Example 2
A social worker was told by a mother that her child had been beaten by his teacher because the child was hyperactive and weak at school. There were marks all over his body. Although the mother went to complain to the school director as well as someone from the educational program at UNRWA, she received no response.

Other school children were found fighting with each other using sharp objects such as sharpeners or razor blades.

Example 3
In a rare example, one of the participants felt comfortable enough to admit that she herself had physically abused her own child. The participant had hit her 12 yr old child on the head with a wooden stick and the child fell unconscious. The child was taken to the clinic where the participant worked, and the clinic staff nurse rushed the child to the hospital where she was treated. Fortunately the child was fine in the end. The participant explained having reacted in this matter due to personal family problems compounded with the child's refusal

3.1.2 Behavioural Indicators

Only 8 of the participants revealed any sort of behavioural indicators of child abuse and neglect, and of these, 5 reported hearing of these cases from third party sources i.e. parent or community member.

Example 4
A mother told one of the social workers that her husband was taking pain killers, and he used to be beaten by his father when he was a boy. His father used to hang him by the legs, and lock him in a dark room; now he is projecting his traumatic experiences onto his 3 children. He is always on medication and when not on medication he may try to kill his family: This family is known by the social affairs office at UNRWA, which follows-up cases to protect the children.

Other professionals mentioned aggressiveness in the child or anger and sadness in their eyes as behavioural indicators.

3.2 Neglect

3.2.1 Physical Indicators

Most of the physical indicators of neglect were related to poor hygiene, dirty appearance, or lack of appropriate clothing (38). The participants also commented that the children would be seen playing in the streets unsupervised with dirty clothes and/or no shoes.

Example 5
In one of the camps, a mother customarily left her children unattended, and they would be seen relieving themselves in the streets (perhaps because they were unaccustomed to toilets); they would also soil their clothes as well as their beds.

Lack of provision of medical treatment and subsequent follow-up, was also cited as another major indicator of neglect. For example, mothers missed vaccinations for their children or delayed seeking necessary medical treatment, preferring to wait until the clinic opened in order to receive free medication and consultation. Some of the health professionals commented that parents often don't give their children the proper dose of medication or leave it unattended and accessible, heightening the danger of a child accidentally ingesting it.

Example 6
An incident was cited of a boy who came to clinic very dizzy and lost consciousness; he had ingested some sort of medication which the nurse was fortunately able to identify on his breath. The boy was treated as an emergency case and then transferred to hospital.

There is also a specific neglect of disabled children, as some families are not attentive to the special needs of disabled and oftentimes neglect their food and clothing. The social workers are the ones that observe the majority of these cases on their home visits or hear about it within the community. One social worker provided details of how initially, a family had rejected the disabled child, and that the mother would be found crying, agonizing over how the community would look upon her child and the family. There are also financial considerations, as the cost of clinical treatment it is high and it is expensive to care for a disabled child. Other cases of neglect of disabled children include parents who try to hide their disabled children and don't register them in their refugee card, or do not obtain a birth certificate for them.

Example 7
A disabled 6 yr old who had sustained lack of oxygen in his leg during birth and could only crawl as a result, was found alone in the house one day by a social worker, crawling on a grimy floor; he was very dirty, obviously unwashed and wearing filthy clothes.

Other categories of neglect include malnourishment of children or a lack of a proper diet. There are instances of children only being given tea for breakfast before going school, or feeding a

baby tea and milk in his bottle. A few also reported accidental burn injuries where hot liquids, such as tea were spilled on a child. Also mentioned was a general a lack of awareness among mothers regarding their newborns.

Example 8
One TBA reported that a mother accidentally rolled over her one-week old newborn, suffocating him as he lay sleeping between both parents in bed after breastfeeding.

Socio-cultural constraints
The heavy burden of living with extended family is often stressful and can increase the risk of a child being abused and neglected. Women living with extended families are sometimes forced to follow traditions that may not be in the best interest of the child. An instance was cited whereby a mother was told to wrap her newborn tightly in cloth around the body. A few nurses also reported abuse and/or neglect among step-families A child, either because he has been orphaned or his parents are unable to care for him, is sometimes sent to live with a stepmother or aunt, and as a consequence he is not well cared for. It also becomes difficult for a mother to care for her child when the husband has more than one wife, and does not provide enough financial support for the family.

3.2.2 Behavioural Indicators
The majority of comments made on behavioural indicators of neglect were from social workers; citing lack of follow-up on the child's education as a major problem, followed by neglecting the development and education of the disabled child i.e. putting the child in a regular school where he is oftentimes exposed to ridicule from other children.

3.3 Psychological abuse

3.3.1 Physical Indicators
Most of the physical indicators identified by all participants were related to symptoms of bed wetting. Social workers commented the most on this symptom, including one who said that,

"95% of psychological cases are bedwetting in girls. The social worker tries very hard to convince the family to take them to the counsellor, but the girls are very shy. Reasons for bedwetting may include parents fighting all the time, and/or because of their specific economic situation, there is over crowdedness in the house and therefore no privacy: If there is a private discussion between mother and daughter then everyone would know."

Aggressive behaviour among children themselves or directed towards others is the second major physical indicator mentioned, followed by isolation of children.

3.3.2 Behavioural indicators
Verbal abuse such as calling a child "*donkey*", implying the child is being stupid, or mothers shouting at their children was commonly cited by all the participants in this category.

3.4 Sexual abuse

3.4.1 Physical indicators

The three physicians that reported physical indicators of sexual abuse said that they were able to identify the abuse when asked to do a physical examination of the child. Two out of the three physicians were requested to check the hymen of the girl.

Example 9
A mother came to see the physician about checking the hymen of her 4-yr old daughter who was sexually abused by her 17-yr old male cousin. The physician explained to the mother it was *"not so important to examine if she is virgin or not, most important that she is abused and there is big problem inside her soul"*. The doctor wanted to refer the child to the psychosocial counsellor, assuring her that everything would be kept confidential, but the mother said she was only concerned about her hymen.

Bedwetting, nightmares and sweating were also mentioned by one of the counsellors as indicators of sexual abuse. Occasionally, girls would come directly to them without the knowledge of their parents. One counsellor reported that most sexual abuse cases were of boys being sexually abused by a male relative (i.e. uncle or relative); the counsellor knew only of 2-3 cases of girls being sexually abused.

3.4.2 Behavioural indicators

Psychosocial counsellors provided very detailed descriptions of the behaviour of victimized children including aggressive behaviour, fear and isolation. One of the counsellors described how drawings sometimes reveal that abuse has taken place, or is uncovered during therapy sessions. During these sessions, some adult women will divulge that they were sexually abused as children, though most cases were of sexual harassment; 3-4 women out of 5-6 women in the therapy group were sexually abused, sexually harassed, or physically abused. Because of the trauma endured as children, some of these women do not want sexual relations, yet are forced to be intimate with their husbands; they cannot say 'no' now, just as they were unable to speak out and say 'no' as children.

Social workers also commented that they mostly learned of these cases directly from the mother or child. In one instance, there was a case involving the father sexually abusing his daughter. One of the social workers learned of the abuse when the mother came to this social worker for financial aid. The father is in jail now, and the girl has been referred to a psychosocial counsellor, though they have not yet gone to the counsellor.

Example 10
One of the nurses described a incident whereby a 10-11-yr old boy was raped by a 25-yr old man. The boy had been sexually harassed by this man before, and the mother suspected something was wrong with her son as he was unable to sit down. The mother removed his pants and saw he was bleeding. She overheard her son talking to his cousin about the rape and how they wanted to avenge the perpetrator themselves, so the mother questioned him and he recounted the incident. The mother came to the nurse for counsel, and the nurse advised her and the father to support their son and not punish him. She suggested referring to another organization. But the mother was apprehensive as they live in a small

community. In the end it was solved internally in a traditional manner, with perpetrator's family having to pay 50,000NIS (Atweh) to the victim's family, and no police were involved. Yet the nurse believes that the family will still try to take revenge against the man and most likely assault him. The nurse also mentioned recently overhearing some women talking about this case at a funeral, questioning why the boy hadn't protected himself. They were saying that at the age of 10 he was "all grown-up" and should have been able to defend himself. Instead of supporting him, they were implying that the child was somehow to blame.

Further to this example, two of the psychosocial counsellors and one of the social workers commented that boys are more victimized and exposed to sexual abuse than girls, but that oftentimes it goes unnoticed. They added that boys might not display any symptoms and they have greater freedom of movement. Also, they might not necessarily know if what has happened to them is abnormal, and that most of the time, the abuser is a male relative of the boy. This is consistent with the findings in the 2007 ICPH/Birzeit study "**Child Abuse and Neglect in the West Bank: Training, Perception and Management of Cases among Palestinian Physicians,** where it was uncovered that the second major group of perpetrators of sexual abuse of boys was a male relative.

Sometimes the counsellors will find out though a mother who tells her that her son had said a certain thing, and then they both question the boy. Other times, the boy will behave aggressively with the mother, even to the point of hitting her. The mother will go to counsellor herself and recount her son's behaviour, and then learns of the sexual abuse.

3.5 General indicators (CAN) affecting both personal and professional life

In addition to the discussions regarding verifiable physical and behavioural indicators affecting the occurrence of child abuse and neglect, there was much discussion and general consensus among the participants regarding the underlying socioeconomic and political determinants in the occurrence of CAN, this being the Israeli occupation and the ensuing consequences. (Please refer to Figure 1)

Figure 1: General indicators of CAN

3.5.1 Poverty

The impact of the current phase of the economic crisis has hit refugees in the oPt harder than the population at large with respect to unemployment and poverty. Refugees are less likely to find work than non-refugees and as a result they account for a higher ratio of those living in dire poverty. In one example, a nurse described how one mother used to steal chicken and eggs to feed her children.

Neglect is mostly due to bad economic circumstances i.e. a child may ask his father for money for school fees or school trip but because the father cannot afford these, the child is affected psychologically. Furthermore, families are forced to live in cramped conditions. In some instance families are living in just one room, with brothers and sisters sleeping in the same bed. There is no privacy. Also in some cases, children are exposed to intimate acts between their parents.

Example 11
In one poor family, children live in a house with only 2 rooms and no ventilation. The bathroom is outside and the kitchen is very bad. The eldest child is a 16-17 yr old boy who has a psychological problem because of his economic situation; he is supposed to be taking his tawjihi next year so the family built him a little corner in the room made of bricks so that he could study. However, he is embarrassed to have any of his friends over. His father receives unemployment from UNRWA, and gets 350USD per month. Sometimes UNRWA has jobs for the unemployed, perhaps 2x/year, such as janitorial or other odd jobs. The boy started bedwetting when he was 13 yrs old and has been referred to counsellor, but he refuses to go because he feels ashamed.

Many heads of households (usually the fathers) are unemployed and feel the stress and humiliation of not being able to provide for their family, and oftentimes transmit this frustration onto their families, especially when forced to remain at home.

Another major problem of the economic situation is that children are now being forced to forfeit their education in order to support their families. Children as young as 10 years old, as reported by one of the physicians, are working in the markets, or selling various items on the streets. The risk of exposure to exploitation, abuse and neglect is great as they have no adult supervision, other than to verify the quantity of items the child has sold and how much they have earned. Due to their strained financial situation, there may be some children who are tempted to keep the money they earned for themselves rather than handing it over to their family. Consequently the children put themselves at risk of physical abuse from their family. The following is an example provided by one of the nurses:

Example 12
"a 10 year old boy was selling candy on the streets, but kept the money that he made, of 100NIS to himself instead of giving it to his father, so his father took a metal BBQ rod that was hot and hit the boy on his genitals."

3.5.2 Israeli military violence

Children are impacted by violent invasions by Israeli soldiers; they are becoming noticeably more aggressive and many have been traumatized by it.

Example 13
Thirteen years ago Israeli soldiers invaded the house of a 7-yr old girl who was at the time, taking a bath. Since this incident the girl has been very disturbed and weak at school and has developed learning disabilities. She is also bedwetting, although this could be a side effect of the medication prescribed by her psychiatrist.

The UNRWA report "Children in Crisis: Intifada related symptoms of the Nablus area Refugee Camps" emphasized the findings that many children in the West Bank refugee camps are showing symptoms of stress and depression. This was observed by more than two dozen teachers, doctors, social workers, psychologists, parents and children, interviewed in five West Bank refugee camps (UNRWA Emergency Stories-Children in Crisis: Intifada-related symptoms in children of the Nablus area Refugee Camps.). Both doctors and teachers reported that children are suffering from sleeping disorders (i.e. sleep deprivation), which has a direct impact on children's behaviour, academic performance and interpersonal relationships (UNRWA Emergency Stories- Children in Crisis: Intifada-related symptoms in children in the Nablus area Refugee Camps.). Many children cannot sleep because of anxiety, which increasingly manifests itself as hyperactivity, and some children are smoking now at the age of 10 because the association with “releasing tension" (UNRWA Emergency Stories- Children in Crisis: Intifada-related symptoms in children of the Nablus area Refugee Camp).

3.5.3 Lack of Freedom of Movement

In the West Bank, the system of closures continues to impede access to workplaces, schools, markets and health-care facilities. Curfews and closures affect access to medical services outside the refugee camp. It forces families to remain within the confines of the camp, destroying the social fabric inherent within Palestinian society. Children play in the streets without adult supervision and are at risk of accidental injuries. Families are forced to remain at home raising levels of stress and frustration, which is consequently reflected onto the child. The number of physical obstacles, including checkpoints, increased from 528 to 563 between January and September 2007 (UNRWA Department of Health Report, 2007). The restriction of movement imposed by the closure system in general, and the Separation Wall in particular, has had a significant impact on UNRWA’s ability to provide humanitarian assistance to the refugee community in the West Bank (UNRWA Department of Health Report, 2007).

4. Management and reporting

The majority of participants (60) reported that counselling parents and/or children was their main method of managing child abuse and neglect cases. Referrals (27), followed closely by Technical Consultation/Procedures (26), came in as the second and third preferred management of cases, while Working within the community/building on social links was mentioned by a very small number of professionals (7) (please refer to table 4 below).

Table 4: Patterns of Management

Participants / Themes	D	N	MW	PC	SW	Total
1. Counselling/consultation	**10**	**21**	**8**	**3**	**18**	**60**
2. Referrals	**8**	**5**	**1**	**2**	**11**	**27**
3. Technical Consultation / Procedures	**6**	**6**		**4**	**10**	**26**
4. Working within the community/building on social links	**3**	**2**		**1**	**1**	**7**

4.1 Counselling/education

Findings revealed nurses were highest in number among professionals offering counselling/consultation (21), followed by social workers (18). Most of their counselling and consultation took the form of talking to the mother about issues such as hygiene (temperature of bath water, or dirty-long nails), diet/nourishment (what to feed the child; sometimes a mother gives Red Bull to the children and they become hyperactive), and how to administer medication to their child. Both nurses and midwives also advise mothers on how to deal with their children, and the mothers feel at ease talking with them, as trust has already been established between them. One TBA also mentioned that because she is well-known in the community, the families listen to her when she speaks or advises them. She admitted that in certain circumstances she even threatens to inform the legal department outside UNRWA, to scare the family into not abusing their child again.

Doctors (10) also mentioned counselling the mothers or family members on general abuse and neglect issues. One doctor mentioned that for physical and psychological abuse, he also tries to find out who the perpetrator is, so that he may talk to them 'gently' with the social support of the psychosocial counsellor.

As for the psychosocial counsellors and social workers, they alternated between counselling the mother and the child. The psychosocial counsellors are more apt to counsel the mother and child within counselling sessions or support groups. Social workers counselled parents mainly during home visits, or when the parents come to them for social assistance whereby abuse and neglect is detected.

4.2 Referrals

Most of the nurses, doctors, and midwives, referred cases of CAN to other health professionals/specialists, and the majority were referred to psychosocial counsellors. Two doctors also referred to psychiatrists.

Social workers mainly reported referring to local institutions such as the YMCA, other UNRWA health programs such the Disability program or Fighting Poverty. Others mentioned referring to counsellors at the school or clinic. Alternately, two psychosocial counsellors referred to other mental health specialists at institutions like the Palestinian Counselling Centre, and one referred to an UNWRA physician.

Psychosocial counsellors also reported that most referrals of child abuse and neglect cases came from the clinical staff or other centres and institutions such as schools, women's centres, or the UNRWA Disability program. Although this is similar to referrals received by social workers, the majority of referrals for social workers come from the family or child victims themselves as they are in frequent direct contact with families through home visits.

4.3 Procedures/Protocols

Of those interviewed, a number of physicians (3) and nurses (2), reported that they their job was to merely treat the case medically, and not go further than that. One physician even stated that you can, *"treat abuse by treating the cause of the abuse i.e. a hyperactive child whose parents have reached their limit with the child and start to abuse him—but if they treat the hyperactivity then the abuse might go away."*

Yet most social workers reported following specific procedures when confronted with cases of child abuse and neglect, depending on their level of authority and the family's consent. One social worker clearly stated:

"I cannot work on my own, have to go back to talk to my supervisor if I discovered abuse; I cannot interfere; if he has permission then may he can interfere according to his training; he has intervened but depends on his limits and authorities."

Other social workers reported assessing specific needs of the family to help care for the child and prevent further abuse and neglect. For example, for families with disabled children, they would assess the need for special equipment; family assistance; fees for special education schools; or occupational therapy at centres like Abu Raiya.

Among all participants, the psychosocial counsellors were the most structured in their responses as to how they manage CAN cases, citing step by step procedures, These included defining their role as counsellors; building trust; trying to solve the issues; trying to solve issues within the camp; or contacting the legal and social department.

4.4 Working within the community/building social links

In situations when the health and social professionals are not able to mediate with or talk to the family directly about CAN cases, HSCPs work with other members of the community, especially relatives. In such instances they ask someone that the family knows well to intervene and broach

the subject of the way they are treating the child, and try to encourage them to cooperate and speak with the professionals.

4.5 Recording cases of child abuse and neglect

Among the participants, 56%, mainly nurses said that they do not record cases of child abuse because of 'Professional limitations/conduct". Participants commented that there are "no files or registry for child abuse and neglect victims"; "not my job"; "they don't ask us to register these cases"; "UNRWA only concerned about primary healthcare."

Of those interviewed, 42.5%, mainly social workers and counsellors, stated that they do record cases of child abuse and neglect. Everything is documented including procedures, and they have basic forms and intake sheets that they have to fill out. With the counsellors this is more in terms of recording every therapy session or meeting that they have with their patient, and with social workers it is filling cash or social forms that have different subsections for recording information like economic/psychological status of family; this is done mainly during home visits, or when the family comes to their office.

5. Reporting child abuse and neglect (CAN) cases

5.1 "YES" to reporting CAN cases

- 18% said they would report cases to UNRWA senior official

- SW and PC said they would first report to their supervisor to:
  - Authorize appropriate action
  - Provide general guidance
  - Offer legal advice

:

Example 14
One psychosocial counselor remarked that when she feels at risk she reports to her supervisor for protection "as the police will not do anything and there is no UNRWA policy"

- Three counselors described specific procedures:
  - Contact professional supervisor
  - Call administrator, who calls the psychosocial health coordinator
  - Contact UNRWA legal department to protect one 's self
  - Prepare written reports and email to MoSA and UNRWA lawyers & copy all the officials that have previously been made aware of the case

- 18% (mostly nurses and midwives) said they would refer to another HSCP, mainly a doctor or psychosocial counselor.

5.2 "NO" to reporting CAN cases

- "Professional Limitations/Conduct" was the main reason cited by the majority of respondents (45%).Respondents referred to:
    - Lack of 'technical instructions'
    - No system and/or procedures within UNRWA for reporting
    - Job description limits what they can/cannot do e.g. Doctors provide medical attention; SW's provide food, cash

- 27% did not report because of their level of perception/awareness regarding the need to report and what policies exist for reporting

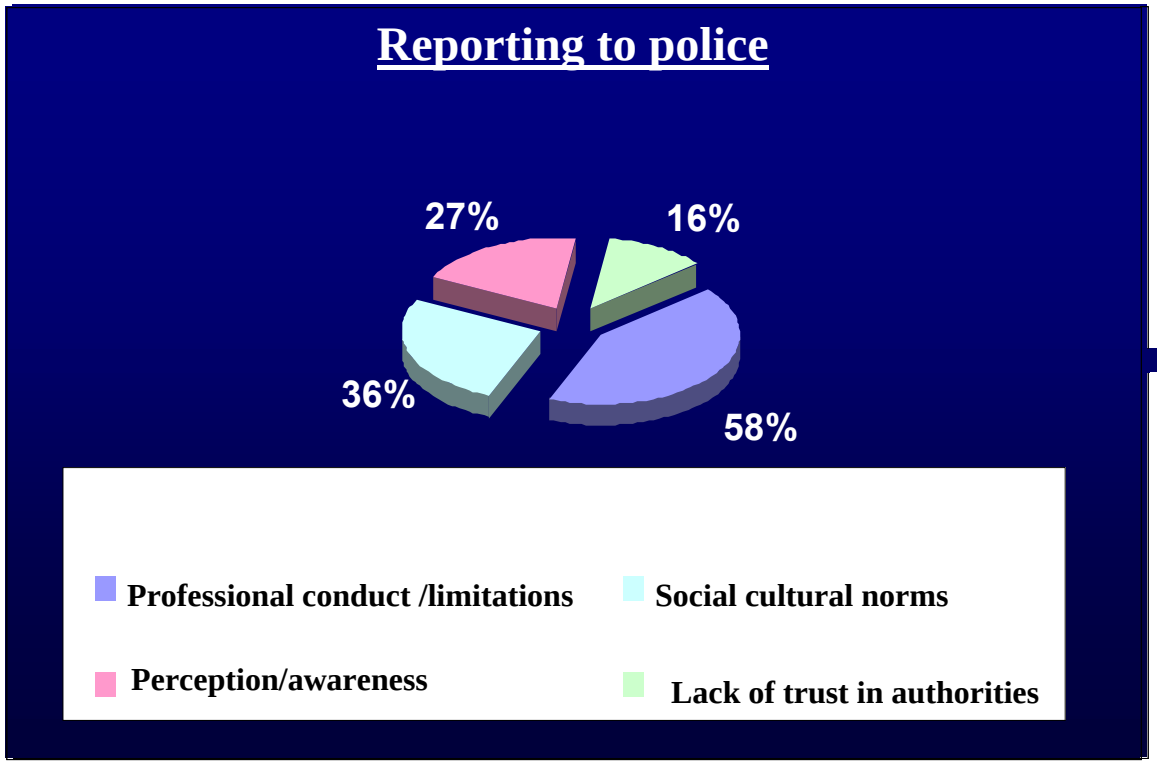
- 15% did not report because of issues relating to "family protection" e.g. 'people are conservative and would talk about it within community'.

5.3 Reporting to the Police

When participants were further asked whether they ever contacted the police in cases of abuse and neglect, without exception, they all responded "No." Forty-two participants remarked that with regards to political and legal issues, that professional conduct/limitation were the main reasons why they did not report, followed by 36% who also said that they would not report to the police because of 'social cultural norms.' (Please refer to Table 5)

Figure 2: Why do you not report cases of child abuse and neglect to the police*?

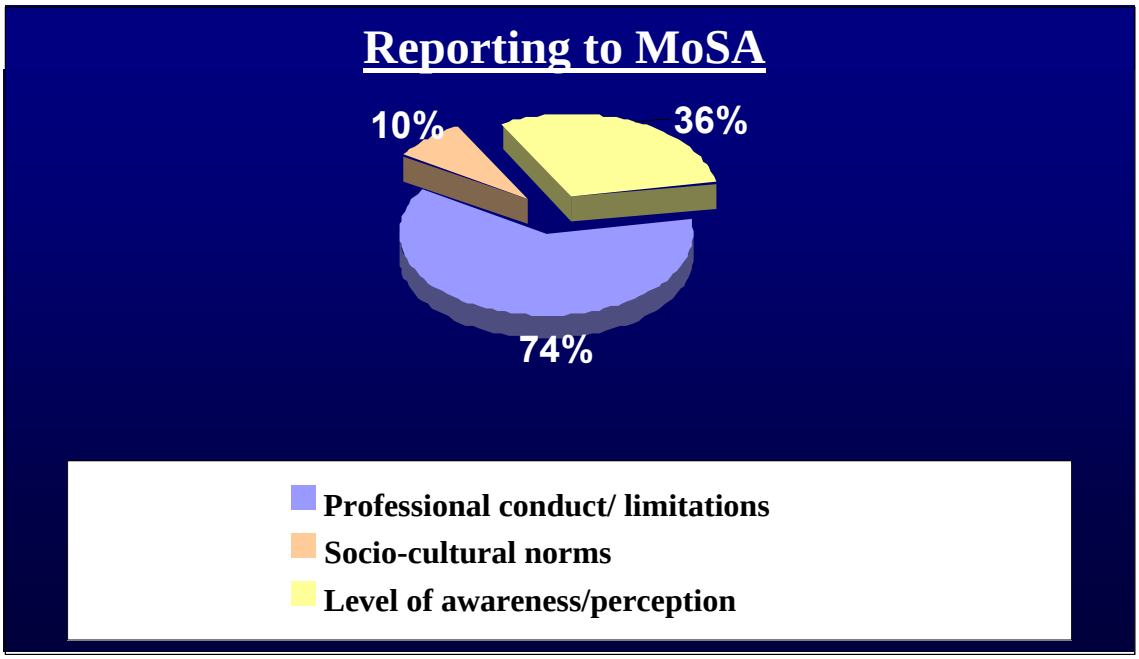
*** Of all participants questioned 0% reported to the police**



5.4 Reporting to the Ministry of Social Affairs (MoSA)

74% said that they would not contact MoSA due to also 'Professional limitations/conduct while another 36% reported that the second major reason they would not contact MoSA, was because of their level of awareness/perception regarding CAN cases (please refer to Table 6). Only one participant reported contacting MoSA in Jerusalem in regards to child abuse and neglect cases, and remarked that they had a very good professional collaborative relationship.

Figure 3: Reporting to MoSA



5.4.1 Social Issues

i. Social cultural norms: Most of participants remarked that child abuse and neglect was a sensitive issue, and the families would not allow or appreciate interference from authorities, as cultural traditions are very conservative. One participant stated that she cannot interfere within her own family, much less with other people in the community.

There are also personal risks involved for the social health professional.

Example 15
One psychosocial counsellor said that if the case reached the police then she would consider herself a failure because it would mean exposing both herself and the victim to danger. The situation could likely get out of control; an uncle or cousin who is responsible for female victim of child abuse and neglect, might well kill her to remove the shame brought to the family by such abuse.

This example is further supported by the research study, "Translating Child Abuse Research into Action", where it was stated that mandated reporting from all professions have described how inadequate law enforcement investigation, ill-prepared prosecution efforts, inappropriate legal decisions leave children exposed and vulnerable to further maltreatment. (Flaherty et al., 2008).

5.4.2 Political/legal issues

i. Lack of trust/confidence in higher authorities/system: participants expressed a lack of confidence in the ability of the police or MoSA to intervene and protect the individuals involved, stating that there are no rules or laws to protect them. Two participants even commented that 'there are no police here", and one participant said in regards to MoSA, that they “don’t know who they are or what they do or even their contact number”.
Some of the HSP’s working in Jerusalem explained that they had to adhere to Israeli law, and follow their procedures even though they felt it was a national problem and did not want the Israeli police involved, fearing it might cause even more instability.

ii. Professional conduct / limitations: Many participants stated that they were not authorized to contact the police, and they had certain limitations according to the position they held., Many felt it was best to contact a coordinator to supervisor if they suspected any abuse, and it would be up to those individuals to contact the police or MoSA. Some comments included "you haven’t the right to contact police according to UNRWA rules" or “here as UNRWA, shouldn't go to anyone but UNRWA, it's a rule that it's forbidden to go outside”.

6. Training

6.1 Training Experience

In its annual report to the Department of Health (2007), UNRWA stated that,

"Supervisors and assistant supervisors undergo continuous development and training to ensure they can effectively undertake their roles. The training of supervisors and assistant supervisors has 2 major components: in-service training; communication and self awareness, counselling intervention, crisis counselling and administrative domains.……training of counsellors during 2007 had in-service training with ' on the job supervision' and formal training.…training on intake and reporting and various mental health themes…."

UNRWA also undertakes much training in coordination with partners. Some of these include primary health care training with the Ministry of Health or other UN agencies such as UNFPA; in conjuction with USAID (HANAN Project) UNRWA also reprinted health education material and distributed them to UNRWA health centres (UNRWA Annual Report of the Department of Health, 2007). It also has a long-standing cooperation with St. John Eye Hospital in Jerusalem which resulted in a number of activities including the Community Health Department Outreach Program and vision screening for school children, in addition to ten training workshops for school teachers and tutors on the screening (UNRWA Annual Report of the Department of

Health, 2007). Other work with NGOs included liaising with the Women's Centre for Legal Aid and Counselling (WCLAC) to coordinate activities on violence against women including meetings and workshops; development of health education materials including posters and flip charts on adolescence, personal hygiene, menstruation and early marriage which were distributed to UNRWA health centres and schools; and joint activities with the Palestinian Family Planning Protection Association on women's sexual and reproductive health which formed part of a broader public health education campaign (UNRWA Annual Report of the Department of Health, 2007).

Yet, despite the amount of time and attention that UNRWA has invested in training and education, it was revealed through this study that 19 out of the 84 participants (23%) received some form of training in child abuse and neglect before being employed by UNRWA, and 23 (27%) after working with UNRWA. From these numbers, it is significant to note that there were only 3 physicians who received any sort of training in child abuse and neglect. None of the midwives received training, and only 10 out of the 29 nurses were trained on subjects relating to child abuse and neglect (please refer to table 7 & 8). Of the 10 nurses, 2 received training before and after working for UNRWA. In addition, 3/4 psychosocial counsellors and 4/22 social workers also had training before and after working with UNRWA.

Table 5 : CAN training before UNRWA

CAN training before UNRWA			Total
	Yes	No	
Physician	1	12	**13**
Nurse	3	26	**29**
Midwife	0	10	**10**
Psychosocial counsellor	3	1	**4**
Social worker	12	16	**28**
Total	**19**	**65**	**84**

Table 6: CAN training after UNRWA

CAN training after UNRWA			Total
	Yes	No	
Physician	2	11	**13**
Nurse	7	22	**29**
Midwife	0	10	**10**
Psychosocial counsellor	4	0	**4**
Social worker	10	18	**28**
Total	**23**	**61**	**84**

It is interesting to note that a psychosocial counsellor working at one of the UNRWA clinics gave an informal training, and this took place because of personal initiative on the part of the nurses. This is significant in that it demonstrates how important the nurses view their role in working with children, and their awareness of issues pertaining to children in difficult circumstances including abuse and neglect. This particular training was useful in that both nurses and midwives sat down as a team with the psychosocial counsellor to discuss

psychosocial problems of children such as bedwetting and children living with drug addicted fathers.

Of the 23 participants that received training after working with UNRWA, 6 were trained on issues relating to psychosocial health, and 7 were trained on issues relating to identification and management of cases, marking this as the two major areas of training that UNRWA had concentrated on. Only 3/23 participants that received training on CAN after UNRWA did not find it useful. Reasons included translation problems and too short training sessions The rest found that the trainings helped them become more aware of issues that affect children, like PTSD, International Convention on the Rights of the Child, and also how they can in identify child abuse and neglect cases and intervene on different levels.

Although UNRWA did conduct trainings in child abuse and neglect, those targeted for these were mostly social workers and psychosocial counsellors rather than nurses, midwives and physicians, implying the limited role the latter are expected to play in cases relating to child abuse and neglect.

6.2 Training Needs

One of the key aims of this research was to identify the perceived skill deficits of social health professionals in the area of child abuse and neglect, and to highlight what is needed to improve their situation. Interviewees identified a number of potential areas for training, with the exception of two participants who were unable to specify any type of training they might need.

An overwhelming majority of participants (77) replied that they needed training on the **Management of Cases**. The types of management identified included: management and reporting of cases (47); counselling/intervention/working with groups and individuals (25); and follow-up/supervision (5) (please refer to table 9).

The absence of procedures linking health professionals to proper channels to follow-up on cases was cited as the main problem of case management. How to *"deal with these problems, investigate these cases, how to interfere"* was commonly cited by the participants. How to deal with children and their families in the context of child abuse and neglect was also an important issue, and 1 social worker and 2 nurses specified that they needed specialized training in the management of sexual abuse cases.

The second critical area of training identified was general theory and information for all the professionals. It was deemed important to have a clear definition of the topic, including types of child abuse and neglect, to help in their approach of cases. Other subjects identified for the general training included information on how to deal with the mentality of children, particularly, how they think and what is their relationship with others i.e. parent, teacher, etc. How to deal with issues like violence among children and child labour were also key issues which were mentioned, in addition to how to address the specific needs of disabled children and their integration into the community. The respondents also requested more information on the current research and statistics that exist in relation to the Palestinian community and child abuse and

neglect. This would also help in their ability to identify and differentiate cases, which is the third major category of training needed.

Knowing what kind of referral mechanisms existed, and what type of organizations deal or specialize in child abuse and neglect cases in order to facilitate contact and cooperation was another important area of training identified. Though only 6 participants mentioned training in the area of child rights, it is still significant in that it implies that there is awareness among the professionals on the subject and that they feel the need to do more to protect children. Two of the 6 participants stated that it is imperative to *"put national rules in Palestinian legislation to stop child abuse and neglect,"* and to lobby and advocate for children's rights.

Table 7 : Mapping of Training Needs

Themes / Participants	General theory and info	Identification/ diagnose cases	Referrals/ collaboration	Management of cases			Child rights	Practical on-site training	Cannot specify	Total # of HSCPs interviewed
				Management and reporting	Counselling/ intervention	Follow-up/supervision				
D	8	4	3	11	3	3	1	1	----	13
N	19	9	4	17	6	2	1	2	1	29
MW	6	2	----	4	3	----	----	----	1	10
PC	3	1	1	1	3	----	----	----	----	4
SW	20	3	4	14	10	----	4	3	----	28
Total	56	19	12	47	25	5	6	6	2	84

7. UNRWA policies on managing and reporting child abuse and neglect cases

When participants were asked if they were aware of any written UNRWA policies on managing and reporting child abuse and neglect cases, all responded no, with the exception one participant who stated that UNRWA had policies governed by the Convention on the Right of the Child (CRC) in effect in UNRWA schools. According to this participant, the school curriculum encompasses child rights and there is a policy that clearly states that any teacher that physically abuses/beats a student will be dismissed, parents should report to UNRWA headquarters and the school counsellor would follow-up with child.

Of the participants who were not aware of any such UNRWA polices, 69% said that such policies were needed for 'organization/management/collaboration' of child abuse and neglect cases. Participants corroborated this by citing examples such as: *'many difficulties so better to have a regime for all health workers to be unified: how to handle such cases is a big dilemma'; 'policies should cover whole community not just the UNRWA health professionals'; 'if there are no technical instructions to follow then they don't do anything, because they only follow "circular"" instructions from UNRWA as in 'do this, do that'; 'give permission to social workers to work within their framework with more authority'; ' would feel more secure and effective within this topic.'*

Of the participants, 27% stated that they needed these policies for 'child protection and development of the child.' Some of the comments made in this regard were: *'because we have to pay more attention to the child and raise them in a health way from beginning because they will be man of the family one day'; ' to be fair on how to treat the child'; ' because you can help mother and child; stop whole family from ruin'; 'need to protect our children'.*

8. Expectations from UNRWA

Over two-thirds of the study participants expressed their desire to improve their knowledge base on the subject of child abuse and neglect, through trainings/workshops, lectures, or courses (please refer to table 10). One nurse even suggested that UNRWA produce brochures on CAN topics for local distribution. For example, she related when working at 'Hilal' (Palestine Red Crescent Society) they had a journal to keep them updated on medical issues like child abuse and neglect. A couple of participants also mentioned the use of various media such as videos and documentaries to illustrate examples of child abuse and neglect.

The next major point the participants wanted to focus on was developing an effective system of management/intervention. They explained that having clear, written policies, protocols, and laws would guide them on the necessary course of action if they come upon child abuse and neglect cases. The policies should not only protect them, but also provide them with the authority to intervene. They expressed a clear need for clear procedures on this subject, about what to do, what to say and how to address the issue, and what their limits are. Some

participants also stated that they need to raise awareness on this subject among the community which will require more financial support from UNRWA.

Another important point that was raised is that UNRWA needs to increase its support to its health and social care professionals. Among the nurses (13) were very emphatic on this point, and felt they needed to spend more time dealing with the cases, and that they would benefit from increased staff and specialized individuals to deal with child abuse and neglect cases. Having a separate program for this subject was also suggested, but more importantly it was deemed critical to have a full-time psychosocial counsellor on-site to assist them. Presently, there is no counsellor at the Al-Zawyeh clinic for instance, and only one counsellor allocated for 2 of the refugee camps where interviews were held. They expressed that they would like UNRWA to develop all the health and social care professionals in the area of child abuse and neglect, and not just target certain groups. In terms of support, the social workers expressed specifically, that they need more authority and protection from UNRWA.

Increasing communication among UNRWA personnel was also mentioned in terms of cooperating on cases, and also establishing a referral system and list of contact organizations and institutions that specialize in child abuse and neglect.

Table 8: What else can UNRWA do to support your work in the area of CAN?

Participants / Themes	D	N	MW	PC	SW	Total
Increase knowledge base	8	21	6	2	22	**59**
Increase communication/networking	2	2	----	1	6	**11**
Support for parents and children	1	2	----	----	4	**7**
Effective system of management/intervention	7	9	4	4	10	**34**
Increase support to UNRWA personnel	7	13	2	3	8	**33**
Nothing	1	1	2	----	----	**4**
Total # of HSCPs	13	29	10	4	28	**84**

IX. Conclusion

This exploratory study revealed that child abuse and neglect is a problem that needs to be addressed systemically by all UNRWA services in an orchestrated manner. It may represent a broader more generalized phenomenon in other Palestinian refugee camps in the occupied Palestinian territory, or even outside the country. However, further research would be required to assess the type and degree of child abuse and neglect in the remaining camps of the country.

As reported by the health and social care professional in the camps which were studied, almost all see a significant enough number of child abuse and neglect cases to warrant further attention by UNRWA in creating a unified system to deal with cases of child abuse and neglect. Most participants reported a pressing need for further training, especially in the areas of understanding children's needs, the development of a more effective system of management, reporting and referral; more efficient cooperation and linkages among the different providers dealing with child abuse and neglect cases; and the protection of staff by UNRWA in their attempts to deal with difficult cases, especially given their perception of the lack of appropriate police protection in the country.

Of significance to note here, is that during the dissemination workshop outlying the preliminary results which was held on November 12, 2008 with UNRWA and various local and international partners, it was mentioned that there is a protocol reporting/referral system in place between the Ministry of Social Affairs and the local police. One of the workshop participants stated that there are protocols and procedures that have been established and ratified by more than 25 groups dealing with child abuse and neglect including several Ministries, NGO's, and UNRWA. Police are being trained in dealing with child abuse and neglect cases and family counsellors are also receiving training. Those that have implemented this system in Gaza commented that the protocols established are user-friendly and those involved in the pilot project see it operating well. Guidelines set forward are being maintained and the system seems to be working, and it is perhaps something that UNRWA can also build on.

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The results also emphasize that focus should not be placed on 'blaming the victim', i.e. families living in hardship, who end up abusing their children. While there is every reason to believe that family consultations, child protection from perpetrators within the family and at school are important elements of future action, it is equally important to keep in mind the broader context of violence against children. Indeed, respondents were able to identify the various influences precipitating child abuse and neglect in terms of direct – such as Israeli army violence - and structural violence – such as poverty and overcrowding affecting everyone in the family and as well as in the community.

While there were not many comments regarding the actual prevention of child abuse and neglect, some participants did comment that they would like to see more support for parents and children from UNRWA. For example one participant stated that UNRWA needs to *'start with parents, they don't receive any warmth from their own family so don't know how to give it to the child-becomes a circle and wants to stop it, and wants UNRWA to be aware of this issue'*. This relates more to the protection of the family as a unit; as when the focus is placed uniquely on the child himself, the root problem of the abuse may not be addressed. Further to this, a few comments were raised regarding not only child abuse, but also violence against women. Most often when the mother is abused, the child is also, and the mother oftentimes takes out her frustration and distress on the child as well.

It is true that much can be done to counsel families and the community and manage child abuse and neglect through a system of counselling and support, but it is equally true that there is also a need to understand the underlying causes of violence against children by adults who have been violated themselves. Broader contextual understanding is necessary in the planning of future training, through which professionals can appropriately manage cases through an understanding of the context within which violations against children occur.

The information revealed in this research indicates that a main influence in the occurrence of child abuse and neglect is Israeli military occupation violence. Participants concurred that violation of family and community could lead to child abuse and neglect. The lack of freedom of movement, and the ensuing unemployment are key issues. One respondent expressed it in this way:

"the country feels more like it is a big prison where you can't move or breathe; everyday is the same for them….cannot go out on a weekend to just any place, especially the children, and therefore they cannot enjoy their summertime."

The overall political situation has built up frustration and depression among much of the population, and poverty is widespread. Almost two thirds of families live below the poverty line (PCBS, 2007) and this has led to an increasing number of children leaving school in order to work to contribute to the family income. Given the current levels of poverty in the country, one must raise questions as to how this problem can be addressed. Very soon after the outbreak of the second Intifada in September 2000, it became clear that the closures in the West Bank imposed by the IDF would have an acute economic impact (UNRWA Emergency Stories: The Impact of the Closures on Food Prices). By early 2002, the Palestinian economy was in a severe recession, and in the World Bank's *Assessment* on the Palestinian economic crisis in March, 2002, stated:

"The proximate cause of the economic crisis is Israel's closure of the Palestinian territories" (UNRWA Emergency Stories: The Impact of the Closures on Food Prices).

The situation is further compounded by the fact that families are forced to live in small crowded rooms because of lack of space and finance, poor sanitation and ventilation. The size of refugee camps has remained essentially the same over the past 60 years while the size of the population has increased fourfold (Sharek, 2008). The lack of space to expand

horizontally has led to haphazard and precarious construction of extra floors onto existing buildings (Sharek, 2008). As such, crowded conditions of the camps can also contribute to an increase in the number of child abuse and neglect cases.

Socio-cultural taboos against reporting child abuse and neglect also need to be addressed in a conservative society, which prohibits the disclosure of such cases by family members, including children themselves. At the dissemination workshop of preliminary results held on November 5, 2008, psychosocial counsellors working in Jerusalem complained that they were bound by Israeli law, and are obliged to contact the authorities in cases of child abuse and neglect or else face reprimand. The dilemma is that they don't want to report these cases, though they live under Israeli authority and control, as they believe it is a national problem.. There is a system is place in Jerusalem to follow-up on families suspected of abusing their children, yet families and health and social care professionals are wary of this system because when a case is reported, a social worker comes immediately to assess the situation and can arrest the family members, or take the children away from the families.

This study indicates a possible need to work towards a better understanding of the occurrence and consequences of child abuse and neglect by professionals in ways that go beyond cultural norms. The testimony below of one nurse may be indicative of the notion that *'all is well here'* and also indicative of the need to raise consciousness through training and advocacy among professionals:

"if we were to compare with the children on the show "Super Nanny" then Palestinian children are angels compared to those children; here the Palestinian woman is a "Super Nanny" by herself; here we give the most priority to our children (food, hygiene, health) children are always well dressed during the Eid despite all the hardships/occupation you won't find a child that is not a well dressed or fed."

The initial results of this study show that more attention should be paid to the educational and communication needs of women health professionals, and in the study this was particularly evident for nurses, midwives and traditional birth attendants. It is surprising that the initial findings of this report indicate that they have so far been afforded the least attention. These particular caretakers have the strongest links to family and community; to women, who are the primary caretakers in the family, and who trust them and confide in them. Mothers are also the ones who visit clinics most often, and face the stress of holding the family together when husbands are facing violation and unemployment or working away from home. In addition, mothers are often abused by their husbands in addition to the children being abused by family members, and it is usually mothers who reveal the problem to nurses, midwives and traditional birth attendants, and not necessarily to doctors. This is precisely why a concerted focus on the further training and supervision and communication with these women caretakers is essential.

It is important to note that feedback from the interviews was generally very positive, in that the process was seen as enriching for participants. Some told us that this was the first time anyone asked them about their experience with child abuse and neglect. Furthermore, they reported that the interviews helped refresh the information they already had regarding the

subject, and that the experience has helped in how they will look at the future cases. This reiterates the interest in, and commitment of, the UNRWA staff to caretaking, and their dedication to the betterment of the lives of children. What is needed now is further support by UNRWA to help these caretakers improve their performance.

Finally, child abuse and neglect is the responsibility of all professionals, whether physicians, nurses, midwives, counsellors or social workers. Future training, management structures and system building endeavours need to take into consideration inter and intra sectoral collaboration, including baseline training in child abuse and neglect for all, then specialty training in relation to job function, followed by periodic discussions of cases among all parties involved. Indeed, children do not live in sectors; they live in communities. Subsequently, child abuse and neglect can only be identified and managed effectively through the cooperation of the various sectors involved, thereby strengthening partnerships and stakeholder relations.

X. Recommendations

1. Project recommendations:

- Enhance the capacity of all those who work with children and families, particularly health professionals and social workers to improve prevention, detection and management through training workshops and/or information sessions

- Increase communication and transparency of information between departments and more collaborative efforts.

- Expand the current pilot project within the West Bank and Gaza Strip to include a broader contextualization and representation

2. Sectoral recommendations:

- Establishment of clear policies and procedures for management and reporting of child abuse and neglect at different levels, taking into consideration inter and intra-sectoral collaboration.

- Evaluate trainings and provide health and social care professionals with continuous and regular follow-up of updated information on child abuse and neglect.

- Support the creation of an accessible, child-friendly reporting system and service, including protection and privacy of individuals involved.

- Establish intra-sectoral committees composed of the various departments of UNRWA to respond to reports of suspected child abuse and neglect, and follow up on training endeavours, homogenize actions, and continuously plan for further development, in line with presented problems and outcomes.

XI. References

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