

Childhood Well-being in Qatar

Survey of Qatari Families | October 2024

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EXECUTIVE SUMMARY

Improving child well-being is among the primary goals of Qatar National Vision 2030. In fact, during the Annual Day on the Rights of the Child, as part of the 58th session of the UN Human Rights Council in Geneva, the Second Secretary of the Permanent Mission of the State of Qatar to the United Nations Office in Geneva emphasized that the “Third National Development Strategy for 2024–2030 allocates considerable attention to child welfare, survival, and development within an integrated approach”¹. The concept of child well-being has multiple dimensions concerning the child’s health, education, entertainment, rights, and family stability. It has received significant attention from the academic community. Hence, reliable data is needed to assess this concept in Qatar. One of the study’s main aims is to create, validate, and refine a comprehensive strategy for child welfare. Children’s well-being has a significant influence on how society develops. Children who are healthy and receive adequate care are more likely to develop into contributing adults. Therefore, cooperation between governments and families is crucial to ensuring children’s overall development.

The Doha International Family Institute (DIFI) expressed an interest in collaborating with the Social and Economic Survey Research Institute (SESRI) at Qatar University. This project was funded by both Qatar University and DIFI. The statements made herein are solely the responsibility of the authors. This report presents the findings of a survey exploring children’s well-being in Qatar. A representative sample of 1,607 Qatari citizens was selected and interviewed using the CAPI (Computer-Assisted Personal Interview) system. Respondents were asked a range of questions about their children’s well-being. They were assured that their answers would be confidential and presented in aggregate form.

Brief Findings:

- The report shows that the vast majority of respondents reported their child’s health as either excellent or very good.
- The Strengths and Difficulties Questionnaire (SDQ) found that the majority of the sample fell within the normal range for all aspects (emotional problems, conduct problems, hyperactivity problems, peer problems, and prosocial behavior), with the highest abnormality observed in peer problems (19%), followed by conduct problems (13%).

- The Pediatric Symptoms Checklist revealed that 94% of the sample showed no psychological impairments.
- The results show strong support for early childhood education and development, with 82% of respondents reporting that they have enrolled their children in a kindergarten, preschool, or nursery.
- Similarly, 93% of respondents said they believed in teaching their children basic literacy skills—such as numbers and letters—prior to enrollment in any institution that precedes first grade.
- It is worth noting that when asked about their child’s early education and development, activities associated with creativity, like music and the arts, were the least popular among respondents, with 55% and 29%, respectively, reporting they never engage their children in those activities.
- Regarding childhood well-being and entertainment, most respondents reported that they did not enroll their child in any extracurricular activity.
- In general, when asked about discipline styles, the majority of respondents disagreed with any statements supporting abuse or causing harm to children.
- 61% of respondents stated that neglect is a serious problem in Qatar. When asked at what age a child is mostly neglected, 41% stated that there is no specific age for child neglect.
- The results show that only 8% of parents reported that their child had been abused by a caregiver.
- The vast majority (96%) of parents indicated that they were satisfied with their partner’s participation in raising their children.
- Most parents described great communication, pride, enjoyment, and positive relationships with their children.
- 81% of respondents reported that their child has access to the internet, and they indicated that, on average, their child spends four and a half hours online per day.
- 90% of respondents agreed or strongly agreed that their child benefits from looking up information online, while 85% stated that their child fully understands personal privacy online.
- Overall, parents had a positive attitude about their child’s social relations online, with 44% saying their child met friends online, while 56% agreed that their child’s relationships were strengthened by their online presence.
- Two key reported downsides stood out: first, 41% of parents reported that being online negatively affected their child’s sleep patterns; second, parents expressed concerns about their child’s perception of personal image online.

¹ <https://mofa.gov.qa/en/qatar/latest-articles/latest-news/details/2025/03/13/qatar-emphasizes-commitment-to-children's-welfare-in-third-national-development-strategy#:~:text=The%20State%20of%20Qatar%20has,development%20within%20an%20integrated%20approach>

01

Introduction

Children today face a diverse range of risks that jeopardize their well-being across physical, emotional, and digital dimensions. Globally, approximately 1 in 6 children (356 million) live in extreme poverty without access to essential services such as clean water, nutrition, and healthcare (UNICEF & World Bank, 2023). In addition, nearly 1 billion children aged 2 to 17 experience some form of physical, emotional, or sexual abuse annually (Hillis et al., 2016). The digital sphere presents emerging dangers, with over 80% of adolescents aged 12–17 encountering harmful content or contact online each year (OECD, 2021; Twenge et al., 2023). Mental health has become a growing concern, with one in seven adolescents globally affected by a mental disorder that contributes significantly to disability and early mortality (UNICEF, 2021). These overlapping vulnerabilities are further intensified in contexts marked by conflict, displacement, and social inequality, underscoring the pressing need for inclusive and targeted policy responses (UNHCR, UNICEF, & IOM, 2023).

Child well-being refers to the overall quality of life children experience across multiple developmental domains, including physical health, emotional security, social inclusion, cognitive development, and spiritual grounding (Ben-Arieh, 2005; OECD, 2021). It reflects not only the fulfillment of basic needs but also the realization of rights, access to participation, and the presence of nurturing environments in both family and community settings (Ben-Arieh, 2005; OECD, 2021). Unlike traditional metrics focused narrowly on material or survival indicators, modern well-being frameworks encompass a broader view, emphasizing children's ability to thrive in safe, inclusive, and empowering environments (Bradshaw et al., 2007; UNICEF, 2024). Child well-being is now widely seen not only as a moral obligation but also as a strategic investment, with strong evidence linking early interventions in health, education, and psychosocial support to improved long-term outcomes in social and economic domains (Yoshikawa et al., 2020; Hirve et al., 2023).

In Qatar, the significance of child well-being is deeply embedded in national development priorities. Qatar National Vision 2030 underscores human development and strong family structures as pillars of national prosperity (General Secretariat for Development Planning, 2008). These goals are further reinforced in the Third National Development Strategy (2024–2030), which highlights the importance of strengthening family cohesion, promoting civic engagement, and ensuring the inclusion of vulnerable groups—particularly children (Planning and Statistics Authority, 2024). Contemporary challenges such as digital exposure, mental health vulnerabilities, and disparities in access to early childhood education have placed greater urgency on policies that promote the well-being of all children (UNICEF, 2021; McGovern et al., 2024; Yoshikawa et al., 2020).

Conceptually, child well-being is shaped by the interplay between external conditions—such as socioeconomic status, family stability, and environmental safety—and internal characteristics, including cognitive abilities, emotional resilience, and personality traits (Ben-Arieh, 2005; Bradshaw et al., 2007). Child well-being is increasingly recognized not only as a development priority but also as a fundamental human right, grounded in international instruments such as the Convention on the Rights of the Child, which affirms every child's right to survival, development, protection, and participation (United Nations, 1989). This interaction is critical in determining the extent to which children can access resources, build capabilities, and develop the psychological tools needed to navigate their environments (Pollard & Lee, 2003).

In this context, the current study—conducted by the Doha International Family Institute (DIFI), in partnership with the Social and Economic Survey Research Institute (SESRI)—builds upon previous regional research on child well-being in the Gulf (DIFI, 2020). It is a direct extension of the earlier regional study, *Child Well-being in the Gulf Region*, conducted by DIFI, which highlighted the critical need to develop localized indicators for measuring and monitoring child well-being in Gulf societies (DIFI, 2020). The study adopts a multidimensional framework consistent with international best practices, examining six key domains: (1) Health, (2) Education, (3) Leisure and Recreation, (4) Protection, (5) Parental Involvement, and (6) Digital Engagement. The study also considers cross-cutting factors relevant to Qatar, such as family dynamics, social interaction, economic stability, and school environments. This structure aligns with global child well-being models that emphasize comprehensive, rights-based approaches (Livingstone et al., 2014; OECD, 2021; UNICEF, 2024).

In this policy context, the study represents a timely and strategic contribution to Qatar's social development agenda. It reinforces efforts to build a cohesive, inclusive, and family-oriented society rooted in Qatari cultural and national values, and informed by robust, context-specific data. It also marks a milestone in ongoing work on child well-being in Qatar by providing an evidence-based analysis of the status of children, which will support the development of a national child well-being index.

02

Methodology

2.1 Sample design

Sampling is the process of selecting a sample of elements from the sampling frame to conduct a survey. It plays a critical role in any survey process, as the ability to make valid inferences about the target population depends on a rigorous sample design. The following section discusses the sample design used in this survey.

The first component in the design is the sampling frame—a list that identifies all elements of the target population. In this survey, the target population includes Qatari nationals who are parents or guardians of at least one child under 18 years of age and currently live in residential housing units in Qatar during the survey reference period. The target population excludes those residing in institutions such as army barracks, hospitals, dormitories, or prisons. It also excludes the non-national population (expatriates). The sampling frame was developed by SESRI with assistance from the Qatar Electricity and Water Company (Kahramaa). This frame includes all housing units in Qatar, along with address information and data indicating whether residents are Qatari nationals or expatriates.

Sampling began by dividing the frame into seven administrative municipalities. Each municipality consists of a number of zones, and each zone is divided into several blocks. In this survey, housing units in each zone were ordered by geographic location to ensure well-distributed sampling across areas. A systematic sample was constructed for Qataris. The basic idea of systematic sampling is to select housing units by taking every k th unit in the frame, where k is the sampling step—defined as the integer part of the ratio between the frame size and the desired sample size. Systematic sampling results in proportionate stratification, where blocks with a given percentage of Qatari housing units are represented by the same percentage of sampled units. Based on previous surveys, SESRI anticipated varying response rates across zones. Therefore, over-sampling was employed in areas with lower expected response rates.

In the Child Well-being Survey, a structured and randomized process was used to identify a Qatari child within each participating household, ensuring fair representation across age groups (0–5 years, 6–11 years, and 12–17 years). Upon visiting a randomly selected household, the interviewer first confirmed whether the family was Qatari. If so, they asked whether any Qatari children under the age of 18 resided in the household. If present, the respondent was asked to list the children's ages in order. In households with multiple children under 18, a computer-based system randomly selected one child. In cases where two or more children were the same age, the system further randomized by selecting either the eldest or youngest child to promote consistency. The interviewer then invited the parent or guardian of the selected child to participate.

Although the randomization process ensured equal selection chances across age groups, the response rates varied. The youngest age group showed a lower response rate, meaning that interviewers frequently failed to complete interviews with parents or guardians of children in that group.

The questionnaire was tailored for the three age groups, with each section containing age-appropriate questions. Skip logic was used to ensure that respondents only answered questions relevant to the selected child's age group, improving flow and accuracy in data collection.

2.2 Sample size, non-response, and sampling error

The survey was conducted from May to June 2024. SESRI used a sample size of 6,050 Qatari households. The following table shows the outcomes of the final contact between interviewers and sampled housing units:

Table 1: Responses by Groups

Responses	Number
Completed	1607
Not completed	4443
eligible	312
Ineligibles	1495
unknown eligibility	2636
Raw response rate (RR1)	35.3%
Adjusted response rate (RR2)	47.3%

Based on Table 1, response rates were calculated. Two response rates are reported. First, the **raw response rate** is the ratio of completed interviews to the total sample size, excluding ineligible units:

$RR1 = \frac{C}{C+E+UE}$ where **C** is the number of completed interviews, **E** is the number of eligible non-responses, and **UE** is the number of units with unknown eligibility.

Second, the adjusted response rate is $RR2 = \frac{C}{C+E+eIE}$ where e is the estimated proportion of eligibilities which is given by this expression $e = \frac{C+E}{C+E+IE}$ where **IE** is the number of ineligibles.

Based on the number of completed interviews presented in Table 1, the maximum sampling error for a percentage estimate is ± 2.8 percentage points. This calculation accounts for design effects (i.e., the effects of weighting and stratification). One interpretation of this margin of error is that if the survey were conducted 100 times using the exact same procedure, the true population value would fall within the margin of error in 95 out of those 100 surveys. It is important to note that sampling errors can be calculated in this survey because the sample is based on a probability sampling design with known selection probabilities. This feature distinguishes probability sampling from other methods, such as quota sampling or convenience sampling.

2.3 Weighting

The final weights in the data are constructed from three components: the base weights reflecting the sample selection probability, the adjustment factors to account for non-response, and the calibration to align the survey results with population figures. Additionally, weight trimming is used, as highly variable weights can introduce undesirable variability into statistical estimates.²

2.3.1 Base weights

These weights are the inverse of the selection probability of each unit in the sample. Since housing units are selected with different probabilities, selection weights are necessary to account for this variation. The weights are given by the following formula:

$$W_{base}^{housing\ unit} = 1/p$$

where $W_{base}^{housing\ unit}$ is the base weight for the housing unit, where p is the probability of selection. The base weights are then adjusted by the number of eligible persons in the household to arrive at person-level base weights:

$$W_{base}^{person} = k * W_{base}^{housing\ unit}$$

where k is the number of eligible persons in the household.

² Weight trimming can reduce variance but increase bias in the statistical estimates. Therefore, weight trimming should only be applied to cases with very large values of weights. The goal is to reduce the overall mean squared errors. Further details can be seen in this paper: Potter, F. (1990). A Study of Procedures to Identify and Trim Extreme Sampling Weights. *Proceedings of the Section on Survey Research Methods, American Statistical Association, 1990, 225-230.*

2.3.2 Adjustment factors for non-response

If the responding and non-responding units are essentially similar with respect to the key subjects of the investigation, the base weights can be adjusted to account for non-response using the following formula:

$$W_{base}^{person} = \alpha W_{base}^{person}$$

where α is the adjustment factor for non-response, based on the estimated propensity of a sampled unit to respond to the survey.³

2.3.3 Weight calibration

The weights are also calibrated to align the results with population estimates. This calibration helps reduce the effects of non-response and under-coverage in the sampling frame. SESRI uses the “raking” method in the calibration process to adjust the weights of the cases in the sample so that the proportions of the adjusted weights for certain characteristics match the corresponding proportions in the population.

2.4 Questionnaire Development and Survey Administration

2.4.1 Questionnaire development

The questionnaire is designed to collect all necessary information related to the study. The questions were written in Arabic and then tested internally at SESRI. This allowed the project team to determine whether respondents were able to understand and answer the questions, and to identify important concerns that could affect responses.

After making the necessary changes to the questionnaire based on this internal pre-test, the survey was programmed into the CAPI (Computer-Assisted Personal Interview) system using the software BLAISE. After debugging the program, a face-to-face pre-test was conducted on a small number of housing units. This pre-test provided valuable information to refine question wording, response categories, introductions, transitions, interviewer instructions, and interview length. Based on this information, the final version of the questionnaire was created and programmed into CAPI for the fieldwork. The fieldwork began on May 14, 2024, and concluded on June 5, 2024.

³ This weighting process is usually called propensity weighting. A good discussion of this process can be found in Vardian M. and G. Forsman (2003), “Comparing propensity score weighting with other weighting methods: A case study on Web data” In *Proceedings of the Section on Survey Statistics, American Statistical Association, 2003, CD-ROM*

2.4.2 Survey Administration

The survey was administered in CAPI (Computer-Assisted Personal Interview) mode. CAPI is a computer-assisted data collection method that replaces paper-and-pen survey methods and is usually conducted at the respondent's home or business using a portable personal computer, such as a notebook or laptop.

Each interviewer received an orientation to the CAPI system, participated in a training program covering the fundamentals of CAPI interviewing and standard protocols for administering survey instruments, and was given practice time on the computers (laptops). During the data collection period, management used a monitoring system to ensure that questions were asked appropriately and responses were recorded accurately.

SESRI is strongly committed to the principle that knowledge of interviewing techniques and field procedures should be supplemented with the basics of survey research to ensure high-quality data collection. This includes ongoing interviewer training, strong interviewer support during fieldwork, and a robust monitoring system and equipment that allow supervisors to monitor and evaluate interviewer activities.

2.4.3 Data Management

After the data collection, all individual interviews were merged and saved in a single BLAISE data file. This dataset was then cleaned, coded, and saved in STATA formats for analysis. After weighting the final responses to adjust for the probability of selection and non-response, the data were analyzed using STATA, the statistical software for the social sciences, where univariate, bivariate, and multivariate analyses were performed. The report examined several factors that influence child well-being, such as the health of the child, education, entertainment, rights and protection, parental participation, and the use of the Internet. The second chapter will provide a detailed explanation of descriptive statistics, and the third chapter will examine the inferential statistical analysis to reveal deeper insights.

2.4.4 Research Ethics Compliance:

The project obtained IRB approval (QU-IRB 035/2024-EA) from the Qatar University Ethical Review Board, and consent was obtained before participants' involvement. All data presented in this report are in aggregate form, ensuring the anonymity and confidentiality of individual responses.

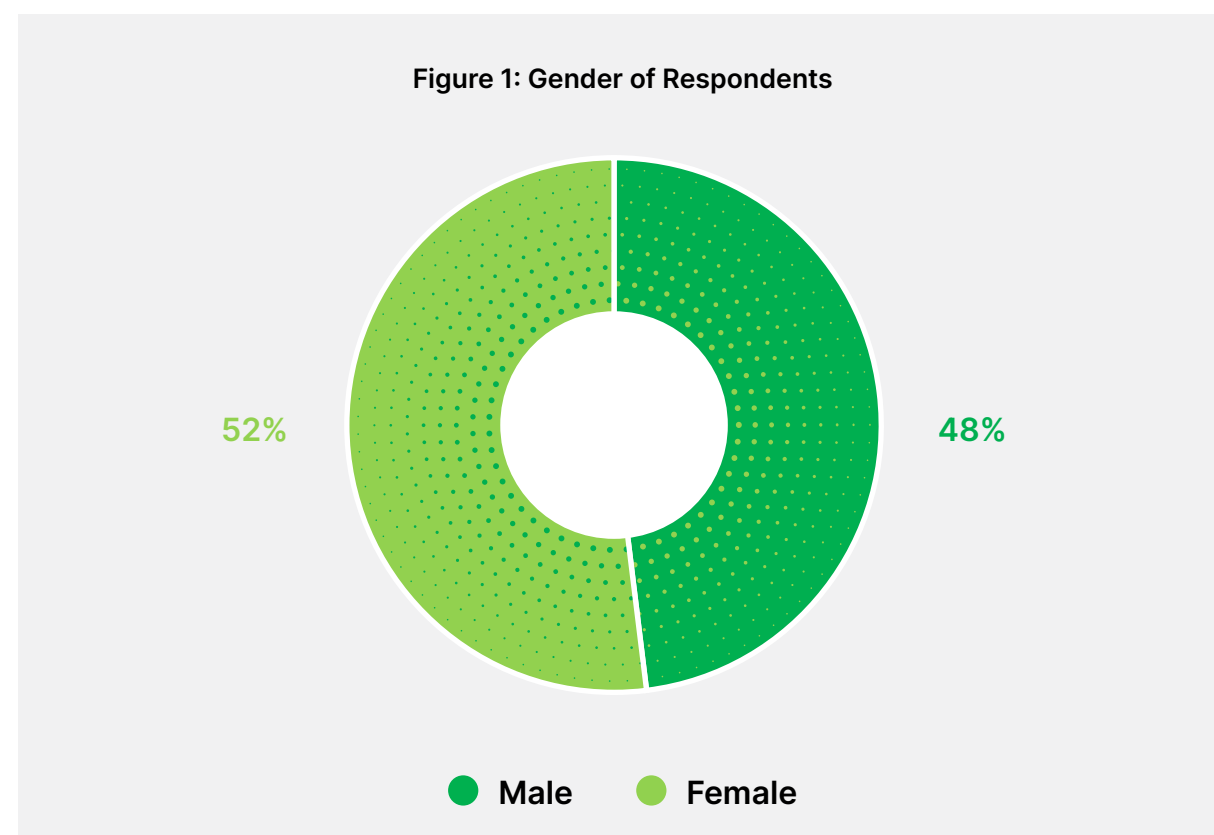
03

Demographic Characteristics

This section will provide the main characteristics of the surveyed population. The attributes of the 1,607 Qatari participants surveyed in this study include details related to their gender, age, marital status, and number of children, as well as certain characteristics related to socio-economic status using variables such as education level, employment status, income, and type of housing. These characteristics are useful for determining the social background of the respondents.

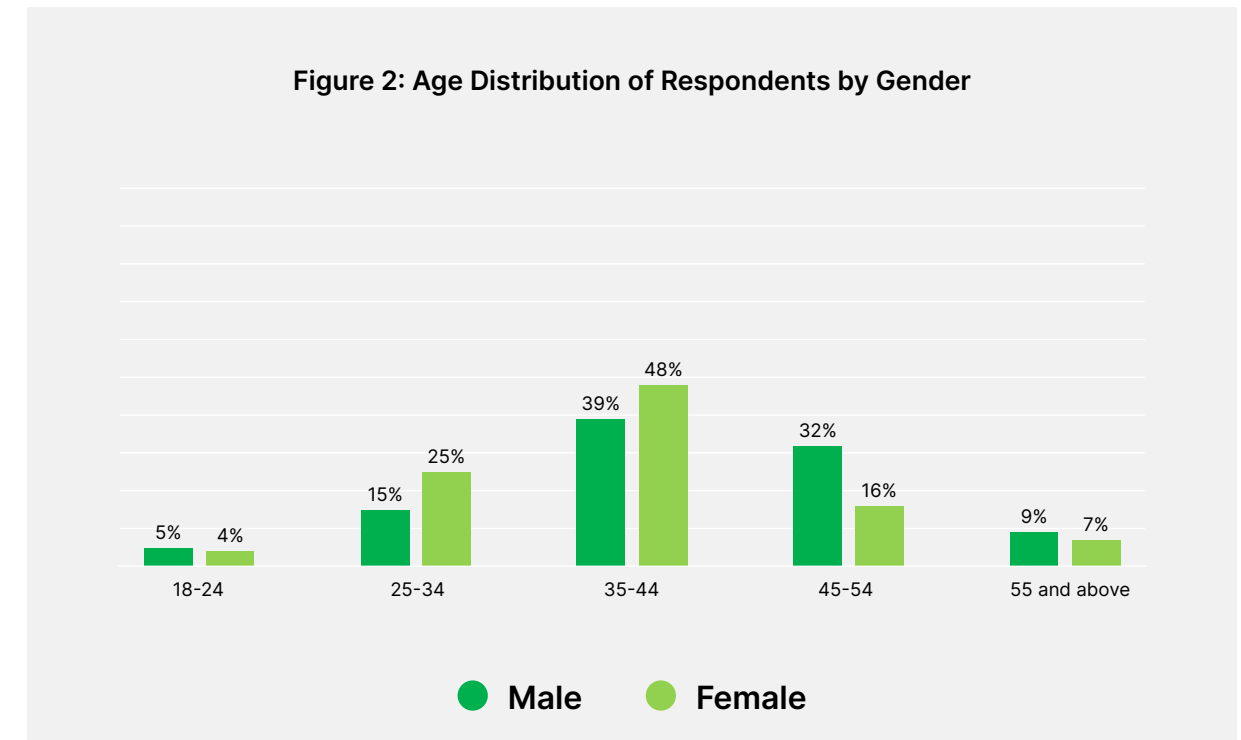
Gender of respondents

The study consisted of 1,607 Qatari nationals. In terms of gender, the proportions were almost equal, with 48% male respondents and 52% female respondents (see Figure 1).



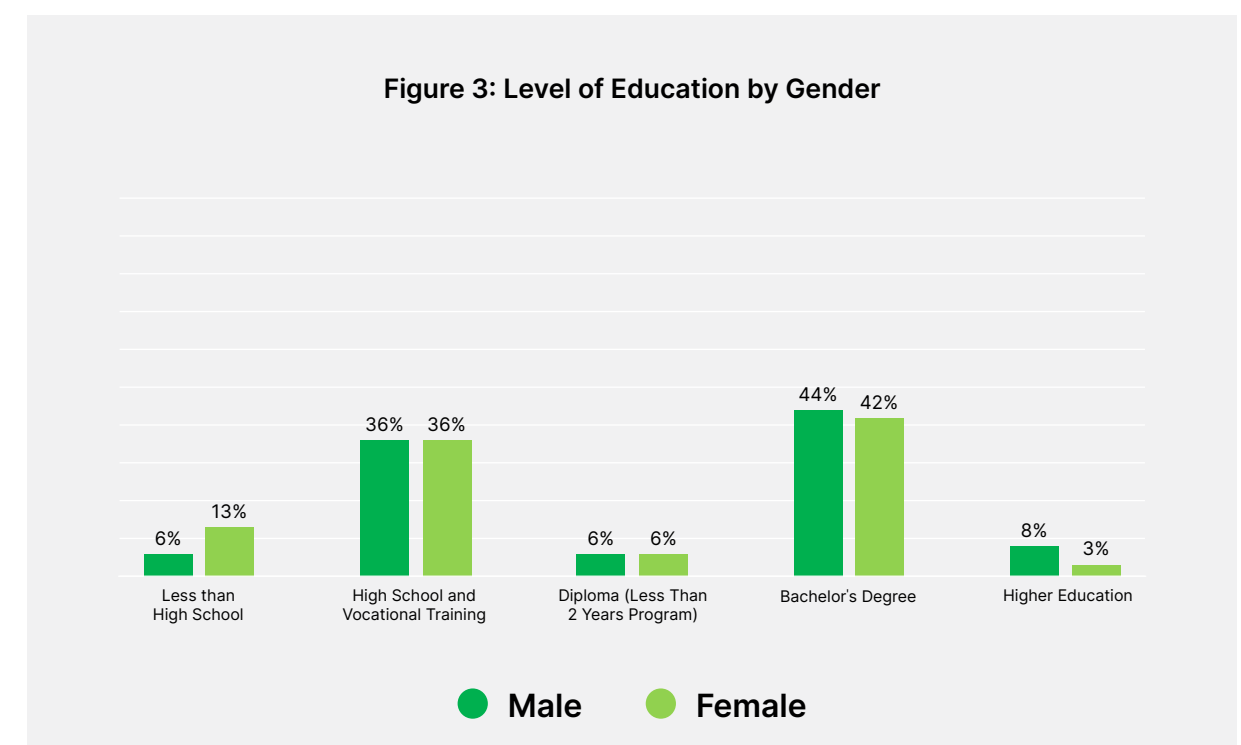
Age distribution of the respondents

The distribution of respondents by age group shows that the largest proportion belongs to the 35–44 age group (39% for males and 48% for females). The average age of the sample is 41 years. The average age is 42 for males and 39 for females. Figure 2 shows the distribution of the age variable with respect to gender.



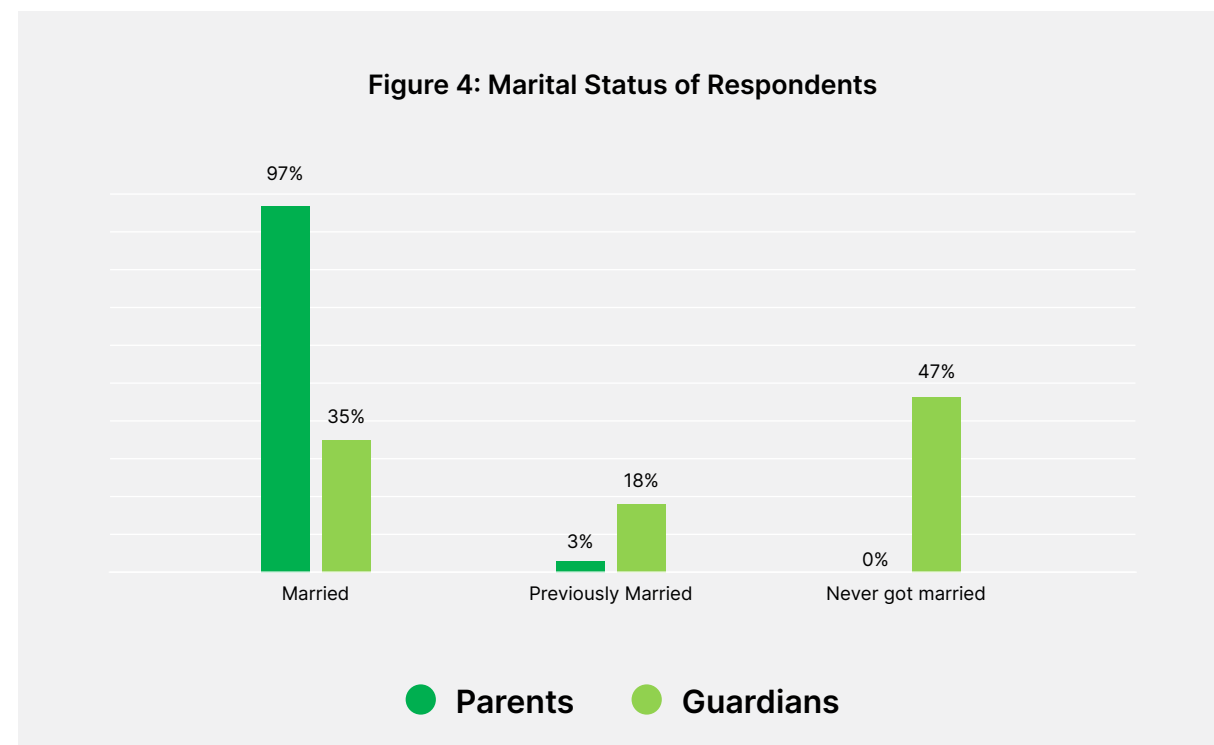
Respondents' level of education

Respondents were asked about the highest level of education they had completed. The results revealed that the majority of respondents had obtained a bachelor's degree (44% for males and 42% for females). Figure 3 shows the distribution of the education variable with respect to gender.

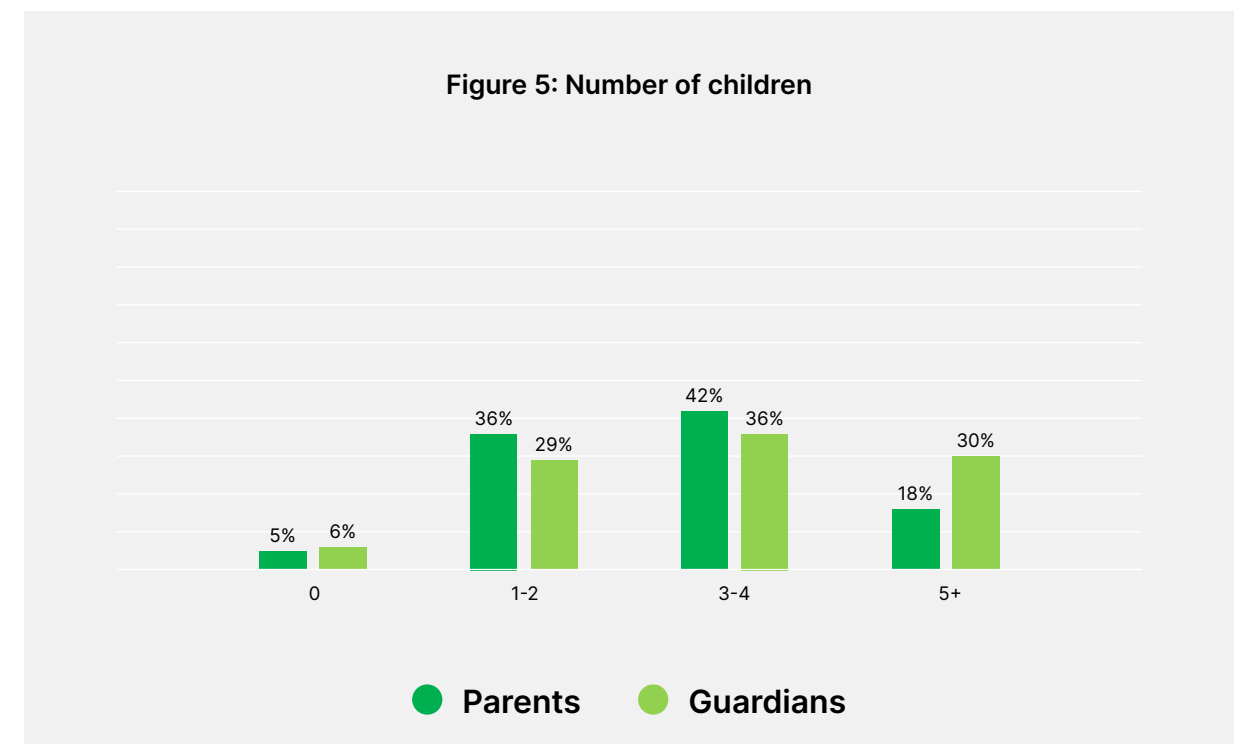


Marital status and number of children

At the time of the survey, the majority of parent respondents were married (97%), while 3% were previously married. In contrast, among guardian respondents who are caring for children in the absence of their biological parents, almost half had never married (47%), 35% were married, and 18% were previously married (see Figure 4).



When asked about the number of children, a high proportion of respondents reported having between 1 and 4 children, with 36% of parents and 29% of guardians having 1–2 children, and 42% of parents and 36% of guardians having 3–4 children. Additionally, a small percentage of respondents in both the parents and guardians groups reported having no children (5% among parents and 6% among guardians) (see Figure 5). Overall, the average number of children among respondents is 3.

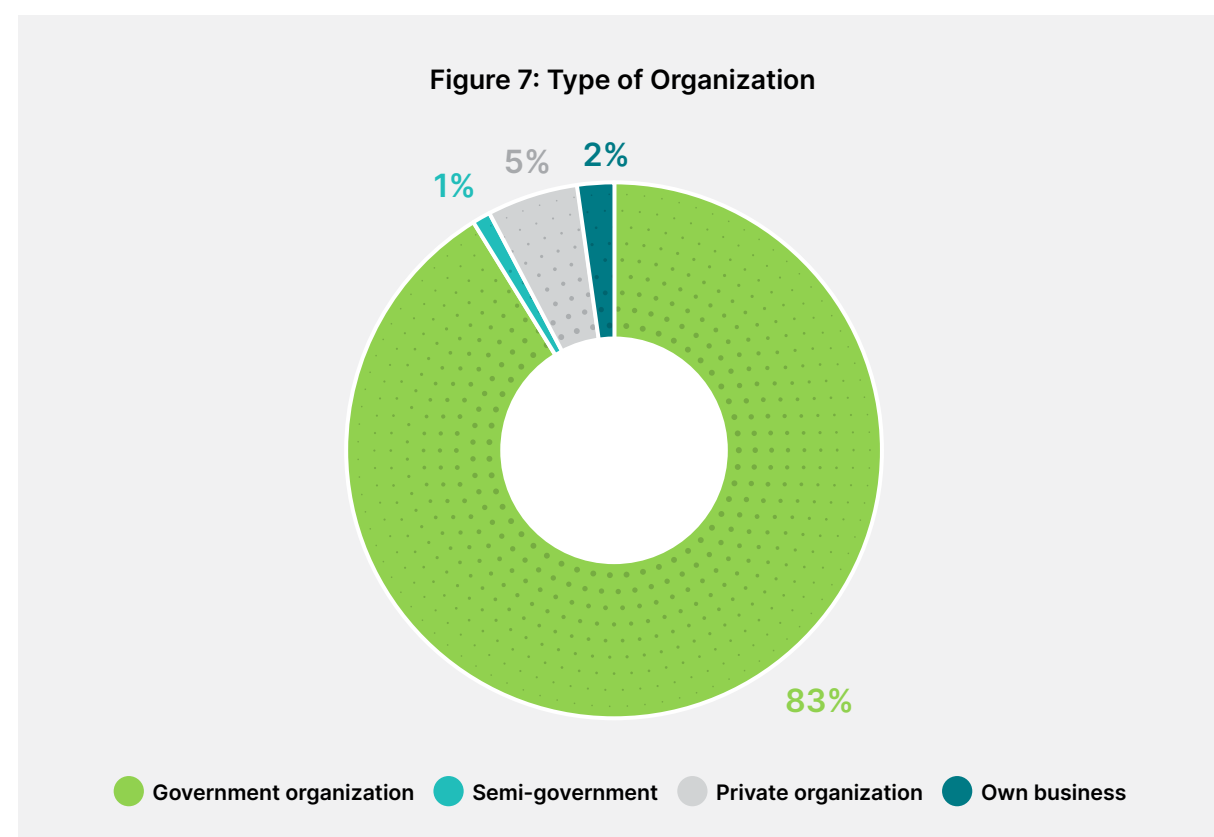


Employment status

Regarding the employment status of the respondents, 87% of male respondents stated that they are employed, compared to 45% of female participants. Figure 6 shows the employment status with respect to gender.

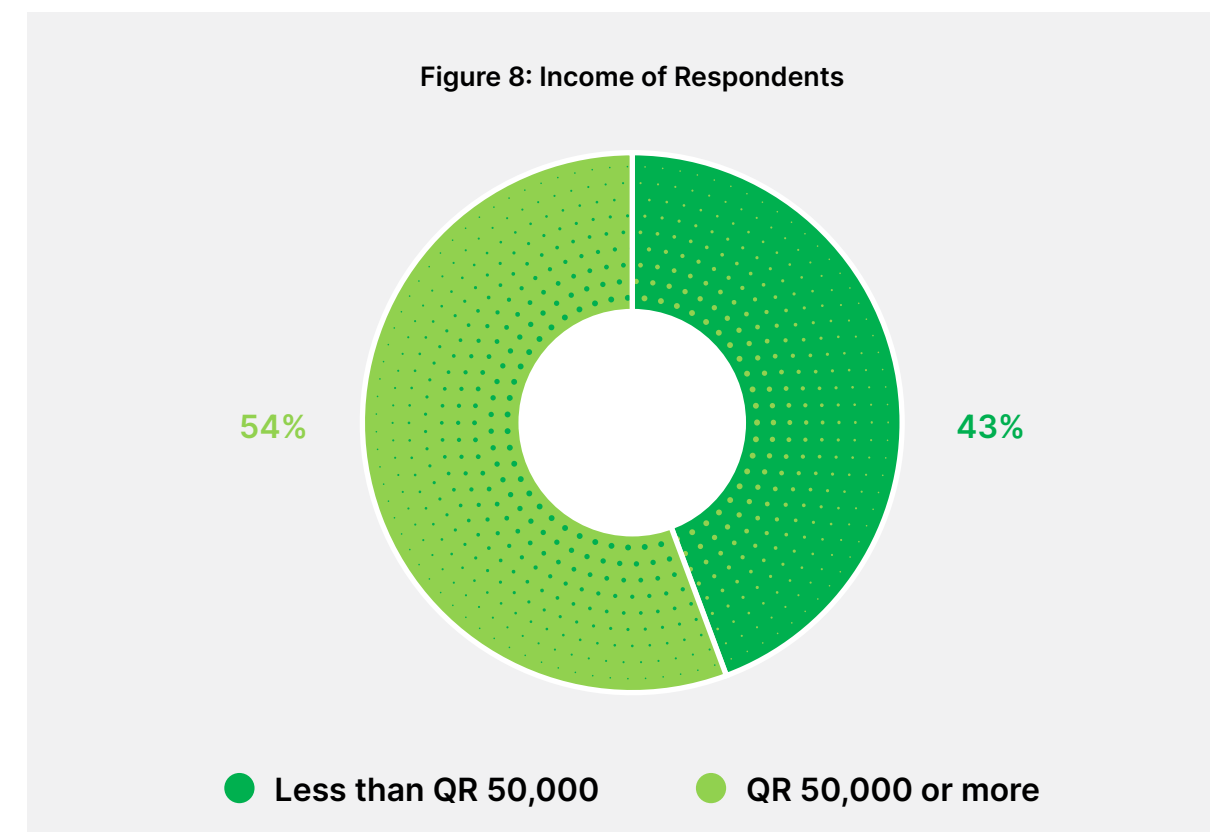


Of the total employed participants, 83% work in the government sector, while 10% work in semi-governmental organizations, such as oil and gas companies. Only 5% of participants work in the private sector, and a negligible 2% own businesses (see Figure 7).



Income and Type of House

With respect to household income, 57% of respondents earn a monthly household income of QR 50,000 or more, while 43% of the sample earn less than QR 50,000 (see Figure 8).



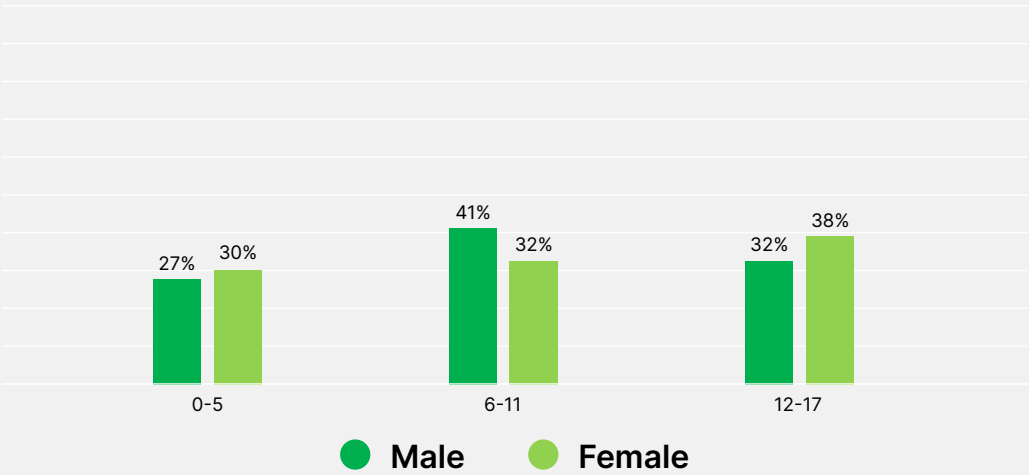
In terms of the type of house, the majority of respondents lived in villas (87%), while around 11% lived in a traditional type of house called “Bait Al Shabi,” 1% lived in a palace, and 1% lived in a flat.

3.1 Demographics Of The Selected Child

Age distribution of the selected child

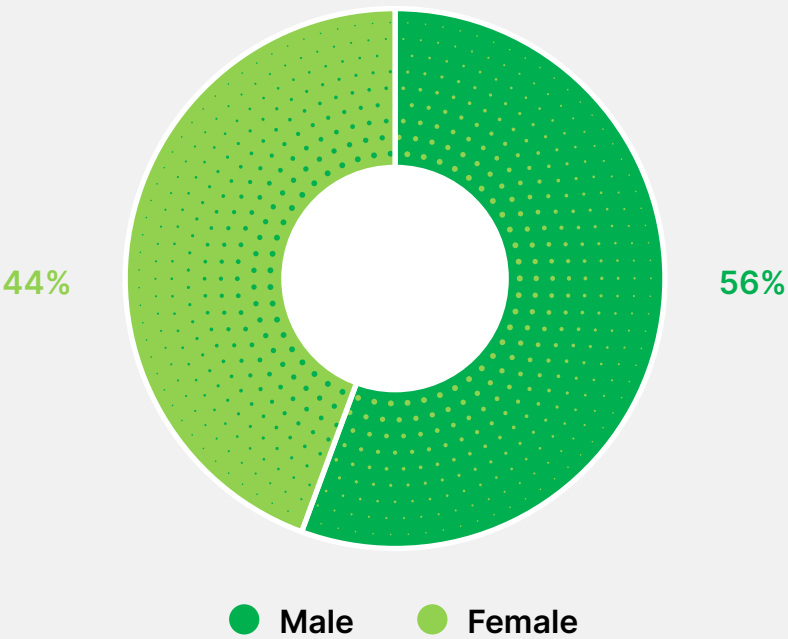
Figure 9 shows the age and gender distribution of selected children among respondents. The results showed that in the 0–5 and 12–17 age groups, the percentages of female children were slightly higher than those of male children (30% vs. 27% in the 0–5 group, and 38% vs. 32% in the 12–17 group). In contrast, in the 6–11 age group, male children represented a higher proportion (41%) compared to female children (32%). As explained in the methodology, children in the 0–5 age group showed a lower response rate, despite the computer randomization process that aimed to ensure equal selection chances for all three age groups. In other words, the interviewer would ask to interview the parent or guardian of the selected child, but the interview did not proceed due to the unavailability of the parent or guardian.

Figure 9: Age Group and Gender of Selected Child



Gender of the selected child

Figure 10: Gender of Selected Child



The pie chart illustrates the gender distribution of selected children among respondents: 56% were male, while 44% were female. As explained earlier in the methodology, the computer randomization process aimed to ensure equal selection chances for children from the three age groups, as well as to achieve a balanced gender sample. Female children showed a lower response rate, meaning that interviews with the parent or guardian of a selected female child did not proceed due to the unavailability of the parent or guardian.

04

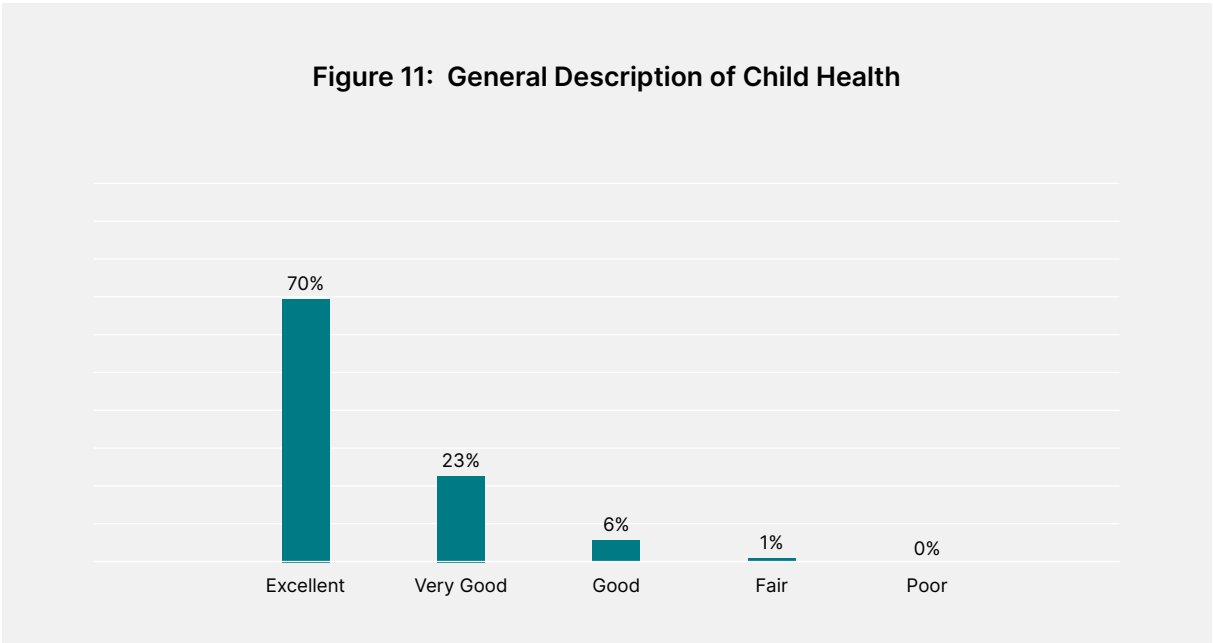
Child Well-being And Health

Both physical and mental health are essential indicators of child well-being, as they influence a child’s overall development and ability to thrive. When both aspects are nurtured, children are more likely to experience positive outcomes in life. The statements in this section are adapted from different sources. The questions in the physical health section were adapted from the National Survey of Children’s Health (NSCH) (U.S. Department of Commerce, 2022) and the KID-SCREEN-10 scale (The KIDSCREEN Group Europe, 2006).

For the mental health measurements, two validated scales commonly used by professionals were employed: the Strengths and Difficulties Questionnaire (Goodman, 1997) and the Pediatric Symptoms Checklist (Jellinek et al., 1988).

4.1 Physical Health

When respondents were asked to describe their child’s health, the vast majority (70%) reported that, in general, their child’s health is excellent (see Figure 11).



Respondents were asked a number of general questions about their child’s physical and mental health, and they were instructed to recall their child’s experiences over the past week. When asked whether their child felt physically fit and well, 55% said “extremely,” 26% reported “very,” while 12% reported “not at all.” Moreover, the majority of respondents (88%) reported that their child “always” or “almost always” felt full of energy.

On the other hand, when asked if their child felt sad, the majority reported that their child “never” or “almost never” felt sad (75%), while 19% said their child “sometimes” felt sad. Additionally, when asked if their child felt lonely, 87% reported “never” or “almost never” (see Table 2).

When respondents were asked whether their child had enough time for themselves, could do what they wanted in their free time, had fun with their friends, and felt they were treated fairly by their parents, most of the reported answers were positive. 89% of respondents stated that their child “always” or “almost always” had fun with friends. In addition, 88% reported “extremely” or “very” when asked if their child was getting on well at school. Moreover, 86% of respondents reported that their child “always” or “almost always” had been able to pay attention (see Table 2).

Table 2: Reported Quality of Healthcare Provider Interactions in the Past 12 Months

Statements	Not at all/ Never (%)	Slightly/ Almost never (%)	Moderately/ Sometimes (%)	Very/ Almost Always (%)	Extremely/ Always (%)
Your child felt physically fit and well.	12%	3%	4%	26%	55%
Your child got along well at school.	2%	3%	7%	32%	56%
Your child felt full of energy.	3%	1%	8%	25%	63%
Your child felt sad.	52%	23%	19%	3%	3%
Your child felt lonely.	71%	16%	8%	2%	3%
Your child had enough time for themselves.	4%	3%	10%	29%	54%
Your child was able to do the things they wanted to do in their free time.	3%	2%	12%	29%	54%
Your child felt that their parent(s) treated them fairly.	3%	1%	4%	18%	74%
Your child had fun with their friends.	2%	1%	8%	24%	65%
Your child was able to pay attention.	1%	2%	11%	28%	58%

Respondents were also asked if a doctor or other health care provider had ever told them that their child had a health or medical condition. 26% reported that their child had an intellectual disability. Moreover, 18% reported that their child had allergies. Additionally, 7% of respondents said that their child had Down syndrome, 2% had ADD or ADHD, 1% had autism or ASD, and no one reported that their child had epilepsy or a seizure disorder (see Table 3).

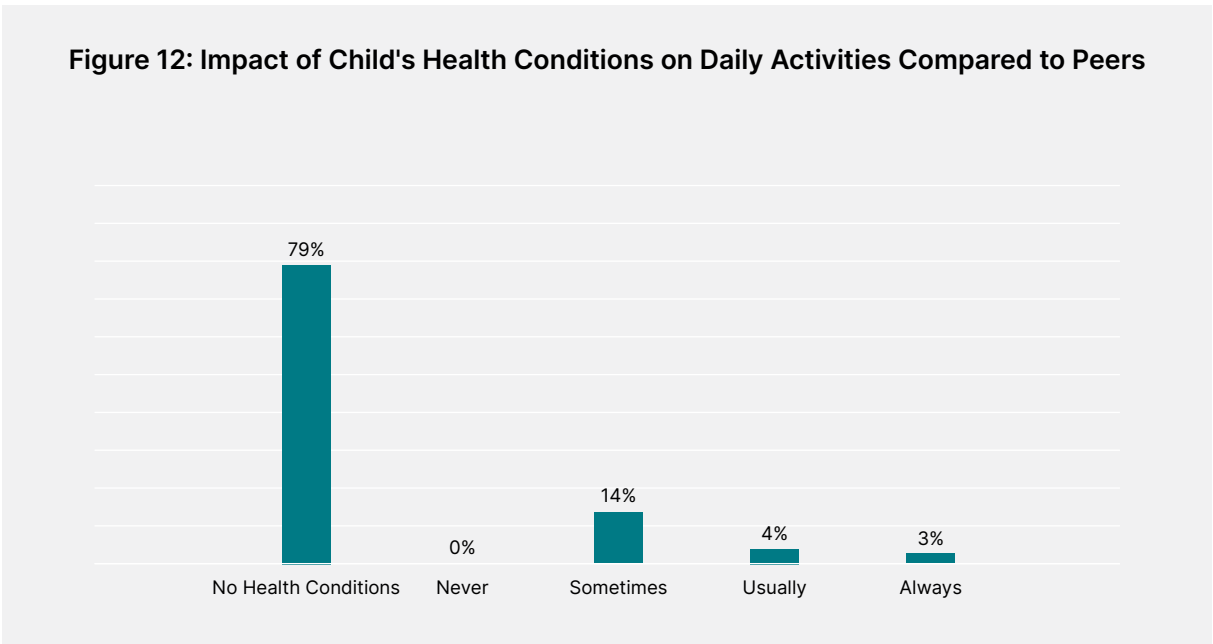
Studies show that 146 children were diagnosed with Down syndrome during the period from 2000 to 2006, with a prevalence rate of 19.5 per 10,000 live births; 40.4% of these were Qataris (Wahab et al., 2006). The DSM-5 defines intellectual disabilities as neurodevelopmental disorders that begin in childhood and are characterized by intellectual difficulties, as well as difficulties in conceptual, social, and practical areas of living (National Academies of Sciences, Engineering, and Medicine, 2015). This means that intellectual disability is a broad concept that could include other disorders, which may explain why the reported percentage is high.

Table 3: Doctor or Health Care Provider Reports on Child's Health and Medical Conditions

Medical Conditions	Yes (%)	No (%)
Allergies	18%	82%
Asthma	9%	91%
Autoimmune disease	1%	99%
Cerebral palsy	9%	91%
Type 2 diabetes	1%	99%
Epilepsy or seizure disorder	0%	100%
Heart condition	1%	99%
Frequent or severe headaches, including migraines	4%	96%
Down syndrome	7%	93%

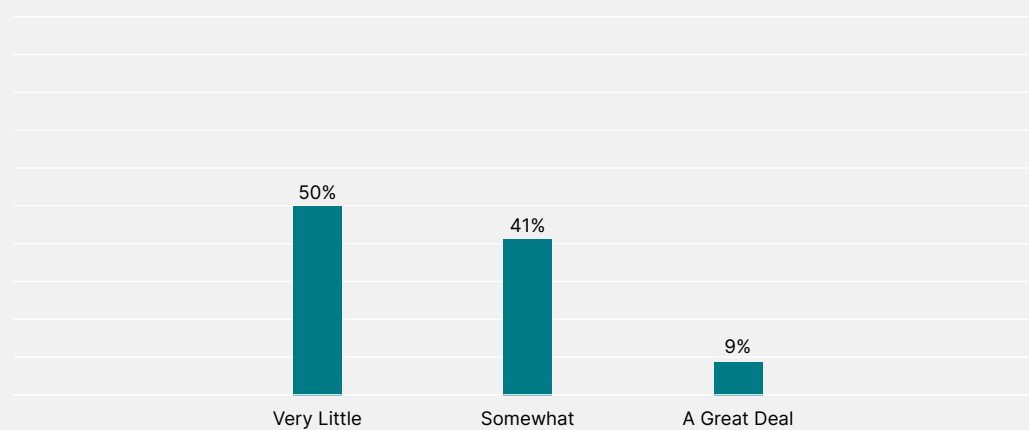
Autism or autism spectrum disorder	1%	99%
Attention-deficit disorder or attention-deficit/hyperactivity disorder (ADD or ADHD)	%2	%98
Behavioral or conduct problems	%1	%99
Developmental delays	%2	%98
Intellectual disability	%26	%74
Speech or other language disorder	%5	%95
Learning disability	%3	%97

Respondents were asked how often, during the past 12 months, their child's health condition or problem affected his or her ability to do things that other children their age do. The majority of respondents (79%) reported that their child does not have any health conditions. On the other hand, 14% of respondents said “sometimes,” followed by 4% who said “usually,” and 3% who reported that it has “always” affected their child’s ability to do things other children their age do (see Figure 12).



Respondents who mentioned that their child's health condition had affected some of their abilities were given a follow-up question to assess the extent of the impact. Half of the respondents said it affected their child's ability **very little**, 41% reported it **somewhat** affected their child's ability, and 9% said it affected them **a great deal** (see Figure 13).

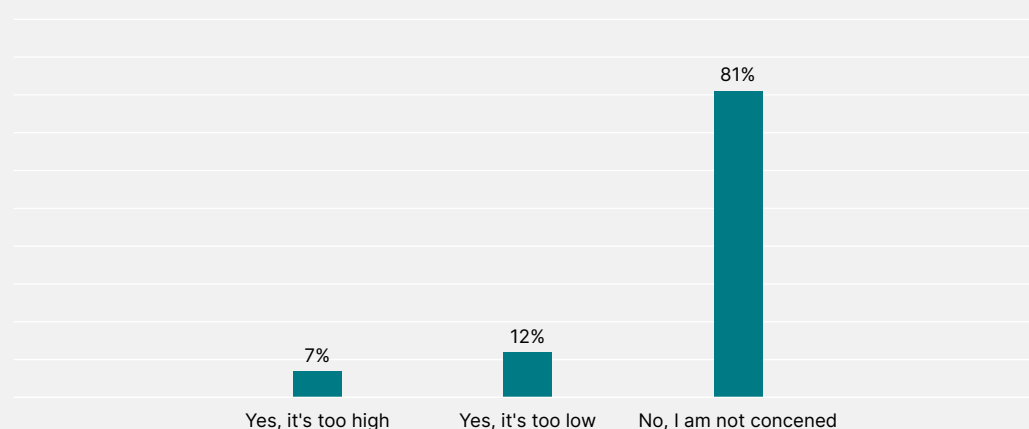
Figure 13: Extent of Impact of Child's Health Conditions on Daily Activities



Body Image and Eating Habits

When respondents were asked if they are concerned about their child's weight, the majority (81%) reported that they are not. Meanwhile, 7% of respondents reported being concerned because their child's weight is too high, and 12% were concerned because it is too low (see Figure 14).

Figure 14: Respondent Concerns Regarding their Child's Weight



The respondents who were concerned about their child's weight being too high were given two follow-up questions: whether a health care provider had told them that their child is overweight, and whether their child had undergone any weight loss surgery. Half of the respondents reported that a health care provider had informed them that their child is overweight (see Figure 15). Moreover, 5% of the respondents said that their child had undergone weight loss surgery (see Figure 16).

Figure 15: Respondents' Reports on Child's Overweight Status Based on Healthcare Provider's Feedback

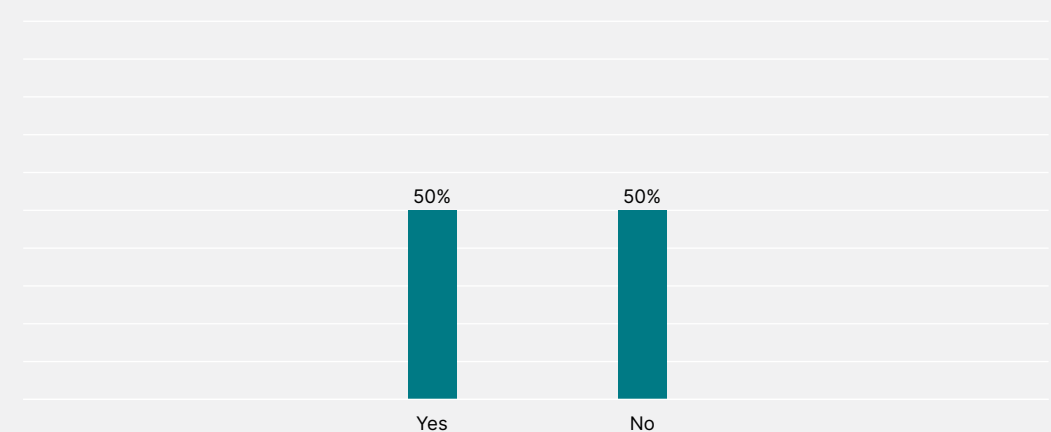
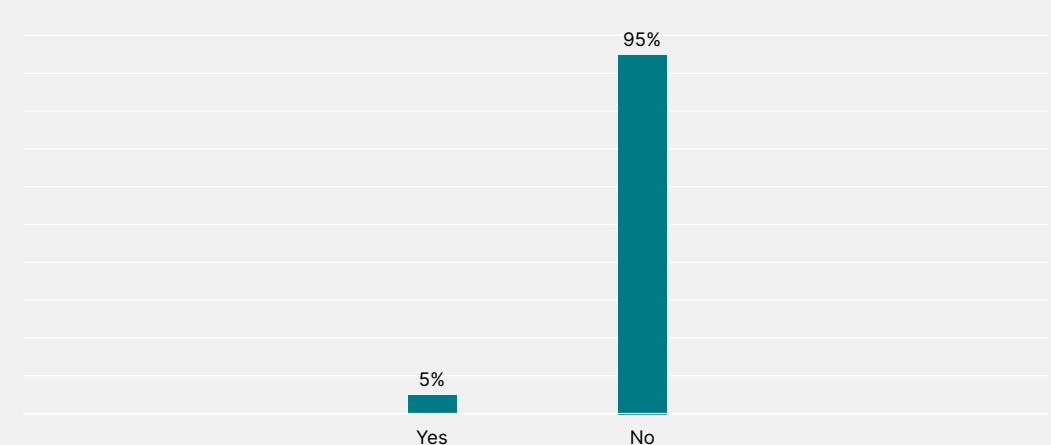


Figure 16: Responses on Child's Weight Loss Surgery



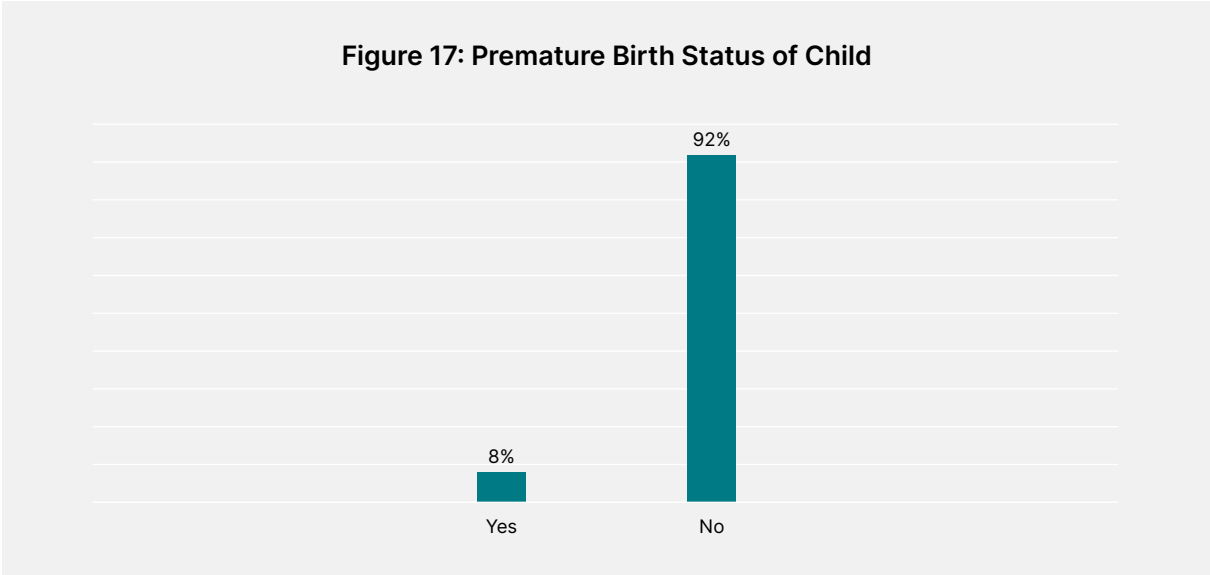
Respondents were also asked about certain unhealthy eating habits and whether their child had engaged in any of them during the past 12 months. The eating habits with the highest response rates were: extremely picky eating (47%), skipping meals (35%), and having low interest in food (23%) (see Table 4).

Table 4: Children Eating Habits in the Past 12 Months

Eating Habits	Yes (%)	No (%)
Binge Eating	13%	87%
Skipping Meals	35%	65%
Having low interest in food	23%	77%
Extremely picky eating	47%	53%
Purging or vomiting after eating	5%	95%
Using diet pills or laxatives	2%	98%

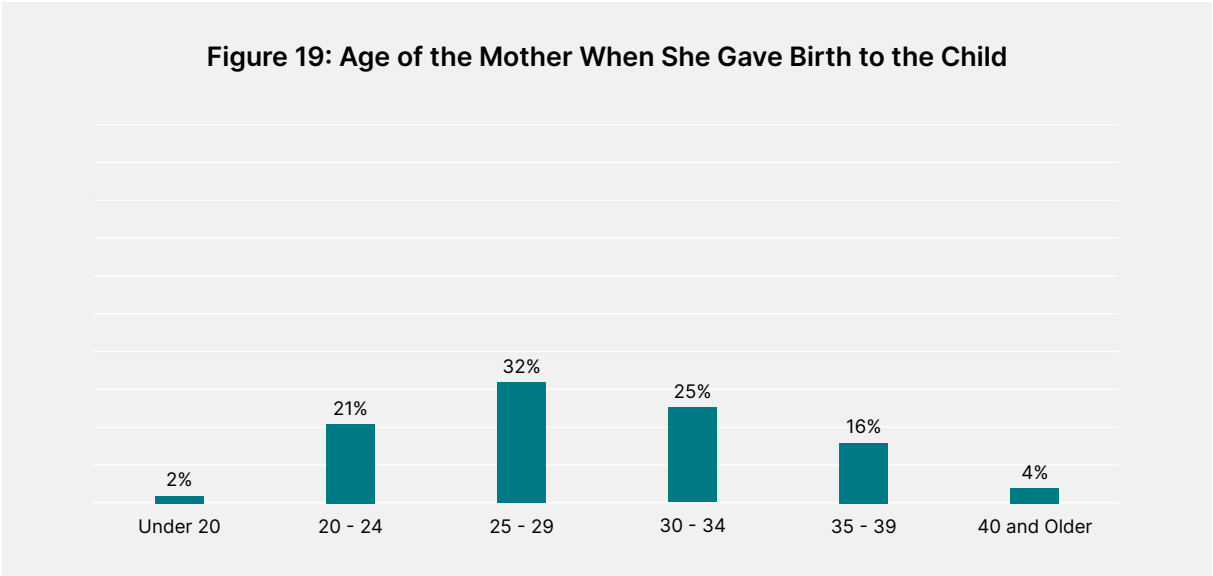
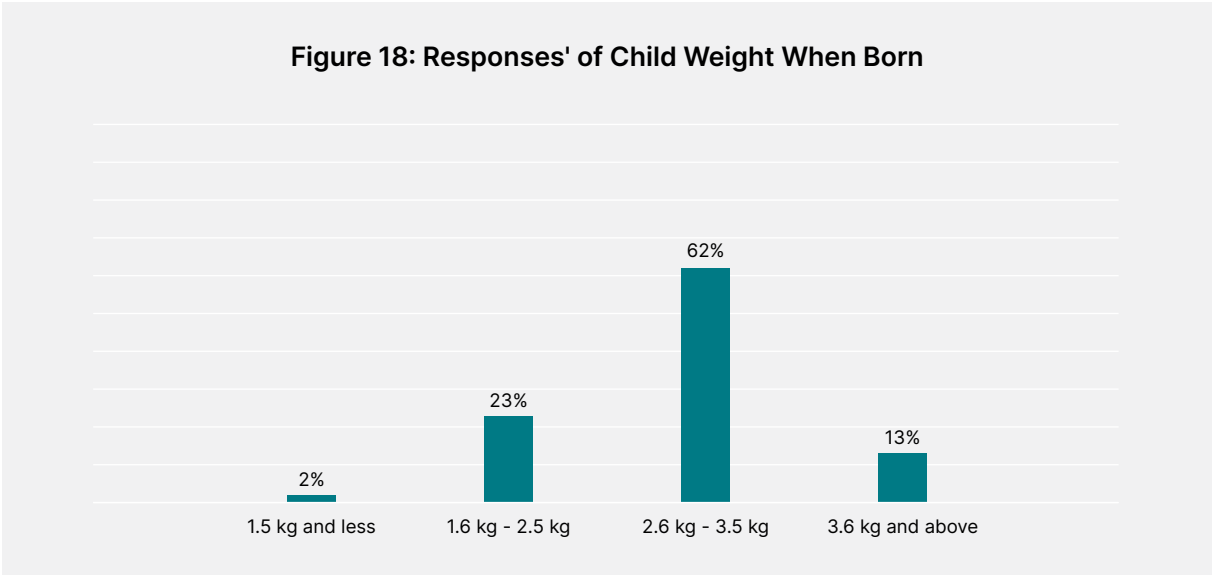
The child as an Infant

Respondents were asked a number of questions about their child as an infant. Eight percent of the sample were reported to have been born prematurely (see Figure 17).



Respondents were also asked about their child’s weight at birth. 62% said that their child weighed between 2.6 kg and 3.5 kg, while 23% reported a birth weight between 1.6 kg and 2.5 kg, and 13% mentioned that it was 3.6 kg or above (see Figure 18).

Moreover, respondents were asked about the age of the mother at the time of birth of the selected child representing the sample. According to the results, a small number of mothers were under 20 years old, and a small number were 40 and above when they gave birth (2% and 4%, respectively). The highest percent-age of mothers gave birth at a younger age, with the largest group (32%) falling in the 25 to 29 age range (see Figure 19).



Respondents were asked if the child was breastfed and when formula was first introduced. The majority of respondents (84%) said that their child was breast-fed (see Figure 20). A range of responses was given when respondents were asked how old the child was when he or she was first fed formula. 19% said the child is still breastfeeding, and 21% said they do not remember. Among those who recalled, 20% reported that the child was less than one month old when formula was first introduced, 25% said it was between one to six months, and 15% said it was after six months (see Figure 21).

Figure 20: Response of Breastfeeding History of Children

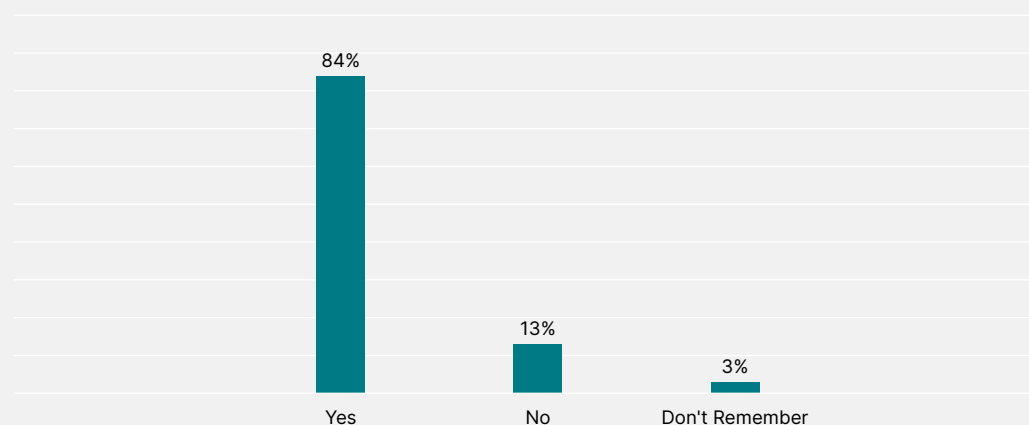
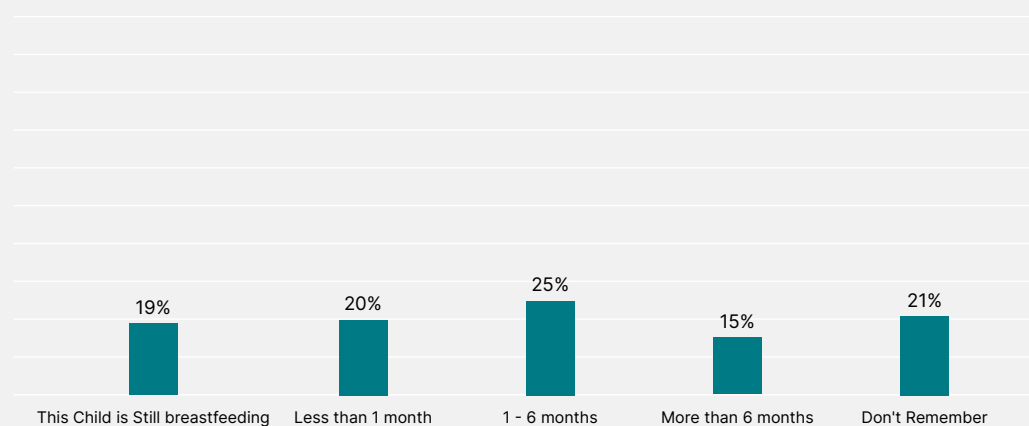
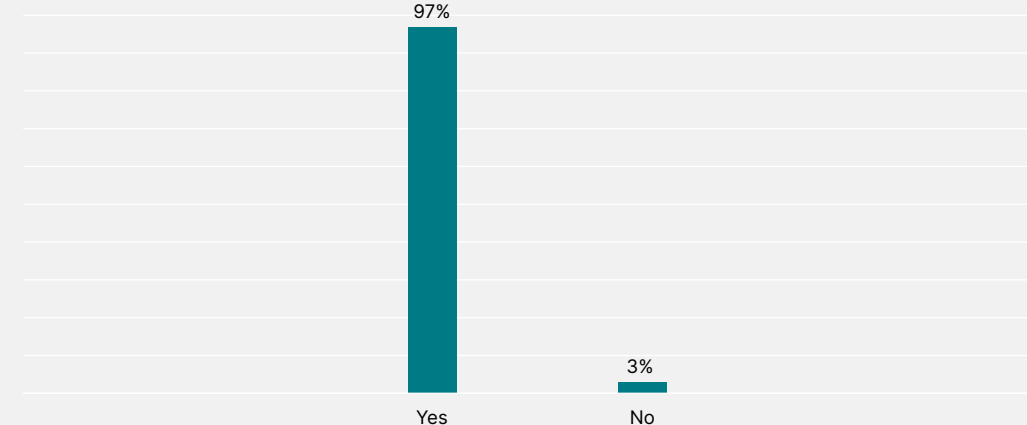


Figure 21: Response of Children Age When First Started Formula Feeding



In addition, when it comes to vaccinations, the majority of respondents (97%) said that their child has received the necessary vaccinations according to his or her age (see Figure 22).

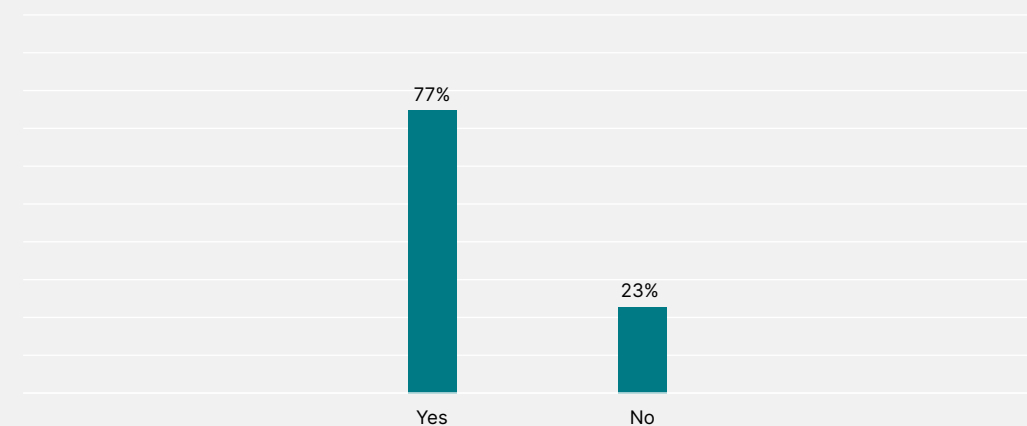
Figure 22: Vaccination Compliance among Children



Quality of Pediatric Care Service

To measure pediatric care services, respondents were asked several questions about healthcare visits and the services received. When asked if their child had a healthcare visit during the past 12 months, 77% said yes (see Figure 23).

Figure 23: Responses on Children's Healthcare Visits in the Past 12 Months



Those who had a healthcare visit were asked about various aspects regarding the doctors or other healthcare providers they interacted with. Many respondents believed that the healthcare provider always or usually spent enough time with the child (61% and 28%, respectively). Respondents also said that the healthcare provider always or usually listened carefully to them (67% and 26%, respectively). Moreover, 61% said that the healthcare provider always helped them feel like a partner in their child's care (see Table 5).

Table 5: Reported Quality of Healthcare Provider Interactions in the Past 12 Months

Statements	Always	Usually	Sometimes	Never
Spend enough time with this child	61%	28%	9%	2%
Listen carefully to you	67%	26%	6%	1%
Show sensitivity to your family's value and customs	80%	15%	4%	1%
Provide the specific information you needed concerning this child	66%	26%	6%	2%
Help you feel like a partner in this child's care	61%	26%	11%	2%

Furthermore, respondents were asked if any medical decisions had been made regarding their child's health care in the past 12 months, such as getting a prescription, referral, or procedure. 56% said yes (see Figure 24). Those who had to make a decision regarding their child's health care were given a number of follow-up questions (see Table 6).

Figure 24: Responses on Decisions Made Regarding the Children's Health Care in the Past 12 Months

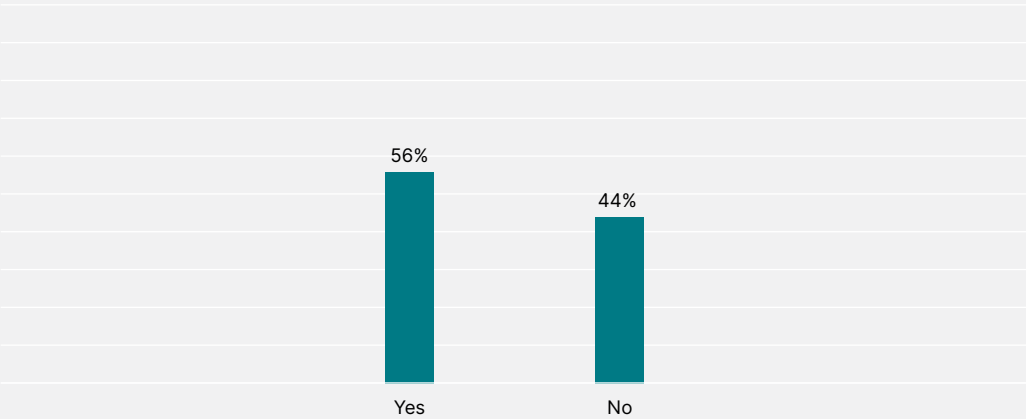
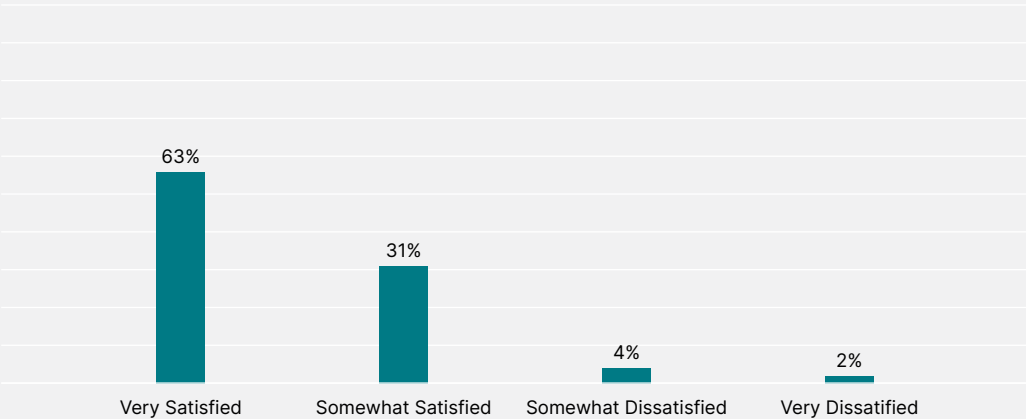


Table 6: Parents' Perceptions of Healthcare Provider Communication about their Child Medical Concerns in the Past 12 Months

Statements	Always	Usually	Sometimes	Never
Discuss with you the range of options consider for their health care or treatment.	49%	30%	18%	3%
Make it easy for you to raise concerns or disagree with recommendation for this child's health care.	47%	31%	16%	6%
Work with you to decide together which health care and treatment choices would be best for this child.	50%	27%	18%	5%

When respondents were asked about their level of satisfaction with the communication between them and their child's doctors, 94% said they were either very satisfied or somewhat satisfied (see Figure 25).

Figure 25: Parent Satisfaction with Communication with their Child's Doctor in the Past 12 Months



When it comes to health insurance, 25% of respondents stated that their child is covered by health insurance (see Figure 26). Those who have health insurance were asked about the type of coverage, and 82% stated that their insurance was obtained through a current or former employer or union (see Figure 27).

Figure 26: Responses in Health Insurance Coverage for Children Currently

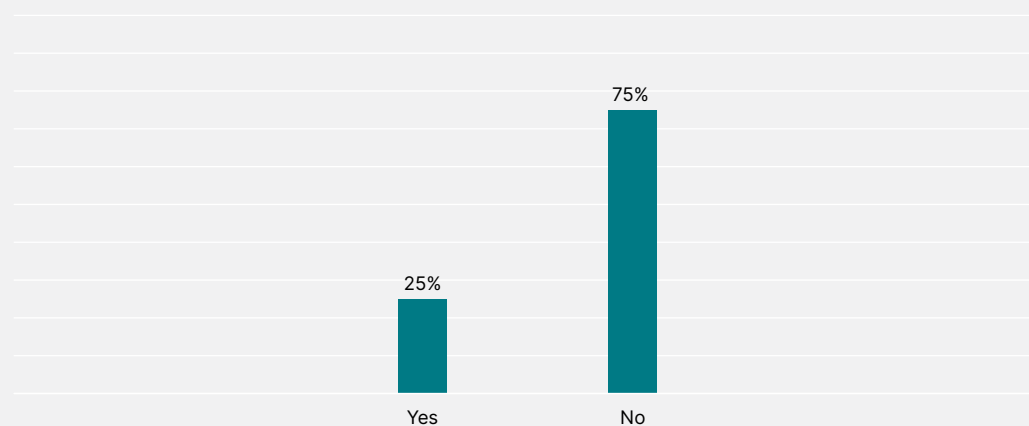
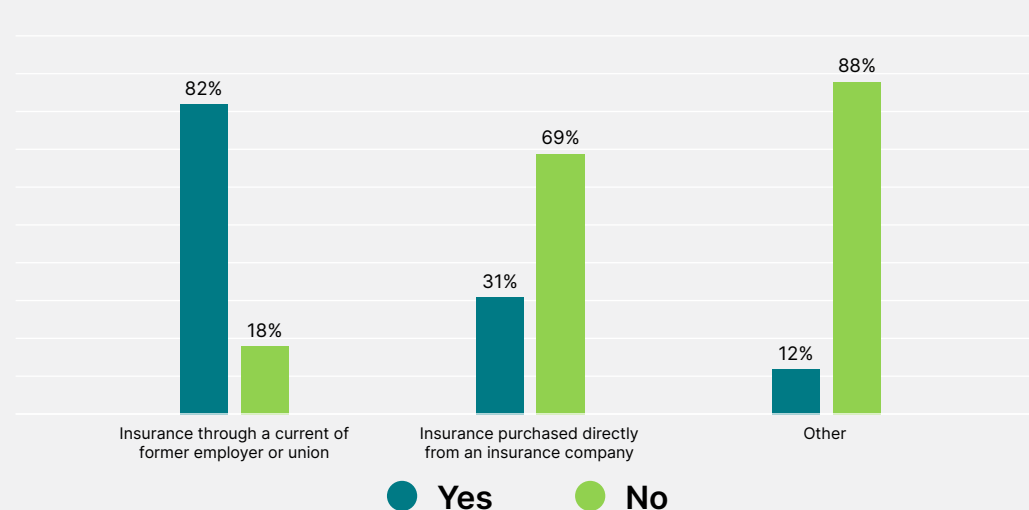


Figure 27: Responses Regarding the Type of the Health Insurance



4.2 Mental Health

When measuring mental health as an indicator of child well-being, we used two different scales: the Strengths and Difficulties Questionnaire (SDQ) (Goodman, 1997), and the Pediatric Symptoms Checklist (Jellinek et al., 1988).

The first scale was the Strengths and Difficulties Questionnaire (SDQ). It consists of 25 statements; however, each statement alone does not measure anything significant. Rather, every five statements together assess a specific aspect of the SDQ. We measured emotional problems, conduct problems, hyperactivity problems, peer problems, and prosocial behavior.

To calculate the Total Difficulties Score, we combined the scores of emotional problems, conduct problems, hyperactivity, and peer problems. Table 7 below

shows the percentage distribution across each category. From the table, we can see that the majority of the sample falls within the normal range for each aspect of the SDQ. In terms of peer problems scores, this category had the highest rate of abnormality at 19%, followed by conduct problems at 13%.

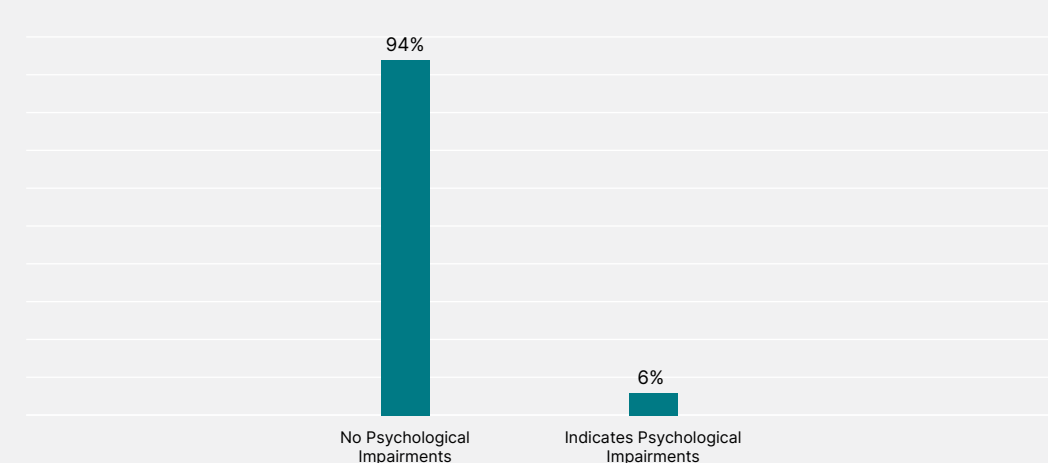
Table 7: Strength and Difficulties Questionnaire Scores

SDQ items	Normal	Borderline	Abnormal
Total Difficulties Score	84%	9%	7%
Emotional Problems Score	84%	7%	9%
Conduct Problems Score	74%	13%	13%
Hyperactivity Score	87%	7%	6%
Peer problems Score	61%	20%	19%
Prosocial Score	79%	10%	11%

The second measurement was the Pediatric Symptoms Checklist (PSC) (Jellinek et al., 1988). The PSC is a psychosocial screening tool designed to facilitate the recognition of cognitive, emotional, and behavioral problems. The scale consists of 35 statements that are added together to produce a score that either indicates normality or suggests psychological impairment. A positive score (indicating psychological impairment) suggests the need for further evaluation by a qualified health or mental health professional.

When analyzing the results of our sample, 6% of the responses indicated psychological impairments (see Figure 28).

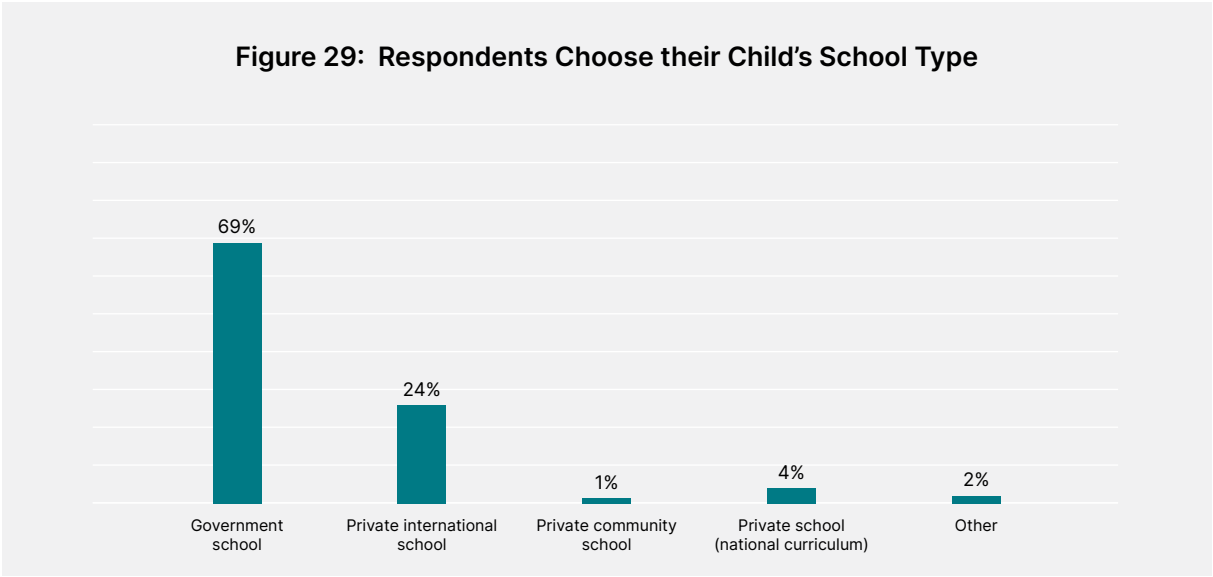
Figure 28: Pediatric Symptoms Checklist Results



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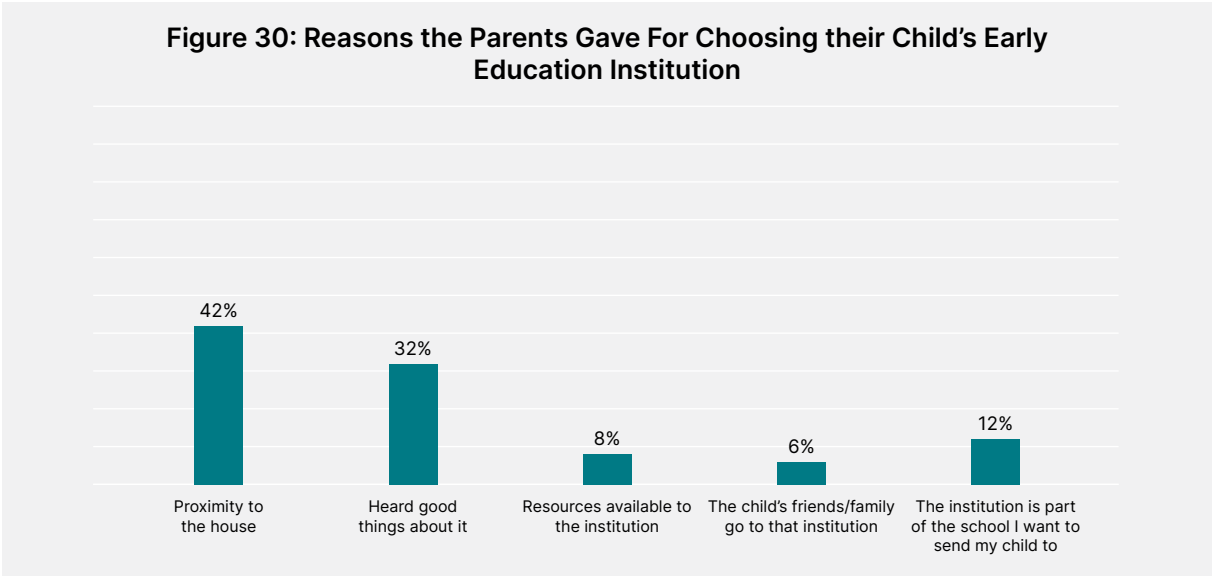
Child Well-being And Education

Education and schooling are an integral part of a child’s life in the modern world. On average, children spend the first half of their weekdays in school and continue to do so into their late teen years. Therefore, it is important to assess the impact of their time at school on their overall well-being. This section aims to quantify the various ways in which education can affect a child’s well-being.



Respondents were asked some general questions regarding their child’s schooling experience. First, they were asked about their child’s method of transportation, with 71% of respondents choosing “car” as the preferred method and 29% choosing “bus.” Among those who chose “car,” 58% indicated that “domestic help” usually took the child to school, while 41% chose the father, mother, or both parents.

Second, respondents were asked about their child’s education prior to enrolling in school. Studies conducted in OECD member states indicate that children who participate in early childhood education and care (ECEC) tend to perform better in primary school and have higher educational outcomes (Garvis et al., 2018, p. 239). The majority of respondents (82%) enrolled their child in a type of pre-school, kindergarten, or nursery. The reasons for their preferences varied, with proximity being the most important factor (see Figure 30).



Notably, 17% of respondents opted not to enroll their child in any of the above options. When asked why, 59% said that one of the parents is a stay-at-home caregiver, 16% said a family member (e.g., grandparents) looked after the child, and 34% indicated that a trusted caregiver stayed home with the child.

Finally, respondents were asked a couple of miscellaneous questions regarding factors that can affect a child’s well-being, such as social skills, academic performance, and self-esteem. The varying results are presented in Table 8.

Table 8: General Information About the Child’s School Life

Questions	Yes	No
Did your child repeat any grade?	4%	96%
Does your child have any difficulty making or keeping friends?	19%	81%
Was your child bullied, picked on, or excluded by other children?	13%	87%
Did your child bully others, pick on them, or exclude them?	7%	93%

Teachers and Their Impact on Well-being

Teachers are integral to a child’s school experience. They can support a student’s well-being in six major ways: providing care, offering support and encouragement, having conversations with students, delivering innovative and fun learning experiences, recognizing students as individuals, and mentoring them (Powell

et al., 2018). This section of the research aims to shed light on teacher–student relationships in the classroom by asking respondents a series of questions to assess their child’s well-being in the school environment.

Overall, parents had a favorable outlook on their child’s schoolteachers. 96% of respondents reported that their child’s teacher had a positive impact on school performance, and 97% expressed trust in the teachers’ qualifications. These positive perceptions were consistent across multiple areas: 94% agreed that teachers can manage the classroom effectively, and 93% agreed that teachers are successful in engaging their children. Additionally, 97% agreed that their child’s teachers provide a healthy learning environment, while 94% indicated that teachers use innovative teaching methods in the classroom.

Parental Involvement in School

In this section, parents were asked about their involvement in different aspects of their child’s school life. It is important to note that the majority (54%) of respondents reported that their child’s school did not contact them regarding any problems with their child over the past 12 months. Data on parental involvement can be found in Table 9.

Table 9: Parents Involvement in School by Gender

Statements	Male		Female	
	Yes	No	Yes	No
I attend parent–teacher conferences at my child’s school.	62%	38%	74%	26%
I receive my child’s report cards.	85%	15%	91%	9%
I know how to reach my child’s teachers.	90%	10%	94%	6%
My child’s teachers and I often communicate about my child’s school progress.	69%	31%	80%	20%
I have given my opinion on the school’s educational strategy.	36%	64%	43%	57%
I help my child with their homework.	58%	42%	78%	22%

Table 10 presents the level of parental involvement in children’s education across three age groups: 0–5 years, 6–11 years, and 12–17 years. The results show that a high proportion of parents across all three age groups reported attending

parent–teacher conferences, receiving their child’s report cards, knowing how to contact their child’s teachers, maintaining regular communication with teachers about their child’s academic progress, and assisting their children with home-work. However, only a small percentage of parents reported being involved in shaping the school’s educational strategy across all age groups.

Table 10: Parents Involvement in School by Child Age Group

Statements		Age group		
		0-5	6-11	12-17
I attend parent–teacher conferences at my child’s school.	Yes	69%	72%	64%
	No	31%	28%	36%
I receive my child’s report cards.	Yes	86%	89%	87%
	No	14%	11%	13%
I know how to reach my child’s teachers.	Yes	92%	94%	90%
	No	8%	6%	10%
My child’s teachers and I often communicate about my child’s school progress.	Yes	75%	76%	73%
	No	25%	24%	27%
I have given my opinion on the school’s educational strategy.	Yes	39%	40%	40%
	No	61%	60%	60%
I help my child with their homework	Yes	74%	74%	60%
	No	26%	26%	40%

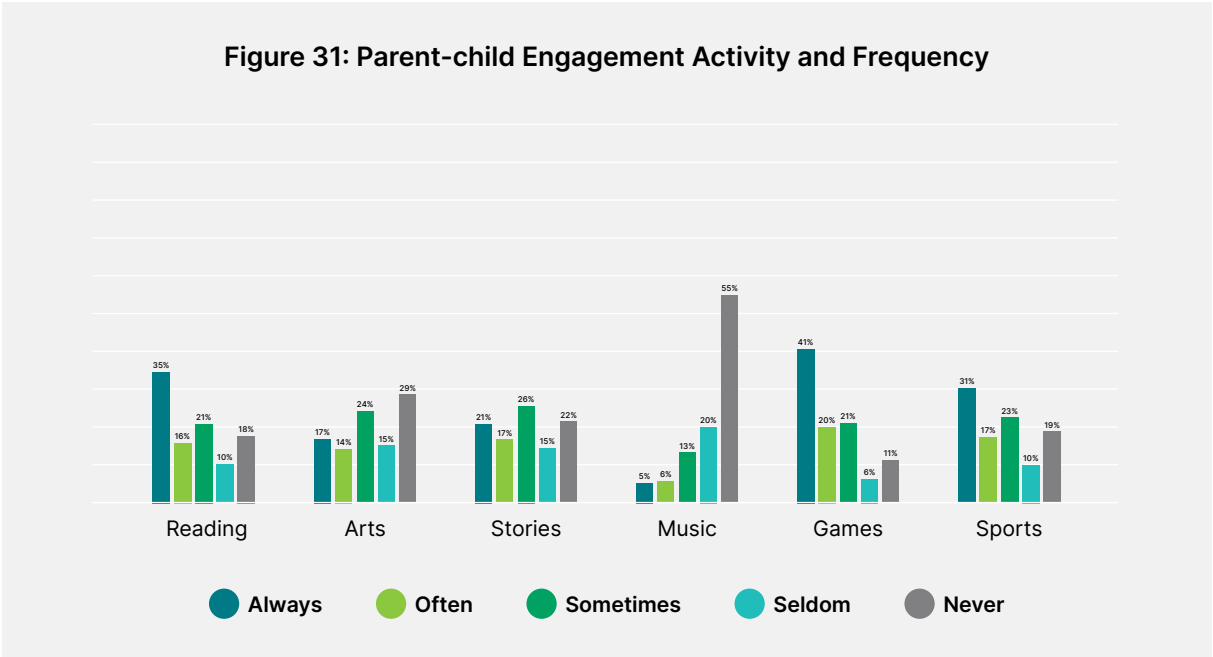
Early Childhood Education:

As previously indicated, early childhood education is vital to students’ overall academic outcomes. Moreover, Puccioni’s research on the subject shows a positive correlation between parents’ engagement in transition practices and a child’s achievement in mathematics and reading, depending on the quality and frequency of these practices (Puccioni, 2015). This section sheds light on those particular practices.

Respondents reported an overwhelmingly positive response to questions regarding their child’s early education, with 93% agreeing that it is important to engage children in basic literacy skills prior to kindergarten. In a similar vein, 98% said they believed it is important to teach their children the alphabet and basic numbers.

Figure 31 provides a detailed look into the different educational engagements. The graph shows that games, reading, and sports are the most popular activities, with 41%, 35%, and 31% of respondents reporting that they always engage

their children in those activities, respectively. On the other hand, music was the least frequently engaged-in activity, with only 5% reporting constant engagement, while 55% of respondents reported that they never engage their children in music. Interestingly, the second least engaged-in activity is arts, with 17% of respondents stating that they always engage their children in arts and 29% indicating that they never do.



06

Child Well-being And Entertainment

How children occupy their time has been shown to be linked to their subjective well-being (SWB). As Harding noted, in order to understand differences among children and their capabilities, it is important to study how they spend their idle time, with whom, and in what contexts and institutions. “Time use” can be either “leisure-based” or “work-based,” with the former being more common in developed countries, while the latter is more prevalent in developing nations. Studies have shown a positive correlation between leisure-based activities and a child’s SWB (Savahl et al., 2019).

In this section, parents were asked about their child’s extracurricular activities and hobbies. Respondents were first asked about the frequency of their annual travels; only 21% said they did not travel for holiday over the past 12 months, in contrast to 37% who said they had traveled once, and 42% who reported traveling more than once.

Hobbies and Extracurricular Activities:

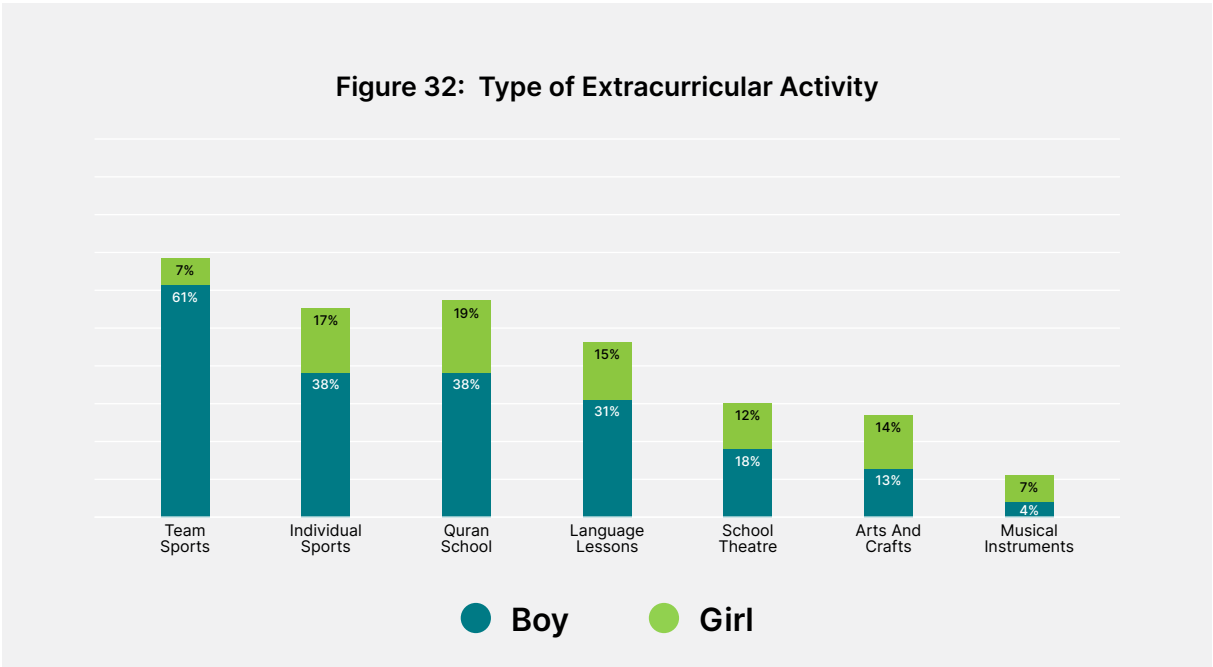
Parents were asked about their child’s memberships, associations, and club affiliations. Table 11 presents a general outline of these activities, while Figure 32 provides more detailed insights into the specifics of these activities across child gender. The results indicate a low level of parental interest in involving their children in extracurricular activities. This may be related to the types of activities offered by the school or the timing of these activities.

Table 11: Child’s Extracurricular Activity

During the past 12 months, has your child participated in...	Boy		Girl	
	Yes	No	Yes	No
A sports team or taken sports lessons after school or on week-ends?	42%	58%	16%	84%
Any club or organization?	34%	66%	14%	86%
Any other organized activities or lessons, such as music, dance, language, or other arts?	12%	88%	14%	86%
Any type of community service or volunteer work?	10%	90%	15%	88%

Among parents or guardians who engage their children in extracurricular activities, a high proportion reported participation in team sports, individual sports, and Quran school. When examined by child gender, boys showed higher participation rates in team sports, individual sports, Quran school, language lessons, and school theatre compared to girls.

Additionally, respondents whose child was enrolled in language lessons were asked about their language of choice. English was the most sought-after language (81%), followed by Arabic (15%) and French (4%).



07

Child Rights And Protections

Protecting children’s rights ensures their overall well-being. States enact laws and regulations aimed at protecting children from harm and exploitation. Some scholars advocate for the robust implementation of these laws, highlighting “the need for positive interventions from states to actively protect children in various contexts” (Ezer, 2004). In Qatar, children’s rights are protected by law. Law No. 11 of 2004, which includes the penal code on exposing children to danger—specifically Articles 268 and 269—punishes those who jeopardize children’s safety⁴. The State has confirmed the importance of this matter in both international forums and domestic settings (Ministry of Foreign Affairs of Qatar, 2024).

Qatar places great emphasis on enhancing children’s rights, as evidenced by the establishment of numerous legal frameworks and the implementation of administrative and practical measures across various sectors (Ministry of Foreign Affairs of Qatar, 2024). This section investigates children’s rights and the notion of protecting children, as this is closely related to overall child well-being. Specifically, it examines parents’ discipline methods, explores the issue of child neglect, and assesses respondents’ awareness of child protection institutions and whether they have had any experience with such institutions.

Parents’ Discipline Methods with their Children

As discipline is part of educating children, the survey asked parents about their different styles of correction and discipline. Discipline can sometimes be harmful and negatively affect a child’s well-being. In other words, “parental communication styles with their children, [and] their disciplinary approaches could sometimes lead to physical or emotional child abuse” (Wilson & Whipple, 2013). Thus, these questions focus on negative approaches to screen for any potential violations of children’s rights.

The majority of respondents (76%) disagreed with the statement “Hitting is discipline.” It is important to note that 20% of respondents agreed with this statement. Moreover, 35% of respondents agreed with the statement “It is okay to hit as long as there is no damage.” The majority of respondents (83%) disagreed that “Children do not listen unless they are hit.” Furthermore, almost three-quarters of respondents (73%) disagreed with the statement “Yelling is a necessary form of discipline.” Similarly, 71% of respondents disagreed with the statement that “Children only obey if parents yell.”

When asked whether parents have the right to hit or yell at their children, more than half of the sample (63%) stated that they disagreed with this statement. In addition, 59% of participants disagreed that hitting a child is acceptable when the child misbehaves. See Table 12 for a summary of these results.

Table 12: Parents’ Different Style of Discipline

Statements	Strongly Agree %	Somewhat Agree %	Somewhat Disagree %	Strongly Disagree %
Hitting is a form of discipline.	4	20	16	60
It is okay to hit as long as there is no physical harm.	6	29	15	50
Children do not listen unless they are hit.	2	15	20	63
Yelling is a necessary form of discipline.	4	23	20	53
Children do not listen or obey unless I yell.	4	24	21	51
Parents have the right to yell at or hit their children.	9	28	18	45
Hitting a child is acceptable when the child misbehaves.	8	33	17	42

Views of Child Neglect Issue in Qatar

When asked about the issue of child neglect in Qatar, more than half of the respondents (61%) indicated that it is a serious problem, as shown in Figure 33. When asked about the age at which children might be neglected, 41% of respondents stated that there is no specific age—expressing their belief that a child should not be neglected at any age.

It is important to note that nearly one-fifth of respondents (19%) believe that neglect is most likely to occur during early childhood, specifically between the ages of 0 and 4, as shown in Figure 34.

⁴ [https://www.almeezan.qa/LawArticles.aspx?LawTreeSectionID=251&lawId=26&language=en#:~:text=Whoever%20jeopardizes%20a%20person%20under,Qatari%20Riyals%20\(QR%2010.000\).](https://www.almeezan.qa/LawArticles.aspx?LawTreeSectionID=251&lawId=26&language=en#:~:text=Whoever%20jeopardizes%20a%20person%20under,Qatari%20Riyals%20(QR%2010.000).)

Figure 33: Respondents' Views about Child Neglect Problem in Qatar

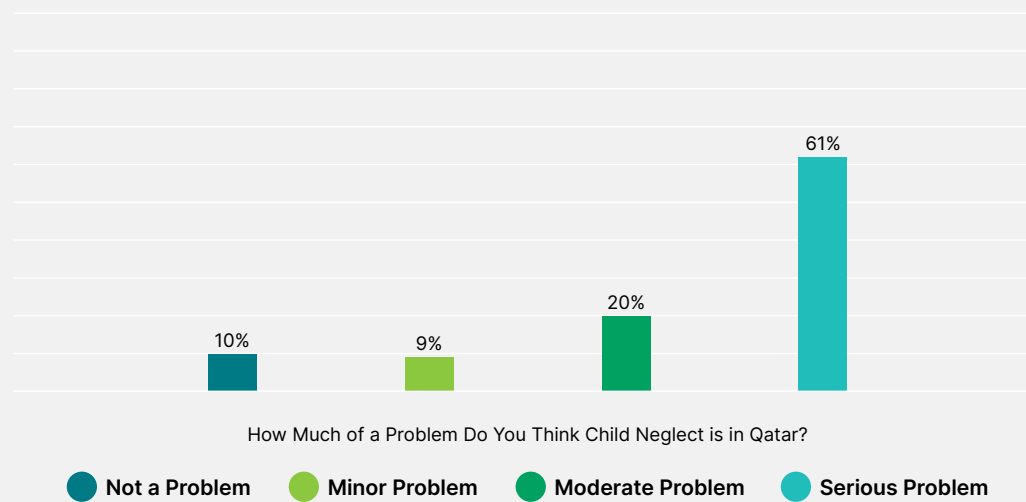
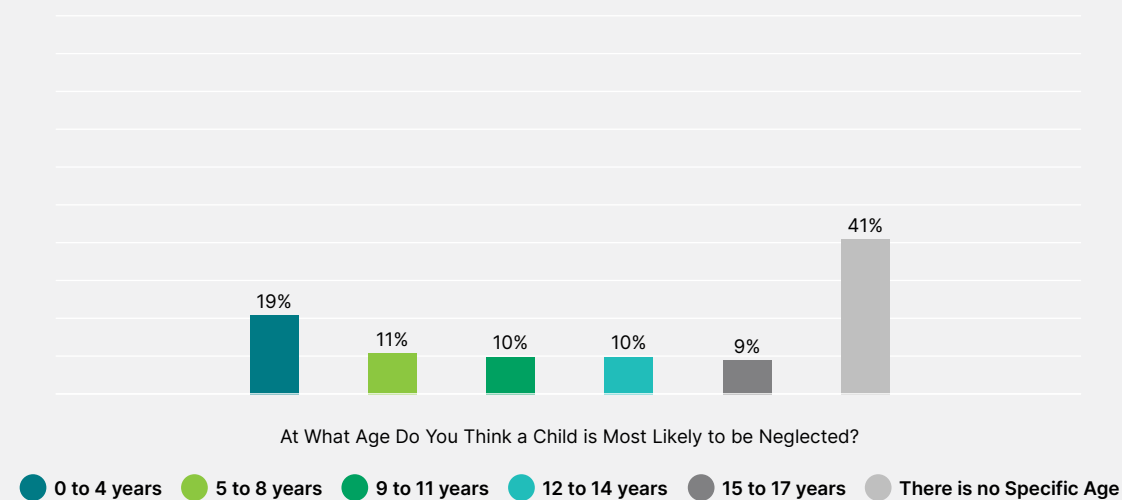


Figure 34: Respondents' Views About What Age the Child Might be Neglected



When asked at what age a parent can leave a child alone for a few hours, 82% of respondents stated that it is acceptable to leave older children—specifically those between 9 and 17 years of age—as shown in Figure 35.

Respondents were also asked whether their child had ever been abused—physically, mentally, or verbally—by a caregiver. The vast majority of participants (92%) reported that their child had not experienced any form of abuse. See Figure 36 for details.

Figure 35: Respondents' Views about the Age they Leave Children for Few Hours

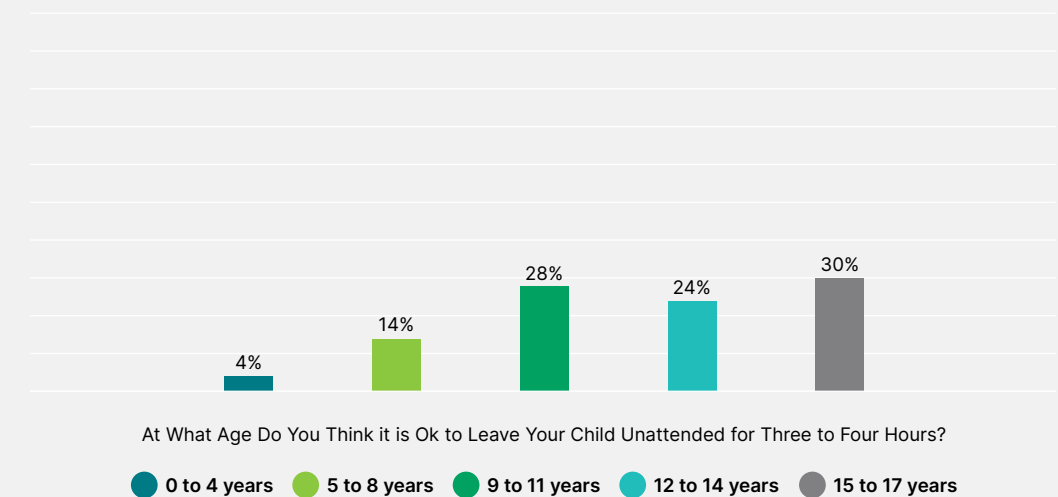
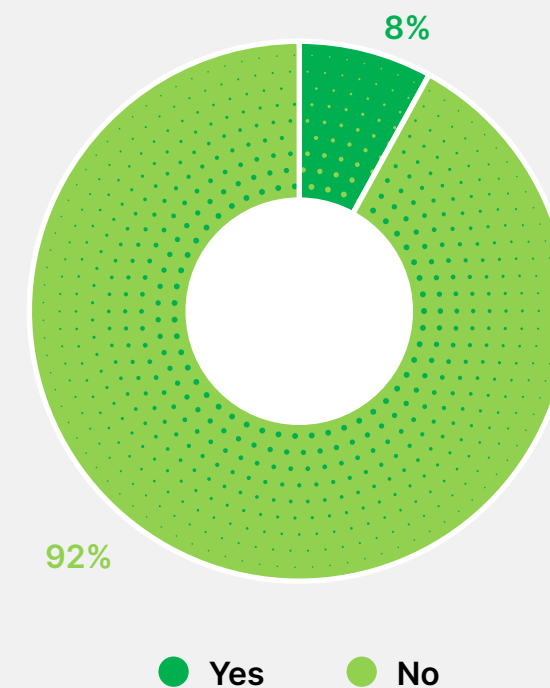


Figure 36: Have your Child Ever Been Abused

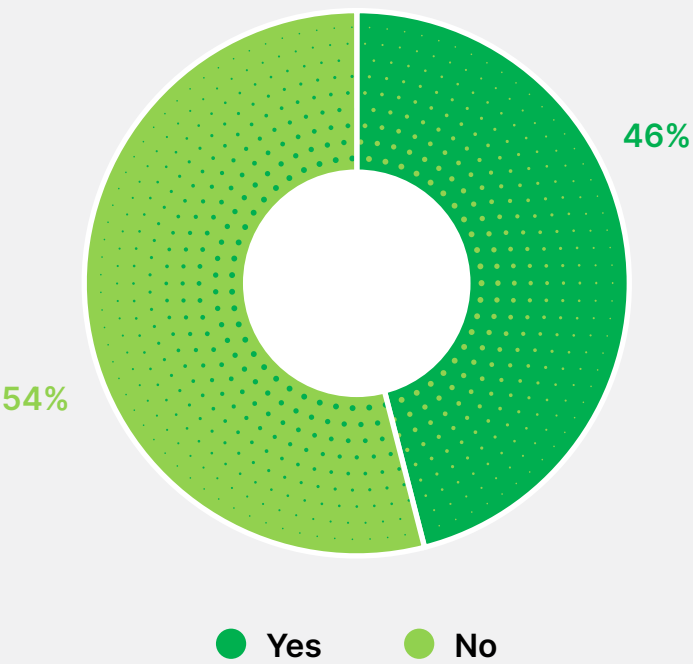


Awareness of Institutions that Protect Children’s rights in Qatar

The survey included a question about whether parents are aware of a specific protection and social rehabilitation center—AMAN. According to the results, 46% of respondents stated that they are aware of AMAN, while 54% said they are not aware of it. This means that more than half of the respondents have no knowledge of AMAN, as shown in Figure 37.

For those who indicated awareness of AMAN, a follow-up question was asked regarding any direct experience with the center. The vast majority (96%) reported that they had not had any direct experience with AMAN.

Figure 37: Are you Aware about the Protection & Social Rehabilitation Center (AMAN)?



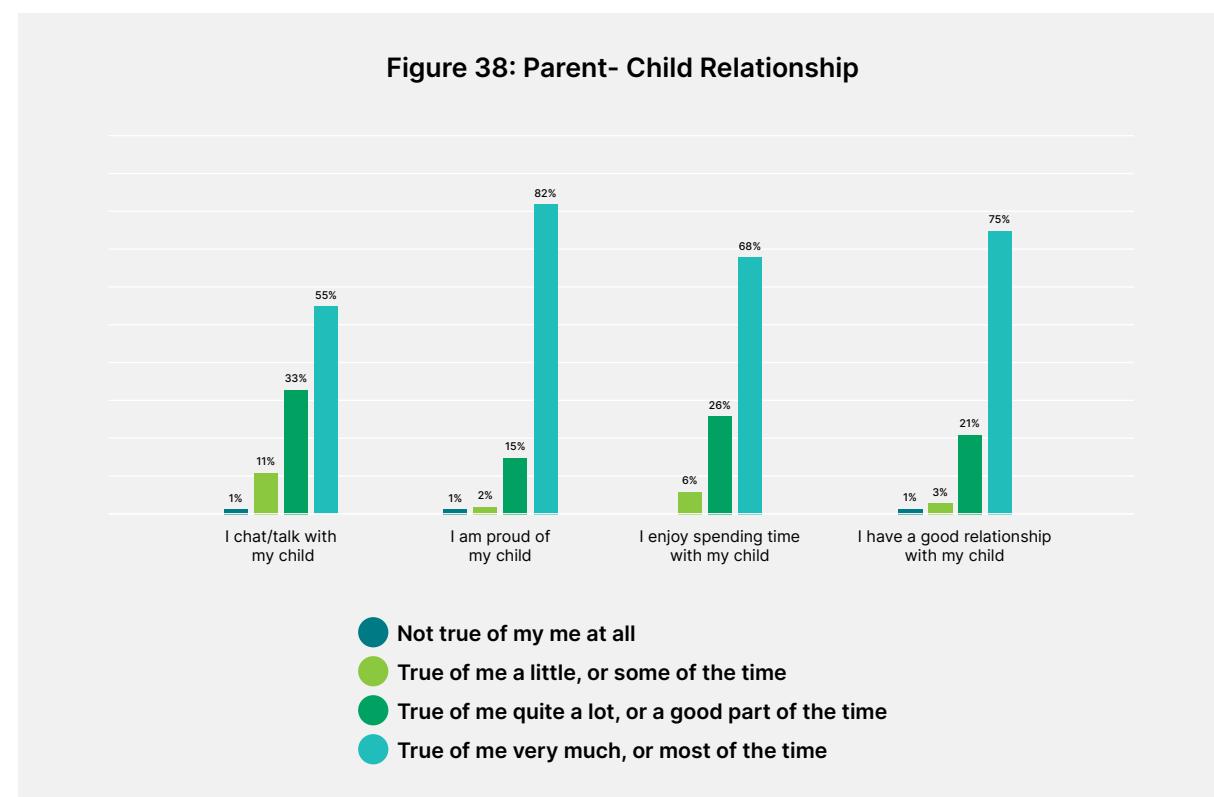
08

Parental Involvement

Parental involvement is critical to children's growth and well-being, influencing many aspects of their lives, including emotional, social, and academic outcomes. Traditionally, mothers have been seen as the primary caretakers, responsible for nurturing and daily care. However, in recent years, there has been a growing shift toward a more balanced approach to parenting responsibilities, with fathers taking on more active roles in childrearing (Pleck, 2010). In this section, we examine the parents' relationships with their children.

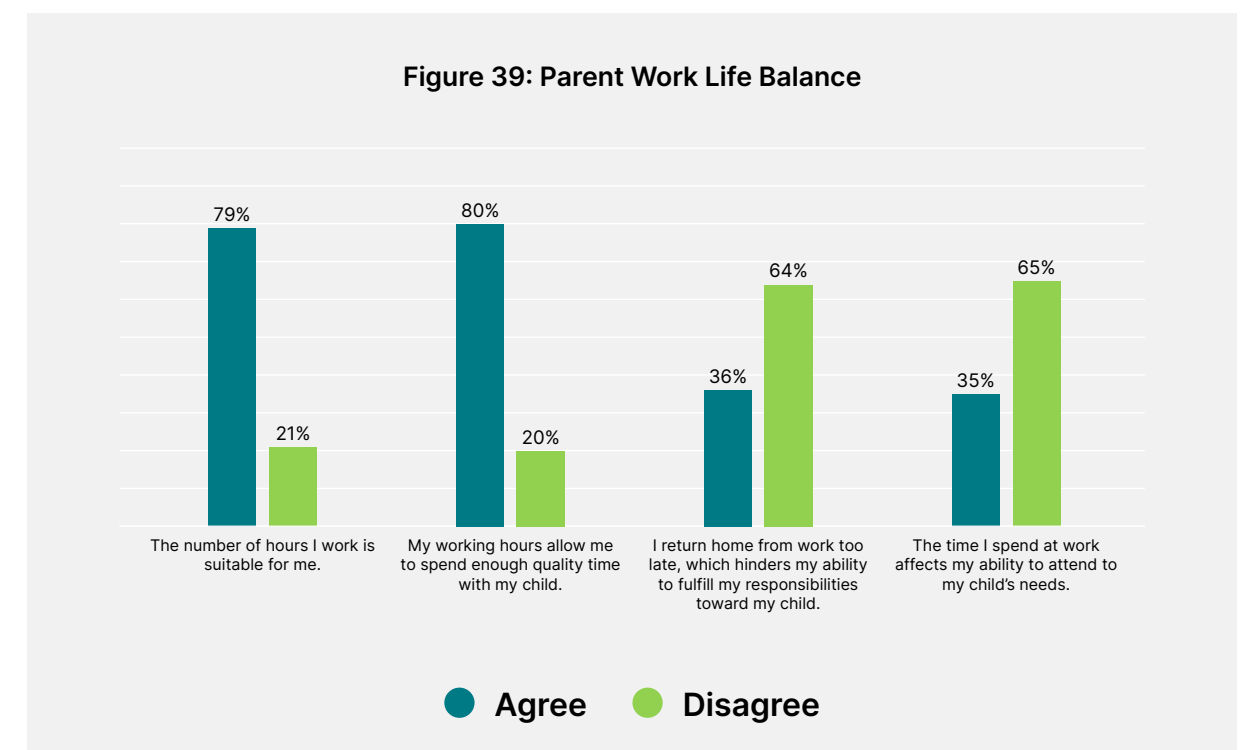
Parent-Child Relationship

The **Parenting and Family Adjustment Scales (PAFAS)** were used to assess changes in parenting practices and parental adjustment in the evaluation of both public health and individual or group parenting interventions. The inventory consists of two components: the *Parenting Scale*, which measures parenting practices and the quality of the parent-child relationship, and the *Family Adjustment Scale*, which measures parental emotional adjustment and partner/family support in parenting⁵. Figure 38 presents the findings related to the nature of parents' relationships with their children across four categories. Each bar reflects the degree to which respondents agreed with statements about their interactions with and feelings toward their child. Overall, the results offer a clear picture of strong parental engagement. The majority of parents reported positive communication, feelings of pride, enjoyment, and healthy relationships with their children.



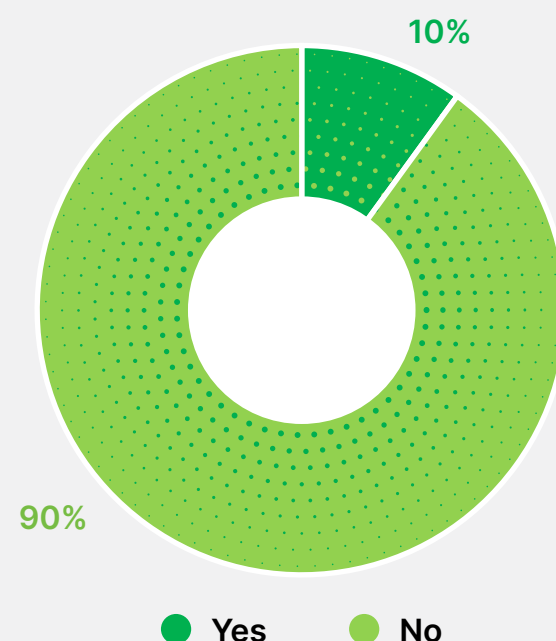
⁵ Sanders, M. R., Morawska, A., Haslam, D. M., Filus, A., & Fletcher, R. (2014). Parenting and Family Adjustment Scales (PAFAS): Validation of a brief parent-report measure for use in assessment of parenting skills and family relationships. *Child Psychiatry & Human Development*, 45, 255-272. <https://link.springer.com/article/10.1007/s10578-013-0397-3> (Page 262)

Using the validated scale by Banu and Duraipandian (2014) to measure work-life balance, the graph below represents respondents' impressions of how their job hours affect their ability to meet parenting responsibilities and spend quality time with their children. According to the findings, the majority of respondents appear to be satisfied with their working hours and their capacity to balance work and home duties. The results also indicate that a sizable minority faces difficulties with late work hours (36% agree) and the impact of work responsibilities on attending to their child's needs (35% agree). This suggests that while many parents are able to strike a balance, a subset still struggles with work-life integration.



Parents were also asked whether they had participated in parent education programs in Qatar that support and educate parents in the field of child-rearing. The vast majority of the sample (90%) stated that they had not used or attended such awareness programs, whereas 10% reported that they had participated and were satisfied with them.

Figure 40: Have you used any Parental Education Programs in Qatar that support and educate parents of parenting style?



Collaboration in Parenting

The table below provides insights into how spouses perceive their involvement in parenting and the division of responsibilities, using the validated scale (Understanding of Parenting Subscale & PAFAS scale). Ninety-seven percent of respondents agree with the statement, “Their spouse is a wonderful parent.” This positive response indicates strong mutual appreciation between partners regarding their parenting roles. Moreover, the same percentage of respondents expressed strong agreement with their spouse about the values and manners to instill in their children.

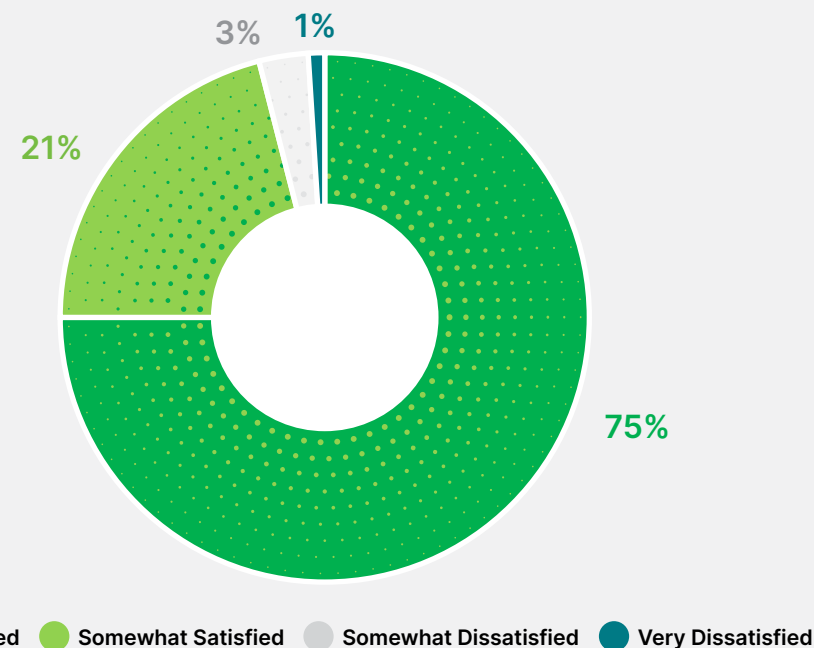
However, the results show a significant divide in perceptions of emotional involvement. A majority noted a lack of interest in their children; nearly half (47%) disagreed with this statement. In addition, a notable proportion believes their partner is not as involved in spending time with the children, with 60% agreeing and 40% disagreeing.

Table 13: Collaboration in Parenting

Statements	Agree	Disagree
My spouse is a wonderful mother/father.	97%	3%
My spouse does not show enough interest in our children.	53%	47%
We are in perfect harmony with each other in raising our children.	95%	5%
We set rules about our children together.	95%	5%
My spouse does not spend enough time with the children	60%	40%
We share equal responsibility in raising our children	86%	14%
We usually agree on the manners we should teach our children.	97%	3%
My spouse generally expects me to take care of the children.	90%	10%
We do not experience conflicts regarding topics related to the children.	88%	12%
I agree with my partner about parenting.	95%	5%
I work as a team with my partner in parenting.	91%	9%

The results also indicate that a vast majority of respondents (96%) are satisfied with their partner’s involvement in raising their children.

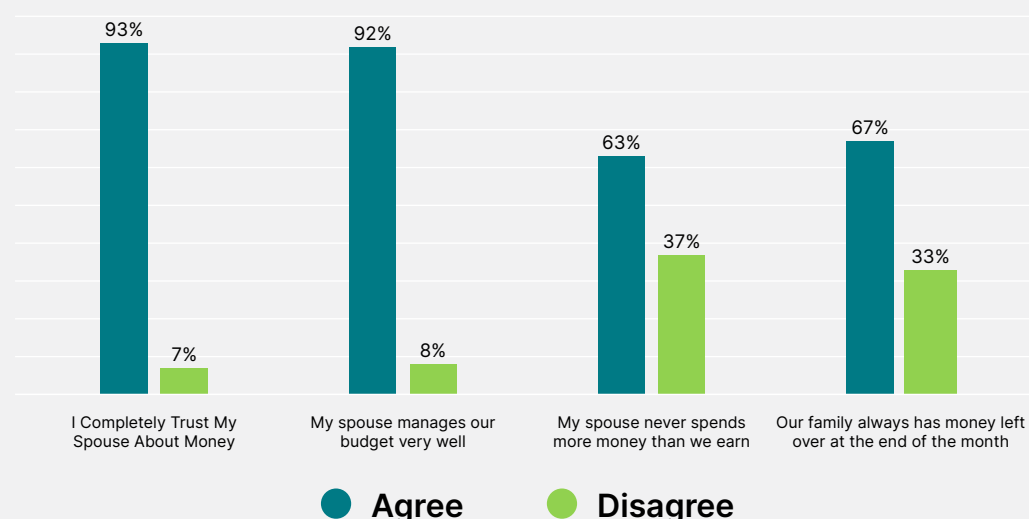
Figure 41: How Satisfied are You With Your Spouse's Involvement in Raising Your Children?



Family Finances

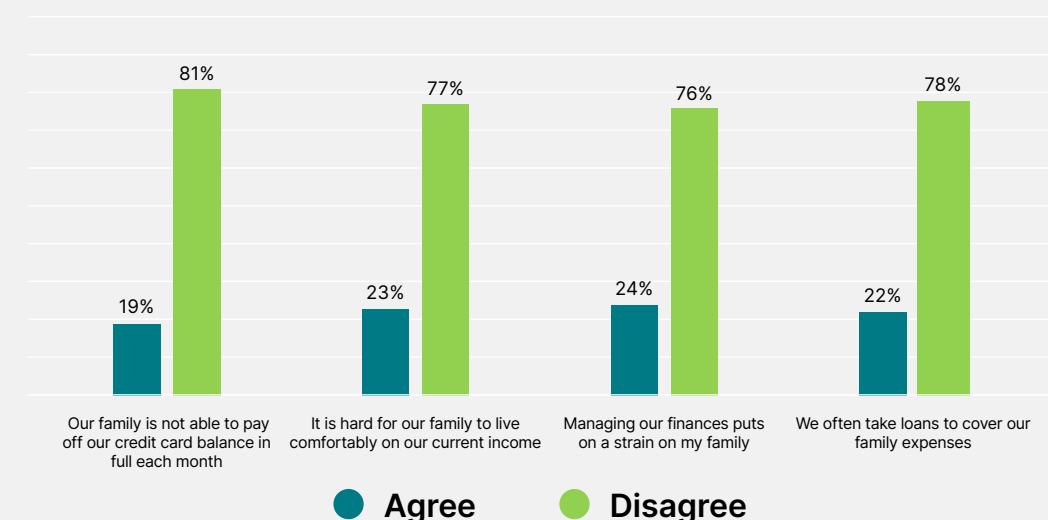
We explored various statements related to different dimensions of financial trust within a marital relationship. The figure below illustrates spouses' opinions about family finances. The results show a high level of trust (93%) and confidence in their partner's responsibility and efficiency in managing the family budget (92%).

Figure 42: Family Finances



Using a scale of agreement and disagreement, the figure below presents respondents' views on family expenses and financial stress across four statements. The results indicate that the majority of the sample is not significantly affected by debt, insufficient income, or reliance on loans. Respondents were also asked whether their family currently holds a financial loan. The findings show that approximately 38% of families fall into the highest loan bracket, with loans ranging between 200,000 and 300,000 Qatari Riyals. The rest of the sample is distributed across the lower loan categories, while a small proportion (3.37%) reported having no loans at all.

Figure 43: Family Finances



The topic of how, when, and why children come to understand the economic world has attracted sporadic empirical research by social scientists over the years (Furnham & Argyle, 1998; Furnham & Okamura, 1999; Strauss, 1952). More recent studies have examined the monetary practices of young people and adults (Lau, 1998; Lewis & Scott, 2000), as well as broader aspects of parents' ideas about rules concerning household work and rewards (Goodnow, 1996; Grusec & Goodnow, 1994). Additional research has investigated determinants of parental attitudes, beliefs, and values regarding pocket money and allowances, including the rules parents establish in this context (Furnham, 2001).

In our study, we examined parents' views on whether children aged five years and older should receive pocket money. The findings show that the majority (58%) believe children should be given pocket money, while 42% disagreed. Furthermore, a significant portion of parents (75%) reported that they do give their children pocket money, with the average monthly amount being 825 Qatari Riyals.

Table 14 presents a set of statements related to various aspects of children’s and parents’ financial behavior. Overall, the results indicate a blend of financial independence among children: 47% of children have a bank account, 73% are allowed to donate money, and 50% occasionally give money to friends. Additionally, an overwhelming majority of parents (95%) stated that they believe it is important to talk to their children about the value of money.

Table 14: Money management with children

Statements	Agree	Disagree
My children donate from their own money.	73%	27%
I increase my child’s pocket money annually.	69%	31%
My child owns stocks.	42%	58%
My child has a bank account.	47%	53%
When I give my child money, he/she saves it.	57%	43%
My child loses or misplaces their pocket money.	24%	76%
My child is reluctant to spend any of his/her own money.	24%	76%
My child sometimes borrows money from his/her friends.	6%	94%
My child sometimes gives money to his/her friends.	50%	50%
Children should be allowed to make all their own spending decisions.	44%	56%
Boys should be given slightly more pocket money than girls.	26%	74%
I believe it is important to talk to children about the value of money.	95%	5%

09

Well-being And The Internet

As the digital landscape becomes increasingly integral to daily life, understanding its effects on child well-being is crucial. The internet offers numerous opportunities for learning and social interaction but also presents challenges that can impact a child’s emotional and social development. This section explores the impact of the internet on children’s development, as well as their emotional and social well-being. The statements in this section are adapted from the *Children’s Well-being in a Digital World: World Index Report 2022*. Notably, 81% of respondents reported that their children have access to the internet. Furthermore, among children with internet access, respondents indicated that their children spend an average of approximately four and a half hours online per day.

Positive Impacts of Technology and Online Activities:

The increasing integration of technology and online activities into daily life has had a profound impact on children’s development, offering a range of benefits that support their growth and learning. Many parents recognize the “*potential benefits that screens might hold for children’s learning and engagement*” (Blum-Ross & Livingstone, 2016, p. 7). Respondents in the Child Well-Being Survey highlighted several positive outcomes, emphasizing how access to digital resources has enhanced their children’s skills, awareness of online safety, and overall happiness.

The majority of respondents (90%) strongly agreed or agreed that their children benefit significantly from being able to look up topics of interest online. Notably, 85% reported that their children fully understand what personal information should and should not be shared online. In addition, 81% acknowledged that technology and being online are important for their children in thinking about and planning for the future. Furthermore, 87% agreed that technology and online resources play a crucial role in helping their children learn new skills. Similarly, 82% stated that digital devices and internet access allow their children to explore hobbies and interests that bring them joy. Lastly, 75% of respondents agreed that technology helps their children participate in activities and moments that are meaningful to them (see Table 15).

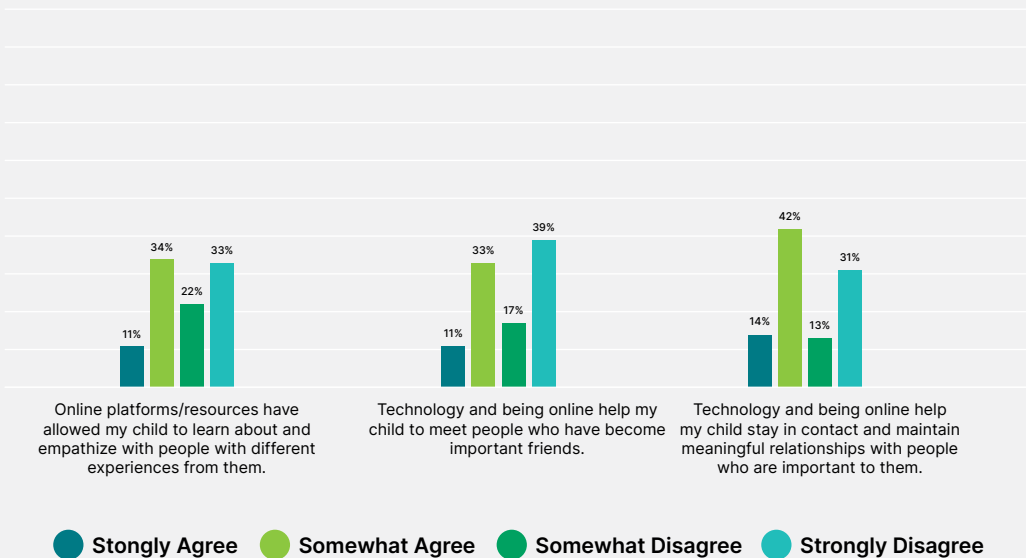
Table 15: Positive Impacts of Technology and Online Activities

Statements	Strongly Agree %	Somewhat Agree %	Somewhat Disagree %	Strongly Disagree %
My child benefits a lot from being able to look up things online that they are interested in.	53	37	5	5
My child fully understands what personal information they should and shouldn't share online.	54	31	8	7
Technology and being online have been important for my child in thinking about and planning for the future.	38	43	11	8
Technology and being online have been important for my child in learning new skills.	40	47	7	6
Digital devices and being online have allowed my child to discover and pursue interests and hobbies that make them happy.	28	54	8	10
Technology and being online help my child participate in activities and events that are important to them.	26	49	9	16

Positive Social Interactions and Relationships through Technology

In today’s digital age, technology plays a significant role in shaping children’s social experiences. Parents increasingly recognize the impact of online platforms and digital resources on their children’s ability to connect with others. According to the child well-being survey, less than half (45%) of respondents agreed or strongly agreed that online platforms enable their child to learn about and empathize with people who have different life experiences. Additionally, 44% believe that technology helps their child meet individuals who have become important friends. Furthermore, 56% agreed or strongly agreed that being online helps their child stay in touch and maintain meaningful relationships with people who matter to them, as illustrated in Figure 44.

Figure 44: Positive Social Interactions and Relationships through Technology



Repetitive Use and Negative Impacts of Technology

Numerous scholars have examined the effects of excessive screen time on overall health, physical activity, cognitive development, and social well-being (Hale and Guan, 2015). As children become more immersed in digital media, parents are increasingly concerned about various aspects of their online behavior. These concerns include the impact of screen time on daily routines, sleep patterns, and children’s ability to assess the reliability of online information. Understanding these challenges is essential to helping children navigate digital environments safely and effectively.

In the child well-being survey, 59% of respondents agreed or strongly agreed that their child often re-watches the same TV shows or repeatedly plays the same games. Additionally, 49% believe that the way their child spends time on phones, computers, or game consoles negatively affects their sleep patterns. Furthermore, 41% agreed or strongly agreed that their child struggles to determine whether the information they encounter online or on social media is accurate. More than a quarter (27%) reported that their child has spent money in apps or on games without realizing it, and 35% agreed or strongly agreed that their child sees things online that worry or upset them, as shown in Table 16.

Table 16: Repetitive Use and Negative Impacts of Technology

Statements	Strongly Agree %	Somewhat Agree %	Somewhat Disagree %	Strongly Disagree %
My child spends a lot of time rewatching the same TV shows or playing the same games repeatedly.	21	38	21	20
The way my child spends time on their phone, computer, or game console negatively affects their sleep patterns.	14	35	21	30
My child struggles to determine whether the information they are exposed to online or on social media is true.	9	32	28	31
My child spends money in apps or on games without realizing it.	8	19	22	51
My child sees things online that worry or upset them.	8	27	19	46

Negative Social and Behavioral Impacts of Technology Use

As children become increasingly immersed in digital environments, some parents report concerning behaviors related to their online activities. A notable percentage of parents observe that their children encounter negative experiences during online interactions and often prioritize screen time over social opportunities. Additionally, many face challenges in encouraging their children to leave the house, as they prefer staying in to engage with digital content. “Screen-time worsens social anxiety and feelings of isolation, which leads to social avoidance and escape into cyber activities” (Dunckley, 2015, p. 228). Concerns also include unhealthy comparisons to online or social media personas and increased anxiety about how others perceive them. These issues underscore the complex impact of digital engagement on children’s social and emotional well-being.

In the Child Well-Being Project, 16% of respondents strongly agreed or agreed that their child has had negative experiences interacting with others online. Additionally, 29% reported that their child turns down opportunities to meet with friends in favor of using their phone, computer, or game console. The same percentage of respondents often find it difficult to get their child to leave the house, as they prefer staying indoors to play video games, stream content, or browse on their phone. Around a quarter of respondents (24%) believe their child compares themselves to people they see online or on social media in an unhealthy way, while 17% strongly agreed or agreed that their child worries a lot about how others perceive them online (see Table 17).

Table 17: Negative Social and Behavioral Impacts of Technology Use

Statements	Strongly Agree %	Somewhat Agree %	Somewhat Disagree %	Strongly Disagree %
My child has negative experiences interacting with other people online.	3	13	18	66
My child turns down opportunities to meet friends so they can stay on their phone, computer, or game console.	6	23	18	53
I often find it difficult to get my child out of the house because they prefer staying in to play video games, stream and watch TV, or be on their phone.	7	22	16	55
My child compares themselves to people they see online or on social media in a way that I think is unhealthy.	6	18	21	55
My child worries a lot about how others perceive them online.	3	14	24	59

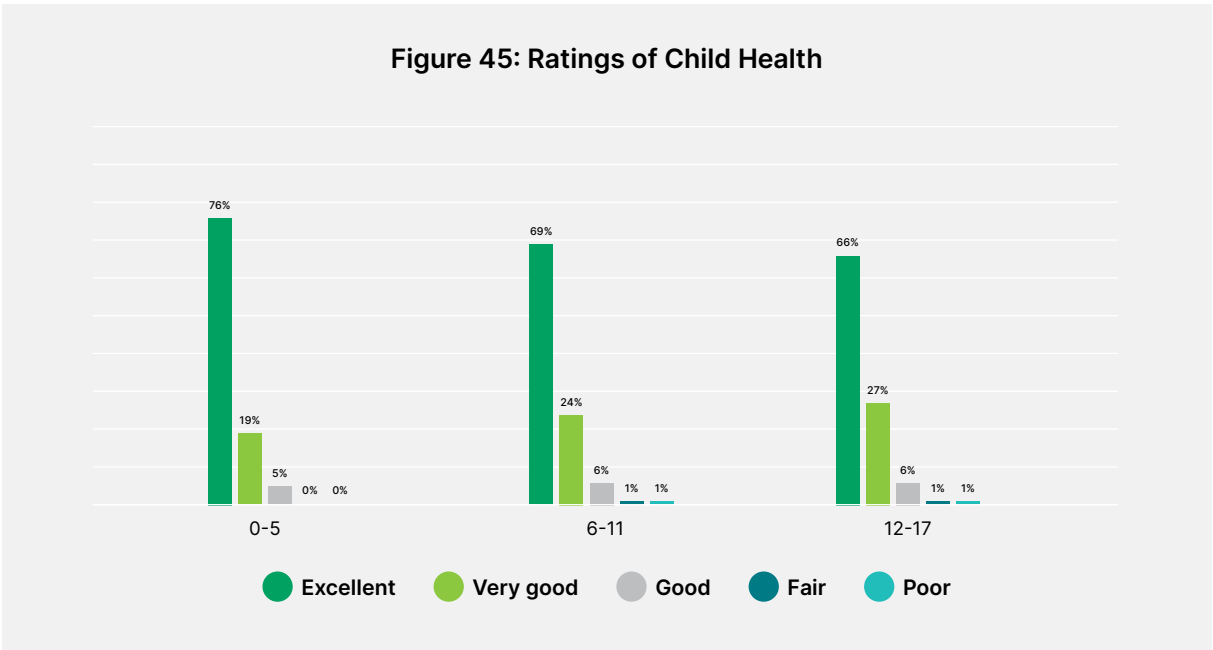
10

Factors Associating With Child Well-being

Child well-being is a multidimensional concept that goes beyond basic health indicators and encompasses all aspects of physical, behavioral, psychological, social, cognitive, and economic well-being. This section analyzes how children's well-being is influenced by various factors, such as family relationships, social interactions, school environment, and economic conditions.

Child well-being and mental health:

Figure 45 shows the assessments of children's health across different age groups. Among children aged 0 to 5, 95% of guardians rated their child's health as excellent (76%) or very good (19%). In the 6 to 11 age group, 93% of guardians reported excellent (69%) or very good (24%) health. Similarly, 93% of guardians with children aged 12 to 17 rated their child's health as excellent (66%) or very good (27%). Overall, these results indicate that a large majority of guardians view their children's health as excellent or very good across all age groups.



The KIDSCREEN-10, used to evaluate the overall quality of life and well-being, includes data only for children between the ages of 6 and 17. Table 18 presents the t-test results for KIDSCREEN-10 scores, highlighting several differences based on the characteristics of the child and the guardian. The difference in average KIDSCREEN-10 scores between children aged 6–11 and those aged 12–17 was not statistically significant ($p = 0.945$). However, child gender showed a significant difference ($p = 0.0181$), with boys having a higher average score (61 points) than girls (59 points), indicating a slightly better perceived quality of life among male children.

The guardian's age was not significantly associated with the child's score ($p = 0.536$), as all age groups (34 and under, 35–44, and 45+) reported similar average scores for their children. In contrast, guardian education level showed a significant association with the KIDSCREEN-10 score ($p = 0.000$). Children of guardians with a bachelor's degree or higher had higher average scores (62 points) than those whose guardians held a diploma or lower qualification (59 points), suggesting that higher educational attainment among caregivers is linked to better perceived quality of life in children.

Employment status also had a significant effect ($p = 0.007$), with employed guardians reporting higher average scores for their children (61 points) compared to unemployed guardians (58 points). Conversely, family income was not significantly related to the child's KIDSCREEN-10 score ($p = 0.566$), with both income groups (less than QAR 50K and more than QAR 50K) showing an average score of 60.

In summary, child gender, guardian education level, and employment status are significantly associated with differences in perceived quality of life, whereas child age, guardian age, and family income do not show a significant impact.

Table 18: Mean differences in KIDSCREEN-10 scores across variable groups

Variables		KIDSCREEN-10		
		Mean	SD	P-value
Child Age	6-11	60	0.737	0.945
	12-17	60	0.662	
Child gender	Male	61	0.615	0.0181
	Female	59	0.680	
Guardian age	≥ 34	61	0.971	0.536
	35-44	61	0.691	
	45+	60	0.790	
Guardian education level	Diploma and lower	59	0.616	0.000
	Bachelor and higher	62	0.677	
Guardian employ status	Employ	61	0.595	0.007
	Unemployed	58	0.690	
Family income	Less than 50K QR	60	0.680	0.566
	50K QR and more	60	0.665	

Table 19 presents the chi-square test that examines whether child and guardian characteristics are associated with emotional and behavioral problems in a child. The child's gender was the only significant factor in the PSC score ($p=0.0181$). The findings show that females scoring higher ($\mu=96$, $SD=4$) than males ($\mu=92$, $SD=8$). This indicates that female children are perceived to have slightly better mental health outcomes than male children according to the PSC.

Table 19: Association between PSC groups and study variables

Variables		PSC		
		No psychological impairments %	Psychological impairments %	χ^2 P-value
Child Age	5-11	94	6	0.701
	12-17	94	6	
Child gender	Male	92	8	0.0181
	Female	96	4	
Guardian age	≥ 34	96	4	0.095
	35-44	95	5	
	45+	92	8	
Guardian education level	Diploma and lower	93	7	0.210
	Bachelor and higher	95	5	
Guardian employ status	employ	93	7	0.508
	unemployed	95	5	
Family income	Less than 50K QR	94	6	0.795
	50K QR and more	93	7	

Table 20 presents a chi-square test that examines whether child and guardian characteristics are associated with children's mental health. The result showed no significant differences based on the child's age ($p=0.493$). The SDQ results reveal that most children across all age groups fall within the normal range for the SDQ level (80%-85%). Similar to PSC, the child's gender was a significant factor in the SDQ level ($p=0.006$). The findings show that females have a higher rate of normal (86%) than males (82%). Moreover, the guardian education level was significantly associated with the SDQ level. The result presented that a guardian with a bachelor's degree or higher (88%) has a child with a high rate of abnormality compared to those with a diploma or lower education level (80%).

Table 20: Association between SDQ levels and study variables

Variables		SDQ			χ^2 P-value
		Normal %	Borderline %	Abnormal %	
Child Age	2-5	80	10	9	0.493
	6-11	84	9	7	
	12-17	85	7	7	
Child gender	Male	82	11	7	0.006
	Female	86	6	9	
Guardian age	≥ 34	83	11	7	0.760
	35-44	84	8	8	
	45+	84	8	8	
Guardian education level	Diploma and lower	80	9	11	0.000
	Bachelor and higher	88	8	4	
Guardian employ status	employ	86	8	6	0.062
	unemployed	80	10	10	
Family income	Less than 50K QR	80	11	8	0.053
	50K QR and more	85	7	8	

As the KIDSCREEN-10 scale was designed for children who attend school, it therefore targets only those who are 6 years of age or older. Similarly, the PSC also screens only children aged 6 and above. In contrast, the SDQ includes items that capture children from the age of 2 to 17 years old. For the purpose of this analysis, since the SDQ covers a broader age range than the other two scales (KIDSCREEN-10 and PSC), it will serve as the primary reported outcome. Moreover, because the SDQ is intended to measure a child's mental health, this value can help confirm our hypothesis that better mental health contributes to overall child well-being.

Analysis of Educational and Social Relationship Factors on Children's Mental Health

Table 21 presents several school environment and social relationship factors that impact the child's well-being. The type of school (government or private) has no significant impact on the SDQ level (p -value = 0.391). Similarly, the person who

takes the child to school shows no significant relationship with SDQ levels (p-value = 0.674). However, having one or more problems in school is significantly associated with SDQ levels (p-value = 0.000). The results indicate that children with school problems are more likely to fall within the borderline range (11% of children with problems vs. 5% without) and the abnormal range (11% with problems vs. 4% without) on the SDQ. This suggests that higher emotional or behavioral difficulties are linked to a greater likelihood of experiencing school-related problems.

Moreover, academic performance is significantly associated with SDQ levels (p-value = 0.000). Students with scores between 90% and 100% generally have higher normal SDQ levels (90%) compared to those with lower scores (85% for 80%–89%, and 75% for below 79%). Repeating grades is also significantly associated with SDQ levels (p-value = 0.001), with students who repeated a grade showing higher rates of borderline (17%) and abnormal (18%) SDQ levels compared to those who did not repeat (7% borderline, 7% abnormal).

Social relationships have a significant impact on children's well-being. The results show that children who struggle to form friendships (p-value = 0.04), experience bullying (p-value = 0.000), or engage in bullying behavior (p-value = 0.000) are more likely to have abnormal SDQ scores. Specifically, children who struggle to make friends show an abnormal rate of 12%, while those who are bullied (21%) or who bully others (24%) also show higher abnormal SDQ levels. These findings highlight the critical importance of positive peer relationships in supporting children's mental and emotional health.

Table 21: Chi-Square Result of School Environment and Social Relationship Factors Affecting Child Mental Health

Questions		SDQ			χ ² P-value
		Normal %	Borderline %	Abnormal %	
Child School type	Government School	86	7	6	0.391
	Private School	83	8	9	
Take your child to school	Parent/Caregiver	85	8	6	0.674
	Domestic Worker	85	7	9	
	School Bus/ Walking	85	9	6	
Having problems in school	No Problems	91	5	4	0.000
	One or More Problems	78	11	11	
Academic Performance (2023-2024)	79% or below	75	14	12	0.000
	80% - 89%	85	9	7	
	90% -100%	90	4	6	
Grade Repetition	Yes	64	17	18	0.001
	No	86	7	7	
Difficulty Making Friends	Yes	81	7	12	0.04
	No	86	8	6	
Experienced Bullying or Exclusion by Peers	Yes	65	14	21	0.000
	No	88	7	5	
Engages in Bullying or Exclusion of Others	Yes	58	17	24	0.000
	No	87	7	6	

Table 22 examines several items related to teacher quality and parental involvement in education, assessing their associations with child SDQ levels. Six out of seven teacher quality items are significantly associated with child SDQ levels. The results show that guardians who agree that teachers are well-equipped (p-value = 0.000), use innovative teaching methods (p-value = 0.000), successfully engage their children (p = 0.000), and manage classrooms effectively (p-value = 0.000) are more likely to have children with normal SDQ levels (86%–87%). On the other hand, guardians who disagree with these statements report higher rates of children in the borderline (9%–23%) or abnormal (17%–24%) SDQ categories, indicating a greater likelihood of emotional or behavioral problems. Additionally, guardians who believe that teachers provide a healthy learning environment (p-value = 0.017) and positively impact their children's performance (p-value = 0.002) are more likely to have children with normal SDQ scores (85%–86%). In contrast, children whose guardians disagree with these statements show higher abnormal SDQ rates (14% and 19%, respectively), highlighting the importance of a supportive and effective educational environment for children's mental health.

Regarding parental involvement, three out of six items are significantly associated with the child's SDQ level. The results show that guardians who attend parent-teacher conferences (p = 0.014), receive report cards (p = 0.000), and contact teachers (p = 0.000) are more likely to have children with normal SDQ levels. Specifically, guardians who attend parent-teacher conferences report a higher rate of children in the normal SDQ category (87%) compared to non-attendees (81%), suggesting that such involvement contributes to better mental health outcomes. Moreover, guardians who receive their child's report cards have children with higher normal SDQ levels (87%) and lower abnormal levels (6%), compared to parents who do not receive report cards (20% abnormal). Guardians who know how to contact their child's teachers also have children with higher normal SDQ rates (86%) and lower abnormal rates (6%), compared to those who do not know how to reach teachers (66% normal, 24% abnormal). These results underscore the importance of teacher quality and specific types of parental engagement in supporting children's emotional and behavioral well-being.

Table 22: Chi-Square Analysis of Teachers' Quality And Parental Involvement In Relation to Children's Mental Health

Items			SDQ			
			Normal %	Borderline %	Abnormal %	χ ² P-value
Teachers' quality	I trust that my child's teachers are qualified	Agree	86	8	7	0.078
		Disagree	70	17	14	
	My child's teachers are prepared and well-equipped to teach my child	Agree	86	7	6	0.000
		Disagree	63	13	24	
	My child's teachers use innovative methods when teaching	Agree	86	7	6	0.000
		Disagree	66	17	17	
	My child's teachers are successful in engaging my child	Agree	87	7	6	0.000
		Disagree	57	22	21	
	My child's teachers provide a healthy learning environment	Agree	85	8	7	0.017
		Disagree	69	13	19	
Parental involvement with child education	My child's teachers can manage the classroom	Agree	86	8	7	0.000
		Disagree	69	9	22	
	I notice that the quality of my child's teachers has a positive impact on my child's school performance	Agree	86	7	7	0.002
		Disagree	67	18	14	
	I attend parent-teacher conferences at my child's school	Yes	87	8	6	0.014
		No	81	8	11	
	I receive my child's report cards	Yes	87	8	6	0.000
		No	71	9	20	
	I know how to reach my child's teachers	Yes	86	8	6	0.000
		No	66	10	24	
	My child's teachers and I often communicate about my child's school progress	Yes	86	8	6	0.128
		No	81	9	10	
	I have given my opinion on the school's educational strategy	Yes	85	8	7	0.95
		No	85	8	8	
	I help my child with their homework	Yes	85	8	7	0.876
		No	84	8	8	

Analysis of Parental Discipline Methods Factors on Children's Mental Health

Table 23 shows the association between parental discipline methods and children's SDQ levels. The results indicate a statistically significant relationship between all items and child SDQ levels.

Guardians who agree that hitting is an acceptable form of discipline (p-value = 0.000) and believe it is acceptable to hit a child as long as there is no physical damage (p-value = 0.000) have children with lower rates in the normal SDQ level (76% for both) and higher rates in the borderline (13% and 14%, respectively) and abnormal levels (10% and 11%, respectively), compared to those who disagree (86% and 88% normal, 7% borderline, 7% and 6% abnormal, respectively).

Similarly, guardians who think children do not listen unless hit or believe yelling is necessary for discipline have children with lower normal SDQ rates (71% and 79%, respectively) and higher borderline (18% and 12%, respectively) and abnormal rates (11% and 8%, respectively), compared to those who disagree (86% and 85% normal, 7% and 8% borderline, 7% abnormal for both).

Moreover, guardians who believe they have the right to yell at or hit their children have children with lower normal SDQ rates (76%) and higher rates in the borderline (14%) and abnormal (10%) levels. Parents who agree that hitting is acceptable when a child misbehaves also have children with lower normal SDQ rates (78%) and higher borderline (13%) and abnormal (10%) rates, compared to those who disagree (87% normal, 6% borderline, 6% abnormal).

Across all items, caregivers who support disciplinary methods involving hitting or yelling have a lower proportion of children in the normal SDQ range and a higher proportion in the borderline and abnormal ranges compared to those who do not support such methods. This consistent pattern highlights a significant association between accepting strict or harsh discipline and increased emotional and behavioral difficulties in children.

These findings underscore the importance of promoting positive, non-violent disciplinary approaches to support children's mental health.

Table 23: Association Between Parental Discipline Methods and Children's Mental Health

Items			SDQ			
			Normal %	Borderline %	Abnormal %	χ ² P-value
Discipline Methods	Hitting is a form of discipline	Agree	76	14	10	0.000
		Disagree	86	7	7	
	It is okay to hit as long as there is no damage	Agree	76	13	11	0.000
		Disagree	88	7	6	
	Children do not listen unless they are hit	Agree	71	18	11	0.000
		Disagree	86	7	7	
	Yelling is a necessary form of discipline	Agree	77	14	10	0.001
		Disagree	86	7	7	
	Children do not listen or obey unless I yell	Agree	79	12	8	0.026
		Disagree	85	8	7	
	Parents have the right to yell at or hit their children	Agree	76	14	10	0.000
		Disagree	87	6	6	
	Hitting a child is okay when the child misbehaves	Agree	78	13	10	0.000
		Disagree	87	6	6	

Analysis of Parental Relationship and Financial Factors on Children's Mental Health

Table 24 shows that several aspects of the guardian-child relationship are associated with children's SDQ levels. The results indicate that guardians who frequently talk or chat with their children tend to have children with a high rate of normal SDQ scores (87%) and a low abnormality rate (6%), compared to other levels of interaction. Conversely, guardians who report not talking to their children at all have children with a lower rate of normal SDQ scores (62%) and a higher abnormal rate (20%).

Similarly, guardians who feel proud of their children "all the time" report high rates of normal SDQ scores (87%) and low abnormal rates (6%), whereas among those who do not feel proud, 40% report a borderline SDQ status for their children, and none report abnormal levels. Guardians who enjoy spending time with their children consistently show higher normal SDQ levels (85%) and lower ab-

normal levels (8%), while those who do not enjoy time with their children report the lowest normal SDQ levels (57%) and the highest borderline rate (30%).

Furthermore, parents who report having good relationships with their children tend to have children with higher normal SDQ scores (86%) and lower abnormality rates (7%). In contrast, those who rate their relationships as “not good” report lower normal SDQ scores (62%), higher borderline rates (24%), and increased abnormal rates (14%).

Across all these items, a positive parent-child relationship—characterized by frequent communication, expressed pride, enjoyment of time together, and a strong overall relationship—is strongly associated with better mental health outcomes in children, as reflected in their SDQ scores.

In terms of working parent relationships, three items are significantly associated with child SDQ levels. The results reveal that guardians who are satisfied with their work hours ($p = 0.002$), believe their working hours allow for quality time with their children ($p = 0.032$), and feel that their work does not hinder meeting their children’s needs ($p = 0.019$) are more likely to have children with normal SDQ scores.

Specifically, guardians who feel their work hours are suitable tend to report higher normal SDQ rates for their children (87%) and lower abnormal rates (5%). In contrast, those who find their work hours unsuitable report lower normal rates (79%) and higher abnormal rates (13%). Likewise, guardians who agree that their working hours allow for sufficient quality time with their children report better outcomes (87% normal, 5% abnormal) than those who disagree (79% normal, 10% abnormal). Finally, guardians who believe that time spent on work negatively impacts their ability to meet their children’s needs report lower normal SDQ scores (81%) and higher abnormal scores (9%) compared to those who disagree (88% normal, 5% abnormal).

These findings suggest that satisfaction with work schedules and the ability to spend quality time with children are key factors associated with better mental health outcomes, as reflected by more favorable SDQ scores. disciplinary approaches to support children’s mental health.

Table 24: Chi-Square Analysis of Guardian-Child and Working Parent-Child Relationships in Relation to Children's Mental Health

Items			SDQ			
			Normal %	Borderline %	Abnormal %	χ^2 P-value
Guardians-Child Relationship	I chat/talk with my child	Not true at all	62	18	20	0.001
		True some of the time	75	11	14	
		True a lot of the time	81	11	8	
		True most of the time	87	7	6	
	I am proud of my child	Not true at all	60	40	0	0.000
		True some of the time	63	7	30	
		True a lot of the time	70	17	13	
		True most of the time	87	7	6	
	I enjoy spending time with my child	Not true at all	57	30	13	0.000
		True some of the time	73	6	20	
		True a lot of the time	83	11	5	
		True most of the time	85	8	8	
	I have a good relationship with my child	Not true at all	62	24	14	0.0015
		True some of the time	64	16	20	
		True a lot of the time	79	12	9	
		True most of the time	86	7	7	
Working Parent-Child Relationship	The number of hours I work is suitable for me.	Agree	87	8	5	0.002
		Disagree	79	8	13	
	My working hours allow me to spend sufficient quality time with my child	Agree	87	8	5	0.032
		Disagree	79	11	10	
	I return home from work too late, hindering my ability to fulfill my responsibilities toward my child	Agree	82	9	9	0.078
		Disagree	87	8	5	
	The time I spend in my work domain impacts my ability to attend to my child's needs	Agree	81	10	9	0.019
			88	7	5	

Table 25 shows that all items related to family finances are associated with child SDQ levels. The results indicate that families who cannot pay off their credit card balance in full each month report 71% of children in the normal SDQ range and 16% in the abnormal range, compared to 87% normal and 6% abnormal among families who are able to pay their balance in full.

Similarly, families who find it hard to live comfortably on their current income have children with 71% in the normal range and 17% in the abnormal range, in contrast to 87% normal and 5% abnormal for families who feel financially comfortable.

Additionally, families who feel that managing their finances is stressful report 75% normal and 13% abnormal SDQ rates, while those who do not feel such stress report 86% normal and 6% abnormal.

Finally, families who rely on loans to cover expenses have children with 75% normal and 16% abnormal SDQ rates, compared to 86% normal and 5% abnormal in families who do not rely on loans.

These findings suggest that children from families facing financial difficulties tend to have lower rates in the normal SDQ category and higher rates in the abnormal category, indicating a negative impact of financial strain on children's mental health and well-being.

Table 25: Chi-Square Analysis of Family Finances in Relation to Children's Mental Health

Items			SDQ			
			Normal %	Borderline %	Abnormal %	χ ² P-value
Family Finances	Our family is not able to pay off our credit card balance in full each month	Agree	71	13	16	0.000
		Disagree	87	8	6	
	It is hard for our family to live comfortably on our current income	Agree	71	12	17	0.000
		Disagree	87	8	5	
	Managing our finances puts a strain on our family	Agree	75	11	13	0.000
		Disagree	86	8	6	
	We often take loans to cover our family expenses	Agree	75	10	16	0.000
		Disagree	86	8	5	

Analysis of Internet Use Factors on Children's Mental Health

Table 26 examines the relationship between children's internet use and various developmental well-being factors, assessing their association with SDQ levels. Children who use the internet for 0–240 minutes per day have the highest rates in the normal SDQ category (87%) and the lowest rates in the abnormal category (6%). As internet usage increases beyond 240 minutes, children's SDQ scores shift toward the borderline and abnormal categories. Those using the internet for more than 361 minutes per day have only 75% in the normal category, with higher rates in the borderline (16%) and abnormal (10%) categories.

In terms of internet use and developmental well-being, seven items were significantly associated with the child's SDQ level. The results indicate that children who fully understand online privacy (i.e., what personal information they should and should not share) have a higher rate in the normal SDQ category (85%) compared to those who do not understand online privacy (76%), suggesting that awareness of online security can be linked to improved mental health outcomes.

Furthermore, children who repeatedly watch the same shows or play the same games have a lower normal SDQ rate (79%) and a higher abnormal rate (9%) than those who use a variety of media (90% normal, 4% abnormal). Children who struggle to evaluate the accuracy of online information also show higher borderline (11%) and abnormal (10%) SDQ levels compared to children who can assess information accuracy (7% borderline, 5% abnormal).

Moreover, guardians who believe that internet use positively impacts their child's thinking and future planning report a higher normal SDQ rate (86%) than those who disagree (76%). In addition, children who spend money on apps or games without realizing it have a significantly lower normal SDQ rate (71%) and a higher abnormal rate (12%) compared to those who do not engage in unintended spending (90% normal, 6% abnormal).

Children who use technology to learn new skills have a higher rate in the normal SDQ category (86%) compared to those who do not use technology for skill development (74%), indicating that intentional internet use can support mental health. Finally, screen time that negatively affects sleep patterns is associated with a lower normal SDQ rate (77%) and a higher abnormal rate (12%) compared to screen use that does not impact sleep (92% normal, 2% abnormal).

These results indicate that children's understanding of online security, intentional use of technology to build skills, and moderate screen time contribute to better mental health outcomes, while repeated media use, unintended spending, and screen time that disrupts sleep are associated with increased emotional and behavioral difficulties.

Table 26: Chi-Square Analysis of Internet Use in Relation to Children's Mental Health

Items			SDQ				
			Normal %	Borderline %	Abnormal %	χ2 P-value	
Time spent on the internet			0-120 min	87	7	6	0.028
			121-240 min	87	7	6	
			241-360 min	82	10	8	
			361+ min	75	16	10	
Internet use and developmental well-being	My child benefits a lot from being able to look things up online that they are interested in.	Agree	85	8	7	0.121	
		Disagree	77	12	12		
	My child fully understands what personal information they should and shouldn't share online.	Agree	85	8	6	0.025	
		Disagree	76	11	13		
	My child spends a lot of time re-watching the same TV shows or playing the same games over and over again.	Agree	79	11	9	0.000	
		Disagree	90	5	4		
	My child struggles to determine whether the information they are exposed to online or on social media is true.	Agree	79	11	10	0.001	
		Disagree	89	7	5		
	Technology and being online have been important for my child in thinking and planning for the future.	Agree	86	8	6	0.019	
		Disagree	76	12	11		
	My child spends money in apps or on games without realizing it.	Yes	71	18	12	0.000	
		No	90	5	6		
	Technology and being online have been important for my child in learning new skills.	Yes	86	8	6	0.001	
		No	74	11	16		
	The way my child spends time on their phone, computer, or game console negatively affects their sleep patterns.	Yes	77	12	12	0.000	
		No	92	6	2		

11

Summary, Conclusions And Recommendations

11.1 Summary and Conclusions

This report presents a pioneering study that explores multiple dimensions of child well-being in Qatar, including physical, emotional, social, and cognitive development. It examines the educational environment, healthcare experiences, and the family's social and economic stability. Indeed, this report provides a holistic view of the concept of child well-being in Qatar.

Regarding child well-being and health, both physical and mental aspects were assessed using a combination of internationally recognized physical health indicators and two validated instruments for mental health. The results indicate that, overall, the physical and mental health of the sample is generally good.

Findings related to education were largely positive. Parents' perspectives on their children's teachers, schools, and school social life were mostly reassuring. Notably promising was the growing interest in early childhood education and development, as parents overwhelmingly expressed their belief in engaging children in educational activities from infancy and as early as possible. However, parents also reported low involvement with their children's schools—a trend that should be reversed through the right policies and engagement strategies.

Extracurricular activities remain underutilized. Global studies have shown a strong positive correlation between leisure-based activities and a child's emotional and physical well-being. Therefore, we recommend increasing student participation in such activities and offering options that align with family lifestyles and are accessible within their local communities.

The report also addressed key concerns such as child neglect, abuse, and public awareness of these issues and the centers dedicated to addressing them. Investigating these challenges can help policymakers identify gaps and develop social protection systems to safeguard vulnerable children.

The study also revealed that, in general, families are stable. A majority of parents expressed satisfaction with their partner's participation in raising their children. Furthermore, Qatari parents reported strong communication, pride, enjoyment, and positive relationships with their children—indicating a stable and supportive foundation.

As highlighted in the report, the majority of respondents (81%) stated that their child has access to the internet. This is expected, given the essential role of technology and the internet in today's information society. The findings reflect both positive and negative parental perceptions. On the positive side, parents noted

that their children's happiness is enhanced by exploring interests and hobbies online. They also acknowledged that online platforms help strengthen their children's friendships and relationships. On the negative side, 49% of respondents reported that excessive online presence negatively affects their child's sleep patterns, and others expressed concern about the harmful impact of social media on their child's self-image.

11.2 Recommendations

The recommendations based on the findings of this study are as follows:

- This report emphasizes the importance of creating policies and systems that prioritize the best interests of children.
- It is recommended to implement early mental health screenings and interventions, particularly focusing on peer relationship support and behavioral issues, to prevent further psychological difficulties in children.
- The KIDSCREEN-10 scores show significant differences based on guardian characteristics. For example, children of guardians with higher education levels (bachelor's degree or above) or employment report better perceived quality of life scores. Child gender also plays a role, with boys showing slightly higher scores than girls.
- Given the importance of early childhood education and development, there should be programs and policies that provide guidance and resources for parents of infants. Examples include TV shows featuring patterns, colors, and shapes, children's stories in Arabic, coloring books that aid motor skill development, and outdoor activities. It is therefore essential to invest in the early childhood workforce involved in children's formative years.
- Parental involvement in schools showed the lowest level of agreement within the education section of the report, highlighting a need to better integrate parents into the school community. This can be achieved through social media engagement or by creating initiatives that encourage parents to volunteer at schools.
- The majority of surveyed parents expressed low interest in involving their children in extracurricular activities. As this report shows a positive link between leisure-based activities and children's well-being, it is recommended to offer more extracurricular options tailored to cultural and societal norms. Schools should also encourage participation, perhaps by offering academic credits or incentives for engagement.

- Since neglect was identified by respondents as a concerning issue, state-activated intervention programs are needed to raise awareness among parents about the negative consequences of neglect on child well-being.
- While the State of Qatar upholds children’s rights, the government—through its programs and institutions such as AMAN—should implement a clearer legal framework that defines children’s rights, specifies the types of incidents that should be reported to authorities, and outlines the jurisdiction of those authorities to ensure the protection of children’s rights.
- Support Qatari families in adopting family-friendly policies such as parental leave, flexible work schedules, and financial assistance to help parents provide stable environments for their children.
- It is important to note that this report provides significant indicators of child well-being in Qatar. These indicators should be monitored regularly to track changes over time, guide policymaking, and support continuous improvement.
- As the internet becomes increasingly integrated into modern life, it is essential that public policy keeps pace. There is no longer an “average” internet user—children of all ages now have access. Therefore, regulations must be established to protect children’s data, privacy, and online presence, including strict penalties for nonconsensual data sharing involving minors.
- More efforts should be made to address the impact of social media images on children’s mental health. This is not a call for censorship, but rather an appeal to raise awareness about the difference between online portrayals and reality.

11.3. Policy Recommendations Based on the Research Findings and Aligned with QNDS3 (2024–2030)

One of the central aims of this research study is to support the implementation of national priorities related to child well-being, as outlined in Qatar’s National Development Strategies. By translating research findings into actionable policy guidance, the study seeks to contribute meaningfully to national efforts to enhance the quality of life for children and families across the country.

The policy recommendations presented in this report are closely aligned with the overarching goals of Qatar National Vision 2030, particularly its pillars of social development and human capital investment. More specifically, they support the implementation of Qatar’s Third National Development Strategy (QNDS3, 2024–2030). These recommendations reinforce the State of Qatar’s commitment to sustainable human development, inclusive growth, and social cohesion through the advancement of child- and family-centered policy frameworks.

11.4. Policy Recommendations

1. Develop a comprehensive, standalone Child Rights Law that prioritizes the best interests of the child, in alignment with the principles of the Convention on the Rights of the Child (CRC), which Qatar has ratified. This law should strengthen the national legal framework on child well-being and require all relevant institutions—including schools, healthcare providers, and the judiciary—to consistently apply the principle of the child’s best interest in all decisions and actions that affect children.

2. Integrate Early Mental Health Screening and Support into Education and Health Systems to strengthen the strategic framework pertaining to children’s mental health and institutionalize early mental health assessments in primary healthcare and schools, with referral pathways for peer support and behavioral concerns through the following:

2.1. Enact a standalone national strategy on child and adolescent mental health⁶ under the Ministry of Public Health (MoPH) and the Ministry of Education and Higher Education (MoEHE), mandating early detection, prevention, and intervention for child mental health.

2.2. Integrate mental health screening into school and health systems as a mandatory part of routine child health assessments. This includes:

(1) developing a standardized, culturally adapted tool (e.g., SDQ or Arabic KIDSCREEN) to be used during

- (a) annual school check-ups,
- (b) pediatric visits, and
- (c) school entry assessments.

(2) establish certification and continuing education modules on early identification of emotional, behavioral, and social disorders, with mandatory training for:

⁶ At present, Qatar does not have a standalone national policy that focuses exclusively on the mental health of children and adolescents. Instead, mental health concerns for these age groups are incorporated within broader national strategies. The Qatar National Mental Health Strategy (2013–2018), followed by the National Mental Health and Wellbeing Strategic Framework (2019–2022), include components related to youth mental health, aiming to integrate services across all age groups and relevant sectors. Specialized care is available through programs such as the Child and Adolescent Mental Health Services (CAMHS) under Hamad Medical Corporation, which provides comprehensive, multidisciplinary support for individuals under 18. In addition, digital innovations like the TASMU Adolescent Mental Health app have been introduced to facilitate early identification and intervention. Despite these advancements, professionals continue to emphasize the importance of developing a dedicated national policy that specifically addresses the mental health needs of children and adolescents. Such a policy would help establish a unified and specialized approach to care, ensuring that this population receives consistent, age-appropriate support nationwide.

- (a) school counselors,
- (b) social workers,
- (c) primary healthcare staff, and
- (d) teachers to support early detection and referral.

2.3. Enhance awareness and destigmatization efforts through a national campaign targeting parents, teachers, and children, building on Qatar's existing observance of World Mental Health Day, which takes place on 10 October. The national campaign should aim to:

- (a) raise awareness of the importance of mental health,
- (b) reduce the stigma around seeking support, and
- (c) promote positive coping strategies across all age groups.

3. Reduce Well-being Disparities by Socioeconomic Status and Gender

Implement targeted family support programs for children from lower-educated or unemployed households and promote gender-sensitive interventions to close well-being gaps and enhance equitable access to quality services.

Specific policy measures are:

3.1. Provide Conditional Cash Transfer (CCT) Programs for low-income or unemployed families to incentivize (a) school attendance; (b) health check-ups; and (c) participation in parenting or skill-building sessions. This program can be administered via the Ministry of Social Development and Family (MSDF) and integrated with family support services.

3.2. Establish a National Positive Parenting Support Program and include a national parenting curriculum tailored to the needs of lower-educated guardians, with topics such as (a) emotional support and communication; (b) gender-equitable child rearing; and (c) health and nutrition basics. Some components of this program can be delivered through schools, health clinics, or online platforms.

3.3. Develop protection screening tools in schools to detect and flag at-risk children for targeted academic and psychosocial support.

3.4. Launch Gender-Responsive School Programs with life skills for girls to (a) boost self-esteem, leadership, and STEM participation; and (b) address cultural or psychological barriers to well-being. This policy measure should be accompanied by gender-sensitivity training for teachers and school

counselors to recognize and address gender-based disparities.

3.5. Offer scholarships, learning grants, or performance incentives for students from families with low parental education or job insecurity, and encourage private sector support through public-private partnership (PPP) models.

4. Strengthen and scale up ECD programs with Arabic content, cognitive development tools, and trained early childhood educators in Qatar, specifically:

4.1. Develop a standalone multisectoral national Early Childhood Development Framework (0–5 years) under the leadership of the Ministry of Education and Higher Education (MoEHE), in coordination with the Ministry of Public Health (MoPH) and the Ministry of Social Development and Family (MSDF). Support implementation of the strategy by developing a National Action Plan on ECD with clear goals, service standards, developmental milestones, and indicators across health, nutrition, learning, parental support, timeframe, and allocated resources.

4.2. Commission the development and dissemination of Arabic-language learning materials tailored to the Qatari context to expand the production and utilization of (a) educational TV programs and mobile apps focused on colors, numbers, language, and basic science; and (b) interactive books, stories, rhymes, and games that reflect local culture and values. Partner with Qatar Media Corporation and DIFI for culturally resonant media content.

4.3. Establish nation-wide access to public pre-kindergarten programs through (a) provision of free or subsidized pre-kindergarten services (ages 3–5) nationwide, prioritizing poor and low-income families; and (b) create incentive schemes for private providers offering affordable, high-quality Arabic-language preschool education in partnership with the government.

4.5. Enhance public awareness on early learning with specific reference to the promotion of the Arabic language and implement a national campaign (e.g., “The First Five Matter”) to (a) educate parents and caregivers about brain development and the importance of early stimulation; (b) promote Arabic-language resources; and (c) encourage fathers’ involvement in early education. Utilize mosques, community centers, and digital platforms to reach broad audiences.

5. Enhance Parental Engagement in Schools through Structured Policies and Digital Tools

To strengthen parent-school collaboration in Qatar, the government can introduce a national framework that formalizes family engagement across education levels. Specific policy measures are:

5.1. Develop a National Parent-School Partnership Policy and enact a mandatory national framework under the Ministry of Education and Higher Education (MoEHE) requiring all schools (public and private) to (a) establish annual parent engagement plans; (b) allocate time and staff resources for parent outreach; and (c) create school-parent committees or advisory councils.

5.2. Enhance Parents' Volunteer Initiatives in Schools and strengthen schools' efforts to offer structured volunteer opportunities for parents such as (a) assisting in classroom activities, school events, and trips; (b) leading reading programs or extracurricular clubs; and (c) supporting cultural celebrations and heritage projects. Recognize participation through certificates, school acknowledgments, or digital badges to incentivize participation.

5.3. Integrate family engagement strategies into teacher training programs and professional development. Specifically train school leaders on (a) inclusive communication practices; (b) conflict resolution with families; and (c) empowering parents from diverse socio-economic and linguistic backgrounds.

5.5. Include parental engagement indicators in school evaluations and make parental involvement a performance criterion in national school quality assessments. Monitor metrics such as (a) parent meeting attendance; (b) volunteer hours; and (c) engagement with digital platforms.

5.6. Launch an Annual National Parent-School Partnership Week as a nationwide campaign to celebrate and raise awareness about the role of families in education. Encourage schools to host workshops, open houses, and parent-led sessions during this week.

5.7. Offer incentives for high-family engagement schools through (a) recognition programs or grants for schools demonstrating exemplary family engagement (b) Publish annual case studies of best practices to encourage peer learning.

6. Expand Culturally Appropriate Extracurricular Activities and Incentives

6.1. Mandate the integration of extracurricular activities into student evaluation and require schools to allocate a percentage of final grades or competencies to participation in extracurricular activities. Recognize achievements through (1) certificates and badges; (2) university admission portfolios; and (3) merit-based awards tied to excellence in civic or cultural engagement.

6.2. Develop and launch a National Digital Platform for Extracurricular Program Tracking to (1) register student participation; (2) track hours and skills developed; and (3) issue digital certificates. Integrate the platform with the National Student Information System (NSIS) and higher education applications.

6.3. Issue regulations requiring school transportation services (e.g., buses) to align with the schedules of students participating in extracurricular activities to support working parents who are unable to transport their children after such programs.

6.4. Provide financial incentives and funding mechanisms through (1) annual grants or performance-based funding to schools and organizations with high extracurricular participation and innovation; (2) stipends or subsidies for families with limited means to enroll their children in fee-based programs; and (3) encouragement of corporate sponsorships of school clubs (e.g., sports gear, science fair support) through targeted incentives or formal recognition under corporate social responsibility (CSR) initiatives.

6.5. Embed extracurricular learning into career and life skills development through (1) alignment of extracurricular themes with national skill priorities (e.g., STEM, leadership, community service) to prepare youth for employment and civic participation; and (2) partnership with the Ministry of Labor and institutions like Qatar Foundation to integrate real-world skills.

7. Undertake State-Led Prevention and Intervention Policy Measures on Child Neglect

7.1. Develop a National Child Neglect Prevention Strategy as an integrated component of the child protection system, outlining a coordinated, multi-sectoral approach to identify, prevent, and respond to all forms of neglect. The strategy should include clear definitions, risk indicators, public

awareness mechanisms, early intervention services, and referral protocols embedded across health, education, and social service sectors to ensure early detection and family-centered support, in alignment with national child welfare priorities.

7.2. Launch a nationwide awareness campaign on child neglect and create a culturally sensitive, multi-platform initiative titled “Neglect is Harm Too,” utilizing various mediums such as (1) television, radio, and social media in Arabic and English; (2) short videos, infographics, and testimonials; and (3) mosque sermons and community center workshops. The campaign should focus on types of neglect, signs of harm, and positive parenting practices.

7.3. Integrate neglect education into parenting and family initiatives in Qatar and embed child neglect awareness modules in (1) antenatal and postnatal care visits; (2) kindergarten orientation sessions; and (3) premarital education programs and family counseling programs (like those implemented by WIFAQ). Collaborate with health centers, AMAN, WIFAQ, and Qatar Foundation (e.g., DIFI) for curriculum development.

7.4. Develop a risk-based early intervention system through (1) equipping primary schools, nurseries, and primary healthcare providers with screening tools to flag early signs of neglect (e.g., chronic absenteeism, hygiene issues, malnutrition); (2) creating a referral mechanism to relevant authorities (e.g., CPU, SIDRA, AMAN, relevant departments of MDAF) when early risks are identified; and (3) training frontline service providers on neglect identification—particularly teachers, nurses, pediatricians, social workers, and early childhood educators. Focus on detecting subtle forms of neglect and understanding family stressors that may lead to it.

7.5. Establish Mobile Family Outreach Teams as part of the child protection system and deploy multidisciplinary mobile teams (social worker, nurse, and child development specialist) to visit at-risk homes and deliver (1) on-the-ground parental guidance; (2) child development assessments; and (3) referrals to support services (housing, income support, mental health).

7.6. Create a confidential 24/7 neglect helpline linked to existing help-lines (e.g., 919 of AMAN) supported by a digital resource hub featuring (1) self-assessment tools for parents; (2) video tutorials on childcare; and (3) guidance documents and community service maps.

8. Strengthen Legal Frameworks for Child Protection and Reporting Mechanisms Enhance the legal framework for child protection to define reportable offenses, empower authorities like CPU, AMAN, WIFAQ, and streamline inter-agency response protocols for child protection cases. Specific policy measures include:

8.1. Develop a National Child Protection System Framework: Design a comprehensive national child protection framework aligned with the principles of the UN Convention on the Rights of the Child that Qatar has agreed upon. The framework should articulate a clear vision, goals, and guiding principles, such as the best interests of the child and child participation, and outline key components including prevention, reporting, investigation, intervention, and rehabilitation.

8.2. Establish a Child Protection Monitoring Unit: Set up a national monitoring unit to track child protection case data and response times, evaluate service delivery and inter-agency coordination, and publish annual reports assessing system performance and identifying areas for reform.

8.3. Enact a Comprehensive Child Protection Law: Develop legislation that clearly defines reportable offenses (e.g., physical, emotional, and sexual abuse, neglect, exploitation, witnessing violence, and online harm), mandates reporting obligations for professionals, authorizes child protection officers to intervene, and sets procedures for emergency removal and protective custody.

8.4. Develop a Unified National Reporting and Referral Protocol: Standardize child protection case reporting and referral processes through inter-agency SOPs. Designate child protection focal points in schools (MoEHE), health centers (MoPH), and community centers (MSDF), and coordinate efforts through a centralized registry managed by AMAN or MSDF.

8.5. Establish an Inter-Ministerial Child Protection Task Force: Create a Child Protection Coordination Council comprising key stakeholders (MoEHE, MoPH, MoI, MSDF, judiciary, and AMAN) to oversee framework implementation, monitor compliance, and provide strategic guidance on policy and systemic challenges.

8.6. Train Professionals on Mandatory Reporting and Legal Procedures: Implement mandatory training for frontline professionals including educators, healthcare workers, social workers, and religious leaders focused on identifying abuse, understanding legal responsibilities, and using referral tools and documentation effectively.

8.7. Launch Public Awareness Campaigns on Child Rights and Reporting:

Conduct national awareness campaigns to educate the public on types of child abuse, legal protections, and reporting mechanisms. Use diverse platforms including media, mosques, schools, and digital tools such as a child safety app developed by AMAN.

These policy actions align with QNDS3 Strategic Outcomes 2 and 4 by reinforcing Qatar's commitment to protecting children from abuse, neglect, and exploitation. A comprehensive child protection system enhances timely support for vulnerable children while promoting family stability and social cohesion.

9. Promote Family-Friendly Workplace Policies

Institutionalize family-friendly workplace policies in Qatar, aligned with ILO standards, the UN Convention on the Rights of the Child, and OECD best practices⁷, to support QNDS3 outcomes, particularly SNO 4 (Cohesive Society), SNO 2 (Social Protection for All), and SNO 1 (Thriving Workforce and Competitive Economy). **Specific policy measures include:**

9.1. Review Parental Leave: (1) Amend the Labor Law of the State of Qatar to extend paid maternity leave for both private and public sectors to at least 14 weeks in line with ILO Convention No. 183 (currently it is 50 days in Qatar which equates to approximately 7 weeks and 1 day); (2) Introduce Paid Paternity Leave and offer at least 10–14 working days of paid leave for working fathers, encouraging shared responsibility in early childcare, with optional extensions based on employer policy or collective agreements.

9.2. Enhance policies of flexible work options for working parents, notably (1) part-time work; (2) compressed workweeks; (3) remote or hybrid work models; and (4) staggered hours for parents of children under 12⁸. Encourage public institutions and large employers to adopt these models and report on uptake.

⁷ International benchmark of best practices demonstrates a variety of approaches that aim to balance work and family responsibilities while enhancing child well-being. In Sweden, families are entitled to a total of 480 days of paid parental leave, which can be shared between both parents. Germany supports parents through a combination of maternity, paternity, and extended parental leave, along with flexible part-time work arrangements. In Singapore, public sector workplaces are required to offer on-site childcare, and employees benefit from designated infant care leave. Japan grants parents of young children the legal right to request shorter working hours to accommodate caregiving needs. On a global level, the International Labor Organization (ILO), through Convention No. 183, recommends that women receive no less than 14 weeks of maternity leave, accompanied by job protection and access to essential health services.

⁸ Implementing a staggered hours policy offers valuable flexibility for working parents, allowing them to adjust their schedules to meet family needs particularly when it comes to transporting their children to and from school. This approach not only supports parental involvement in daily educational routines but also aligns with DIFI's research, which underscores the importance of parental participation in school commuting as a key aspect of child well-being, family cohesion and parents' engagement.

9.3. Introduce a policy requiring on-site or subsidized childcare services in workplaces with over 50 employees.

9.4. Provide private, hygienic breastfeeding and infant care facilities in the workplace in both government and private sector premises.

10. Develop a National Child Well-Being Index and Indicator Framework for Qatar across domains such as health and nutrition; education and learning outcomes; safety and protection; family environment and relationships; subjective well-being and mental health; and access to leisure, play, and digital safety. Align the indicators with global models (e.g., UNICEF's Multiple Overlapping Deprivation Analysis, OECD's How's Life for Children?) and adapt them to Qatari cultural, social, and economic contexts.

11. Enhance the Safety and Well-Being of Children When Using the Internet

11.1. Strengthen Qatar's Personal Data Privacy Protection Law (PDPPL), enacted under Law No. 13 of 2016, which includes provisions aimed at safeguarding children's personal data by mandating child-centric design in digital services such as adoption of "privacy by design" and "safety by design" principles in products used by or marketed to children. Enforce features like: (a) default privacy settings for children's accounts; (b) no public-by-default profiles; (c) age-appropriate user interfaces and language; and (d) easy-to-use reporting tools and content filters.

11.2. Create a Government-Accredited "Safe for Children" Digital Label and launch a national certification system for digital platforms, websites, and applications that meet child safety and data protection standards. Display the "Child Safe Qatar" label as a public assurance of compliance with safety regulations.

11.3. Mandate professional development programs on digital psychology, screen-time management, and adolescent mental health for (a) teachers, counselors, and ICT coordinators; and (b) youth mentors and activity supervisors. Equip them to identify signs of digital dependency or cyberbullying and provide early guidance or referral.

11.4. Embed "Digital Education and Literacy" in the Positive Parenting Program in Qatar and create a parent-focused digital parenting toolkit in Arabic and English, with (a) practical tips on supervising social media use; (b) tools for managing screen time and content filters; and (c) guidance on modeling positive online behavior and communication.

12. Undertake Further Research on Child Well-being in Qatar Support the training of researchers, analysts, and policy professionals in child well-being research, measurement, and evaluation, in partnership with DIFI (a Qatar Foundation entity), Qatar University, Hamad Bin Khalifa University, and international institutions to enhance local expertise and innovation.

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REFERENCES

Banu, A. R., & Duraipandian, K. (2014). *Development of an instrument to measure work-life balance of IT professionals in Chennai*.

Blum-Ross, A., & Livingstone, S. (2016). *Families and screen time: Current advice and emerging research*. The London School of Economics and Political Science, Department of Media and Communications.

Canel, A. N. (2013). The development of the marital satisfaction scale (MSS). *Educational Sciences: Theory and Practice*, 13(1), 97–117. <https://eric.ed.gov/?id=EJ1016640>

Dunckley, V. L. (2015). *Reset your child's brain: A four-week plan to end meltdowns, raise grades, and boost social skills by reversing the effects of electronic screen-time*. New World Library.

Ezer, T. (2004). A positive right to protection for children. *Yale Human Rights and Development Law Journal*, 7, 1.

Furnham, A. (1998). *The psychology of money*. Routledge.

Furnham, A. (2001). Parental attitudes to pocket money/allowances for children. *Journal of Economic Psychology*, 22(3), 397–422.

Furnham, A., & Okamura, R. (1999). Your money or your life: Behavioral and emotional predictors of money pathology. *Human Relations*, 52(9), 1157–1177.

Garvis, S., Phillipson, S., & Harju-Luukkainen, H. (Eds.). (2018). *International perspectives on early childhood education and care: Early childhood education in the 21st century (Vol. 1)* (1st ed.). Routledge. <https://doi.org/10.4324/9780203730553>

Goodman, R. (1997). The Strengths and Difficulties Questionnaire: A research note. *Journal of Child Psychology and Psychiatry*, 38(5), 581–586. <https://doi.org/10.1111/j.1469-7610.1997.tb01545.x>

Goodnow, J. J. (1996). From household practices to parents' ideas about work and interpersonal relationships. In S. Harkness & C. M. Super (Eds.), *Parents' cultural belief systems: Their origins, expressions, and consequences* (pp. 313–344). The Guilford Press.

Grusec, J. E., & Goodnow, J. J. (1994). Impact of parental discipline methods on the child's internalization of values: A reconceptualization of current points of view. *Developmental Psychology*, 30(1), 4–19.

Hale, L., & Guan, S. (2015). Screen time and sleep among school-aged children and adolescents: A systematic literature review. *Sleep Medicine Reviews*, 21, 50–58.

Jellinek, M. S., Murphy, J. M., Robinson, J., Feins, A., Lamb, S., & Fenton, T. (1988). Pediatric Symptom Checklist: Screening school-age children for psychosocial dysfunction. *The Journal of Pediatrics*, 112(2), 201–209. [https://doi.org/10.1016/S0022-3476\(88\)80056-8](https://doi.org/10.1016/S0022-3476(88)80056-8)

Lau, S. (1998). Money: What it means to children and adults. *Social Behavior and Personality: An International Journal*, 26(3), 297–306.

Lewis, A., & Scott, A. J. (2000). The economic awareness, knowledge and pocket money practices of a sample of UK adolescents: A study of economic socialisation and economic psychology. *Citizenship, Social and Economics Education*, 4(1), 34–46.

Ministry of Foreign Affairs of Qatar. (2024, March 25). دولة قطر تؤكد اهتمامها لتعزيز وحماية حقوق الطفل [State of Qatar affirms its commitment to enhancing and protecting children's rights]. <https://mofa.gov.qa/>

National Academies of Sciences, Engineering, and Medicine. (2015). *Mental disorders and disabilities among low-income children*. The National Academies Press.

Pleck, J. H. (2010). Paternal involvement. In M. E. Lamb (Ed.), *The role of the father in child development* (5th ed., pp. 58–93). Wiley.

Powell, M. A., Graham, A., Fitzgerald, R., Thomas, N., & White, N. E. (2018). Well-being in schools: What do students tell us? *Australian Educational Researcher*, 45(4), 515–531. <https://doi.org/10.1007/s13384-018-0273-z>

Puccioni, J. (2015). Parents' conceptions of school readiness, transition practices, and children's academic achievement trajectories. *The Journal of Educational Research*, 108(2), 130–147. <http://www.jstor.org/stable/43824186>

Sanders, M. R., Morawska, A., Haslam, D. M., Filus, A., & Fletcher, R. (2014). Parenting and Family Adjustment Scales (PAFAS): Validation of a brief parent-report measure for use in assessment of parenting skills and family relationships. *Child Psychiatry & Human Development*, 45, 255–272. <https://doi.org/10.1007/s10578-013-0397-3>

Strauss, A. L. (1952). The development and transformation of monetary meanings in the child. *American Sociological Review*, 17(3), 275–286.

The KIDSCREEN Group Europe. (2006). *The KIDSCREEN questionnaires: Quality of life questionnaires for children and adolescents*. Pabst Science Publishers.

U.S. Department of Commerce. (2022). *National Survey of Children's Health Methodology Report*. US Census Bureau. <https://www.census.gov/data.html>

Wahab, A. A., Bener, A., Sandridge, A. L., & Hoffmann, G. F. (2006). The pattern of Down syndrome among children in Qatar: A population-based study. *Birth Defects Research Part A: Clinical and Molecular Teratology*, 76(8), 609–612. <https://doi.org/10.1002/bdra.20290>

Wilson, S. R., & Whipple, E. E. (2013). Communication, discipline, and physical child abuse. In A. L. Vangelisti (Ed.), *Parents, children, and communication* (pp. 299–317). Routledge.



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