



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

Summary Report for Lebanon, oPt, and Yemen

Nathalie Bavitch, MPH

October, 2010



This publication is funded
by the European Union

“This publication has been produced with the assistance of the European Union. The contents of this publication are the sole responsibility of Save the Children Sweden and can in no way be taken to reflect the view of the European Union.”

TABLE OF CONTENTS

Acknowledgement	3
Acronyms	4
Introduction	5
Methodology	8
Limitations	14
Results – Discussion - Recommendations	16
A) General Characteristics	16
B) Education	22
C) Personal Hygiene	26
D) Changes during puberty	29
E) STIs, HIV and AIDS	37
F) SRH seeking behavior and services utilization	47
G) Engagement, marriage, and childbirth	55
H) Violence	62
General Recommendations	79
 Appendix I: SCS KAP indicators	 81
Appendix II: Lebanon and oPt Questionnaires – English versions	82
Appendix III: Lebanon and oPt Questionnaires – Arabic versions	82

ACKNOWLEDGEMENT

The author would like to thank all who supported and participated in this survey, especially:

The children, parents, and service providers that participated in the interviews;

The teams involved in carrying out the two baseline surveys in Yemen;

The volunteers/ data collectors:

In Lebanon: Al Aaraj Rana, Baayno Ramona, Bader Robert, Doumit Myriam, Ghanem Diana, Khalife Carla, Khatonian Chiara, Mahfouz Joelle, Makdissi Lorette, Najem Lara, Nassif Darine, Nasif Elie, Skaiff Cathy, Tannous Marguerita,

In oPt: Ajouri Manal, Akhdar Suhaib, Alawi Ahmad, Alawi Amjad, Al Zaghary Sahar, Ameen Tareq, Ansari Mirna, Awad Ala', Azzeh Afaf, Daghameen Rukaya, Emad Rawia, Farouki Haitham, Jabir Abir, Jhajha Fatma, Jouher Iman, Kastiro Do'a, Khalil Suad, Khatib Omar, Massad Ekhlal, Mousa Khoulood, Mustafa Rabab, Rabah Laila, Salem Rabab, Sweiti Yousra, Zaatara Fadi,
for their motivation and their hard work in the field;

The Kafa (enough) Violence and Exploitation team in Lebanon, and the Juzoor Foundation for Health and Social Development team in Palestine, for providing assistance in the preparations and field coordination of the survey;

The partner Lebanese NGOs - Afel, Baytouna, Libami, and the Social Development Center - and the UNRWA office in oPt, for providing access to the populations and facilitating data collection;

The Save the Children Sweden team, for providing support in all aspects of the survey;

Ms Asma Tabbarah for her support in data entry;

Mr Georges Nahhas for his support in data entry and database management.

AUTHOR

Nathalie Bavitch

Page 3

Nathalie Bavitch, MPH

Professional Researcher / Consultant in Health Behavior and Education.

SUBMITTED TO

Save the Children Sweden Regional Office for Middle East and North Africa

ACRONYMS

CPP – Child Protection Policy

DHS – Demographic and Health Survey

FGD – Focus Group Discussion

FGM – Female Genital Mutilation

GSHS – Global School based Student Health Survey

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

ICPD – International Conference on Population and Development

IEC – Information, Education, Communication

KAP – Knowledge, Attitudes and Practices

MDG – Millennium Development Goal

MENA – Middle East and North Africa

MoSA – Ministry of Social Affairs

NGO – Non-Governmental Organization

oPt – Occupied Palestinian Territory

SCS – Save the Children Sweden

SPSS – Statistical Package for Social Sciences

SRH – Sexual and Reproductive Health

STIs – Sexually Transmitted Infections

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

WHO – World Health Organization

INTRODUCTION

Background

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

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

Child marriage defined as a marriage involving a child under the age of 18 – is widely acknowledged as a form of gender-based violence due to the physical and psychological harm it bears on a child. Not only does child marriage oblige girls to have regular sexual relations prior to the age of 18, it puts them at increased risk of health complications related to childbirth and exposes them to heightened protection threats associated with domestic violence and divorce. In Yemen, there is a comparatively high rate of child marriage: 52.1 percent¹ in rural areas where 32.3 percent of child marriages involve girls between the ages of 10-14.² In Palestine, the most recent national demographic and health survey (DHS) carried out in 2004 reported that 50% of Palestinian women get married during childhood at or before the age of 18. Early marriage is an existing phenomenon also in Lebanon where family status laws allow for early marriage (as young as 9, in the case of the Shi’a) and, in some cases, allow parents to waive child consent provisions.

Sexual abuse although a much more hidden phenomena, more and more evidence is starting to appear from children themselves. In oPt research³ showed that out of 365 abused children, assisted by the MoSA in the year of 2004, 18 were sexually abused and 182 emotionally abused. The results of the study also suggested a relationship between violence against children

¹ Oxfam et al (2005) Early Marriage in Yemen. Research to Inform a Campaign on Early Marriage, Oxfam, Shima (network on violence against women), Women’s National Committee, Women’s Studies Development Center, University of Sana’a, Sana’a, Republic of Yemen.

² SOUL (2004) Child Rearing Practices Study. In Districts of Ul Udayn and Zaydiua, Society for the Development of Women and Children with UNICEF. Sana’a, Republic of Yemen.

³ Musleh and Taylor (2005)

and poor socioeconomic status of the family, whereby in Palestine the percentage of Palestinian living under the poverty line is alarmingly increasing. In Lebanon, a SCS study by the partner organization KAFA was found that 16.1% of respondents (N=165) experienced at least one form of sexual abuse (as defined by KAFA): 12.5% experienced sexual acts, 8.7% were subjected to attempted sexual acts, and 4.9% were exposed to sexual photographs or movies.⁴ The average age of victims was 10.3 years. Furthermore, fifty-five per cent of incidents of sexual abuse occurred at the home, 27% at the school, 5.5% at a neighbor's house and 5.1% in a relative's house. The 2006 study by SCS in Yemen showed that 20% of health workers in basic health services in the Lahej governorate had observed the symptoms of sexual abuse among children⁵. The study also showed that health workers were unable to appropriately respond to these children as they all reported that they had responded by the treatment of the symptoms, and were unable to refer due to the absence of a referral system. Sexual abuse is influenced by a range of factors including illiteracy and gender gaps; Yemen ranks for the second year in a row on the last place in the Global Gender Gap Report, has low levels of female youth literacy (36 literate young women per 100 young men) and a high incidence of youth motherhood (recent increase of 2% to 17%)⁶.

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

Regarding **FGM**, most of the types as identified by the World Health Organization occur in Yemen, especially in the coastal areas, such as in the proposed impact area of Lahej⁷. Country wide FGM is prevalent among 26% of the women and 20% of the daughters⁸. However in the coastal areas prevalence is much higher and a recent study by SCS⁹ in Lahej and Aden shows that more than 80% of school aged girls reported to have been circumcised and that despite recent activities to reduce the occurrence of FGM it is still widely supported. A Ministry of Health Decree in 2001 banned the practice of FGM by all public and private health personnel. The same study also showed that a majority of health workers had observed complications of FGM, both immediate complications and long term complications.

About the project

⁴ Kafa (March 2008) "Child Sexual Abuse: The Lebanese Situation." (Draft)

⁵ Save the Children (2008). Knowledge Attitudes and Practices Survey among Youth in Basatin and Kharaz Refugee Camp (unpublished)

⁶ Yemen Youth Assessment Final Report (2008). Equip3. USAID mission, Cairo, Egypt.

⁷ Soheir Stolba, A Clinical-Based Research Study of FGM/C in Selected Areas of Yemen, December 2000, Pacific Institute for Women's Health and International Health and Development Associates.

⁸ UNCEF(2005). At a glance Yemen. Statistics. www.unicef.org/statistics/yemen. Accessed October 13th, 2008.

⁹ Save the Children (2008). Ibid.

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

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

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

Purpose of the baseline survey

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

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

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

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

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

1. Develop/adapt information and education materials as well as capacity building programs addressing children, adolescents, parents, and service providers, based on country specific needs;
2. Use the collected evidence to develop the advocacy plan of civil society organizations, SCS and partners for national and regional advocacy;
3. Measure the impact of the project by the end of the action through the establishment of a baseline of the specific indicators.

This report describes the findings of the three surveys conducted among children, their parents, and service providers:

- **In Yemen:** in Aden, Abyan, and Lahej, among the returnees/refugees, and the Yemeni population;
- **In Lebanon:** in the impact area of Bourj Hammoud / Sin El Fil;
- **In oPt:** in the 5 impact areas of Al-Arroub, Aqabet Jaber, Ayda & Azzah, Ein El-Sultan, and Dura.

METHODOLOGY

Yemen Baseline Surveys

The two baseline surveys involved several data collection tools: Knowledge-Attitudes-Practices (KAP) questionnaires for youth, parents and services providers, and two observation checklists for services providers: one for health workers and one for teachers.

Survey teams were recruited for each location, and included refugees and Ministry of Education staff. SC staff acted as team supervisors. The survey team received training on survey objectives, review of the KAP questionnaires and other tools, sampling, confidentiality, informed consent, and interviewing techniques. The questionnaires were piloted and finalized.

Data collection required around 2 to 3 weeks for each survey. The survey among refugees/returnees was implemented in 2007, while the survey among the Yemenis was implemented in November 2008.

Sampling used a 30 cluster approach for both household surveys, while random sampling was used for the service providers. Clusters were identified randomly from the population lists developed from CSO data and key informants. The teams then went to the selected clusters, identified the mosque or center, span a pen and entered all households on the right side of the direction that the pen indicated. In the household, one child aged between 10 and 17 was randomly selected (using pieces of folded paper with all 10-17 children's names). The child and one of his/her parents were then interviewed after consent was obtained from child and parent.

In Kharaz and Basatin, 14 health workers and 20 teachers were interviewed. The health workers included doctors, nurses, practical midwives, and one community health worker. Furthermore, 357 refugees/returnees were interviewed. In Aden, Lahej, and Abyan, 117 teachers and 703 households were interviewed.

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

Preparatory phase

Although the original plan was to conduct a school based survey in Lebanon and oPt using a random sampling framework, the closing of schools made it impossible. The survey was instead conducted through the community centers in Lebanon's impact area, and the UNRWA health clinics in oPt's impact areas. The sampling frames consisted of the future beneficiaries of the project activities.

This induced recollecting basic information about the target populations, as well as gaining access to those populations through different channels than those already identified for the project. These, along with a strike of UNRWA staff in oPt that lasted from 26 May to 7 June 2010, caused delays to the preparatory phase of the survey.

Sampling

➤ Lebanon:

Children and parents:

The sampling population consisted of beneficiaries of 4 community centers/NGOs in one impact area: Bourj Hammoud/Sin El Fil. The centers were selected based on the following criteria:

- The availability of beneficiaries lists to sample from,
- The diversity of the populations served,
- The readiness of the center to participate in the survey within the proposed timeframe,
- The readiness of the center to be involved in the future project's activities.

It was anticipated that after the intervention the knowledge of the children will increase to 60% (based on the SCS project proposal). The current proportion was expected to be of 45%. At 5% significance level and 90% power a minimum sample size of 231 was needed according to Fleiss's calculations. A continuity correction factor was incorporated based on the normal approximation to the binomial distribution, which increased the size approximately by $2/|P_{\text{before}} - P_{\text{after}}|$, for each group. A 10% inflation was added to account for an expected non-response rate, and an additional 5% for incomplete questionnaires. The resulting sample size was 281. This number was then divided on the 4 centers proportional to size. One centre (Social Development Center) restricted the number of participants to 25, thus the remaining 40 were distributed over the other centers proportional to size (50% Afel = 20 children, 10% Baytouna = 4 children, and 40% Libami = 16 children). Numbers were rounded up to account for fractions which increased the total sample size to 283.

Center	Pop	Sample
Afel	250	(109+20)=129
Baytouna	50	(22+4)=26
Libami	200	(87+16)=103
SDC	150	25
Total	650	283

The centers were then provided with a set of randomly sampled numbers corresponding to the numbers of the sampled files. The centers' staff conducted sampling of the files themselves, in order to ensure confidentiality of the information in the files.

Service providers:

The service providers were identified by Kafa. These were:

- Health workers in the impact area SDC health centers: Doctor, nurse, midwife,
- Social workers, educators, psychologists, etc, in the impact area NGOs and SDCs.

Since the schools were closed, the teachers could not be reached at the time of data collection. This was another limitation of the survey timing. However, two head teachers working at the NGO centers were interviewed.

➤ **oPt:**

Children and parents:

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

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

It was anticipated that after the intervention the knowledge of the children will increase to 60% (based on the SCS project proposal). The current proportion was expected to be of 45%. At 5% significance level and 90% power a minimum sample size of 231 was needed according to Fleiss's calculations. A continuity correction factor was incorporated based on the normal approximation to the binomial distribution, which increased the size approximately by $2/|P_{\text{before}} - P_{\text{after}}|$, for each group. A 10% inflation was added to account for an expected non-response rate, and an additional 5% for incomplete questionnaires. The resulting sample size was 281. This number was then divided on the 5 health centers proportional to size. Numbers were rounded up to account for fractions which increased the total sample size to 284.

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

Service providers:

The service providers were identified by Juzoor. These were:

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

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

Survey instrument

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

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

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

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

The adaptation of the Yemen questionnaires consisted of:

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

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

The final questionnaires included the following:

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

Data collection

➤ In Lebanon:

Two social workers were identified in each participating center, to conduct the interviews with the parents and children. Due to time constraints, more data collectors were recruited to help out. One data collector carried out the interviews with the service providers. The total number of data collectors in Lebanon was of 14.

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

Prior to data collection, data collectors received a one-day training on the survey objectives, child protection, interviewing skills, questionnaire administration, proper introduction of the survey to the participants, child participation guidelines, and the importance of the voluntary participation and informed consent. After the training, the data collectors signed the Kafa Child Protection Policy (CPP), a document which states that the data collectors must behave in a way that will not be harmful and considered offensive towards children and their families. The data collectors were also trained on measures to be taken in the case of reporting of violence by a respondent.

Data collection started on July 14, and ended on July 31, 2010. At each center, the data collectors called the children and their parents from the sampled files. If the parent consented, as well as the child, then the interviews were conducted. Two data collectors separately and simultaneously interviewed the child and his parent, in the center's facilities. The completed questionnaires were collected in envelopes, checked by the supervisor, and delivered to the data entry clerks to allow for simultaneous data entry. The field supervisor closely monitored and updated the researcher on the process of data collection, and the status of the interviews.

➤ In oPt:

In total, there were 25 data collectors involved in the survey in oPt. These were divided by teams of two, and assigned to the 5 impact areas. Each team consisted of at least one UNRWA health

worker (nurse, psychosocial counselor, etc) or Juzoor health field worker, paired with a volunteer. The teams were given file numbers and names of the random sample to be interviewed in the area. The teams in each area grouped the names to their respective neighborhoods, and visited the families in their household. They would introduce themselves to the family, introduce the survey objectives, and get the parent's and child's consent to participate. Usually the female data collector would work with the child if it was a girl and with the parent if the child was a boy. In the case more than one child aged 10-17 was present, the data collector alternated picking the children between oldest, youngest, and middle in each household. If the family was not at home at the time of visit, the team would fill out a parent and a child survey and indicate the status of visit as "not present at time of visit". In some cases the team would try to contact the family by phone, otherwise they would ask around the neighborhood if the family is coming soon, or if they were traveling, or have moved. To further ensure the protection of children, data collectors wore name tags, and presented the children interviewed with the phone number of Juzoor for any complaints.

A field supervisor was also recruited. Prior to data collection, the project coordinator and field supervisor were trained on survey administration via Skype. They in turn trained the data collectors in a one-day training on the same principles related above. After the training, the data collectors signed the SCS Child Safeguarding Policy, a document which states that the data collectors must behave in a way that will not be harmful and considered offensive towards children and their families. The data collectors were also trained on measures to be taken in the case of reporting of violence by respondents, in which case they would provide them with a list of contact numbers of the impact area's Protection Supervisors, and would make sure that those who want support will receive it.

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

The completed questionnaires were collected in envelopes, checked by the supervisor, photocopied, and sent to SCS office in Lebanon. This allowed more or less for data entry to be conducted simultaneously.

Data analysis

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

LIMITATIONS

1. Extension of the survey's timeframe

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

- ❖ The preparatory phase was extended of 4 weeks. As a result of schools being closed, the surveys needed to be conducted through other channels within the impact areas. The research team had to identify new access to the populations targeted, which would allow representativeness of the segments that will be participating in the future project interventions. SCS's partners, Juzoor and Kafa, had to regain access to community centers and UNRWA health centers in the impact areas. This process required time, as it involved conducting preparatory meetings, introducing the survey purpose and the centers' role in future interventions, getting the center's commitment to facilitate and participate in the survey during the limited timeframe proposed, and gathering necessary data for the sampling.
- ❖ Furthermore, a strike of UNRWA staff in oPt that lasted from 26 May to 7 June 2010, caused delays to the preparatory phase of the survey.
- ❖ More time was allocated to data entry and analysis, on account of some delays in the data collection in oPt, which postponed reception of questionnaires in Lebanon, and in turn affected data entry and analysis. Data collection in oPt was time-consuming because of the long distances between households in each impact area.

2. Time constraints

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

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

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

- ❖ Only 8 teachers and 3 head teachers could be reached in oPt, and 2 head teachers in Lebanon, due to schools being closed in the summer.
- ❖ Other constraints were faced in Lebanon due to conducting the survey during the summer. These included:
 - A considerable percentage of the population not being accessible due to moving or being on vacation;
 - Community centers staff being on vacation;
 - Children being in summer camps.

3. Tool development

- ❖ The lack of identification of the final tools used for the Yemen surveys presented another hindrance, which led to a time-consuming process of tracking the questions used through the tables in the Yemen surveys reports.
- ❖ The adaptation of the questionnaires has restricted the possibility to compare the Lebanon and oPt results with the 2 Yemen surveys' results.
- ❖ The indicators were too many for one survey. This was reflected by the length of the questionnaires, which had to be shortened after the piloting. More focused survey objectives could have allowed a more in-depth investigation of the target populations.
- ❖ The section about “media habits” was removed from the questionnaires. The information gathered under this section would have allowed for better future planning of campaigns (as per project activities). It is suggested to re-gather data on media habits and reach with a smaller sample prior to planning campaign activities.
- ❖ Time constraints allowed for use of quantitative methods (KAP questionnaires) only. It is suggested to follow up with qualitative research before the development of educational material, peer-to-peer education, and campaigns.

4. Sample sizes

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

RESULTS, DISCUSSION, AND RECOMMENDATIONS

The following are summarized **common** results of the three surveys. Recommendations are *italicized*. More detailed results and recommendations can be found in each of the individual country reports.

The Yemen baseline report relays the results of two populations:

- Yemen population 1: refugees/returnees
- Yemen population 2: Yemenis.

However, it is worth noting that the Yemen surveys do not cover all topics explored in Lebanon and oPt. In some cases there are results for only one of the Yemeni populations surveyed, and in other cases none at all. This has caused limitations and variations in reporting the results of the 3 countries in the present report. This report will therefore be considered as a summary, with Yemen results related exactly as they were written in the Yemen baseline report.

A) General Characteristics

Children

In Lebanon, a total of 244 children were interviewed out of the 282 contacted households, due to refusal (7.9%) and duplication. However, only **229** interviews were considered for analysis. Around **56.3%** were boys and **43.7%** were girls. The children were aged between 10 and 18 with mean age of 13. The majority were Lebanese (83.8%), with other nationalities being: Syrian, Armenian, and Egyptian. Most of the children lived with both their parents (75%), while 16% had separated parents, 5% had a deceased father, and 1%'s father were married to someone else.

In oPt, a total of 137 children were interviewed out of the 284 sampled households, due to refusal (2.9%), duplication, and cancellation of some interviews. However, only **120** interviews were considered for analysis. Around **32.5%** were boys and **67.5%** were girls. The underlying causes for this might be related to social norms, as the data collectors found more girls at home than boys. The children were aged between 10 and 17 with mean age of 14.36. The children were all Palestinian. 30.8% came from Arrub, 31.7% from Dura, 25% from Ayda and Azzah, 11.7% from Ein El Sultan, and only one child from Aqabet Jaber. This low frequency in Aqabet Jaber was due to a high percentage of participants that were not found at home, incomplete interviews, and some missing questionnaires (see Limitations). The children of Aqabet Jaber are therefore underrepresented in the sample. Most of the children lived with both their parents (95%), while 3% had separated parents, 1% had a deceased father, and 1%'s father were married to someone else.

In Yemen, for the refugee/returnee young people’s survey, a total of 360 households were targeted, but only **357** interviews were acceptable for analysis. Of these, 57% lived in Basatin and 43% lived in Kharaz. 54% of the youth identified themselves as Somali, 3% as Ethiopian, 39% as Yemeni Returnee, and 4% as Yemeni. Also, **49%** were boys and **51%** were girls. The youth were aged between 10 and 18 years with average age of 14.11 years. 40% of youth do not live with neither their mother nor their father, 28% live with their mother only, 12% live with their father only, and 8% live with neither of their natural parents. The survey also showed that a high number of youth live in so called ‘broken families’ and it seems that a large number of youth came to Yemen without their father or mother or that their father moved on to another country on arrival. In addition a substantial number of youth may have to miss their mothers at least during the week as they moved to Aden.

The survey among Yemenis included a total of **703** households in Abyan, Lahej and Aden. In the 3 governorates, ~88% of the Yemeni children interviewed lived with their father; 95% of children lived in house with his/her mother; 85% of children lived in a house with both parents, 10% of children lived in a house where the father was absent or deceased, 2.5% of children lived in a household where his/her mother was absent or deceased, and 2.5% of children lived in household where both his mother and father was absent or deceased. Children were aged between 7 and 17 years. Also, **54%** were males, and **46%** were females.

Table 1: Number of children surveyed by country and by gender

	Boys	Girls	Total
Yemen population 1: Refugee/returnee	49%	51%	357
Yemen population 2: Yemenis	54%	46%	703
Lebanon	56.3%	43.7%	229
oPt	32.5%	67.5%	120

Table 2: Average age of children, by gender

	Boys	Girls	Average total
Yemen population 1: Refugee/returnee	13.96	14.39	14.11
Yemen population 2: Yemenis	No info		
Lebanon	13	13	13
oPt	13.67	14.70	14.36

Table 3: Lebanon and oPt: Family status

		LEB	N %	OPT	N %
Family status	Parents together	173	75.5%	112	94.9%
	Parents separated	37	16.2%	4	3.4%
	Father deceased	11	4.8%	1	.8%
	Mother deceased	0	.0%	0	.0%
	Both parents deceased	0	.0%	0	.0%
	Father married	2	.9%	1	.8%
	Mother married	0	.0%	0	.0%
	Other	6	2.6%	0	.0%
	Total	229	100.0%	118	100.0%

Table 4: Children nationalities

	Yemen population 1: Refugee/returnee	Yemen population 2: Yemenis	Lebanon % (n)	oPt % (n)
Lebanese			83.8 (n=192)	
Palestinian			1.3 (n=3)	99.2 (n=119)
Iraqi				
Sudanese			0.4 (n=1)	
Kurd				
Armenian			3.5 (n=8)	
Syrian			7.4 (n=17)	
Egyptian			2.6 (n=6)	
Non-ID			0.9 (n=2)	
Somali	54% (n=192)			
Ethiopian	3% (n=11)			
Yemeni returnee	39% (n=138)			
Yemeni	4% (n=15)	100%		

Parents

In Lebanon, a total of 245 parents were interviewed out of the 282 contacted households, due to refusal (6.4%) and duplication. However, only **174** will be considered for analysis. The majority were females (86.2%), and **82.8%** were the “mother of the child”. Other interviewed respondents included “father”, “aunt/uncle”, “older sister/brother”, “grandparent”, and “other”. The “parents” were aged between 17 and 64, with mean age of 42. The majority were Lebanese (89.7%), with

other nationalities being: Syrian, Armenian, Egyptian, and Palestinian. Most parents were married (82.9%), while 6.5% were separated, 5.9% were widowed, 2.9% single, and 1.8% divorced.

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

In Yemen, no parents were interviewed among the refugee/returnee population; however, information on **702** parents were interviewed among the Yemeni population; **63%** of respondents were mothers, 27% were fathers, and 10% were other family members. Out of the other family members (N=70), only 45% indicated their relationship to the child interviewed. These included 11 aunts, 7 brothers, 4 sisters, 7 grandmothers, 2 uncles, and 1 cousin.

Table 5: Number of parents surveyed by country

	Total
Yemen population 1: Refugee/returnee	0
Yemen population 2: Yemenis	702
Lebanon	174
oPt	142

Table 6: Relationship to child

	Yemen population 2: Yemenis	Lebanon	oPt
Biological Mother	63%	82.8	87.8
Biological Father	27%	10.9	7.9
Older Sister/Brother	1.56	.6	1.4
Grandparent	1	.6	.7
Aunt/Uncle	1.85	4.0	
Other	0.14	1.1	2.2

Service providers

In Lebanon, a total of **68** service providers were interviewed; **26.5%** provided health services – the “health workers”, and **73.5%** provided services in education, counseling, and social work – the “other service providers”. The health workers included doctors (10.3%), nurses (10.3%), and a midwife (1.5%). The other service providers included educators/animators (35.3%), social workers (35.3%), head teachers (2.9%), and psychosocial counselors (2.9%). They were mostly females (91.2%), rendering the males underrepresented in the sample. Most of them (41.5%) were aged between 30 and 40, while 33.8% were above 40, 23.1% between 20 and 29, and 1.5% below 20. Around 2.9% have been providing services for children aged 10-17 for less than a year, while 36.8% had been working with children for 1 to 9 years, and majority (60.3%) have worked with children for 10 or more years.

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

In Yemen, **14** health workers and **20** teachers were interviewed in Kharaz and Basatin. Regarding the health workers: 43% were male and 57% female; 36% were between 20 and 29 years of age, 43% between 30 and 39, while 21% were over 40 years. Also, 64% were Yemenis while the rest, 36%, were Somali. Furthermore, 36% were doctors, 36% were nurses, 21% were practical midwives, and one was a community health worker. About 57% had been on the job between 1 and 9 years and 21% had been working with youth more than 10 years.

In Aden, Lahej, and Abyan, **117** teachers were surveyed; 11.1% were males, and 88.9% were females. Most teachers surveyed were between 30-40 years (83.6%); none was older than 40 years.

It is noted that most interviewed service providers are females, rendering the males underrepresented (table 8).

Table 7: Number of service providers by country, by type of services

	Health workers	Other SP	Total SP
Yemen population 1: In Basatin and Kharaz	14	20	34
Yemen population 2: In Aden, Lahej, and Abyan	0	117	117
Lebanon	18	50	68
oPt	35	18	53

Table 8: Gender of service providers

	LEB	Valid Percent	OPT (1missing)	Valid Percent	Yemen 1 (HW only)	Valid Percent	Yemen 2	Valid Percent
Valid Male	6	8.8	14	26.9	6	43	13	11.1
Female	62	91.2	38	73.1	8	57	104	88.9
Total	68	100.0	52	100.0	14	100.0	117	100.0

B) Education

Ability to read and school enrolment status

In Lebanon, 98% of children can read, most being able to read Arabic (95%), followed by French (86%), and English (53%). About 95.6% of children are presently enrolled in school, with more girls being enrolled than boys. The enrollment status of boys decreases by age, with only 76.9% in the age group 16-18 being enrolled. This might be due to boys having to work, or a shift to enrolment in technical/vocational education, which starts at these ages. Out of those who are presently attending school, the majority are attending private schools (61.2%), while 29.7% are attending public schools, and 7.7% semi-private schools.

Overall, 4.4% are not enrolled in school; 10 having dropped out, and 2 having never attended school. Out of those who dropped out, 50% had dropped out before grade 5, while all had dropped out by grade 8. The children who were not presently enrolled were 70% Lebanese, 20% Syrian, and 10% Armenian. Around 60% were aged between 13 and 15 years, and 90% were above 13 years of age. Furthermore, most of them were males (80%). The reasons given by those who never attended school were: “need to help father”, and “not being clever”. The reasons given by those who dropped out of school were: “school was boring”, “cost is too high”, “not being clever”, and “becoming too old”.

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

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

In Yemen, 49% of the refugee/returnee children attend school. These are 48% of the girls and 51% of the boys. Out of the refugees/returnees who do not attend school: 57% were Somalis, 2% Ethiopians, 36% Yemeni returnees, and 5% Yemeni. There were two particularly vulnerable groups: 15 -18 year olds and Somalis who live in a household with at least one parent who is absent/dead. Both of these groups independently contributed most to non-attendance rate. Among the young refugees/returnees, 27% of boys not attending school said the reason was: “wanting to earn money”, while 24% said they were “not clever”, and 21% stated the “lack of supplies” as reason.

Also, regarding the Yemeni population, 89% of all children in the households (2910 children of school age; 7-17), attend school: 92% of the boys and 85% of girls. Overall, 11% of all school aged children were not enrolled in school; of this group, 26% said that they had never attended school and 74% had dropped out of school. 26% out of the children who had never attended

school were 7 years old. The enrollment rates decrease by both gender and age; 93% of girls 7 to 12 years old were enrolled in school vs. 97% of boys. For the older age group; 77% of girls age 13 -17 were enrolled in school vs. 87% of boys. 49% of the six year olds within the sample had started school; 51% of girls and 46% of boys. 65% of the children who had either dropped out of school or never attended were girls, and 35% were boys. 11% of the non-enrolled boys had never attended school; whereas, 26% of the non-enrolled girls had never attended school. While there was no difference in non-enrollment status between the three governorates (Aden, Abyan and Lahej), there was a difference between rural/semi-urban children; 13% of the non-enrolled children were living in an urban area had never attended school, while 29% of the non-enrolled children living in a rural/semi-rural area had never attended school; however, urban girls suffer the highest rates of never attending school. The last grade completed as reported by the children who dropped out of school ranged from grade 1 to 10 with the average and the median grade being 5; 50% of the children had dropped out before or by grade 5; while 71% of the children who dropped out completed class 6 or less.

Table 9: Enrolment Status

	Yemen pop 1: Refugees/ returnees			Yemen pop 2: Yemenis			Lebanon			OPT		
	Girl	Boy	Total	Girl	Boy	Total	Girl	Boy	Total	Girl	Boy	Total
Drop out	No info			74%	89%	5.2%			0.9%			5.0%
Never attended				26%	11%	2.3%			4.4%			
Enrolled	48%	51%	49%	83%	96%	92.4%	98.0%	93.7%	95.6%	96.2%	94.6%	95.7%

It is noticed that the enrollment status of children is higher in Lebanon and oPt as opposed to Yemen. The lowest enrolment is among the refugee/returnee population in Yemen. Also, it is noted that girls have lowest enrollment rates than boys in Yemen, while it's the opposite in Lebanon and oPt.

Non formal education

In Lebanon, nearly half (**48.9%**) of the children are enrolled in non-formal education, with slightly more boys being enrolled than girls. The most attended form of non-formal education is religious education, attended by 26.6% out of all children.

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

In Yemen, 55% of the refugees/returnees attend non formal education. Those who do not attend school are much less involved in non-formal education, indicating that children who do not attend school tend to not attend any form of education. The same appears to be true for boys, who are involved at a much lower rate than girls (45% vs. 65%). The most important form of non-formal education is religious education, so it may be necessary to partner with these institutions.

Among the Yemenis, **~40%** of all children said that they were involved in other forms of education. 64% of the children had attended some other form of education either at the time of the survey or before: these were ~ 52% of girls vs. 73% of boys; and ~37% of non school attending children vs. 66% of school attending children. 47% of all children both past and present, attended religious education. Private language courses were the second most popular form of non-formal education attended.

Table 10: Enrollment in non-formal education by gender

Enrolled in non-formal education	Boys	Girls	Total
Yemen population 1: In Basatin and Kharaz	44%	65%	55%
Yemen population 2: In Aden, Lahej, and Abyan	No info		40%
Lebanon	49.6%	48%	48.9%
oPt	43.2%	42.3%	42.6%

Membership in youth groups

In Lebanon, 24.5% of children are members of youth groups, with more girls than boys being members. About 30.5% of children 13-15 were members of youth groups, followed by the age group of 16-18 (24.1%), and the age group 10-12 (19.4%). Out of the children who are members of a youth group, 32% are members of church groups, 26% are members of NGO youth groups, 20% are members of sports clubs, and 20% are members of the Scouts Movement.

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

It is much more effective to target children through school educational activities in Lebanon and oPt than it is in Yemen, especially among the refugee/returnee population. These can be targeted through both school activities and non-formal education organizations (which have higher attendance rates than schools), namely religious education and private language courses.

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

In Yemen however, it is recommended to explore whether children who are not attending school can read, and which languages are preferred. It is would not be effective nor efficient to target the children through print material if more information about their ability to read and their language preferences cannot be obtained.

C) Personal Hygiene

Hygiene practices

In Lebanon, the majority of children (**73%**) bathe “once a day or more”, while 24% bathe “every other day”, and 3% “twice a week”. The bathing frequency does not vary much among age groups. However, more boys (81%) bathe “once a day or more” than girls (63.6%). On the other hand, most parents (**90.8%**) said their children wash their genitals “once a day or more”.

In oPt, only **37%** of children bathe “once a day or more”, while 38% bathe “every other day”, 18% “twice a week”, and 7% “once a week or less”. The bathing frequency decreases with age and is slightly higher for girls. On the other hand, most parents (**70.9%**) said their children wash their genitals “once a day or more”.

In Yemen, **72%** of the refugees/returnees bathe “once a day or more”, while 22% bathe “every other day”, 5% “twice a week”, and 1% “once a week or less. There is no information on the Yemeni population bathing habits.

Table 11: Frequency of bathing

	Once a day or more	Every other day (4 times a week)	Twice a week (every third day)	Once a week or less
Yemen population 1: Refugee/returnees	72%	22%	5%	1%
Yemen population 2: Yemenis	No info			
Lebanon	73%	24%	3%	0
oPt	37%	38%	18%	7%

When comparing the 3 countries, it is noticed that children in oPt have the least favorable hygiene practices. *It is recommended to provide education about appropriate amount of bathing and washing genitals, especially focusing efforts on oPt children. Also, education activities need to be tailored to boys and girls separately, since there were found to be differences among their practices.*

Source of information on personal hygiene

In Lebanon, most children mentioned their mother (**83.8%**) as source of information on personal hygiene, followed by their father (23.5%), and their teacher (18.7%). Mothers were mentioned by 94% of girls and 76% of boys, suggesting that mothers are the main source of information regardless of gender. Other relatives also play a role as sources of information for 10.9% of children. Neither social workers, health workers, friends, nor the media were identified as important sources of information.

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

In Yemen, most refugee/returnee youth (around 80%) mentioned their parents as source of information on personal hygiene, followed by their teacher (around 25%). Health workers were much less mentioned; however, there is a strong gender bias with regards to health workers who were mentioned by 15% of boys (N=169) and only 3% (N=181) of girls (p=.001). Friends were also more mentioned by boys: 80% of boys reported hearing about health and hygiene from a friend while only 1% of girls reported this (p=.001).

It is recommended to provide education for mothers in both oPt and Lebanon, and to both parents in Yemen on personal hygiene of their children and skills to educate them, since they are the main source of information mentioned by children regardless of gender. Education can also target fathers, teachers, and sisters who were mentioned as important sources of information as well under this topic. Education interventions need to take into account gender biases observed in Yemen; boys could be targeted through peer education while girls are targeted most effectively through their mothers.

Girls' knowledge about personal hygiene issues

In Lebanon, **68.4%** of girls identified 3 or more causes for infection/irritation of the genitals. The most identified causes were: “nylon underwear”, followed by “wiping back to front when going to the bathroom”. The least identified causes were: “pantyhose” and “soap that contains perfume or deodorant”.

Regarding menstrual hygiene, **76.8%** of girls knew that the tampon/pad should be changed many times during the day during menstruation.

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

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

The knowledge of girls regarding causes of infection/irritation of the genitals is higher for Lebanon than for oPt. However, knowledge regarding menstrual hygiene is not very different among girls in the two countries. *It is recommended to provide education about causes of infection/irritation of the genitals and menstrual hygiene to girls in both countries, with more extensive efforts in oPt.*

Table 12: Number of identified causes for infection of genitals

		LEB	Valid Percent	OPT	Valid Percent
Valid	0	3	3.1	10	13.3
	1	6	6.1	16	21.3
	2	22	22.4	10	13.3
	3 or more	67	68.4	39	52.0
	Total	98	100.0	75	100.0
Missing	System	2		6	
Total		100		81	

Overall, it is not recommended to provide peer education as an education method for personal hygiene topics, since children do not seem to seek the information from their “friends” on these issues. In fact, only 2.6% of children in Lebanon and 7.5% of children in oPt mentioned “friends” as their source of information, perhaps due to shyness about the nature of the issue, or not perceiving the source to provide credible information. Furthermore, media channels were not mentioned as a prominent source and may not be very effective in reaching the children in future activities. Printed materials were not mentioned by any children in Lebanon and only 4.2% of children in oPt as sources of information, suggesting either of the following:

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

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

D) Changes during puberty

Children

Children were asked questions about changes occurring during puberty.

Physical changes

In Lebanon, more girls (**50%**) identified 3 or more physical changes (occurring in girls) than boys (**37.2%**) (occurring in boys). The most identified physical changes by girls were: “breast growth” and “start of menstruation”. The most identified physical changes by boys were: “hair growth” and “height and weight increase”.

In oPt, more girls (**49.4%**) identified 3 or more physical changes (occurring in girls) than boys (**41%**) (occurring in boys). The most identified physical changes by girls were: “breast growth” and “start of menstruation”. The most identified physical changes by boys were: “hair growth” and “height and weight increase”.

Table 13: Number of identified physical changes in girls

		LEB	Valid Percent	OPT	Valid Percent
Valid	0	13	13.0	9	11.1
	1	9	9.0	10	12.3
	2	28	28.0	22	27.2
	3 or more	50	50.0	40	49.4
	Total	100	100.0	81	100.0

Table 14: Number of identified physical changes in boys

		LEB	Valid Percent	OPT	Valid Percent
Valid	0	35	27.1	7	17.9
	1	14	10.9	6	15.4
	2	32	24.8	10	25.6
	3 or more	48	37.2	16	41.0
	Total	129	100.0	39	100.0

In Yemen, for the refugee/returnee population, more changes were mentioned for boys than for girls, with changes most mentioned by girls for boys being “voice changes”, while boys

themselves mentioned most “hair growth”. For girls answers by boys were very limited, while girls’ answers focused on the “breast growth” and “start of menstruation”.

Table 15: Girls responses to identification of physical changes in girls

	Yemen population 1: Refugee/returnee	Yemen population 2: Yemenis	LEB % of all girls	OPT % of all girls
Don't know		No info	9%	12.35%
Breasts start to grow	80%		74%	71.60%
Hair growth (genital/underarms)	10%		51%	50.62%
Height increases	24%		36%	38.27%
Body becomes more muscled			9%	23.46%
Widening of hips			10%	18.52%
Menstruation starts	75%		55%	59.26%
Oily skin, pimples	11%		14%	17.28%
Increase in perspiration gland secretion			7%	9.88%
Other			11%	2.47%

Table 16: Boys responses to identification of physical changes in boys

	Yemen population 1: Refugee/returnee	Yemen population 2: Yemenis	LEB % of all boys	OPT % of all boys
Don't know		No info	18.60%	20.5%
Hair growth	56%		53.49%	59.0%
Voice changes	52%		43.41%	41.0%
Height and weight increase	47%		50.39%	48.7%
Body becomes more muscled/strong			22.48%	38.5%
Broadening of shoulders	47%		3.88%	20.5%
Changes in sex organs	23%		12.40%	10.3%
Oily skin, pimples	26%		6.98%	20.5%
Increase in perspiration gland secretion			1.55%	17.9%
Other			3.10%	10.3%

There are some differences in the multiple choice answers between Lebanon and oPt on one hand, and Yemen on the other. However, the answers could be categorized within the Lebanon and oPt categories.

More girls identified physical changes occurring during puberty than boys in both Lebanon and oPt. The most identified changes were the same in the 3 countries. *Education sessions need to*

target boys and girls separately since differences were found between their levels of knowledge. Education should also focus on the least identified changes.

Worries/problems faced

In Lebanon, 28.4% didn't know any worries and problems adolescents face during puberty, while 13.9% said that adolescents do not face any problems. Only **7.9%** identified 3 or more worries/problems. The most identified worries/problems were: "irritability and anger" and "inability to concentrate on study".

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

Table 17: Number of worries/ problems identified

		LEB	Valid Percent	OPT	Valid Percent
Valid	0	114	49.8	57	47.5
	1	63	27.5	26	21.7
	2	34	14.8	13	10.8
	3 or more	18	7.9	24	20.0
	Total	229	100.0	120	100.0

In Yemen, results from the refugee/returnee population were re-calculated from the original report to represent percentages out of the whole children population. About **34.5%** of children didn't know any worries faced, while **12%** said there were none. The most identified was "irritability and anger", by 32.5%.

Knowledge about worries/problems faced during adolescence was low in the 3 countries. However, more children in oPt identified at least 3 worries and problems faced than in Lebanon (such data is not available for Yemen). The most identified worry/problem was the same for the 3 countries.

It is recommended to provide education for children on worries and problems faced during puberty, as well as skills to face these problems such as communication skills, anger management, self esteem, etc. These sessions could include the parents of the children in order to improve communication between the two (especially that in both oPt and Lebanon, children and parents answers revealed "conflict with parents" to be a serious problem faced). This would also improve better communication about SRH issues between the two, which is needed for project activities since the parents are key sources of information for children regarding all SRH topics.

Table 18: Worries/problems faced

	Yemen population 1: Refugee/returnee (of total SS)	Yemen population 2: Yemenis	LEB % of total SS	OPT % of total SS
Do not know	34.5%	No info	28.38%	24.17%
No problems or worries	12%		13.97%	8.33%
Abdominal cramps	9.5%		3.93%	4.17%
Nocturnal emissions	14.6%		2.18%	1.67%
Feeling fatigued / tired	15.1%		3.93%	12.50%
Eating too much	6.2%		6.99%	4.17%
Get sad / depressed	9%		6.99%	23.33%
Irritability / Anger	32.5%		37.12%	30.83%
Cannot concentrate on study	15.1%		10.92%	18.33%
Timidity/shyness			9.61%	21.67%

Parents and service providers

Physical changes

In Lebanon, health workers identified less physical changes in both boys and girls than parents and other service providers. About **62%** of parents, **53%** of health workers, and **74.5%** of other service providers identified 3 or more physical changes in girls during puberty. The most identified changes were: “breast growth”, “start of menstruation”, and “hair growth (genitals and underarms)”.

The percentages decreased when identifying changes in boys; around **52.3%** of parents, **41.2%** of health workers, and **62.7%** of other service providers identified 3 or more physical changes in boys during puberty. The most identified changes were: “hair growth (face, arms, legs, and pubic)”, and “voice changes”.

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

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

In Yemen, no data was collected about parents’ level of knowledge regarding changes occurring during puberty. However, results are shown regarding health workers from Basatin and Kharaz (n=14). One of the health workers did not know of any physical changes as a result of puberty for either boys or girls. Changes for boys were more mentioned than for girls by the health workers. Most mentioned for girls were “breast growth” and “start of menstruation”. Most mentioned for boys were “voice changes”, “hair growth” and “changes in sex organs”.

Table 19: Service providers: Physical changes occurring in girls during puberty

	LEB		LEB		OPT		OPT		Yemen pop 1:	
	Health worker		Other SP		Health worker		Other SP		Health worker	
	Cnt	% of all HW	Cnt	% of all other SP	Cnt	% of all HW	Cnt	% of all other SP	Cnt	% of all HW
Don't know	0	0.00	0	0.00	0	0.00	0	0.00	1	7%
Breasts start to grow	17	100.00	45	88.24	34	97.14	18	100.00	12	86%
Hair growth (genital/underarms)	10	58.82	38	74.51	29	82.86	16	88.89	10	71%
Height increases	2	11.76	23	45.10	18	51.43	6	33.33	6	43%
Body becomes more muscled	1	5.88	1	1.96	11	31.43	7	38.89		
Widening of hips	1	5.88	7	13.73	13	37.14	11	61.11		
Menstruation starts	12	70.59	29	56.86	34	97.14	17	94.44	11	79%
Oily skin, pimples	2	11.76	11	21.57	16	45.71	9	50.00	8	57%
Increase in perspiration gland secretion	1	5.88	2	3.92	5	14.29	1	5.56		
Other	10	58.82	20	39.22	2	5.71	2	11.11		

It is noted that the parents’ knowledge is higher in Lebanon than oPt regarding physical changes, while the service providers knowledge is higher in oPt than Lebanon. Also, parents and service providers in both countries have less knowledge about physical changes occurring in boys than those occurring in girls. The most identified changes are the same for the 3 countries.

Table 20: Service providers: Physical changes occurring in boys during puberty

	LEB		LEB		OPT		OPT		Yemen pop 1:	
	Health worker		Other SP		Health worker		Other SP		Health worker	
	Cnt	% of all HW	Cnt	% of all other SP	Cnt	% of all HW	Cnt	% of all other SP	Cnt	% of all HW
Don't know	1	5.88	1	1.96	0	0.00	0	0.00	1	7%
Hair growth	11	64.71	46	90.20	30	85.71	17	94.44	11	79%
Voice changes	8	47.06	42	82.35	31	88.57	17	94.44	13	93%
Height and weight increase	4	23.53	23	45.10	23	65.71	9	50.00	10	71%
Body becomes more muscled/strong	3	17.65	14	27.45	17	48.57	12	66.67		
Broadening of shoulders	1	5.88	3	5.88	20	57.14	11	61.11	10	71%
Changes in sex organs	5	29.41	12	23.53	23	65.71	10	55.56	11	79%
Oily skin, pimples	3	17.65	7	13.73	12	34.29	9	50.00	8	57%
Increase in perspiration gland secretion	0	0.00	2	3.92	7	20.00	3	16.67		
Other	10	58.82	22	43.14	3	8.57	1	5.56		

Worries/problems faced

In Lebanon, the parents and service providers' knowledge regarding worries faced by adolescents was very low in comparison with knowledge about physical changes. This reflected a strong need of awareness-raising regarding the psychosocial health of children, which would improve communication between the children and their care-givers as well. Only **16.7%** of parents, **3.9%** of other service providers, and **none** of the health workers identified 3 or more worries or problems faced during puberty. Furthermore, 70.6% of health workers and 70.6% of other service providers did not identify any worries. This also showed a higher level of knowledge by parents of worries faced by their children than the service providers. The most identified worries were: "irritability and anger".

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

In Yemen, all health workers (**100%**) agreed that puberty causes problems and worries for adolescents. Most (71%) health workers mentioned “irritability/anger” as a problem faced rather than physical issues such as nocturnal emission (43%) or abdominal cramps (21%). Other mentioned worries included “not being able to concentrate” (36%), and “feeling sad/depression” (29%).

Table 21: Service providers: Worries/problems faced

	LEB		LEB		OPT		OPT		Yemen pop 1	
	Health worker		Other SP		Health worker		Other SP		Health worker	
	Cnt	% of all HW	Cnt	% of all other SP	Cnt	% of all HW	Cnt	% of all other SP	Cnt	% of all HW
Don't know	0	0.00	1	1.96	1	2.86	1	5.56	2	14%
No worries	0	0.00	0	0.00	0	0.00	0	0.00	0	-
Abdominal cramps	0	0.00	0	0.00	4	11.43	1	5.56	3	21%
Nocturnal emissions	0	0.00	2	3.92	7	20.00	1	5.56	6	43%
Feeling fatigued / tired	0	0.00	1	1.96	9	25.71	4	22.22	2	14%
Eating too much	0	0.00	0	0.00	8	22.86	6	33.33	3	21%
Get sad / depressed	0	0.00	3	5.88	20	57.14	11	61.11	4	29%
Irritability / Anger	4	23.53	8	15.69	24	68.57	9	50.00	10	71%
Cannot concentrate on study	0	0.00	2	3.92	9	25.71	7	38.89	5	36%
Timidity/shyness	1	5.88	7	13.73	16	45.71	6	33.33		
Other	16	94.12	50	98.04	7	20.00	6	33.33		

It is noted that the parents' knowledge is higher in Lebanon than oPt regarding worries faced by adolescents, while the service providers knowledge is higher in oPt than Lebanon. Also, parents and service providers in both countries have a much lower level of knowledge about worries and problems faced than physical changes. The most identified worry is the same for the 3 countries.

Sexual and reproductive health risks

In Lebanon, all service providers recognized that children aged 10-17 face SRH risks, as opposed to **73%** of parents. However, more parents identified at least one SRH risk than service providers. Few parents (**9.4%**), **none** of the health workers, and **11.1%** of the other service providers identified 3 or more SRH risks faced by children. The most identified SRH risks were: “un-intended pregnancy”, “STIs, including HIV and AIDS”, and “sexual violence and exploitation”.

In oPt, the large majority of health workers (**91.4%**) and other service providers (**94.4%**) recognized that children aged 10-17 face SRH risks, as opposed to only **40.8%** of parents. Few

parents (8.6%), 28.1% of the health workers, and 35.3% of the other service providers identified 3 or more SRH risks faced by children. The most identified SRH risks were: “un-intended pregnancy”, for health workers and service providers, and “sexual violence and exploitation” for parents.

Less parents in oPt than in Lebanon are aware that adolescents face SRH risks. However, the large majority of service providers are aware of that fact. However, the parents and service providers level of knowledge regarding the types of SRH risks faced is low; furthermore, service providers in oPt have higher knowledge levels than those on Lebanon regarding SRH risks faced.

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

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

More education is needed for parents in oPt and service providers in Lebanon.

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

E) STIs, HIV and AIDS

Children

Sexually transmitted infections and their symptoms

In Lebanon, 55.5% of children couldn't identify any sexually transmitted infection (STI) a person can get through sexual intercourse. Only **0.9%** could identify 3 or more STIs, while 41.5% identified 1 STI, with more boys identifying 1 STI than girls. The most identified STI was: "HIV & AIDS".

Around **78.2%** of children couldn't identify any signs or symptoms that suggest that a person has an STI. Only 1.7% could identify 3 or more STI symptoms, while 13.1% identified 1 symptom. The most identified STI symptoms were: "painful urination and "burning pain or itching in penis vagina".

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

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

Table 22: Percentage of children by number of identified STIs

		LEB		OPT	
		Count	N %	Count	N %
STIs identified	0	127	55.5%	47	39.2%
	1	95	41.5%	59	49.2%
	2	5	2.2%	10	8.3%
	3 or more	2	.9%	4	3.3%
	Total	229	100.0%	120	100.0%

Table 23: Percentage of children by number of identified STI symptoms

		LEB		OPT	
		Count	N %	Count	N %
STI symptoms identified	0	179	78.2%	95	79.2%
	1	30	13.1%	15	12.5%
	2	16	7.0%	7	5.8%
	3 or more	4	1.7%	3	2.5%

It is noticed that, in both oPt and Lebanon, children knowledge levels regarding STIs are low. Some differences are noted as well between girls and boys.

HIV and AIDS

In Lebanon, around **70%** of children have heard of HIV and AIDS, with slightly more boys than girls, and with increase of awareness with older age.

Out of those who heard of HIV and AIDS, only **15.3%** could identify 3 or more modes of transmission of HIV, with more girls than boys and with increase of knowledge with older age. The most identified modes of transmission were: “sexual relations” and “blood transfusion”. The least identified were “mosquito or other insect bites” and “breast milk”. **12.1%** believed that “casual contact with an infected person” is a mode of transmission.

Also, out of those who heard of HIV and AIDS, only **14%** could identify 3 or more ways to avoid getting HIV, with more girls than boys, and with increase of knowledge with older age. The most identified ways to avoid getting HIV were: “abstinence from sex” and “using condoms for every act of sexual intercourse”. The least identified ways to avoid getting HIV were: “encouraging partner to stay faithful” and “avoiding commercial sex workers”. **21.7%** believed that “avoiding casual contact with an infected person” is a way to avoid getting infected with HIV.

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

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

Also, out of those who heard of HIV and AIDS, only **25.6%** could identify 3 or more ways to avoid getting HIV, with more boys than girls, and with increase of knowledge with older age. The most identified ways to avoid getting HIV were: “abstinence from sex” and “avoiding

sharing razors and blades”. The least identified ways to avoid getting HIV were: “using condoms for every sexual act” and “avoiding commercial sex workers”. **43.6%** believed that “avoiding casual contact with an infected person” is a way to avoid getting infected with HIV.

In Yemen, no data was collected about the Yemeni children level of knowledge regarding HIV and AIDS. On the other hand, **68%** of the refugee/returnee children had heard of HIV/AIDS. Overall, more girls had heard of HIV/AIDS than boys, and more Yemeni returnees had heard of HIV/AIDS than Somali youth. Out of the 238 refugee/returnee youth who had heard of HIV and/or AIDS, 206 (87%) answered the question “How can a person avoid getting infected with HIV?” Of these, 14% did not know how to avoid getting infected with HIV. The majority related 2 ways (32%) or 3 ways (33%) to avoid getting infected with HIV.

Table 24: Percentage of children who have heard of HIV and AIDS

		% of youth who had heard of HIV and/or AIDS
Yemen population 1: Refugees/returnees	Male (N=171)	59%
	Female (N=179)	77%
	Total (N=350)	68%
Yemen population 2: Yemenis	No info	
Lebanon	Male (N=90)	70.3%
	Female (N=67)	67%
	Total (N=157)	68.9%
OPT	Male (N=25)	65.8%
	Female (N=53)	75.7%
	Total (N=78)	72.2%

Table 25: Percentage of children by number of identified modes of HIV transmission

	LEB		OPT	
	Count	N %	Count	N %
Modes of HIV transmission 0	49	31.2%	21	26.9%
1	44	28.0%	15	19.2%
2	40	25.5%	17	21.8%
3 or more	24	15.3%	25	32.1%

Table 26: Ways to avoid getting HIV

	Yemen population 1: Refugee/returnee (n=208)	Yemen populati on 2: Yemenis	Lebanon	oPt
Don't know	14%	No info	22.9%	3.8%
Avoid sex completely/abstinence	52%		30.6%	42.3%
Stay faithful to partner	16%		3.8%	19.2%
Encourage partner to stay faithful			.0%	9.0%
Avoid contaminated blood (unscreened blood transfusions)	51%		22.3%	28.2%
Use condoms for every act of sexual intercourse	18%		23.6%	3.8%
Avoid sharing syringes	47%		17.2%	15.4%
Avoid sharing razors and blades	49%		5.1%	35.9%
Avoid commercial sex workers			.6%	6.4%
Avoid casual sex			1.3%	10.3%
Avoid Casual contact with infected person			21.7%	43.6%
Other			9.6%	6.4%
Avoid intravenous drugs (Yemen)	14%			

It is noted that children in Lebanon have less knowledge about HIV and AIDS than those in oPt. However, more children in oPt have misconceptions about HIV and AIDS than those in Lebanon. Also, knowledge about HIV and AIDS increases with age in both countries.

On the other hand, children in Yemen have a fair level of knowledge about HIV and AIDS. Also, none of the children has misconceptions as related to “casual contact with infected people”.

It is recommended to provide education on STIs and HIV & AIDS, with separate tailored sessions for girls and boys, and more focus on younger age groups. Correcting misconceptions about HIV & AIDS should be one of the objectives of the education interventions, especially in oPt, to reduce the stigma against HIV infected people. The sessions also need to focus on the least identified answers.

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

Parents and service providers

Sexually transmitted infections and their symptoms

In Lebanon, health workers were the most knowledgeable about STIs. About **55.6%** of health workers, **40%** of other service providers, and only **7.5%** of the parents identified 3 or more STIs. The most identified STI was: “HIV & AIDS” followed by “syphilis”.

Only **17.8%** of parents, **38.9%** of health workers, and **14%** of other service providers could identify 3 or more STI symptoms. The most identified STI symptoms were: “burning pain or itching in penis/vagina”, and “discharge from penis/vagina”.

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

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

Table 27: Parents: Number of STIs identified

		LEB	N %	OPT	N %
STIs identified	0	51	29.3%	20	14.1%
	1	87	50.0%	78	54.9%
	2	23	13.2%	18	12.7%
	3 or more	13	7.5%	26	18.3%
	Total	174	100.0%	142	100.0%

Table 28: Service providers: Number of STIs identified

		LEB				OPT			
		HW	N %	Other SP	N %	HW	N %	Other SP	N %
STIs identified	0	0	.0%	0	.0%	0	.0%	0	.0%
	1	2	11.1	20	40.0	2	5.7%	1	5.6%
	2	6	33.3	10	20.0	2	5.7%	4	22.2%
	3 or more	10	55.6	20	40.0	31	88.6%	13	72.2%
	Total	18	100.0	50	100.0	35	100.0%	18	100.0%

Table 29: Parents: STI symptoms identified

		LEB	N %	OPT	N %
STI symptoms identified	0	66	37.9%	86	60.6%
	1	37	21.3%	29	20.4%
	2	40	23.0%	12	8.5%
	3 or more	31	17.8%	15	10.6%
	Total	174	100.0%	142	100.0%

Table 30: Service providers: STI symptoms identified

		LEB				OPT			
		HW	N %	Other SP	N %	HW	N %	Other SP	N %
STI	0	5	27.8	24	48.0%	4	11.4%	0	.0%
symptoms	1	2	11.1	11	22.0%	0	.0%	2	11.1%
identified	2	4	22.2	8	16.0%	4	11.4%	3	16.7%
	3 or more	7	38.9	7	14.0%	27	77.1%	13	72.2%
	Total	18	100.0	50	100.0%	35	100.0%	18	100.0%

HIV and AIDS

In Lebanon, nearly all parents (**99.4%**) and service providers (**98.5%**) have heard of HIV and AIDS.

Out of those who heard of HIV and AIDS, **44.4%** of parents, **38.9%** of health workers, and **46%** of other service providers could identify 3 or more modes of transmission of HIV. The most identified modes of transmission of HIV were: “sexual relations” and “blood transfusion”. The least identified modes of transmission were “mosquito or other insect bites” and “breast milk”. Also, **9.4%** of parents, **5.6%** of health workers, and **6%** of other service providers thought that “casual contact with an infected person” is a mode of transmission. This relates misconceptions that need to be corrected in future awareness raising activities, to reduce the stigma against HIV infected people.

Also, out of those who heard of HIV and AIDS, only **33.3%** of parents, **16.7%** of health workers, and **40%** of other service providers identified 3 or more ways to avoid getting HIV. The most identified ways to avoid getting HIV were: “using condoms for every act of sexual intercourse” and “Avoiding sharing needles” (including sterilizing medical equipment). The least identified ways to avoid getting HIV were “encouraging partner to stay faithful” and “avoiding commercial sex workers”. Also, **17.8%** of parents and **2%** of other service providers thought that “avoiding casual contact with an infected person” is a way to avoid getting infected with HIV. This misconception also needs to be corrected.

Around **50%** of service providers have received training and health education sessions on HIV/AIDS. This, along with the previous results, suggests that training needs to tackle the service providers' knowledge about STIs, HIV and AIDS.

In oPt, all service providers and **90%** of parents have heard of HIV and AIDS.

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

Out of those who heard of HIV and AIDS, **34.5%** of parents, **87.9%** of health workers, and **100%** of other service providers identified 3 or more ways to avoid getting HIV. The most identified ways to avoid getting HIV were: “abstinence from sex” and “Avoiding contaminated blood”. The least identified ways to avoid getting HIV were: “avoiding commercial sex workers” and “encouraging partner to stay faithful”. Also, **31%** of parents, **30.3%** of health workers, and **38.9%** of other service providers thought that “avoiding casual contact with an infected person” is a way to avoid getting infected with HIV. This misconception also needs to be corrected.

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

Table 31: Parents: Number of modes of HIV transmission identified

	LEB	N %	OPT	N %
Modes of HIV transmission 0	6	3.5%	7	6.0%
1	34	19.9%	22	19.0%
2	55	32.2%	37	31.9%
3 or more	76	44.4%	50	43.1%
Total	171	100.0%	116	100.0%

Table 32: Service providers: Number of modes of HIV transmission identified

	LEB				OPT			
	HW	N %	Other SP	N %	HW	N %	Other SP	N %
Modes of HIV transmission 0	1	5.6	0	.0%	0	.0%	0	.0%
1	5	27.8	11	22.0	0	.0%	0	.0%
2	5	27.8	16	32.0	7	21.2%	2	11.1%
3 or more	7	38.9	23	46.0	26	78.8%	16	88.9%
Total	18	100.0	50	100.0	33	100.0%	18	100.0%

Table 33: Parents: Number of ways to avoid getting HIV

	LEB	N %	OPT	N %
Ways to avoid HIV identified 0	22	12.6	8	6.9%
1	41	23.6	32	27.6%
2	53	30.5	36	31.0%
3 or more	58	33.3	40	34.5%
Total	174	100.0	116	100.0%

Table 34: Service providers: Number of ways to avoid getting HIV

	LEB				OPT			
	HW	N %	Other SP	N %	HW	N %	Other SP	N %
Ways to avoid HIV identified 0	2	11.1	2	4.0	2	6.1%	0	.0%
1	8	44.4	6	12.0	0	.0%	0	.0%
2	5	27.8	22	44.0	2	6.1%	0	.0%
3 or more	3	16.7	20	40.0	29	87.9%	18	100.0%
Total	18	100.0	50	100.0	33	100.0%	18	100.0%

In Yemen, only health workers and teachers from Kharaz and Basatin were asked about HIV and AIDS. All health workers and all teachers had heard of HIV & AIDS. Most health workers (79%) thought that one can avoid HIV/AIDS by avoiding injections with non sterilized syringes, followed by abstaining from sex (64%), and avoiding sharing razors and blades (57%). Most teachers (80%) thought that one can avoid HIV/AIDS by avoiding sharing razors and blades, followed by avoiding blood transfusions with blood that has not been screened (70%). Avoiding injections with non sterilized syringes was mentioned 60%, while staying faithful to partner was mentioned and abstaining from sex by 55% and 50% respectively.

Table 35: Health workers: Ways to avoid getting HIV

Preventing HIV/AIDS	LEB	%	OPT	%	Yemen pop 1	%
Abstain from sex	1	5.6%	27	81.8%	9	64%
Use of condom	14	77.8%	14	42.4%	3	21%
Stay faithful to partner	4	22.2%	11	33.3%	5	36%
Do not take drugs intravenously	4	22.2%	21	63.6%	5	36%
Avoid blood for transfusion that has not been screened	0	.0%	22	66.7%	3	21%
Avoid injections by non sterilized syringes	4	22.2%	21	63.6%	11	79%
Avoid sharing razors and blades	1	5.6%	18	54.5%	8	57%
Other	5	27.8%	0	.0%	1	7%
Do not know	0	.0%	0	.0%	1	7%

Table 36: Other service providers: Ways to avoid getting HIV

Preventing HIV/AIDS	LEB	%	OPT	%	Yemen pop 1	%
Abstain from sex	11	22.0%	13	72.2%	10	50%
Use of condom	40	80.0%	6	33.3%	4	20%
Stay faithful to partner	16	32.0%	6	33.3%	11	55%
Do not take drugs intravenously	24	48.0%	17	94.4%	3	15%
Avoid blood for transfusion that has not been screened	11	22.0%	17	94.4%	14	70%
Avoid injections by non sterilized syringes	24	48.0%	17	94.4%	12	60%
Avoid sharing razors and blades	6	12.0%	15	83.3%	16	80%
Do not know	0	.0%	0	.0%	-	-

It is noticed that service providers in oPt have considerably higher knowledge levels about STIs and HIV and AIDS than service providers in Lebanon. This could be explained by the fact that more service providers in oPt have attended training around the subject than in Lebanon. However, it should be noted that more parents and service providers have misconceptions about HIV modes of transmission and prevention in oPt than Lebanon.

It is also noted that the parents' level of knowledge in both countries is very low. Also, in both countries, health workers are more knowledgeable than other service providers.

Based on the above, it is recommended to provide training on STIs and HIV and AIDS for parents and service providers in oPt, Lebanon, and Yemen, with concentration on:

- *Parents in Lebanon and oPt, as they are important sources of information for children;*
- *Service providers in Lebanon;*
- *Service providers working in education, social work, counseling;*
- *Misconceptions about HIV modes of transmission and prevention, especially in oPt, in order to reduce stigma around HIV infected people;*
- *The least identified answers as per the results.*

F) SRH seeking behavior and services utilization

Children

Source of information on SRH

In Lebanon, 70.7% of children identified their “mother” as primary source of information or help in matters of sexual and reproductive health. This was followed by “father” and “gynecologist or doctor”. **In oPt, 76.7%** of children identified their “mother” as primary source of information or help in matters of sexual and reproductive health. This was followed by “father”, “sister”, and “gynecologist or doctor”. **In Yemen**, the refugee/returnee children were asked about their source of help and information if they face problems related to puberty. More than half of them (**52%**) identified their “mother”. This was followed by “father”, “siblings”, and “friends”.

In the three countries, more girls sought their mother, while more boys sought their father. “Teachers”, “social workers”, “counselors”, and “midwives/nurses”, and the media were not mentioned by many children.

Only 3.1% in Lebanon and 0.8% in oPt do not seek help or advice in SRH. The two main reasons (for Lebanon) were: “embarrassment” and “worry about breach of confidentiality”.

It is recommended to convey educational messages through the parents (both mothers and fathers since they are sought differently by boys and girls). It is also recommended to prepare the parents by educating them on SRH issues and ways to communicate about these topics with their children. Since “gynecologists and doctors” (in Lebanon and oPt) and “siblings” (in Yemen) were considered as a prominent source of information and help, it is also recommended to train them in providing youth-appropriate advice and counseling. It would also be beneficial to start introducing the service providers that were less sought after as “child-friendly” and approachable sources of information, through organization of interactive education sessions on SRH.

Since friends and the media were not mentioned as eminent sources of information on SRH in Lebanon and oPt, it is recommended to use the strongest and most mentioned channels. In Yemen however, friends can be used as peer educators, especially when targeting boys.

Table 37: Sources of information

	Yemen Male N=164	Fem N=175	Total N=359	LEB Male N=129	Fem N=100	Total N=229	OPT Male N=39	Fem N=81	Total N=120
DON'T KNOW				3.1%	.0%	1.7%	12.8 %	2.5%	5.8%
Seek no help or advice	2%	2%	2%	3.9%	2.0%	3.1%	.0%	1.2%	.8%
Teacher	<1%	<1%	<1%	10.9%	6.0%	8.7%	12.8 %	2.5%	5.8%
Mother	15%	87%	52%	56.6%	89.0%	70.7%	69.2 %	80.2%	76.7%
Father	48%	5%	26%	41.9%	16.0%	30.6%	64.1 %	2.5%	22.5%
Brother	19%	2%	10%	1.6%	3.0%	2.2%	10.3 %	1.2%	4.2%
Sister	4%	20%	12%	3.9%	13.0%	7.9%	.0%	33.3%	22.5%
Friend	27%	7%	17%	7.8%	7.0%	7.4%	7.7%	17.3%	14.2%
Relative				4.7%	2.0%	3.5%	7.7%	3.7%	5.0%
Gynecologist/doc tor				25.6%	26.0%	25.8%	28.2 %	17.3%	20.8%
Nurse/midwife				.0%	1.0%	.4%	.0%	.0%	.0%
Psychosocial counselor				1.6%	4.0%	2.6%	.0%	8.6%	5.8%
Social worker				7.0%	13.0%	9.6%	5.1%	2.5%	3.3%
Health center				7.0%	10.0%	8.3%	12.8 %	1.2%	5.0%
Youth center				.0%	1.0%	.4%	.0%	.0%	.0%
Religious leader				.0%	1.0%	.4%	.0%	.0%	.0%
Printed material (brochures)				.0%	.0%	.0%	.0%	.0%	.0%
Radio				.0%	.0%	.0%	.0%	.0%	.0%
TV				.0%	.0%	.0%	.0%	1.2%	.8%
Book				.8%	.0%	.4%	.0%	2.5%	1.7%
Internet				3.1%	1.0%	2.2%	.0%	1.2%	.8%
Other				10.1%	12.0%	10.9%	5.1%	2.5%	3.3%

Asking questions about SRH topics

In Lebanon, 73.7% of children had not asked their teacher about reproductive and sexual health topics. Girls were more likely than boys not to have asked their teacher about such topics. Children were also asked about the teacher's response when asked a question about SRH. About **22.8%** said that the teacher answered their question (rather than scolding, refusing to answer, or referring).

In addition, **32.9%** of children had not asked their parents about reproductive and sexual health topics. Boys were more likely than girls not to have asked their parents about such topics. About **61.4%** said that the parents answered their question (rather than scolding, refusing to answer, or referring).

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

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

Thus, interventions in this area need to focus both on getting more children to ask their parents and teachers, and preparing the parents and teachers to be able to respond. Seeing that more children had asked their teachers about SRH topics in oPt than Lebanon, it is advised to explore the reasons behind that difference in order to remove the barriers between children and teachers in Lebanon.

Table 38: Questions to teacher about SRH topics

How did your teacher react when you asked him/her about reproductive and sexual health topics?				
	LEB		OPT	
	Count	N %	Count	N %
I did not ask the teacher	168	73.7%	57	49.6%
The teacher scolded me	5	2.2%	5	4.3%
The teacher refused to answer	1	.4%	10	8.7%
The teacher referred me to ask somebody else	2	.9%	0	.0%
The teacher answered my question	52	22.8%	43	37.4%

Table 38: Questions to parents about SRH topics

How did your parent/s react when you asked them about reproductive and sexual health topics?				
	LEB		OPT	
	Count	N %	Count	N %
I did not ask my parents	75	32.9%	40	34.8%
My parent/s scolded me	6	2.6%	0	.0%
My parent/s refused to answer	4	1.8%	6	5.2%
My parent/s referred me to ask somebody else	3	1.3%	0	.0%
My parent/s answered my question	140	61.4%	69	60.0%

Attitude towards sexual and reproductive health education

In Lebanon, 39% of children believe that education on sexual and reproductive health should begin before the age of puberty. Girls were more likely than boys to state so.

The majority of children (**87%**) support the discussion of SRH topics in classrooms and awareness sessions, with the main reason being: “improvement of youth awareness”. Other children do not support the discussion of SRH topics because they do not believe there’s a need for it, or think that youth might be embarrassed.

On the other hand, the large majority of parents (**94.8%**) believe that sexual and reproductive health rights should be included in the school program. Around 74% of those who support the SRHR education in schools believe it should start before the age of **13**, with the average age being 11.45.

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

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

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

It is noticed that the children’s attitudes are less favorable in oPt than in Lebanon regarding education on SRH. On the other hand, parents and children attitudes are relatively positive regarding the discussion of SRH topics in schools. *These findings can be used in advocacy efforts with the schools in order to include SRHR topics within the curriculum.*

Table 39: Attitude towards start of SRH education

In your opinion, when should education on reproductive and sexual health start?				
	LEB		OPT	
	Count	N %	Count	N %
Don't know	8	3.5%	7	6.4%
Before the age of puberty	89	39.2%	25	22.7%
During the age of puberty	112	49.3%	59	53.6%
When one is getting ready for marriage	13	5.7%	18	16.4%
Other	5	2.2%	1	.9%

Usage of SRH services

In Lebanon, the majority of children (**80.3%**) do not use the health centers' SRH services, with fewer girls stating so than boys. The most stated reason for not using the health center services was that children do not know what services are available. "Other" reasons included: "shyness", "do not need to go", and "prefer to ask parents".

In oPt, about **28.3%** children do not use the health centers' SRH services, with more girls stating so than boys. The most stated reason for not using the health center services was that children do not know what services are available.

Table 40: Usage of SRH services at health center

	LEB		OPT	
	Count	N %	Count	N %
Don't use the health center/UNRWA clinic	184	80.3%	34	28.3%
Screening of STIs	3	1.3%	10	8.3%
Medication for STIs	3	1.3%	3	2.5%
Testing for HIV	3	1.3%	1	.8%
Counseling on HIV	2	.9%	0	.0%
Contraceptives	1	.4%	1	.8%
Pregnancy testing	11	4.8%	6	5.0%
Antenatal care	2	.9%	6	5.0%
Postnatal care	0	.0%	1	.8%
Psychosocial counseling	12	5.2%	9	7.5%
Referral to special care	4	1.7%	8	6.7%
Education sessions	9	3.9%	11	9.2%
Other	22	9.6%	31	25.8%

Thus, it is suggested to sensitize the children in the impact area about the child-friendly services available at the health centers by advertising them; this is especially relevant for Lebanon, where a very low percentage of children use the SRH services. It is also recommended to implement educational interventions with the aim of increasing the children's knowledge about their sexual and reproductive health rights, to ensure that they can claim their right to SRH.

Table 41: Reasons for not using SRH services at health center

	LEB	N %	OPT	N %
NA	15	8.2%	8	23.5%
Don't know what services are available	121	65.8%	21	61.8%
Too far	9	4.9%	0	.0%
Center does not have medicine/service	1	.5%	0	.0%
Only for married couples	2	1.1%	0	.0%
Too crowded	1	.5%	0	.0%
Long waiting hours	1	.5%	0	.0%
Unqualified staff	0	.0%	0	.0%
Staff unfriendly	0	.0%	2	5.9%
Not hygienic	0	.0%	0	.0%
Parents do not want me to go	1	.5%	1	2.9%
Worried about confidentiality and safety of information shared	1	.5%	0	.0%
Too expensive	0	.0%	0	.0%
Other reasons	32	17.4%	2	5.9%

In Yemen, children were asked about using the health services in general and not SRH services in particular. Around 82% of the refugee/returnee children reported using the curative services when sick. Reasons for not using the health center services included: “unavailability of medication”, “crowdedness”, “unfriendly staff”, “unhygienic conditions”, and other.

Health centers can be used to access the children in Yemen as most of them use their services. *However, it is recommended to introduce child-friendly SRH services to the centers, as well as work on improving the conditions and training the staff in order to better respond to the children needs.*

Parents and service providers

Source of information on SRH

In Lebanon, oPt, and Yemen, most parents and service providers believe that the “mother” is the primary source of information and help in matters of sexual and reproductive health. This is followed by “father”. However, in **Lebanon and oPt**, parents and service providers’ answers were different from the children as to the importance of service providers, friends, and the media. In fact, the caregivers believed that service providers and the media were important sources of information on SRH to children, who in their turn sought little information and help from these

sources. This misconception is very indicative for planning future communication activities through the right channels. **In Yemen**, older sisters (21%), brothers (29%) and best friends (29%) were also seen as sources for advice and help on puberty problems. None mentioned health workers or teachers as possible sources.

Table 42: Sources of information and help in SRH (Lebanon and oPt) and puberty problems (Yemen)

	Yemen pop 1: Refugees/ returnees		Yemen pop 2: Yemenis	Lebanon		oPt	
	Health (n=14)	Other SP	No info	Health	Other SP	Health	Other SP
Don't know		No info		.0%	.0%	.0%	.0%
Seek no help or advice	14%			.0%	.0%	5.7%	.0%
Teacher				27.8%	20.0%	8.6%	33.3%
Mother	71%			61.1%	78.0%	62.9%	88.9%
Father	64%			50.0%	68.0%	51.4%	77.8%
Brother	29%			5.6%	4.0%	8.6%	.0%
Sister	21%			11.1%	4.0%	8.6%	11.1%
Friend	29%			.0%	10.0%	31.4%	22.2%
Relative				.0%	6.0%	2.9%	5.6%
Gynecologist/docto r				55.6%	16.0%	22.9%	22.2%
Nurse/midwife				11.1%	12.0%	20.0%	11.1%
Psychosocial counselor				33.3%	18.0%	2.9%	.0%
Social worker				27.8%	40.0%	60.0%	55.6%
Health center				.0%	6.0%	8.6%	16.7%
Youth center				.0%	10.0%	2.9%	.0%
Religious leader				.0%	6.0%	2.9%	.0%
Printed material (brochures)				.0%	2.0%	.0%	.0%
Radio				.0%	.0%	.0%	.0%
TV				.0%	2.0%	5.7%	11.1%
Book				5.6%	.0%	2.9%	16.7%
Internet				.0%	.0%	11.4%	27.8%
Other				33.3%	44.0%	.0%	.0%

Perception about knowledge

In Lebanon, 65.3% of parents consider themselves to be knowledgeable enough to provide advice on RH issues, with more male respondents stating so than female respondents. Additionally, **77.9%** of service providers consider themselves to be knowledgeable enough to provide advice on RH issues. This confirms the previous findings about who the children consider to be their source of information.

However, **76.1%** of service providers were not asked by any children for SRH information in the month preceding the survey, and around **18%** were approached by between 1 and 10 children.

Around **57.4%** of service providers have received training in sexual and reproductive health. However, less health workers (41.2%) have received training in SRH than other service providers (62.7%).

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

However, **66%** of service providers were asked by only 1-10 children for SRH information in the month preceding the survey, and around 28.3% were approached by between 21 and 30 children. This also confirms the previous findings about who the children consider to be their source of information.

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

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

G) Engagement, marriage, and childbirth

Children

In both Lebanon and oPt (5 missing) **all** interviewed children were single.

In Yemen, among the refugee/returnee youth, **5** children were engaged, and **4** children were married. Two of those were aged between 10 and 14, and 6 of them were girls. Among the Yemeni children, ~97% (N=600 out 622) reported neither to be married or engaged; **1.9%** (N=12) reported to be engaged (all girls), **2** boys and **6** girls reported to be married and engaged, while **2** girls reported to be married.

Ideal ages for engagement and marriage

In Lebanon, more children (**87.3%**) believed that the ideal engagement age for boys is above 18 years than girls (**79%** of children). An increase is observed with regard to ideal age for marriage. With very close percentages, **95% and 96.9%** of children believe that the ideal age for marriage is above 18 years for girls and boys respectively. However, more children thought that boys should get married at a later age (25 or older) than girls. Interestingly, when comparing girls' responses to boys' responses, it is noticed that girls' ideal ages for engagement and marriage were higher in trends than boys.

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

In Yemen, **50%** of refugee/returnee children believe the ideal engagement age is less than 18 years, with more girls (63%) stating so than boys (43%). Around **94%** of these believed that the ideal marriage age is above 18 years.

Also, around **80%** of Yemeni children believed that the ideal marriage age is above 18 years, with girls having a preference for lower age groups than boys.

For oPt and Lebanon, the difference in engagement and marriage ages for girls and boys suggests that gender issues need to be tackled. It is noticed as well that girls' attitude towards engagement and marriage are healthier than the boys' attitude in Lebanon, and poorer than boys' attitude in oPt. Interventions targeting children attitudes in both countries therefore need to be tailored to boys and girls differently.

On the other hand, more concentrated efforts are needed for children in Yemen (both refugees and Yemenis) than those in Lebanon and oPt, since their attitudes towards early marriage and engagement are poorer than those in the two other countries, and some children under 18 were

found to be either engaged or married in the two populations. Interventions need to tackle girls' attitudes more than those of boys, as they have poorer attitudes than boys.

Attitude towards continuation of education

In Lebanon, 90.4% of children believe that children under 18 who are engaged should continue their education. These numbers decrease with regard to continuation of education of married children under 18, where **80.3%** of children are in favor.

In oPt, 84.2% of children believe that children under 18 who are engaged should continue their education. These numbers decrease with regard to continuation of education of married children under 18, where **77.9%** of children are in favor. In both cases, considerably more girls are in favor of continuation than boys.

In Yemen, among the refugee/returnee population, **58%** of girls and **48%** of boys would continue their education if married, as opposed to **64%** of the Yemeni children (69% of boys and 59% of girls).

Children in oPt have less favorable attitudes towards continuation of education for engaged and marriage children than Lebanon, while children in Yemen (both populations) have the least favorable attitudes. The Yemen results might explain the lower level of school enrolment of children; however, only a few children reported being married, and none of the children reported “engagement or marriage” to be a reason for school drop-out.

It is recommended to provide education sessions on the harms of early marriage and the importance of continuing education, to children in the 3 countries, with more concentrated efforts in oPt and Yemen.

Ideal age first child-bearing

In Lebanon, 80% of children thought that the ideal age for having a first child is above 18 years, with the majority of those stating the ideal age to be above 25 years. Interestingly, more girls than boys thought that the ideal age is above 25 years. Only **43%** of children think that pregnancy and child birth should be avoided during adolescence. Out of these, only **1%** identified 3 or more complications of delivery during adolescence; while most (55%) did not identify any complications. The most identified complications were: “overweight newborns” and “spontaneous abortion”.

In oPt, 74.6% of children thought that the ideal age for having a first child is above 18 years, with the majority of those stating the ideal age to be between 19 and 24 years. More boys than girls thought that the ideal age is above 25 years. About **60%** of children think that pregnancy and child birth should be avoided during adolescence. Out of these, only **14.9%** identified 3 or more complications of delivery during adolescence; while most (44.8%) did not identify any complications. The most identified complications were: “overweight newborns” and “spontaneous abortion”.

In Yemen, only **23%** of all refugee/returnee children (N=353) said that pregnancy should be avoided during adolescence. The main reasons given by the refugee/returnee children who said

that pregnancy should be avoided during teen years (N=81) were: “young mothers and fathers cannot care for the youth” (78%), “mother could die” (66%), “baby may die” (50%), “baby will likely be unhealthy” (16%), “mother could leave school” (10%), and “father could leave school” (7%).

Table 43: Attitude towards childbirth during adolescence

Are there any reasons why pregnancy/child birth should be avoided when a person is in his/her adolescence?		LEB	Valid Percent	OPT	Valid Percent	Yemen population 1	Valid Percent
Valid	No	75	32.9	18	16.1		29.0
	Yes	98	43.0	67	59.8		23.0
	Don't know	55	24.1	27	24.1		48.0
	Total	228	100.0	112	100.0		100.0

When comparing the results in the 3 countries, it is noticed that there are differences in attitudes between them as well as between girls and boys, with Yemen children having the least favorable attitudes towards childbirth during adolescence.

Table 44: Children: Number of identified complications of childbirth during adolescence

		LEB	Percent	OPT	Percent
Valid	0	54	55.1	30	44.8
	1	34	34.7	14	20.9
	2	9	9.2	13	19.4
	3 or more	1	1.0	10	14.9
	Total	98	100.0	67	100.0

In both Lebanon and oPt, the children’s knowledge about the complications of childbirth during adolescence is very low, with better knowledge levels in oPt than Lebanon.

The findings therefore show that even among the children who believe pregnancy should be avoided during adolescence, very few know the reasons why. This suggests that education about the complications and other consequences (social, economical, psychological) of childbirth during adolescence is needed in the 3 countries, especially in Yemen.

Parents

Ideal ages for engagement and marriage

In Lebanon, more parents (**96.5%**) believed that the ideal engagement age for boys is above 18 years than for girls (**85%** of parents). An increase is observed with regard to ideal age for marriage. With close percentages, **97.7% and 99.4%** of parents believe that the ideal age for marriage is above 18 years for girls and boys respectively. However, more parents thought that boys should get married at a later age (25 or older) than girls. When comparing the trends between male respondents and female respondents, it is noticed that female respondents tended to give a “higher” ideal age for both girls and boys engagement and marriage than male respondents.

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

In Yemen, around **92.4%** of the Yemeni population parents believed that the ideal age for boys’ marriage is above 18 years, while **89%** of parents thought so regarding girls’ ideal marriage age. Also, more parents (53.5%) thought that boys should get married at a later age (25 or older) than girls (38.4%).

Again, the least favorable attitudes among the 3 countries are observed in Yemen.

Attitude towards continuation of education

In Lebanon, **94.8%** of parents believe that children under 18 who are engaged should continue their education, with more female respondents in favor of continuation of education than male respondents. These numbers decrease with regard to continuation of education of married children under 18, where **84.7%** of parents are in favor of continuation, with more female respondents than male respondents being in favor.

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

In Yemen, **70%** of the Yemeni population parents believed that children under 18 who are married can continue their education. The differences by gender show that there is a perception that girls are less likely to continue school after marriage than boys.

It is also noted that Yemen has the least favorable attitude among the 3 countries regarding continuation of education.

Ideal age first child-bearing

In Lebanon, only **62.7%** of parents think that pregnancy and child birth should be avoided during adolescence. Out of these, only **12.3%** identified 3 or more complications of delivery during adolescence. The most identified complications were: “spontaneous abortion” and “mental and physical disabilities in children”.

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

Table 45: Parents: Number of identified complications of childbirth during adolescence

		LEB	Percent	OPT	Percent
Valid	0	40	37.7	37	35.2
	1	28	26.4	26	24.8
	2	25	23.6	19	18.1
	3 or more	13	12.3	23	21.9
	Total	106	100.0	105	100.0

Based on the results, education interventions need to target parents in the three countries (especially in Yemen). These should tackle:

- *Consequences of early engagement and marriage;*
- *Gender issues as they relate to engagement and marriage;*
- *Complications and other consequences (social, economical, psychological) of childbirth during adolescence.*

Service providers

Ideal ages for engagement and marriage

In Lebanon, **97% and 98.5%** of service providers thought that the ideal age for girls and boys respectively to get engaged is above 18 years. Around **98.5% and 97%** of service providers thought that the ideal age for girls and boys respectively to get married is above 18 years. These percentages are similar to those of ideal ages for engagement. However, the ideal age groups for girls are higher than those for engagement, whereby 67.2% of service providers thought that the ideal marriage age for girls is 25 years or older, as opposed to only 34.3% thinking this age group is best for engagement. Also, more service providers thought that boys should get married at a later age (25 or older) than girls.

In oPt, **all** service providers thought that the ideal age for engagement and marriage of both girls and boys is above 18 years. However, the ideal ages of engagement and marriage are lower for

girls than for boys; in fact, most service providers thought that girls should get engaged and married between 19 and 24 years, while boys should do so after the age of 25 years.

In Yemen, 78% and 93% of health workers in Basatin and Kharaz thought the ideal age for girls and boys respectively to get engaged is above 18 years. **All** health workers believed that the ideal age for marriage of both girls and boys is above 18 years. However, the ideal age groups for engagement and marriage were lower for girls than for boys; in fact, considerably more health workers (57%) thought that boys should get engaged at a later age (25 or older) than girls (21%); and 71% of the health workers thought that boys should get married at a later age (25 or older) as opposed to girls (43%).

In Aden, Lahej, and Abyan, **83.5% and 96.5%** the interviewed teachers believed that the ideal age for girls and boys respectively to get married is above 18 years. Also, considerably more teachers (81.9%) thought that boys should get married at a later age (25 or older) than girls (27%).

It is evident then that the attitudes of health workers in Yemen are less favorable than those of Lebanon and oPt. This is especially true for the service providers' opinion about ideal ages of engagement, which are much lower than ideal age of marriage in Yemen, whereas no significant differences were found in oPt and Lebanon. Gender differences also were found to affect the attitudes of service providers in the 3 countries. Furthermore, when the health workers were asked what they thought was the actual age of marriage for girls in Yemen, half of them (50%) said that it ranged between 15 and 18 years; this was followed by 21% indicating the age range of 19-20 years. Official statistics give a much lower age range for Yemen as a whole. In fact, there is a comparatively high rate of child marriage in Yemen, even as compared with the Middle East where this practice is relatively widespread. Currently, rural Yemen is estimated to have a child marriage rate of 52.1 percent¹⁰. In rural areas of Yemen, 32.3% of child marriages involve girls between the ages of 10-14.¹¹

Attitude towards continuation of education

In Lebanon, 95.6% of service providers believe that children under 18 who are engaged should continue their education. These numbers are somewhat similar with regard to continuation of education of married children under 18, where **98.5%** of service providers are in favor.

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

In Yemen, in Aden, Lahej, and Abyan, only **36%** the interviewed teachers believe that children under 18 who are married should continue their education, with more teachers in urban schools stating so than those in rural schools.

¹⁰ Oxfam et al (2005) *Early Marriage in Yemen. Research to Inform a Campaign on Early Marriage*, Oxfam, Shima (network on violence against women), Women's National Committee, Women's Studies Development Center, University of Sana', Sana', Republic of Yemen.

¹¹ SOUL (2004) *Child Rearing Practices Study. In Districts of Ul Udayn and Zaydiua*, Society for the Development of Women and Children with UNICEF. Sana', Republic of Yemen.

Service providers in Yemen have very poor attitudes towards continuation of education as compared to Lebanon and oPt. *Interventions should reach teachers in rural schools as well urban schools.*

Ideal age first child-bearing

In Lebanon, 97% of service providers think that pregnancy and child birth should be avoided during adolescence. Out of these, only **10.3%** identified 3 or more complications of delivery during adolescence. The most identified complications were: “spontaneous abortion” and “mental and physical disabilities in children”.

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

In Yemen, all interviewed health workers in Basatin and Kharaz believed that pregnancy and child birth should be avoided during adolescence. Reasons mostly given by the health workers included: “mother could die” (64%), “baby could die” (64%), “parents cannot take care of baby” (50%), “baby could be unhealthy” (36%), and “mother could leave school” (21%).

In the 3 countries, the service providers’ attitudes towards childbirth during adolescence are highly favorable. However, knowledge levels about the reasons were not high. It is noted that the knowledge level of service providers in oPt concerning complications of childbirth during adolescence is considerably higher than those in Lebanon.

Table 46: Service providers: Number of identified complications of childbirth during adolescence

		LEB	Percent	OPT	Percent
Valid	0	44	64.7	7	13.2
	1	8	11.8	6	11.3
	2	9	13.2	8	15.1
	3 or more	7	10.3	32	60.4
	Total	68	100.0	53	100.0

Based on the results of children, service providers, as well as parents, it is clear that child marriage is prevalent only in Yemen. The expressed attitudes of all respondents confirm this fact as well. In Lebanon and oPt, education interventions are needed to raise the awareness of all targeted populations on the complications of childbirth during adolescence, as well as to reinforce their favorable attitudes by raising awareness on the consequences of early engagement and marriage. In Yemen however, interventions need to target the improvement of children, parents’, and service providers’ attitudes about child marriage, continuation of education, and childbirth during adolescence.

H) Violence

Children

In Lebanon, there were no reports of violence from any of the children respondents. **In oPt**, there were only two reports of violence from one adult and one child respondent, in Arrub, and Ayda and Azzah; however, signs of abuse were noted by data collectors in all impact areas.

Attitude towards violence

Children were asked some questions regarding their attitude towards violence.

In Lebanon, regarding violence at home, **91%** of children disagreed with the statement: “it is appropriate for a husband to hit his wife or for a brother to hit his sister”, with more girls disagreeing than boys, and older children disagreeing more than younger children.

On the other hand, **96.9%** of children agreed with the statement: “I have the right to live without any kind of violence”, with no differences between girls and boys, and older children agreeing more than younger children.

Furthermore, **96.9%** of children agreed with the statement: “I have the responsibility to make sure I don’t hurt others”, with slightly more girls agreeing than boys; however, older children seemed to agree less than younger children, perhaps due to getting more involved in arguments and fights.

In oPt, regarding violence at home, **95.6%** of children disagreed with the statement: “it is appropriate for a husband to hit his wife or for a brother to hit his sister”, with more girls disagreeing than boys, and no remarkable differences among age groups.

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

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

When comparing results of children in Lebanon and oPt, it is noticed that the children attitudes towards violence at home and their right and responsibility to live violence-free are highly favorable. *Since there are differences between girls and boys, and among age groups, it is suggested to target girls and boys and different age groups with tailored interventions. The interventions should aim at educating the children on their rights regarding protection from violence so that they recognize when their rights are being violated and know how to protect themselves.*

Table 47: Attitude towards violence at home, by gender

		LEB						OPT					
		Male		Fem		Total		Male		Fem		Total	
		Cnt	%	Cnt	%	Cnt	%	Cnt	%	Cnt	%	Cnt	%
"It is appropriate for a husband to hit his wife or for a brother to hit his sister"	Disagree	115	89.1	94	94.0	209	91.3	36	92.3	73	97.3	109	95.6
	Agree	14	10.9	6	6.0	20	8.7	3	7.7	2	2.7	5	4.4
	Don't know	0	.0	0	.0	0	.0	0	.0	0	.0	0	.0

Table 48: Attitude towards the right to live without violence, by gender

		LEB						OPT					
		Male		Fem		Total		Male		Fem		Total	
		Cnt	%	Cnt	%	Cnt	%	Cnt	%	Cnt	%	Cnt	%
"I have the right to live without any kind of violence"	Disagree	4	3.2	2	2.0	6	2.7	1	2.8	3	4.3	4	3.8
	Agree	122	96.8	95	96.9	217	96.9	35	97.2	65	92.9	100	94.3
	Don't know	0	.0	1	1.0	1	.4	0	.0	2	2.9	2	1.9

Table 49: Attitude towards the responsibility not to hurt others, by gender

		LEB						OPT					
		Male		Fem		Total		Male		Fem		Total	
		Cnt	%	Cnt	%	Cnt	%	Cnt	%	Cnt	%	Cnt	%
"I have the responsibility to make sure I don't hurt others"	Disagree	5	3.9	1	1.0	6	2.6	2	5.1	5	6.7	7	6.1
	Agree	124	96.1	98	98.0	222	96.9	37	94.9	68	90.7	105	92.1
	Don't know	0	.0	1	1.0	1	.4	0	.0	2	2.7	2	1.8

In Yemen, children from the Yemeni population were asked whether “parents need to hurt or humiliate them in order to teach them or discipline them”. A little less than half of the children (45%) agreed with this statement, with youngest age groups agreeing most. Children were also asked about whether “teachers need to hurt or humiliate them in order to teach them or discipline them”. Around 39% of children agreed with this statement. Gender differences were observed for both statements.

Both these results suggest that Yemeni children’s attitudes towards violence are less than satisfactory. *There is a need for interventions targeting the children attitudes, as well as education on their rights regarding protection from violence, and on protection strategies.*

Knowledge about violence and sexual abuse

In Lebanon, the large majority of children (**83.8%**) said that there is violence against children aged 10-17 in their community. This shows that children are aware of violence in their community, and is indicative that violence is witnessed by the children themselves.

Nearly all children (**99%**) have identified 3 or more forms of physical abuse, with no differences between girls and boys, or among age groups. The most identified forms were: “burning with a match, cigarette, or hot water”, and “hitting with an object”. The least identified forms were: “shaking” and “forcing a child to stay in an uncomfortable position”.

Similarly, nearly all children (**99.6%**) have identified 3 or more forms of emotional and psychological abuse, with no differences between girls and boys, or among age groups. The most identified forms were: “parents abandoning their child”, and “neglecting the child’s emotional needs”.

Finally, **95.6%** of children have identified 3 or more forms of sexual abuse, with no remarkable differences between girls and boys, or among age groups. The most identified forms of sexual abuse were: “having sex with a child” and “making a child touch his or her private parts or someone else's private parts”.

Most children thought that the perpetrators of sexual abuse are males. “Male strangers” was the most identified perpetrator, mentioned by **51%** of children. Around 18% of children mentioned “friends” as the perpetrators, as opposed to only 2.6% who mentioned “boyfriends”.

On the other hand, only **14.4%** of children have identified 3 or more protection strategies from violence. Interestingly, more girls identified 2 or more protection strategies than boys. The most identified protection strategies were: “running or getting away” and “yelling”.

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

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

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

Finally, **83.8%** of children have identified 3 or more forms of sexual abuse, with no remarkable differences between girls and boys, and the age group 16-18 having the lowest knowledge level. This shows that the children’s are less knowledgeable about sexual abuse than physical or emotional abuse. The most identified forms of sexual abuse were: “having sex with a child”,

“making a child touch his or her private parts or someone else's private parts”, and “touching a child’s private parts”.

Around **28%** of children didn’t know the identity of the perpetrators of sexual abuse. Most children thought that the perpetrators of sexual abuse are males. “Male strangers” was the most identified perpetrator, mentioned by **30%** of children. Around 14.2% of children mentioned “friends” as the perpetrators, as opposed to only 9.6% who mentioned “boyfriends”.

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

It is noted that children in oPt are less aware of violence in their community than children in Lebanon. This is perhaps due to lower knowledge levels of children in oPt about the forms of violence that was observed regarding physical, emotional, as well as sexual abuse. In both countries, children had less knowledge about the forms of sexual abuse than the two other types of abuse, which might be explained by the “taboo” nature of the subject.

Also, children in oPt had lower knowledge about the possible identity of perpetrators of sexual abuse as well as protection strategies than those in Lebanon. However, in both countries, most children seemed to think that “males” were the perpetrators.

It is recommended to:

- Reinforce the children knowledge about the forms of violence, especially regarding sexual abuse;
- Tailor interventions to girls, boys, and different age groups;
- Focus on the least identified forms of abuse;
- Identify and remove the barriers facing communication between children and their caregivers (service providers and parents) on violence, and specifically sexual abuse;
- Educate children on the possible gender and identity of perpetrators of sexual abuse;
- Educate children on protection strategies and the availability of NGOs and other response services for victims of violence;
- Take into consideration that friends were more mentioned than boyfriends as perpetrators of sexual abuse, when planning for peer education in interventions related to SRH.

Table 50: Forms of physical abuse

Does physical abuse include:	LEB				OPT			
	No	Yes	Don't know	Total	No	Yes	Don't know	Total
Hitting with a hand	15.28	84.28	0.44	100.0%	6.67	87.50	1.67	95.83
Hitting with an object	3.06	96.51	0.00	100.0%	12.50	82.50	0.83	95.83
Shaking	41.92	56.33	1.75	100.0%	25.00	67.50	3.33	95.83
Pulling child's hair	10.48	89.08	0.44	100.0%	8.33	85.83	0.83	95.83
Burning with a match, cigarette, or hot water	1.31	98.25	0.44	100.0%	9.17	85.00	1.67	95.83
Forcing a child to stay in uncomfortable position, (such as kneeling in a corner)	45.85	52.40	1.75	100.0%	31.67	60.83	3.33	95.83
Forcing a child to take excessive physical exercise	35.37	63.32	1.31	100.0%	16.67	75.83	3.33	95.83

Table 51: Forms of emotional abuse

Does emotional or psychological abuse include	LEB				OPT			
	No	Yes	Don't know	Total	No	Yes	Don't know	Total
Bad name calling	6.99	93.01	0.00	100.00	5.00	90.00	0.83	95.83
Shouting	19.65	80.35	0.00	100.00	9.17	85.83	0.83	95.83
Saying to the child that no one loves him or her	8.73	90.39	0.87	100.00	6.67	88.33	0.83	95.83
Locking a child in a space by themselves	17.90	81.66	0.44	100.00	9.17	85.83	0.83	95.83
Threatening	13.97	86.03	0.00	100.00	10.83	84.17	0.83	95.83
Parents abandoning their child	1.31	98.69	0.00	100.00	5.00	90.00	0.83	95.83
Neglecting the child's emotional needs	5.24	94.32	0.00	99.56	10.83	82.50	2.50	95.83

Table 52: Forms of sexual abuse

Does sexual abuse include	LEB				OPT			
	No	Yes	Don't know	Total	No	Yes	Don't know	Total
Touching a child's private parts	3.93	93.01	3.06	100.00	6.67	81.67	5.83	94.17
Making a child touch his or her private parts or someone else's private parts	2.62	94.32	3.06	100.00	9.17	81.67	5.00	95.83
Having sex with a child	0.87	95.20	3.93	100.00	5.83	85.83	4.17	95.83
Showing a child magazines or films which show pictures of people with little or no clothes on	7.86	89.08	3.06	100.00	11.67	79.17	5.00	95.83
Telling a child 'dirty' stories or 'dirty' jokes	13.97	81.22	4.80	100.00	10.83	76.67	5.00	92.50

Table 53: Perpetrators of sexual abuse

	Lebanon			OPT		
	Male	Female	Total	Male	Female	Total
Don't know	24.03	18.00	21.40	38.46	23.46	28.33
Male stranger	48.06	55.00	51.09	7.69	40.74	30.00
Friend	16.28	20.00	17.90	23.08	9.88	14.17
Boyfriend	3.10	2.00	2.62	10.26	8.64	9.17
Uncle	5.43	7.00	6.11	2.56	4.94	4.17
Brother	3.88	11.00	6.99	12.82	11.11	11.67
Neighbor	13.95	17.00	15.28	0.00	9.88	6.67
Father	10.08	17.00	13.10	7.69	9.88	9.17
Other	18.60	34.00	25.33	12.82	11.11	11.67

Table 54: Protection mechanisms from violence

	LEB		OPT	
	Count	%	Count	%
Don't know	15	6.55	10	8.33
Say "No"	40	17.47	17	14.17
Tell a grown-up you trust	73	31.88	47	39.17
Run or get away	115	50.22	35	29.17
Yell	91	39.74	22	18.33
Do not take gifts in exchange of doing something you are not comfortable with	1	0.44	1	0.83
Learn more about violence against children through the internet, books, etc	2	0.87	1	0.83
Call a child helpline	8	3.49	3	2.50
Keep emergency numbers	2	0.87	3	2.50
Other	68	29.69	18	15.00

Knowledge about dating violence

In Lebanon, only **33.8%** of children have heard of the term “dating violence”, with more girls than boys, and more children in older age groups than younger. Around **75%** of the children believed that all forms of dating violence are not acceptable.

Children were also asked what they would do in case they were victims of any form of dating violence. The vast majority (**81.9%**) said that they would “break up with their partner”; **20%** would report it to someone they trust, 7% to the police, and 2.2% to an NGO. It is noted that more boys would break up with their partners than girls, and more girls would inform someone they trust than boys.

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

Children were also asked what they would do in case they were victims of any form of dating violence. Around **44.2%** said that they would “break up with their partner”; while **41.7%** would report it to someone they trust. Very few would report to the police (11.7%), or to an NGO (0.8%). It is noted that more girls would break up with their partners or inform someone they trust than boys. However, more boys would report to the police than girls.

When comparing results between oPt and Lebanon, more children in oPt have heard of the term “dating violence” than Lebanon; however children in Lebanon had more favorable attitudes than oPt.

Children need to be educated on protective mechanisms to be able to respond adequately to dating violence. Their knowledge of available support NGOs and services also needs to be raised.

Table 55: Protection mechanisms against dating violence

	Lebanon			OPT		
	Male	Female	Total	Male	Female	Total
Don't know	10.9%	2.0%	1.3%	7.7%	3.7%	5.0%
Inform someone you trust	83.7%	32.0%	20.1%	35.9%	44.4%	41.7%
Break up with your partner	7.8%	79.6%	81.9%	41.0%	45.7%	44.2%
Report to the police	1.6%	6.0%	7.0%	20.5%	7.4%	11.7%
Report to a specialized NGO	4.7%	3.0%	2.2%	2.6%	.0%	.8%
Do nothing	10.9%	1.0%	3.1%	.0%	1.2%	.8%
Other		10.0%	10.5%	15.4%	13.6%	14.2%

Parents

Knowledge about violence and sexual abuse

In Lebanon, the large majority of parents (**90.2%**) said that there is violence against children aged 10-17 in their community. This shows that parents are aware of violence in their community.

Nearly all parents (**96%**) have identified 3 or more forms of physical abuse, with more female respondents than male respondents. The most identified forms of physical abuse were: “burning with a match, cigarette, or hot water”, and “hitting with an object”. The least identified forms were: “forcing a child to stay in an uncomfortable position” and “Forcing a child to take excessive physical exercise”.

Similarly, nearly all parents (**98.9%**) have identified 3 or more forms of emotional and psychological abuse, with more male than female respondents. The most identified forms were: “parents abandoning their child” and “saying to the child that no one loves him or her”.

Finally, **97.7%** of parents have identified 3 or more forms of sexual abuse, with more female than male respondents. The most identified forms of sexual abuse were: “having sex with a child” and “making a child touch his or her private parts or someone else's private parts”.

Most parents thought that the perpetrators of sexual abuse are males. “Father” was the most identified perpetrator, mentioned by **55.2%** of parents. This was followed by “male stranger”, “brother”, and “uncle”, suggesting that parents mostly think that the perpetrators of sexual abuse are family members.

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

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

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

Finally, **85.1%** of parents have identified 3 or more forms of sexual abuse, with more male than female respondents. The most identified forms of sexual abuse were: “telling a child 'dirty' stories or 'dirty' jokes”, and “showing a child magazines or films which show pictures of people with little or no clothes on”.

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

It is noted that more parents are aware of violence in their community in Lebanon than oPt. The result reported in oPt could be due to lack of communication and/or parents’ denial about the prevalence of violence.

The parents’ levels of knowledge about forms of violence are lower in oPt, especially regarding sexual abuse. This might be explained by the “taboo” nature of the subject as well. *It is therefore recommended to:*

- *Concentrate awareness raising efforts on forms of sexual abuse;*
- *Create interventions to tackle the lack of communication around sexual abuse;*
- *Focus educational interventions on the least identified forms of violence, as well as non-violent discipline, and consequences of violence on the child;*
- *Tailor interventions to males and females.*

Furthermore, parents in both countries have identified “male” strangers and family members as perpetrators of sexual abuse, which gives an indication about the reality. *However, parents also need to be educated about the gender of perpetrators.*

Table 56: Number of identified forms of physical abuse by gender

		LEB						OPT					
		Male		Female		Total		Male		Female		Total	
		Cnt	%	Cnt	%	Cnt	%	Cnt	%	Cnt	%	Cnt	%
Forms identified	0	0	.0%	2	1.3%	2	1.1%	0	.0%	5	4.0%	5	3.5%
	1	1	4.2%	1	.7%	2	1.1%	0	.0%	0	.0%	0	.0%
	2	2	8.3%	1	.7%	3	1.7%	0	.0%	2	1.6%	2	1.4%
	3 or more	21	87.5%	146	97.3%	167	96.0%	17	100.0%	117	94.4%	134	95.0%

Table 57: Number of identified forms of emotional abuse by gender

		LEB						OPT					
		Male		Female		Total		Male		Female		Total	
		Cnt	%	Cnt	%	Cnt	%	Cnt	%	Cnt	%	Cnt	%
Forms identified	0	0	.0%	1	.7%	1	.6%	0	.0%	5	4.0%	5	3.5%
	1	0	.0%	0	.0%	0	.0%	0	.0%	0	.0%	0	.0%
	2	0	.0%	1	.7%	1	.6%	0	.0%	3	2.4%	3	2.1%
	3 or more	24	100.0%	148	98.7%	172	98.9%	17	100.0%	116	93.5%	133	94.3%

Table 58: Number of identified forms of sexual abuse by gender

		LEB						OPT					
		Male		Female		Total		Male		Female		Total	
		Cnt	%	Cnt	%	Cnt	%	Cnt	%	Cnt	%	Cnt	%
	0	0	.0%	2	1.3%	2	1.1%	1	5.9%	17	13.7%	18	12.8%
	1	0	.0%	0	.0%	0	.0%	0	.0%	2	1.6%	2	1.4%
	2	1	4.2%	1	.7%	2	1.1%	0	.0%	1	.8%	1	.7%
	3 or more	23	95.8%	147	98.0%	170	97.7%	16	94.1%	104	83.9%	120	85.1%

Service providers

Response to violence in the community

In Lebanon, the majority of service providers (**89.7%**) said that there is violence against children aged 10-17. This shows that they are aware of violence in their community. However, health workers seemed to be less aware of violence than other service providers.

Most service providers (**82%**) believe that violence against children occurs “at home from adults”. This is followed by “at school from teachers”.

Most service providers (**79.1%**) observe among their child patients/students signs that indicate violence. If violence is suspected as cause of the signs, most of the service providers (**57.4%**) refer the child to a specialized service such as an NGO or a counselor. Very few reported to the police (10.3%).

Only **one** health worker reported “treating the physical symptoms”, suggesting that the health workers in the impact area health centers do not treat victims of violence; this is most probably due to lack of specialization or adequate credentials.

On the other hand, the service providers’ workplaces (health centers, schools, NGOs, etc) have established systems for violence response. For instance, **79.4%** have referral systems, while **77.9%** have treatment and follow up. These centers however seem to lack the most in help lines and counseling for child victims of violence and sexual abuse.

Furthermore, **58.8%** of the service providers’ workplaces do not have any programs addressing the prevention of sexual abuse. However, more health centers (74.4%) didn’t have such programs than NGOs (32%). The least available intervention was “Development of IEC materials”, *which suggests that more efforts need to be planned in future project interventions with the field partners (including the NGOs and health centers) around communication and education on sexual abuse.*

In oPt, The majority of service providers (**92.5%**) said that there is violence against children aged 10-17. This shows that they are aware of violence in their community. However, health workers seemed to be less aware of violence than other service providers.

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

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

Around **25.7%** of the health workers reported “treating the physical symptoms”, suggesting that few health workers in the impact area health centers treat victims of violence.

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

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

In both Lebanon and oPt, the majority of service providers are aware of violence in their community. Also, in both countries, more health workers are aware of violence than other service providers. This could be an indication that health workers are less involved in the response to violence and less sought after by victims than other service providers such as counselors, who might be more acquainted with the community's social realities. *It is thus suggested to involve the health workers in both countries in responding to violence.*

Furthermore, more service providers in oPt are aware of violence in their community than in Lebanon. This could be due to:

- A lower prevalence of violence in Lebanon;
- A lower level of knowledge in Lebanon about the signs of violence.

In fact, less service providers observe signs of violence among their patients/students in Lebanon than in oPt, due to the same reasons.

Service providers mostly believe that violence occurs at home from adults, as well as at school from teachers, and between youth in the neighborhood. *Violence therefore needs to be tackled as it relates to the 3 populations of the KAP: children, parents, and service providers.*

When signs of violence are observed, the service providers in both countries mostly "refer" the victim either to a specialized NGO, or to their supervisor, etc. Very few report to the police in both countries. *It is thus recommended to create a coordinated response and referral mechanism involving the service providers, and to train these on their roles and responsibilities in adequate response to victims of violence. Training of service providers should include confidentiality, safety, and child protection principles.*

Seeing that health workers are also minimally involved in the treatment of symptoms of violence, it is also suggested to reinforce the health workforce at the impact area centers and equip them to be able to respond to victims of violence and be available for referral.

The prevention and response structures at the health centers, NGOs, and schools also need to be supported, with a focus on strengthening the least available programs where appropriate:

- *Help lines, counseling, and development of IEC material in Lebanon,*
- *Investigation, appropriate judicial involvement, and research in oPt.*

In Yemen, 71% of health workers (all from Basatin) said that violence against school-aged children in their community was common, as opposed to 29% (all from Kharaz) who did not think so. About **64%** of health workers (all from Basatin) had observed symptoms that indicated violence being used against children, while 36% (all except one were from Kharaz) had not observed any symptoms of violence. Most thought that violence against children occurs “at home from adults” (57%), followed by “between youth themselves” (43%), and “at school from older students” (36%). The symptoms observed were mostly bruises (89%). Cuts and broken bones were observed by 33% of the health workers. Twenty percent of health workers indicated that they had observed bruises as a result of sexual violence. When violence is suspected as cause of the signs, **57%** of health workers reported treating the symptoms, and discussing the reason of the symptoms with the caretaker of the child (**57%**).

Around **48%** of teachers from Aden, Lahej, and Abyan said that there is violence against school-aged children in their community. Most teachers (**66%**) believe that it occurs “at home from adults”. This is followed by “between youth themselves in the neighborhood” (34%), and “at school from teachers” (22%). About **27%** of teachers observe among their students signs that indicate violence. If violence is suspected as cause of the signs, **43.9%** of the teachers talk with the child and ask him about the reasons of the symptoms. This is followed by “asking the parents to come to school” (24.4%).

These results show that less service providers in Yemen are aware of violence in their community than oPt and Lebanon. However, most think that the violence occurs “at home from adults”, followed by “between youth” and “at school”. *This confirms that in Yemen as well, violence needs to be tackled at 3 levels: children, parents, and service providers.*

Also, less service providers (especially teachers) observe signs of violence in their child patients/students. Even when they observe signs, the service providers are not specific in describing them, and concentrate more on physical signs than behavioral, psychological, and other.

When signs of violence are observed, the service providers mostly “talk” with the victim and treat the symptoms. *This shows a need for training of service providers on their roles and responsibilities in response to violence. Training should include confidentiality, safety, and child protection principles.*

As the knowledge of service providers in Yemen about the forms and signs of violence was not measured, it is not possible to compare with oPt and Lebanon. *However, their lack of awareness of violence in their communities, as well as their answers related to signs of violence and their response to it give an indication that the Yemen service providers need to be educated about the identification of violence, as well as be trained on adequate response. A coordinated referral and response mechanism needs to be created among all partners in each impact area, in order to ensure proper care is provided for the victims of violence. It is important to focus on the health workers in Basatin, which seem to have the lowest awareness about violence.*

Table 59: Service providers on prevalence of violence against children in their community

	Yemen 1 (HW)	LEB (HW)	OPT (HW)	Yemen 2 (Other SP)	LEB (Other SP)	OPT (Other SP)
Yes	71%	83.3%	88.6%	47.8%	92.0%	100.0%
No	29%	16.7%	8.6%	52.2%	8.0%	.0%
Don't Know		.0%	2.9%		.0%	.0%

Table 60: Location of violence

	Yemen 1 HW	Yemen 2 Other SP	LEB HW	LEB Other SP	OPT HW	OPT Other SP
At home from adults	57%	66.0%	80.0%	87.0%	74.2%	66.7%
At home from older siblings	29%	22.6%	13.3%	15.2%	35.5%	50.0%
At school from teachers	21%	22.2%	53.3%	41.3%	41.9%	27.8%
At school from older students	36%	5.6%	13.3%	19.6%	51.6%	61.1%
Between youth themselves in the neighborhood	43%	34.0%	13.3%	17.4%	54.8%	83.3%
Other		3.8%	46.7%	47.8%	6.5%	27.8%

Table 61: Observing signs that indicate violence

	Yemen 1 (HW)	LEB (HW)	OPT (HW)	Yemen 2 (Other SP)	LEB (Other SP)	OPT (Other SP)
Yes	64%	62.5%	85.7%	27%	86.0%	100.0%
No	36%	37.5%	14.3%	73%	14.0%	.0%

Table 62: Course of action if violence is suspected

If you suspect violence, you	LEB				OPT			
	HW		Other SP		HW		Other SP	
	Count	%	Count	%	Count	%	Count	%
Do nothing	0	.0%	0	.0%	1	2.86	0	0.00
Treat the physical symptoms	1	1.5%	1	1.5%	9	25.71	1	5.56
Refer to a specialized service	8	11.8%	31	45.6%	17	48.57	9	50.00
Refer to supervisor	0	.0%	6	8.8%	22	62.86	13	72.22
Report to the police	3	4.4%	4	5.9%	3	8.57	0	0.00
Discuss directly with the perpetrator	1	1.5%	1	1.5%	3	8.57	3	16.67
Provide counseling to the child	2	2.9%	12	17.6%	15	42.86	11	61.11
Providing counseling to the family	5	7.4%	9	13.2%	13	37.14	6	33.33
Other	9	13.2%	20	29.4%	1	2.86	4	22.22

Table 63: Established response systems to violence

	LEB		OPT	
	Count	%	Count	%
Identification of violence/ sexual abuse	33	48.53	16	30.19
Reporting	46	67.65	17	32.08
Referral	54	79.41	20	37.74
Investigation	36	52.94	11	20.75
Treatment and follow up	53	77.94	23	43.40
Appropriate judicial involvement	29	42.65	13	24.53
Help lines, advice, and counseling for child victims of violence/sexual abuse	8	11.76	19	35.85

Table 64: Programs addressing the prevention of sexual abuse

	LEB				OPT			
	NGO		Health centre/clinic		UNRWA school		Health centre/clinic	
	Count	%	Count	%	Count	%	Count	%
Program not available	8	32.00	32	74.42	10	62.50	20	68.97
Community education	10	40.00	5	11.63	5	31.25	5	17.24
Development of IEC materials	6	24.00	4	9.30	5	31.25	4	13.79
Training of front line personnel	9	36.00	4	9.30	5	31.25	4	13.79
Advocacy for policy development and legal reform	8	32.00	3	6.98	5	31.25	4	13.79
Research	8	32.00	2	4.65	5	31.25	3	10.34

Knowledge about violence and sexual abuse

In Lebanon, all service providers (**100%**) have identified 3 or more forms of physical abuse. The most identified forms of physical abuse were: “burning with a match, cigarette, or hot water” and “hitting with an object”. The least identified forms were: “forcing a child to stay in an uncomfortable position” and “forcing a child to take excessive physical exercise”.

Only **16.2%** of service providers identified 3 or more signs of physical abuse as per the SCS guidelines. Contrary to expectations, less health workers identified 3 or more signs than “other service providers” working in education, counseling, and social work. This is perhaps due to victims not being referred or treated by health workers. The most identified signs of physical abuse were: “unexplained recurrent injuries” and “aggression towards others”.

Similarly, **94.1%** of service providers have identified 3 or more forms of sexual abuse, with more “other service providers” than health workers. The most identified forms of sexual abuse were: “having sex with a child” and “touching a child’s private parts”.

Only **16.2%** of service providers identified 3 or more signs of sexual abuse as per the SCS guidelines. There were no differences in knowledge levels between health workers and other service providers. The most identified sign of sexual abuse was: “being isolated and withdrawn”.

Most service providers thought that the perpetrators of sexual abuse are males. “Father” was the most identified perpetrator, mentioned by **38.2%** of service providers. This was followed by “uncle”, “neighbor”, and “brother”, suggesting that service providers believe most sexual abuse is perpetrated by close male family members.

In oPt, all service providers (**100%**) have identified 3 or more forms of physical abuse. The most identified forms of physical abuse were: “burning with a match, cigarette, or hot water”, “Hitting with an object”, and “Forcing a child to stay in uncomfortable position”.

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

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

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

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

It is noted that the service providers’ knowledge about forms of physical and sexual abuse was high in both Lebanon and oPt. However, their knowledge on signs of physical and sexual abuse was not as high, and was much lower in Lebanon than oPt. This might be due to service providers being more trained in oPt than Lebanon. Furthermore, this explains the fact that less service providers in Lebanon are aware of violence in their community, or could identify signs of violence among their patients/students, than those in oPt.

It is recommended to train the service providers on the SCS guidelines in order to help them identify signs of abuse and respond effectively. Efforts should concentrate on health workers in both countries, since they were found to be less knowledgeable than the other service providers.

Training needs

In Lebanon, 91.2% of the service providers feel that they have a responsibility to address violence in the community. However, only **40.9%** of service providers feel they have enough knowledge and skills to deal with children who have been sexually abused. In fact, only **31.3%** have received training on dealing with children who have been subject to violence or sexual abuse. Furthermore, only **25.4%** have received training regarding communication with children and their families, and facilitating children participation. Also, about **97%** of service providers feel confident in supporting children who have been sexually abused.

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

In Yemen, 64% of health workers (nearly all from Basatin) and around **92%** of teachers (in Aden, Abyan, and Lahej) felt that they have a responsibility to address violence in the community.

It is recommended to explore and tackle the barriers facing the service providers motivation and accountability towards violence victims in their community (especially in Kharaz and oPt). Training needs to target the service providers in providing youth-appropriate advice and counseling.

GENERAL RECOMMENDATIONS

Survey management:

- It is recommended to allocate more time for such surveys, especially when considering:
 1. The wide variety of indicators that need to be covered;
 2. The multiple targeted populations (children, parents, and different types of service providers);
 3. The geographical locations (Lebanon and oPt), and the time required to remotely and *adequately* supervise data collection and the quality of gathered data in another country;
 4. The change of plans perceived at the beginning of the survey, which required re-investment in gaining access to new NGOs and centers, and the gathering of new information upon which to plan the survey.

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

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

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

- Technical guidelines;
 - Qualitative research involving the children themselves in describing what child-friendly SRH services mean to them. This could also include qualitative perspectives of children survivors of violence about the quality of services received (through focus groups, and in-depth interviews)-to improve the quality of services for survivors of violence and sexual abuse.
- Regarding the section on “media habits” that was suppressed from the survey tools, it is suggested to use the section for conducting a smaller scale survey of the children media habits prior to campaign planning, in order to ensure better reach.
- It is also recommended to conduct qualitative research prior to development of material in order to explore misconceptions and attitudes. This will serve as complementary information to the survey results.

Educational interventions

All educational interventions need to:

- Start with qualitative research to complement the results of the KAP;
- Develop tailored programs for the different needs and levels of knowledge observed between boys and girls, and male respondents and female respondents;
- Develop tailored programs for the different age groups based on noted differences in knowledge and attitudes;
- Focus on the least identified answers and correct the misconceptions, as per the results of the KAP;
- Use print material as “support” and not as a sole activity;
- Engage the main sources of information for each topic as mentioned by children.

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

APPENDIX I:

SCS KAP INDICATORS

Protective skills

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

Protective mechanisms:

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

APPENDIX II:
LEBANON AND oPt QUESTIONNAIRES – ENGLISH VERSIONS

Appendix III:
LEBANON AND oPt QUESTIONNAIRES – ARABIC VERSIONS