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للطفولة المبكرة
Arab Network for Early Childhood

Situational Assessment of Young Children and Their Families During the Multidimensional Crisis in Lebanon

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List of main acronyms

ANECD	Arab Network for Early Childhood Development
BMI	Body Mass Index
CNS	Central Nervous System
COVID	Corona Virus
ECCE	Early Childhood Care and Education
ECD	Early Childhood Development
ECDI	Early Child Development Index
FGD	Focus Group Discussion
HCC	Higher Council for Childhood
KMO	Kaiser-Meyer-Olkin
MEHE	Ministry of Education and Higher Education
MOSA	Ministry of Social Affairs - Lebanon
SABER	Systems Approach for Better Education Results
SEM	Structural Equational Modeling
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations High Commissioner for Refugees
UNRWA	United Nations Relief and Works Agency

Executive Summary

The aim of ECD intervention programs is to make sure that all young children (0-8 years old) have equal access to essential needs. Young children grow and develop best in a warm, caring, stimulating, and responsive environment that provides them the opportunity to play and explore their environment which enables them to learn from their day-to-day exposure and stay protected from risk of danger, trauma, maltreatment, punishment, and other adverse life experiences. Research shows that there are large gains from in Well-being investing in ECD; however, in Lebanon, there is a gap in literature aiming to investigate the status of ECD after the 2019 health, economic and political crises.

The multidimensional crisis in Lebanon has had a significant impact on the well-being of young children and their families, with limited access to basic services, displacement, mental health issues, disrupted education, and increased risk of violence and exploitation. Addressing these issues will require a coordinated effort from government agencies, NGOs, and other stakeholders to provide support and resources to vulnerable families and children.

Situational assessment of young children and their families during the multidimensional crisis in Lebanon is a comprehensive report that assesses the state of ECD in the country. The report is based on extensive international and local based data, research, and analysis, including a survey questionnaire that was distributed to thousands of parents, teachers and caregivers.

The report highlights the key challenges faced by ECD in Lebanon, including limited access to quality ECD services, inadequate funding, and a lack of awareness and understanding of the importance of ECD among parents and caregivers.

The questionnaires responses analysis provides valuable insights into the experiences and perspectives of children, parents, teachers, healthcare givers and caregivers. The data collected revealed a range of issues, including a need for increased access to ECD services, better training and support for caregivers, and greater community involvement in promoting ECD.

Based on the findings of the report and questionnaire, a series of recommendations have been proposed. These include increasing investment in ECD, improving access to quality services, having crisis ready services, increasing public awareness, understanding of the importance of ECD, and enhancing the training and support provided to caregivers.

The report provides a valuable resource for policymakers, practitioners, and others working in the field of ECD in Lebanon. It highlights the urgent need for action to address the challenges faced by ECD and provides practical recommendations for improving the state of ECD in the country.

Background of the Study

ECD is a critical period for setting the foundation for a child's physical, cognitive, emotional, and social development, and that investing in ECD can have long-term benefits for individuals, communities, and societies.

Major international organizations have a slightly different definition of ECD based on their respective mandates and areas of focus:

UNICEF defines ECD as the process of physical, cognitive, emotional, and social development that occurs during the early years of a child's life, from birth to age 8. This includes activities that promote nurturing care, such as responsive caregiving, proper nutrition, and access to health care and early learning opportunities.

The United Nations Educational, Scientific and Cultural Organization (UNESCO)'s definition of ECD is focused on the learning and development of young children. They define ECD as "a holistic process that promotes the physical, cognitive, social and emotional development of children from birth to eight years of age, with the active participation of their parents, caregivers and community."

While the World Bank defines ECD as the period from conception to age 8, during which a child's brain is rapidly developing and their early experiences have a significant impact on their future outcomes. The World Bank emphasizes the importance of providing children with nurturing care, health and nutrition interventions, and access to high-quality early education.

Global interest in ECD

The Sustainable Development Goals (SDGs) are a set of 17 goals adopted by the United Nations General Assembly in 2015. The SDGs aim to end poverty, protect the planet, and ensure that all people enjoy peace and prosperity by 2030. One of the key goals of the SDGs is to ensure that all children have access to quality education, healthcare, and social support during the early years of their lives. This is where the Nurturing Care Framework for Early Childhood Development comes in.

The Nurturing Care Framework for Early Childhood Development was developed by the World Health Organization (WHO), the United Nations Children's Fund (UNICEF), and other partners in 2018. It is closely related to the SDGs as it is designed to support and promote the achievement of several SDGs related to health, education, and social development. Specifically, the Nurturing Care Framework aligns with SDG 3: Good Health and Well-being (having access to basic services, displacement, mental health issues, disrupted education, and increased risk of violence and exploitation), SDG 4: Quality Education, and SDG 10: Reduced Inequalities.

The framework aims to guide countries in developing policies and programs that promote the healthy development of young children.

The Center on the Developing Child at Harvard University has been at the forefront of research on ECD for over a decade. Their work focuses on understanding the science behind

how early experiences shape brain development and the factors that can influence that development positively or negatively.

One of the key findings from the Center's research is that the first few years of life are a critical period for brain development, and experiences during this time can have a profound impact on a child's lifelong outcomes. This includes their physical and mental health, cognitive abilities, social and emotional skills, and academic and professional success.

The Center's research also emphasizes the importance of a nurturing and stable environment for young children. When children experience chronic stress or trauma, such as poverty, neglect, abuse, or exposure to violence, it can disrupt their brain development and have lasting negative effects on their health and well-being.

Global focus and research on ECD

Recent studies conducted by UNICEF, UNESCO, and the World Bank have highlighted the importance of ECD in shaping a child's future.

UNICEF's research indicates that investing in ECD can lead to significant economic benefits, with a return on investment of up to 17 times the initial cost. UNESCO has emphasized the role of quality early learning opportunities in promoting children's cognitive and social development. The World Bank's studies have shown that ECD interventions can help break the cycle of poverty by improving health outcomes, increasing educational attainment, and boosting earning potential.

These studies demonstrate the critical role of ECD in promoting equitable and sustainable development. They highlight the need for policymakers to prioritize early childhood investments, including access to quality health care, nutrition, and early learning opportunities.

Although ECD research has been expanding in recent years, there are still several gaps that need to be addressed. Here are some of the key areas:

- Lack of data: ECD research often relies on data collected from small and homogeneous samples, which makes it difficult to draw generalizable conclusions. There is a need for larger and more diverse data sets to improve the accuracy of ECD research.
- Lack of longitudinal studies: Longitudinal studies that follow children over an extended period are critical to understanding the long-term impact of early childhood interventions. There is a need for more long-term studies to assess the effectiveness of different ECD programs and policies.
- Lack of focus on low- and middle-income countries: Most of the ECD research is conducted in high-income countries, and there is a need for more studies in low- and middle-income countries where the need for ECD interventions is the highest.

ECD in a newly established Lebanese context

It is of vital importance that children in Arab countries and societies have justice and enjoy their development; and this includes their right to be happy, have freedom, have social

justice and equality, and be in an enriching environment (ANECD, 2020). This justice cannot be accomplished if children are not in good health nor receiving proper growth, care, safety, and education in a sustainable way.

Lebanon, a middle-income country in the Eastern Mediterranean region with a population of approximately 6 million people, has a high level of inequality, with significant disparities between the wealthy and poor. According to the latest statistics from UNICEF, 8.6% of children under five years of age in Lebanon are stunted, 6.2% are underweight, and 2.6% are wasted.

The country has been facing multiple crises, including economic collapse, political instability, and the COVID-19 pandemic. These crises have had a significant impact on young children and their families.

- Economic challenges: The economic crisis in Lebanon has led to high levels of poverty and unemployment, which have had a significant impact on young children and their families. Many families are struggling to meet their basic needs, including food, shelter, and healthcare. Children are also facing increased risk of child labor and exploitation.
- Disrupted education: The COVID-19 pandemic and the economic crisis have led to disruptions in education, with many schools closing and families unable to afford educational expenses. The lack of access to education is likely to have long-term consequences for young children's development and well-being.
- Mental health concerns: The multiple crises in Lebanon have had a significant impact on the mental health of young children and their families. ANECD reports indicate an increase in stress, anxiety, and depression among children and caregivers. The lack of access to mental health services and support has further exacerbated these issues.
- Healthcare challenges: The economic crisis and the COVID-19 pandemic have also led to significant challenges in accessing healthcare services, including immunization and other preventive healthcare services. The lack of access to healthcare is likely to have long-term consequences for young children's health and development.

The Arab Network for Early Childhood (ANECD) has been working to address these challenges by providing support to families and caregivers, promoting access to education and healthcare services, and advocating for policies that prioritize the well-being of young children. However, the ongoing crises in Lebanon continue to pose significant challenges for young children and their families.

What aggravates the situation is the existence of data gaps in ECD research on the national level which include:

- Limited research on the impact of ECD interventions: There is a lack of research assessing the effectiveness of ECD interventions in Lebanon. This is critical given the high levels of poverty, displacement, and conflict in the country.

- Lack of coordination among stakeholders: There is a need for better coordination among different stakeholders involved in ECD in Lebanon, including government agencies, NGOs, and academic institutions.

Insufficient attention to the needs of vulnerable groups: There is a need for more research focusing on the needs of vulnerable groups, such as refugees and children living in poverty, who may be at greater risk of poor ECD outcomes.

In response to these challenges, the Ministry of Public Health (MoPH) in Lebanon collaborated with WHO and UNICEF to develop a national action plan for ECD, which was launched in 2019. The action plan is based on the Nurturing Care Framework for ECD and aims to promote the healthy development of children from birth to five years of age.

The action plan has five strategic objectives, including:

1. Strengthening the capacity of families, caregivers, and communities to provide nurturing care to young children.
2. Enhancing the availability, accessibility, and quality of health, nutrition, and early learning services for young children.
3. Strengthening policies and regulations to support the implementation of the Nurturing Care Framework.
4. Increasing investments in ECD to ensure sustainability and scale-up of interventions.
5. Strengthening monitoring, evaluation, and research on ECD to inform policy and programming.

The implementation of the action plan involves collaboration between multiple stakeholders, including the MoPH, Ministry of Education and Higher Education, Ministry of Social Affairs, and civil society organizations. The plan also emphasizes the importance of engaging communities and families in promoting ECD.

The action plan developed by the MoPH, WHO, and UNICEF is a comprehensive approach that addresses multiple factors that contribute to ECD. The success of the plan will depend on sustained commitment and collaboration among all stakeholders involved in its implementation.

ECD status in Lebanon: A multi-crisis dimensional mission

After the Corona Virus (COVID-19) pandemic and the outcome of the catastrophic August Beirut explosion, Lebanon started facing one of the world's worst economic depressions. This Lebanese crisis has laid its excessive negative effects, increasing daily, on children, who are growing hungry, working to help their family, and not receiving the proper health care due to an increase in medicine prices (UNICEF, 2021). Noteworthy, children in Lebanon have already been suffering of poverty and lack of basic services such as "education, housing, nutrition, health care, clean water and sanitation, and access to correct and useful information" and the COVID-19 pandemic as well as the Beirut explosion have contributed to worsening the situation (ANECD, 2020). According to the World Bank, children in Lebanon

don't have equal chances to develop healthy due to uncontrollable factors (Unicef, world bank, ECDAN, 2018). Early childhood development is essential when it comes to children development since poverty and inequality are transmitted from one generation to another. In Lebanon, not all children have the same chance to obtain a healthy ECD (El-Kogali & Krafft, 2015).

Thus, it is very important to research and monitor the status of ECD in Lebanon to ensure that children are obtaining a proper holistic care and growth, health, and maturation of socio-emotional, cognitive, language, and psychomotor development during early childhood. Having proper ECD means that children from birth to eight years old have a good start in life which can be confirmed through the delivery of nurturing and encouraging environment that meets the child's essential needs like "health, nutrition, safety, security, responsive care, and opportunity for early learning to ensure the overall health and wellbeing of young children" ('Maternal and Child Health Directorate', 2019).

Thus, the purpose of this research is to assess the early childhood care and development situation of young children and their families during the multi-dimensional crisis in Lebanon, in an aim to fill some of the gaps related to ECD and help in its advancement on the national and regional levels.

1. Objectives of the Research

This research aims at helping policymakers, stakeholders, partners, and others to:

- Learn more about young children under eight care and development and the challenges facing their families during the multidimensional crisis in Lebanon
- Examine cross-country and -sectoral data collected
- Anticipate related trends and issues that may affect young children under 8 and their families during the multi-dimensional crisis
- Identify related community wants, needs, and assets
- Identify the gaps in the system in relation to the young children under eight needs
- Set ECD priorities on the national level
- Raise recommendations and policy briefs for policymakers in Lebanon
- Orient funders and ECD stakeholders in the country

2. Research Questions

1. What are the challenges facing families of children under eight during the multidimensional crisis in Lebanon?
2. What is the status of young children under eight in Lebanon in each ECD domain?
3. What are the related issues that may affect young children under eight and their families during the multidimensional crisis?
4. How can ECD domains help in ensuring a proper development for children under eight?

3. Research Methodology

For this situational analysis, a mixed methodology was adapted exploring both quantitative and qualitative inputs. As in survey research, the researcher is usually interested in how and to what extent the responses differ their variability, how close some responses are related to others, and how responses vary within certain demographic variables or within the measures of social, political, or psychological variables (Creswell, 2007). Thus, both quantitative and qualitative methods were used to collect the data.

4. Data collection method

Multiple sources of evidence and triangulation were used. After the desk work, the first source of evidence was an online questionnaire, using Kobo Toolbox, which targets the parents and primary caregivers reached through partner organizations, ministries, and schools; parents and caregivers self-administered this survey. The second source of evidence was a face-to-face questionnaire that targets parents and primary caregivers reached through partner organizations, ministries, and schools; this data collection was carried out by data collectors physically sitting with parents and caregivers. In addition to the questionnaires, a third source of evidence was used to collect data to obtain more reliability: Focused Group Discussions (FGDs) with parents, teachers, and healthcare providers (school nurses and psychologists) were conducted where sets of guided interview questions were prepared ahead of time focusing on assessing the status of ECD in Lebanon.

The designed research tools aim to support the exploratory study conducted to provide a cursory look at the ECD in Lebanon. To begin with the Questionnaire, the designed household survey helped to produce statistically comprehensive data on more than 100 indicators of the ECD domains. The data collected through the survey instrument served the key ministries and stakeholders in Lebanon to identify the strategic issues in the ECD domains that might be affected by the Lebanese crisis in order to draw the policies to improve the quality of education, health, nutrition, and social care in the ECD settings for the children between beginning to 8 years old.

The data collection survey tool includes 9 sections aiming at conducting a comprehensive study exploring ECD under its different domains and their affecting circumstances covering:

- General demographic information
- Milestones and development, as the children's developmental milestones are reached within age range, the survey tool was developed in age spectrum segregated as follows: 0 to 3 months, 4 to 6 months, 7 to 9 months, 10 to 12 months, 1 to 2 years, 2 to 3 years,

4 to 5 years, and 5 to 8 years since children acquire skills through "iterative processes, manifestations of child behaviors are episodic, particularly during the first 1,000 days."

- Education includes early childhood, early childhood education, and primary education service provision for children between 0 to 8 years old, the cost of Education and access to regulated Education services.
- Health includes the reception of healthcare and treatment, access to immunizations, and medical support services.
- Nutrition includes the type of feeding program, the provision and quality of food and water, the need for nutrition supplements or fortified foods, and the changes occurring on the access to nutrition in each household.
- Social and emotional development includes the indicators covering the well-being of children and social habits with focus on the quality of interactive time for the children.
- Changes brought by Lebanon crisis includes the changes on the different levels such as social, financial, and access to primary services.
- Children mental health to inform about the impact of the different risk factors: poverty, reduced health and nutrition, insufficiency of care and lack of education on the child's mental health.
- Caregivers' mental health includes the mental health status care of the caregiver, parent who is responsible of the child's care.

The survey tool was filled through parents and caregivers' responses as direct observation of the child's development and reporting on the different ECD domains in the child's context. The responses were considered the most reliable to measure the provision and access to the different services in the child's life. The development of the research instrument followed procedural strategies in multi-phase and multi-method approach. The first phase of the work focused on identifying the ECD domains which served the research questions and scaling in order to generate items. A review of the selected items by ECD experts, data experts and researchers took place in order to make the tool more reliable and contextualized. The second phase of the instrument development consisted of piloting the selected items to measure the child development in Lebanon and the impact of the multi-dimensional crisis on the ECD domains. Based on the piloting-testing results, some amendments on the initial survey tool were conducted to have the final version to be used for data collection. The final phase of the work involved the validation of the survey tool in its final form including the Questionnaire for Parents of children under 8 years old.

The questionnaires were translated to Arabic (see appendix 1). In addition to the questionnaires, a third source of evidence was used to collect data to obtain more reliability. Regional FGD with parents, teachers, and healthcare providers were conducted. Three focus group discussions were conducted in each Governorate where set of guided interview questions (see appendix 3) were prepared ahead of time focusing on assessing the status of ECD in Lebanon.

a. Participants in the research

The participants in this research were invited randomly to take part and included parents, primary caregivers, teachers, and healthcare providers who were reached through partner organizations, ministries, and schools in the 5 governorates in Lebanon: Beirut, Bekaa, Mount of Lebanon, South, and North. 1379 questionnaires were filled to ensure reliability since the minimum sample number for such research is 384. As much as possible data from the online questionnaires was collected and which targeted the Governorates where the goal was not achieved. Standard quantitative indicators on child outcomes shed light on areas of inequity, highlighting which group of children benefit from existing ECD services, and which children remain underserved. The questionnaire explored the challenges facing families of children under the age of eight during the multidimensional crisis in Lebanon. On the other hand, qualitative surveys and stakeholder interviews were implemented with the goal of gaining a deeper understanding of the occurrence of gaps in service provision. As for the focus group, 15 groups from the five Governorates were interviewed. In each Governorate, three focus groups were conducted where a group of 5 parents, another of 5 teachers and a third of 5 healthcare providers were interviewed. The interview was transcribed and analyzed in a later state along with the data collected from the questionnaires.

b. Data collection phases and procedures

Several steps of data collection were taken in this research. The steps were divided into three main phases: The preparatory phase of the data collection, the final phase of the data collection, and the data analysis. Following is a small outline which details the methodological steps:

The preparatory phase

- A desk review was conducted referring to published reports by national and international partners focusing on the key areas of investigation.
- To begin with, access and ethics were implemented before and after the data collection procedure. As mentioned earlier, the population of this research is parents, teachers, and health cares in Lebanon. An informed consent letter was prepared and sent to the Ministry of Education and Higher Education (MEHE) and other organizations to get the approval of in-center data collection (see appendix 4). Participants were informed prior to the research conduct that it is voluntary and that they can stop at any time. Also, they were told that they do not have to answer any question that they do not want to answer. In addition, participants were informed that their responses will be kept confidential. Prior to each focus group and questionnaire, individuals were asked to complete an informed consent form to ensure voluntary agreement to participate in the study.

The actual data collection procedures involved 4 main ways:

Step 1: The online survey was distributed using Kobo Toolbox to parents and primary caregivers through the Community based organizations linked to Arab Network for Early Child Development (ANECD) partner organizations, the ministries of Education, Health and Social Affairs, and the public kindergartens and schools functioning under the umbrella of the Ministry of social affairs.

Step 2: The data from face-to-face survey was collected from field work with the parents reached in Step 1.

Step 3: 15 groups from the five governorates were interviewed. In each governorate, three focus groups were conducted where a group of 5 parents and primary caregivers, another of 5 teachers, and a third of 5 healthcare providers got interviewed. The interviews were transcribed and analyzed in a later stage along with the data collected from the questionnaires.

Step 4: Triangulation method was adopted. The common and uncommon data from each method was also analyzed. This confirmed the research findings and reliability of the research.

c. Data analysis

A pilot study was conducted to examine the validity and the reliability for the items in the questionnaire. Data was analyzed both quantitatively and qualitatively. Various statistical tests were applied to ensure the validity such as Kaiser-Meyer-Olkin measure of sampling adequacy (KMO), Bartlett's test of sphericity and Communalities. As for the reliability, Cronbach's Coefficient alpha is going to be used for the internal consistency between the items in the survey.

For the final data, the descriptive statistics were executed on the results to present the global view by using the appropriate tables and figures in addition to Mean and Standard deviation as statistical indicators for central tendency and dispersion.

In the next step, the inferential statistics was used to study the association between the demographic information and the items of Early Child Development Index (ECDI). Various statistical tests were applied like Chi-square, T-test, Anova and Correlation.

Based on the results, further statistical tests were used such as Anova to study the relations between items or indicators based on other indicators called Moderator or Mediation.

At the end, the Structural Equational Modeling (SEM) was applied to test and evaluate multivariate causal relationships between the indicators of ECDI.

The ECDI was developed by the World Health Organization (WHO) and UNICEF in collaboration with other international organizations. It is based on the principles of the International Classification of Functioning, Disability and Health (ICF) and the World Health Organization's Multicenter Growth Reference Study.

It measures the developmental status of young children across the following domains:

Physical development: This domain assesses children's growth, health, and motor skills. Indicators include measures of height, weight, and head circumference, as well as assessments of gross and fine motor skills.

Social-emotional development: This domain assesses children's ability to interact with others and regulate their emotions. Indicators include measures of social competence, such as the ability to make friends and cooperate with others, as well as measures of emotional regulation, such as the ability to calm down when upset.

Approaches to learning: This domain assesses children's curiosity, motivation, and persistence. Indicators include measures of children's interest in learning, their ability to pay attention and follow directions, and their willingness to try new things.

Language development: This domain assesses children's ability to understand and use language. Indicators include measures of children's vocabulary, comprehension, and expressive language skills.

Cognitive development: This domain assesses children's ability to think, reason, and solve problems. Indicators include measures of memory, attention, and problem-solving skills (UNICEF, 2017).

5. Literature review

a. Introduction

A child's early years exert a critical influence on a wide range of health and social outcomes throughout their life. Research now shows that the roots of many challenges in adult society - mental health problems, obesity or stunting, heart disease, crime, reading and writing difficulties, poor numeracy skills, and others can be traced back to early childhood. Indeed, economists believe, relying on available evidence, that investing in early childhood is the most cost-effective investment a country can make, and that the payoffs, which are spread over a lifetime, represent nine times - on average - the amount originally invested (UNICEF, 2014).

The nurturant qualities of the environments where children grow up, live, and learn matter the most for their development, yet parents cannot provide strong nurturant environments without help from local, regional, national, and international agencies. Recognizing the strong impact of ECD on adult life, it is

imperative that governments recognize that disparities in the nurturant environments required for healthy child development will impact differentially on the outcome of different nations and societies. In some societies, inequities in ECD translate into vastly different life chances for children; in others, however, disparities in ECD reach a critical point where they become a threat to peace and sustainable development. Though ECD is often framed as a 'luxury' on which resource-rich nations can afford to focus, it is an important matter to be considered in all countries, resource-rich and resource-poor alike (El-Kogali & Krafft, 2015). Governments can make major and sustained improvements in society by putting in place the right policies that consider this fruitful body of research while at the same time fulfilling their national obligations under the Convention on the Rights of the Child. Investing in ECD is an investment in a country's future (UNESCO, 2021b).

b. Historical background on early childhood development

The roots of early childhood education go as far back as the early 1500s, where the concept of educating children was attributed to Martin Luther (1483-1546). Back then, very few people knew how to read, and many were illiterate. Martin Luther believed that education should be universal and made it a point to emphasize that education strengthened the family as well as the community. This meant that teaching children how to read at an early age would be a strong benefit to society (McCartney & Phillips, 2008).

The philosophical foundations of early childhood education were provided by John Amos Comenius, John Locke, and Jean Jacques Rousseau. Its curriculum and methodology were created by the likes of Johann Heinrich Pestalozzi, Friedrich Froebel, Maria Montessori, and Rudolf Steiner. Most recently, it was scientifically grounded by the research and theories of Sigmund Freud, Jean Piaget, and Erik Erikson. While there are differences in the approaches of these progenitors of early childhood education, they are all overshadowed by one common principle: early childhood curriculum and practice must be adapted to the maturing needs, abilities, and interests of the child (Elkind, 2010).

Thus, the theorists for early education all would like to see the achievement of a common goal - to see the successful development of children in their primary years. How that goal is achieved differs in the structure of each curriculum (Bonnay, 2022).

c. Early development of the brain – the science behind ECD

In the past, scientists thought the brain was fully formed by the time a child was born. Thus, they believed that education or experience could do little to shape individual brain development. More recent research has revealed, however, that the brain keeps changing throughout life, with a great deal of brain formation taking place between birth and the age of three. Childhood experiences, moreover, shape the actual architecture and wiring of the brain (Young, 2002). Thus, the care and stimulation that children receive in their earliest years is critical to their cognitive development and future lives.

Connections within the brain are made before birth and continue to be made more rapidly throughout childhood and well into adolescence. Indeed, early childhood is a period of incredibly rapid brain development. A newborn baby has approximately one hundred billion neurons - the building blocks of the brain's electrical system. At birth, approximately only 17 percent of neurons are linked through synaptic connections; these neurons have not yet differentiated and specialized by function. The number of possible connections is, moreover, unlimited (OECD, 2007). Stimuli and experiences influence the formation of neural connections and the development of the sensory pathways (vision, sound, speech, touch, smell, and perception). The sensing pathways are the core neuronal pathways and interact to influence and develop higher brain functions such as emotion, language, and behavior (Bauer et al., 2010).

Brain development is the result of the interaction of nature - biological endowment or genetics - and nurture or experiences. Genetics provide the hardwiring, or the blueprint, needed to build the brain. Experiences (the stimulation the brain receives from the environment) are responsible for the synaptic connections and pruning that take place within the brain - and therefore have a major effect on brain development, with far-reaching consequences (Jeong et al., 2018).

During the early years of a child's life, brain plasticity is at its peak. Plasticity refers to the capacity of the brain to change in response to stimuli by creating and strengthening neuronal connections and weakening or eliminating others (OECD, 2007). In addition, brain development goes through sensitive periods when its activity is focused on developing specific and important brain functions and structures.

These sensitive periods constitute windows of opportunity for boosting a child's development. Experiences during these periods, more than at any other time, physically shape the structure of a child's brain because the brain is more malleable and more receptive to outside experiences. Unfortunately, the extreme plasticity of the brain during these periods is a double-edged sword that leads to both adaptation and vulnerability. Normal experiences (such as good nutrition and patterned visual information) during these sensitive periods support normal brain development. Abnormal experiences (such as prenatal alcohol exposure, occluded vision, or malnutrition) can cause both abnormal neural and behavioral development (Black, 2018).

As children grow, peers and other adults start to play a more prominent role in shaping and reinforcing their brain development. Approximately by 36 months, children begin to develop through social and play-based interactions with other children. By the time a child is three years old, the interactive stimulation of play with other children and early educators takes on a more prominent role, and the child increasingly becomes part of a social group. Previous research did not address the interdependence of socioemotional and cognitive development. Rather, it emphasized the development of cognitive skills. New research on the brain, however, suggests that socioemotional and cognitive skill development are intertwined and benefit from a holistic approach to ECD (OECD, 2007).

Research also shows that poor health in early childhood, as measured by low birth weight and nutritional status, is associated with poorer cognitive development and negative long-term schooling outcomes. Inadequate nutrition from before birth through the first two years of life, for example, can harm brain development too (Black, 2018).

In brief, the brain develops rapidly during the early years, and experiences during this period can shape the structure and functioning of the brain. ECD emphasizes the importance of providing a nurturing and stimulating environment for optimal brain development, including positive experiences, early interventions, and strong relationships with caregivers (Shonkoff, 2016).

d. Universal principles of ECD

Based on Jeong (2021) and Britto (2017), there are several principles which are universally characteristics of ECD; they are consistently upheld irrespective of society and a child and family's place within that society.

First, the early years of life are marked by the most rapid development, especially of the central nervous system (CNS).

Second, there are several sensitive or 'critical periods' in the development of the human brain that occur almost exclusively during this time period. For each of these critical periods, specific regions of the brain undergo crucial growth and formation.

Third, the environmental conditions to which children are exposed in the earliest years literally "sculpt" the developing brain. The more 'nurturant' the physical, social, and economic environments of children during the early years, the greater the chances for successful development of the growing child.

Fourth, the development occurring during this time provides the essential building blocks for a lifetime of success in many domains of life, including economic, social, and physical well-being. Certainly, people continue to develop beyond the early years; however, science has demonstrated that healthy ECD is fundamental to health, success, and happiness not only for the duration of

childhood, but throughout the life course. As such, the environmental conditions to which children are exposed in the earliest years of development are consequential over the entire life course.

Fifth, and related to the preceding point, the pervasive socioeconomic inequities in adult health outcomes have roots in socioeconomic inequities in ECD. That is, during the earliest years of life, differences in the extent of nurturance provided by children's environmental conditions lead to differences in ECD outcomes; the effects of these early inequities last for a lifetime, and translate into inequities in health in later childhood, adolescence, and in adulthood (Pia R. Britto et al., 2017; Jeong et al., 2021).

e. Vulnerability and resilience in early child development

Over the past four decades, the study of vulnerability and resilience has played a central role in the emergence of developmental psychopathology as an integrative framework for understanding pathways to positive and negative adaptation. Though distinct in meaning and history, the concepts of vulnerability and resilience both stem from observed differences in how well individuals adapt to the challenges posed by life, either in normative or in extraordinary situations. *Vulnerability* generally refers to the predisposition or susceptibility of some people to specific diseases or maladaptive development in the face of negative experiences. This concept originated in the idea of vulnerability to injury in battle, from the Latin verb *vulnerare* (to wound). *Resilience* generally refers to positive adaptation that has been manifested in the face of negative experiences. This concept has origins in the idea of physical materials that withstand stress without breaking or cracking and in the idea of springing back or recovery, stemming from the Latin verb *resilire* (to recoil or leap back) (McCartney & Phillips, 2008).

Vulnerability	Susceptibility to a specified negative outcome in the context of risk or adversity
Risk	Elevated probability of a negative or undesirable outcome in the future
Risk factors	Measurable attributes of people, their relationships, or contexts associated with risk
Stressor	An experience or event expected or observed to have significant negative or disruptive effects on the adaptation of individuals or other systems (families, organizations)
Adversity	Lasting or repeated experiences expected or observed to have significant negative effects or disruptive effects on

	adaptation; multiple stressors usually involved
Stress	The state of disturbance in adaptation within an organism (or system) resulting from a stressor, often characterized by disequilibrium in functioning and efforts to restore adaptive functioning
Coping	Efforts to adapt to stress or other disturbances created by a stressor or adversity
Developmental tasks	Standards of performance or achievement in various domains of adaptation expected by a particular society or social group for individuals during different periods of development, and that vary by culture, gender, period in history, and situation
Resilience	Positive patterns of adaptation in the context of risk or adversity
Assets or promotive factors	Measurable attributes of people, their relationships, or contexts generally associated with positive outcomes or development (regardless of adversity or risk level)
Protective factors	Measurable attributes of individuals, their relationships, or contexts particularly associated with positive outcomes or development in the context of risk or adversity

Table 1: concepts related to vulnerability and resilience in child development (McCartney & Phillips, 2008).

Developmental theories about vulnerability and resilience and their application in prevention science or policy are becoming more complex, dynamic, multi-level, multidisciplinary, and systems oriented. Exciting new work on the neurobiology of vulnerability and resilience is emerging, as investigators capitalize on new tools for assessment and analysis, and new knowledge in molecular genetics and neuroscience, to probe gene–environment interaction and co-action, the boundaries of brain plasticity, and the processes by which early experience alters gene expression or sets biological regulatory systems (Sinno et al., 2013).

There is also a growing attention to cultural and contextual differences, as investigators study more diverse cultures and consider context-specific risk and

protective factors along with the possibility of context-by-context interactions. Long-neglected, culturally based protective systems, including religion and many other cultural traditions and practices, are garnering more empirical attention. Multi-level dynamics are taking center stage, as investigators from different disciplines team up to examine how interactions across system levels (from genes to person to family, media, or national policy) co-regulate human development and adaptation in the face of challenge. At the same time, interventions to promote resilience are becoming more evidence based, theoretically informative, and embedded in community systems (Phillips, D. A., Lipsey, M. W., & Dodge, 2019).

f. The domains of ECD

There are five important areas or "domains" of ECD. Although listed separately, all five outcomes are considered interdependent, especially cognitive, and socioemotional development (Vegas & Santibanez, 2009). The 5 domains of ECD are:

- Physical health and wellbeing
- Social competence
- Emotional maturity
- Language and cognitive skills
- Communication skills and general knowledge.

Figure 1 shows the placement of the 5 domains as the core for any analytical approach of the ECD framework. The macro and micro contexts and the ECD policies act through the target groups on these domains to promote life outcomes.

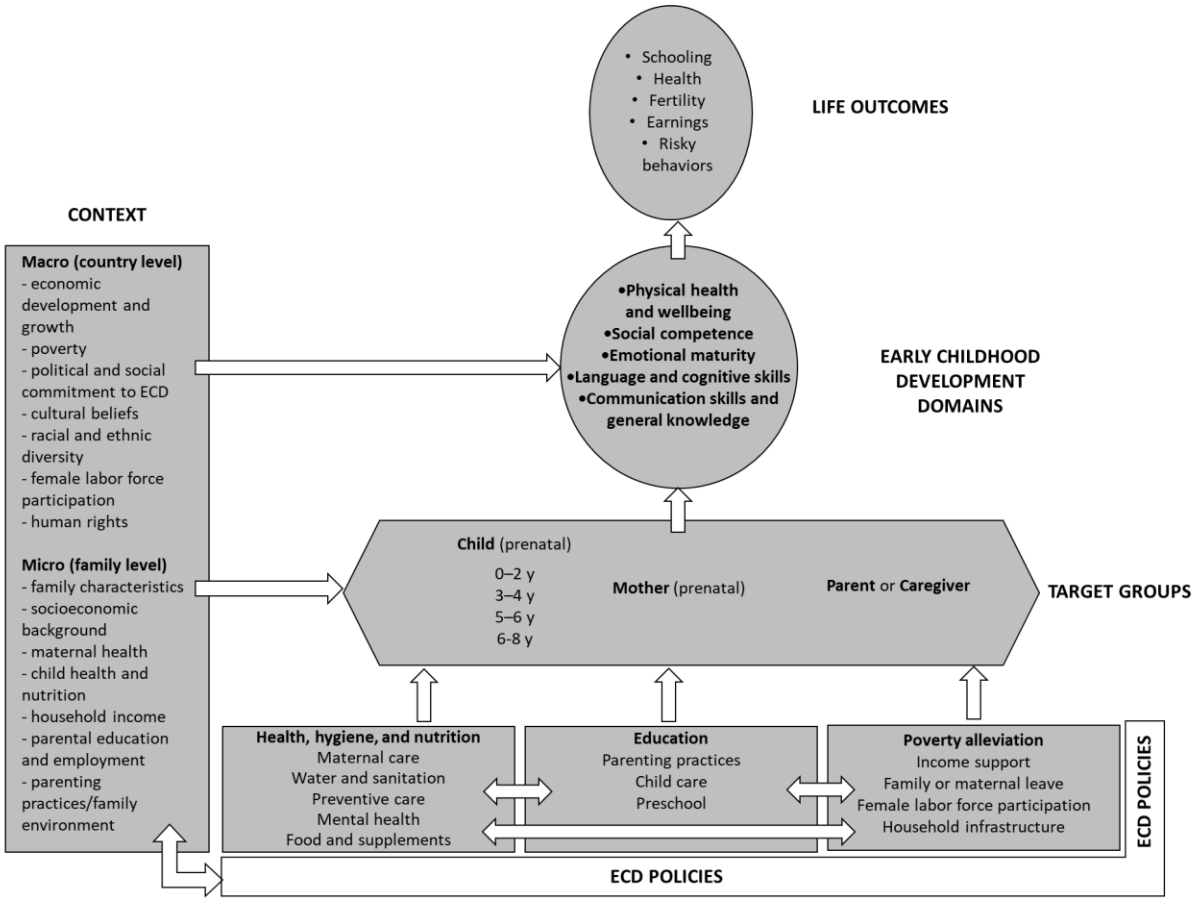

Figure 1: ECD domains in the general ECD analytical framework based on (Vegas & Santibanez, 2009)

g. Physical health and wellbeing

The physical domain covers the development of physical changes, which includes growing in size and strength, as well as the development of both gross motor skills and fine motor skills. The physical domain also includes the development of the senses and using them. When young, children are learning how to perform different activities with their fingers in coordination with their eyes such as grasping, releasing, reaching, pinching, and turning their wrist. Because these small muscle movements take time to develop, they may not come easily at first (OECD, 2017).

These fine motor skills help kids perform tasks for daily living, like buttoning buttons, picking up finger foods, using a fork, pouring milk, going to the restroom, and washing their hands.

In addition to these fine motor skills, kids also learn to use their larger muscles, like those in their arms, legs, back, and stomach. Walking, running, throwing, lifting, pulling, pushing, and kicking are all important skills that are related to body awareness, balance, and strength. Later, toys that allow them to pick things up and fit them into slots are good for developing beginning skills.

Physical development also can be influenced by nutrition and illness. Kids need to have a healthy diet and regular wellness check-ups to promote proper child development (Bauer et al., 2010).

h. Social competence and emotional maturity

The socio-emotional domain includes a child's growing understanding and control of their emotions. They also begin to identify what others are feeling, develop the ability to cooperate, show empathy, and use moral reasoning.

This domain includes developing attachments to others and learning how to interact with them. For instance, children learn how to share, take turns, and accept differences in others. They also develop many different types of relationships, from parents and siblings to peers, teachers, coaches, and others in the community.

Children develop self-knowledge during the socio-emotional stage. They learn how they identify with different groups and their innate temperament will emerge in their relationships. It is during early childhood that the enhanced autonomous functioning of children plays a more critical role in determining the nature of social relationships and the subsequent consequences associated with these. In addition, the increased cognitive, physical, and communicative skills that are gained over the course of early childhood facilitate the growth of a variety of social abilities (WHO, 2020).

i. Language and cognitive skills

Language development is dependent on the other developmental domains. The ability to communicate with others grows from infancy, but children develop these abilities at different rates.

Aspects of language include:

- Phonology: Creating the sounds of speech
- Pragmatics: Communicating verbally and non-verbally in social situations
- Semantics: Understanding the rules of what words mean
- Syntax: Using grammar and putting sentences together

Reading out loud to kids from birth and beyond has a major impact on their emerging language and literacy skills. One of the most important things to do with a child throughout their early life is to read to them - and not just at bedtime (McCartney & Phillips, 2008).

Hearing new vocabulary words spoken expands a child's vocabulary and helps them prepare to identify unfamiliar words when used in context.

As they get older, holding regular conversations, answering questions, and asking for child's ideas or opinions are an important part of their language development.

The cognitive domain includes intellectual development and creativity. As they develop cognitively, kids gain the ability to process thoughts, pay attention, develop memories, understand their surroundings, express creativity, as well as to make, implement, and accomplish plans.

By the end of early childhood, a child can count to 10, knows his colors, and can read his name. He knows the difference between fact and fiction, making him capable of understanding the difference between the truth and a lie, according to the Child Development Institute (Trawick-Smith, 2018).

j. Communication skills and general knowledge

Communicative development includes child's skills to understand the spoken word and express herself verbally. During early childhood, a child goes from speaking in short sentences to speaking in sentences of more than five words. A child, once understandable only to those closest to her, now speaks clearly enough that even strangers understand his words. He talks about experiences, shares personal information, and understands positional concepts such as up and down. At this age, it becomes possible to carry on a back-and-forth conversation (McCartney & Phillips, 2008).

k. ECD related policies

ECD can be supported by and integrated into many programs and policies. Having an overarching national commitment to ECD is an important element of promoting children's healthy development. As part of national strategies, it is important to identify or establish a leading agency or high-level council to plan, coordinate, implement, and evaluate national action on ECD (UNESCO, 2010). Prioritizing ECD in a country requires identifying the policies in place and policy gaps in ECD promotion. One tool that can be useful for countries in assessing their policies for ECD is the Systems Approach for Better Education Results (SABER) ECD tool (World Bank, 2013). This tool assesses policies from a multisectoral perspective and across a variety of actors to identify countries' progress towards ECD goals and to generate policy steps to promote ECD. A checklist approach can be used to identify whether policies to promote ECD are in place at a country level, including such indicators as childhood immunizations, salt iodization, parenting programs, free pre-primary, and legal protections of young children. The tool focuses on three policy goals across systems: (1) establishing an

enabling environment, (2) implementing widely, and (3) monitoring and assuring quality. For instance, this tool has been used to assess ECD globally, including in some MENA countries specifically Lebanon. Assessing policies, both "on the books" and "on the ground" connecting them to outcomes and identifying a way forward with SABER-ECD can be powerful tools for countries' protection of children and human development (El-Kogali & Krafft, 2015).

ECD national and regional policies along with ECD crisis and conflict response and mitigation plans, can be tackled from a wide range of issues starting from the provision of early childhood care and education services to health, hygiene, and nutrition programs for parents and children, to poverty reduction interventions and others. These policies can be targeted to the child, parent, and/or primary caregiver. Interventions can take place at home, school, or childcare center; a hospital, clinic, or community health center; or at a community gathering space.

Civil society groups are conceptualized as being organized at, and acting on, all levels of social organization from local residential through global. The ability of civil society to act on behalf of children is a function of the extent of "social capital" or connectedness of citizens, and the support of political institutions in promoting expressions of civil organization. When civil society is enabled, there are many avenues through which they can engage on behalf of children. Civil society groups can initiate government, non-government organization, and community action on social determinants and policies related to ECD. They can advocate on behalf of children to assure that governments and international agencies adopt policies that positively benefit children's well-being. Finally, civil society groups are instrumental in organizing strategies at the local level to provide families and children with effective delivery of ECD services, to improve the safety, cohesion, and efficacy of residential environments, and to increase the capacity of local and relational communities to better the lives of children. Although research on the direct effect of civil society on ECD is limited, the strong statistical association between the strength of civil society and human development in societies around the globe leaves little doubt about its importance to ECD (Abouzeid et al., 2021).

l. Contribution of genes and environments to children's development

Gene–environment processes are not static over time. Environments evolve and the expressions of genes change as well. The evidence from quantitative genetic and, more recently, molecular genetic studies is clear in showing that genetic and environmental influences are operating together to produce the wide variations that we see between children in their physical and psychological functioning. Researchers of early childhood must prepare themselves for integrating findings and research methods from molecular biology with the very best procedures currently used in mainstreaming developmental psychology (McCartney & Phillips, 2008).

The correlations and interactions between genes and environments also can change. Gene–environment processes also vary between population groups and across eras within populations. This dynamism requires that if the interplay between genes and environments is to be fully understood, investigations of gene–environment processes must be conducted within a developmental context and with serious consideration to the environmental, historical, and systemic conditions of the population under study. Therefore, research examining gene–environment transactions must be guided by developmental theories (Sinno et al., 2013).

Some effects of Gene-environment on ECD related domains are presented hereafter:

Effects on stature and physical development

Environmental effects on Body Mass Index (BMI=Weight/[Height]^2) are reflected in rapid generational changes, evidenced as increases in the rates of obesity in children in the US. From 1988 to 1994, the rate of obesity in 2- to 5-year-olds rose from 7.2 percent to 10.4 percent (Ogden et al.,2002). In this case, environmental conditions are implicated because genetic influences do not change this rapidly. Correlational research revealing that breastfeeding in infancy reduces children's risk for childhood obesity also points to the importance of early environmental experiences in physical development (Dietz, 2001).

Effects on cognitive development

Individual differences in children's cognitive development include several interrelated domains of skill and performance, ranging from processing speed and capacity to complex problem solving, to language understanding and use. The two areas of inquiry that have received the most attention among researchers studying ECD are general cognitive ability (e.g., intelligence or IQ) and verbal communication skills.

General cognitive ability

Typically, general cognitive ability is estimated to be moderately heritable, based on twin and adoption studies of preschoolers. Longitudinal studies also suggest that genetic influences on general cognitive ability increase over early and middle childhood, while shared environmental effects are modest and often disappear by middle childhood. This may reflect developmental changes arising from shifts in the degree to which children have more control, and parents less control, over their environments and daily experiences. Nevertheless, interventions for improving cognitive performance have been shown to be effective, and it is important to emphasize that about half of the variance in cognitive abilities is accounted for by non-shared environmental influences.

On the other hand, single-gene disorders and chromosomal abnormalities are the most common causes of major deficits in general cognitive ability. Down's syndrome is a chromosomal abnormality characterized by the presence of a third twenty-first

chromosome, and it is the most widespread cause of mental retardation in both males and females (Nomaguchi & Milkie, 2017).

Language and communication

Many components of language and literacy development are moderately heritable. In this domain, the effects of the shared environment are often more evident, compared to the domain of general cognitive ability. Expressive language skills – compared to receptive skills – appear to be more genetically variable, and more of this genetic variance overlaps with genetic influences on general cognitive ability. In contrast, shared environmental influences appear to be more prominent for receptive language skills, compared with expressive skills (The National Academies of Science Engineering and Medicine, 2015). Deater-Deckard & Panneton, (2017) reported heritability estimates of 25 percent and 39 percent for lexical and grammatical development, respectively, in 2-year-olds. Shared environmental effects were estimated at 69 percent for grammar and 48 percent for lexical development. Common genetic and environmental processes are thought to underlie lexical and grammatical development, but it is less clear whether general verbal and non-verbal language development shares genetic and environmental influences (Fisher & Vernes, 2015). Verbal and non-verbal skills in 2-year-olds are moderately correlated, and less than half of this similarity is accounted for by common genetic influences.

However, in contrast, College et al. (2002) found extensive overlap in the genetic influence on verbal and non-verbal skills in 4-year-olds. Genetic factors appear to be highly influential when it comes to more severe language and communication problems and disorders. Similarly, variance in vocabulary scores for children with persistent language problems in early childhood was largely accounted for by genetic factors, whereas variance in vocabulary scores for children with transient language problems was more likely to be accounted for by environmental factors (Bishop et al., 2003).

The genetic basis of dyslexia and other reading and communication disorders is currently under intense study, and the results of this research will allow for a clearer understanding of how genes and environments work together in shaping children's language development (Oliver & Plomin, 2007).

Effects on socioemotional development

Temperament is the framework for personality. It is rooted in biologically based individual differences, is moderately stable over time and across settings, and is modified by gene–environment processes. Individual differences in temperament are observable from infancy and are implicated in many crucial aspects of children's development and adaptation(Jeong et al., 2021).

The temperament dimension of *negative affectivity* includes anger, sadness, discomfort, and low sooth ability. Quantitative genetic research indicates that approximately one-third to two-thirds of the variance in negative affectivity is heritable. Angry reactions to restraint

and the initiating of fights are estimated to be heritable, and this genetic variance appears to contribute mainly to the observable stability of individual differences. Some evidence for shared environmental influence also has been found, and environmental sources of variance contribute to both continuity and change in these behaviors across infancy and the preschool years. Molecular genetic research has implicated dopamine and serotonin genes in negative emotionality. Infants who have at least one long (dopamine D4 receptor) DRD4 allele display less negative emotionality and less anger in response to restraint. Molecular genetics research has linked the DRD4 gene to attentional control, but this finding has not yet been replicated in young children (Shonkoff, 2016).

The dimension of *effortful control* includes anticipation and enjoyment of low-intensity stimulation, perceptual sensitivity, and enhanced control of attention and impulses. High levels of effortful control are correlated with lower levels of negative emotionality. Many studies have indicated moderate heritability in the components of effortful control, including task orientation, persistence, and related aspects of "difficult" temperament. Shared environmental effects stemming from family socio-economic status and observed maternal warmth account for some of the variability in task persistence in early childhood (Sinno et al., 2013).

The dimension of *extraversion* or *surgency* includes activity level, novelty seeking, positive affect, and low shyness. Activity level refers to the amount and intensity of physical movement and it is one of the most thoroughly researched dimensions of early childhood temperament. Overall, activity level has been found to be moderately heritable and to be relatively uninfluenced by shared environmental factors. Among children at the extremes of activity level, the strength of genetic effects may increase, and the genetic effects on activity level appear to be moderately to highly stable across time points from infancy to 3 years of age (Sinno et al., 2013).

The temperament dimension of *sociability* refers to the enjoyment of interpersonal interaction (contrasted with shyness and enjoyment of being alone). Sociability is moderately heritable, with one-quarter to three-quarters of the variance attributed to genetic influences. Some studies also show evidence of shared environmental effects. Genetic effects on sociability and shyness are moderately to substantially stable across 14 to 36 months of age. As with surgency, the heritability of more extreme forms of sociability is greater than that found for moderate sociability.

The dimension of *adaptability* is often identified as an important component of temperament, and it includes flexibility, distress in response to novelty, emotional regulation, and high soothability. Adaptability is moderately heritable, and evidence for modest shared environmental effects is sometimes found. However, genetic effects accounted for all the twin similarity in distress to novelty. The finding that the presence of the long form of DRD4 was associated with increased regulation of state in neonates

suggests that genetic variation in the dopamine system also may play a role in adaptability (Sinno et al., 2013).

Effects on psychopathology

The environmental and genetic influences on psychopathology in early childhood vary depending on the type of symptom being examined, child age, and gender. The evidence for genetic variance is greatest and most consistent for externalizing problems. Internalizing problems (i.e., depression, anxiety, somatic problems) are moderately heritable throughout early and middle childhood, but the effects of the shared environment are less consistent (OECD, 2017). In one study, nearly one-quarter of the variance in girls' internalizing problems from ages 4 through 12 years was attributed to the shared environment, but there were no shared environmental influences found for boys. With respect to age differences, Schmitz et al. showed that the effects of the shared environment decreased, and the effects of genetics increased on both internalizing and externalizing problems (i.e., aggression, non-compliance, delinquency, attention problems) from early to middle childhood. Other investigations of externalizing problems in early childhood converge to show similarly moderate to high heritability estimates (OECD, 2017).

m. ECD environments

In any given country, the macro context (that is, the economic, political, and social context) affects the nature and extent of social policies, which directly affect children's well-being, the type of programs made available to young children and their caregivers, and the organizations that translate these policies into programs for young children. The micro context - the interaction between a child and her or his primary caregiver during the early years - sets children on a trajectory that affects their future development. In addition, the availability of programs, services, and policies directed at children, their caregivers, or both, affects this interaction and trajectory.

Theses macro and micro-environments are not hierarchical, but rather are interconnected. At the most intimate level is the family environment. At a broader level are residential communities such as neighborhoods, relational communities such as those based on religious or other social bonds, and the ECD service environment (Trawick-Smith, 2018).

The family environment is the primary source of experience for a child, both because family members (or other primary caregivers) provide the largest share of human contact with children and because families mediate a child's contact with the broader environment (Russell & Gleason, 2018).

Perhaps the most salient features of the family environment are its social and economic resources. Family social resources include parenting skills and education, cultural practices and approaches, intra-familial relations, and the health status of family members. Economic resources include wealth, occupational status, and dwelling conditions. The

gradient effect of family resources on ECD is the most powerful explanation for differences in children's well-being across societies (Pia R. Britto et al., 2017).

Young children need to spend their time in warm responsive environments that protect them from inappropriate disapproval and punishment. They need opportunities to explore their world to play, and to learn how to speak and listen to others. Families want to provide these opportunities for their children, but they need support from community and government at all levels.

Children and their families are also shaped by the residential community (neighborhood where the child and family live) and the relational communities in which they are embedded. Residential and relational communities offer families multiple forms of support, from tangible goods and services that assist with child rearing, to emotional connections with others that are instrumental in the well-being of children and their caregivers (Alderman, 2011).

At the residential/locality level, both governments and grass-roots organizations also play a highly influential role. Many resources available to children and families are provided on a community-level through local recognition of deficits in resources, problem-solving, and ingenuity. There are, however, inequities in ECD that are apparent between residential communities, which must be addressed in a systematic way (Russell & Gleason, 2018).

"Relational community" refers to the people, adults, and children, who help form a child's social identity: tribal, ethnic, religious, language/cultural. Often, this is not a geographically clustered community. Relational communities provide a source of social networks and collective efficacy, including instrumental, informational, and emotional forms of support. However, discrimination, social exclusion, and other forms of subjugation are often directed at groups defined by relational communities. The consequences of these forms of discrimination (e.g., fewer economic resources) can result in discernable inequities. Moreover, relational communities can be sources of gender socialization, both equitable and non-equitable. Relational communities are also embedded in the larger socio-political contexts of society; as such, reciprocal engagement with other relational groups, civil society organizations, and governmental bodies is a means of addressing the interests and resource needs of their members (Goelman et al., 2011).

The influence of the *regional and national environments* is fundamental in determining the quality and accessibility of services and resources to families and communities. They are also salient for understanding the levels of social organization at which inequalities in opportunity and outcome may be manifest, and the levels of organization at which action can be taken to ameliorate inequities. There are many interrelated aspects of regional environments that may be significant for ECD: physical (e.g., the degree of urbanization, the health status of the population), social, political, and economic. These aspects of the regional environment affect ECD through their influence on the family and neighborhood, and on ECD services (Alderman, 2011).

In contrast to more intimate environments, such as the family, the significance of large environments, such as the region, is that regions influence large numbers of children. Thus, changing the environment at this level can influence the lives of many children (Lee et al.,

2015). More research and accumulated knowledge are required to understand how regional characteristics can be modified to positively influence ECD.

The most salient feature of the national environment is its capacity to affect multiple determinants of ECD through wealth creation, public spending, child- and family-friendly policies, social protection, and protection of basic rights. The chances that children will face extreme poverty, child labor, warfare, diseases, being left in the care of a sibling, is determined, first and foremost, by the countries in which they are born. Although ECD outcomes tend to be more favorable in wealthy countries than poor ones, this is not always the case. A commitment of 1.5–2.0 percent of GDP to an effective mix of policies and programs in the public sector can effectively support children's early development. Those nations with less economic and political power are less free to determine their internal policy agendas and are more influenced by the interests of the international community, including other nations and multilateral organizations (Irwin et al., 2007).

The *global environment* can influence ECD through its effects on the policies of nations as well as through the direct actions of a range of relevant actors, including multilateral economic organizations, industry, multilateral development agencies, non-governmental development agencies, and civil society groups. A major feature of the global environment in relation to children's wellbeing is the element of power in economic, social, and political terms. Power differentials between types of actors, particularly between nations, have many consequences, including the ability of some nations to influence the policies of other nations to suit their own interests. Although power differentials may have invidious effects on ECD, they can be exploited for the benefit of children, too. Requiring a minimum level of government spending on ECD and compliance with the Rights in Early Childhood provisions of the Convention on the Rights of the Child (UNCRC), as pre-conditions for international developmental assistance, are two mechanisms that can be used (Irwin et al., 2007).

n. Family systems and support

Ample evidence suggests that family is associated with a myriad of development outcomes for children across the world. The attachment theory of Bowlby (1969) shows that secure attachment to a trusted caregiver who provides consistent caring, support, and affection in early life is a key requisite for healthy ECD . Securely attached infants and toddlers use their emotional and physical security as a base from which to explore their environment. Successful attempts at exploration increase the child's confidence and encourage further exploration. Thus, the child begins to learn about and master her/his environment and to gain in both competence and self-confidence (The National Academies of Science Engineering and Medicine, 2015).

Family structure has also been hypothesized to affect child well-being. Research from resource-rich nations has shown that, on average, children from single-parent headed households - of which most are single mothers - tend to demonstrate poorer academic and socialization outcomes than their counterparts in two-parent households. However, the

literature in this field also suggests that presenting the relationship in this distilled manner may be overly simplistic.

There are also a host of other family characteristics that have been studied with respect to ECD and child well-being in general. Family health conditions have a particularly strong impact. Maternal physical and mental health has been associated with compromised child development outcomes including malnourishment, psychosocial functioning, and cognitive development. A review of children's physical outcomes associated with parental depression includes allergies, asthma, frequent colds and coughs, and headaches (Murphy et al., 2018).

Families need to be able to access the resources that enable them to make choices and decisions in the best interests of their children, including services such as parenting and caregiver support, quality childcare, and primary health care and education. Globally, one particular area where families require social protection is in resolving the demands of work and home life. Heymann's research on children and families in resource-poor countries demonstrates the importance of access to quality childcare for families the world over her research demonstrates that millions of children worldwide are being left home alone, left in informal childcare often in the care of other children, or being brought to work and exposed to unsafe working conditions. Public provision of quality, affordable childcare is part of the solution to this problem (Irwin et al., 2007).

o. Parental stress and ECD

The sociocultural and physical environment in which the parent and child are embedded sets the stage for many aspects of the stress and its effects on the child's development and coping parents will experience. Nomaguchi and Milkie turn a sociological lens on parenting stress and its effects with an emphasis on social structures, statuses, and culture (e.g., socioeconomic status and social class, race, ethnicity, gender). Some of these factors are stable over time and contribute in powerful ways to shaping parenting stress within families and among groups of families in similar socioecological niches. Other factors are emergent, forcing modern-day parents to reorganize and adapt to stress in new and productive ways (e.g., increases in mothers' participation in the labor force; increased incarceration rates among modern parents). If not mitigated, this chronic stressful state becomes instantiated in parenting and child developmental trajectories that are maladaptive. Parenting stress transpires within parent–child dyads, but there is a need to focus specifically on the consequences of chronic parenting stress on the developing child (Nomaguchi & Milkie, 2017).

p. Economies and return on investment of ECD

Investing in ECD programs can have significant economic benefits for individuals, families, and societies as a whole. These benefits can be realized in the short term as well as the long term (J. J. Heckman, 2011).

In the short term, ECD programs can lead to improved health outcomes for young children, which can result in reduced healthcare costs for families and society. ECD programs can also lead to increased parental workforce participation, as parents are able to work while their children are in childcare. This can result in increased tax revenues for governments and reduced costs for social welfare programs.

In the long term, ECD programs can have even greater economic benefits. Studies have shown that children who participate in high-quality ECD programs are more likely to succeed in school, earn higher incomes as adults, and have lower rates of criminal activity. This can result in increased productivity and economic growth for societies.

Furthermore, the economic benefits of ECD programs are often distributed fairly among different income groups. Children from disadvantaged backgrounds often experience the greatest benefits from ECD programs, as they are more likely to face challenges that can negatively impact their development. By investing in ECD programs, governments can help to reduce economic inequality and promote social mobility.

There is a growing body of research that supports the economic benefits of investing in ECD programs, especially that governments around the world are investing in big budgets in an aim to give positive development to their societies. Studies have shown that investing in ECD can have a significant return on investment (ROI) in terms of economic and social outcomes.

One of the most well-known studies on the ROI of ECD programs is the High Scope Perry Preschool Study (see paragraph *Early childhood interventions from around the world*). The study followed a group of at-risk children who participated in a high-quality preschool program in the 1960s. The study found that the children who participated in the program had higher levels of educational attainment, higher earnings, and lower rates of criminal activity compared to a control group who did not participate in the program. The study estimated that the ROI of the program was $17 for every $1 invested.

Other studies have also found significant ROI for ECD programs. For example, a study in North Carolina found that investing in high-quality early childhood education programs for at-risk children resulted in a ROI of $7.30 for every $1 invested. Another study in Chicago found that a high-quality preschool program resulted in a ROI of $8.24 for every $1 invested.

The benefits of ECD investments are not just limited to economic outcomes. Studies have also shown that ECD programs can have a positive impact on children's cognitive and social-emotional development, health outcomes, and future success in school and the workforce.

Overall, the research on the ROI of ECD programs highlights the importance of investing in early childhood development as a cost-effective way to promote economic and social well-being (J. Heckman et al., 2010).

q. ECD Meta-analysis

Meta-analysis of long-term studies on ECD have provided strong evidence for the relevancy of early interventions. These studies have demonstrated that high-quality ECD interventions can have long-lasting positive effects on children's cognitive, social, and emotional development, as well as their future outcomes in education, employment, and health.

One of the main findings of meta-analysis is that ECD interventions have a positive effect on children's cognitive development. For example, a meta-analysis of 123 studies found that children who participated in high-quality ECD programs had better language, literacy, and math skills than those who did not participate. These effects were particularly strong for children from disadvantaged backgrounds.

Meta-analysis have also shown that ECD interventions can have a positive effect on children's social and emotional development. A meta-analysis of 74 studies found that ECD programs led to improvements in children's social skills, emotional regulation, and behavior. These effects were particularly strong for children who were at-risk or experiencing disadvantage.

Furthermore, meta-analysis have demonstrated that ECD interventions can have long-lasting effects on children's outcomes in education, employment, and health. For example, a meta-analysis of 19 long-term studies found that children who participated in high-quality ECD programs were more likely to complete high school, attend college, and earn higher incomes as adults. Other meta-analyses have shown that ECD interventions can lead to improvements in health outcomes, including reduced rates of obesity, chronic disease, and mental health problems (Goh, S. K., Tan, K. L., & Poon, 2019).

r. ECD under multidimensional crisis

When young children experience an emergency due to conflict or a natural disaster, it can change their entire early life experiences and alter their life trajectories. An increasing number of children today are born into crises caused by violent conflicts and environmental changes. There are currently more than 70.8 million forcibly displaced people worldwide: 25.9 million are refugees, 41.3 million are internally displaced, and 3.5 million are asylum seekers (UNHCR, 2020). Approximately 35 million of these uprooted individuals are children ages 0-18. In 2018 alone, 29 million babies were born in crisis settings (UNICEF, 2019). For many children, protracted conflicts mean a lifetime of displacement and disruption.

The impact of adversity on ECD is also highlighted in a 2020 paper by Samara et al. that discusses the prolonged exposure of children in the Middle East to the toxic stress of war trauma (Samara et al., 2020). In Lebanon specifically, the ongoing economic and political crisis has made it increasingly difficult for families to provide for their children's basic needs, as described in a 2021 UNICEF report titled "Surviving without the basics: The ever-worsening impact of Lebanon's crisis on children." A follow-up report in 2022, "A worsening

health crisis for children: The consequences of the failing health system has immediate and longer-term impacts on children," further underscores the urgent need for action to address the multifaceted challenges faced by children in Lebanon (ACAPS, 2022).

Young children may sustain deep emotional scars from witnessing violence, migrating under difficult physical conditions, and living in dangerous and stressful conditions for long periods of time. They also may be separated from their parents or primary caregivers. Moreover, crisis-affected children frequently lack access to adequate health care and early learning opportunities, face food and water shortages, and experience the loss of a parent or other caregiver, physical injuries, and other extreme challenges to survival, which increase their mortality rates. For many years, attention to the effects such disruptions have on the developing child has been severely limited or nonexistent. However, due to the number and nature of recent crises, international aid agencies and other critical actors have started to broaden their focus to include the plight of very young children (Bonnay, 2022).

In the past months, the COVID-19 pandemic has created a double tragedy for children and families already displaced or caught in conflict. Early childhood interventions that support development from conception to age eight can create a buffer against the difficulties young children face in emergencies. These efforts can be enhanced by the people who are most important in a child's environment - parents and primary caregivers, teachers, health-care workers, and others (Shah & Lombardi, 2021).

Aggregate shocks and infant mortality

The most severe condition affecting ECD is infant and early child mortality. One recent comprehensive study of developing countries has identified a clear link between aggregate economic contractions of sufficient magnitude and increases in the likelihood of mortality in the first year of life. Baird, Friedman, and Schady (2010) pool all available Demographic and Health Surveys (DHS) from 59 developing countries around the world to construct a dataset of 1.7 million live births over series of varying lengths, depending on the timing and number of surveys taken, in each country. The authors identify a large negative association between infant mortality in a given year and their measure of crisis - deviations of per capita gross domestic product (GDP) from trend. A 1 percent decrease in per capita GDP results in an increase in infant mortality of between 0.24 and 0.40 deaths per 1,000 children born. On average, the country-specific year-on-year decrease in infant mortality in their data is 2.5 deaths per 1,000 live births; thus, a 1 percent shortfall in per capita GDP from expected trends results in an increase in infant mortality of between 10 and 15 percent of the average annual mortality decline and a crisis on the order of 7–10 percentage points of GDP completely erase the expected secular gain (Baird et al., 2011).

Aggregate shocks and nutritional pathways

If economic crises affect the mortality of infants and young children, it is highly probable that crisis can also influence the health of surviving children to a substantial degree. One long-standing concern that has received much of the attention in the literature is the effect

of crises on nutritional status. For example, in a speculative exercise that uses data available from the 1997 East Asian crisis, Bhutta et al., (2009) model the plausible impacts of the 2008 economic crisis on various infant and child health indicators for the Asia region. While noting the insufficiency of some data, their results suggest maternal anemia rates may increase 10–20 percent, the prevalence of low birth weight by 5–10 percent, childhood stunting by 3–7 percent, wasting by 8–16 percent, and under-age-five mortality by 3–11 percent. The most notable potential pathway for these impacts is lower quantity and quality of nutritional intake resulting from increased food insecurity and lower household income (Alderman, 2011).

Social instability and poverty

One of the major risks to skill formation in children is poverty. Conditions associated with poverty are in turn associated with worse physical health (the normal functioning of the body), psychosocial health, and cognitive outcomes observed in children and the greater cumulative exposure to these conditions or risk factors is associated with significantly lower cognitive development (Sameroff et al., 1993). Much recent scholarship has delineated and explored the various interlinkages between poverty and low ECD outcomes.

Conservative estimates from Grantham-McGregor et al., (2007) suggest that over 200 million children under five years of age living in developing countries fail to reach their cognitive development potential because of a range of factors, including poverty, poor health and nutrition, and lack of stimulation in home environments. It is possible that this burden increases during times of crisis as poverty increases and food security is threatened. However, to investigate this claim more carefully it is necessary to understand the pathways through which poverty influences skill acquisition in children (Alderman, 2011).

When children's needs are not met, their development stalls. Poverty, therefore, can have deleterious effects on children's physical and emotional health, as well as their cognitive abilities and educational achievements.

War, violence, and ECD

An overview focused on the prevalence of psychological morbidities in children who have been exposed to war-related traumas or terrorism outlines the psychological responses to war-related stressors in three categories: (1) little or no reaction, (2) acute emotional and behavioral effects, and (3) long-term effects (Shaw 2003). Children exposed to war-related stressors experience a spectrum of psychological morbidities, including posttraumatic stress symptoms, mood disorders, externalizing and disruptive behaviors, and somatic symptoms determined by exposure dose effect. Several studies of individual conflicts or disasters document the consequences of such events on a child's psychosocial development. Very few studies include young children under the age of five. One study in Kenya (Kithakye et al., 2010) examined pre- and post-conflict data from 84 children, between three and seven years of age, living in Kibera, Kenya, during the December 2007 political conflict. The results indicate that children's experiences during the conflict (destruction of their home, death of a parent, harm to parent and child) are associated with

adjustment difficulties. Specifically, the severity of the traumatic experience was associated with increased aggression and decreased pro-social behavior (Punamaki, 2002; Murphy et al., 2018).

s. Early childhood interventions from around the world

Evidence from developed and developing countries shows that ECD programs can have positive effects and enable governments to offset some of the consequences associated with inequality of opportunity. If children from poor families are offered positive and enriching childhood development services through programs that are especially geared to them and their caregivers, it is very likely that their developmental outcomes will be improved (Goh, S. K., Tan, K. L., & Poon, 2019).

Interventions in developed countries

Perhaps the three most studied ECD programs in the developed world are the Carolina Abecedarian Program, the Chicago Child Parent Program, and the High Scope/Perry Preschool Program in the United States. Extensive research has been written about their impressive short- and long-term results.

The Perry Preschool Program in Ypsilanti, Michigan, was initiated in 1962 and ran through 1967. The program provided a half-day of preschool to 123 children aged 3 and 4 years, plus a one-and-a-half-hour weekly home visit with the mother and the child for two years. The beneficiary group was at-risk children from disadvantaged neighborhoods. Children were randomly assigned to a treatment and control group at the start of the program. Program evaluations were performed annually until the children were 11 years old, and then again at ages 14, 15, 19, 27, and 40. Each time the children were assessed, important benefits were documented. Participation in the treatment group resulted in better performance on cognitive and language tests up to age 7; in school achievement tests at ages 9, 10, and 14; and in literacy tests at ages 19 and 27. At age 40, the median earnings of the adults who had participated in the program were more than one-third higher than the mean earnings of adults who had not participated in the program. In addition, participants had lower incarceration rates and were more likely to be employed than nonparticipants (Pia Rebello. Britto et al., 2013).

The Carolina Abecedarian Program is another small-scale intervention that showed similar positive results. Implemented in North Carolina in the United States, the program offered particularly intensive services from birth to age 5 to approximately 100 disadvantaged children. Children were randomly assigned to a treatment or control group. The treatment group received enriched center-based childcare 8 hours per day, 5 days a week, for 50

weeks a year. By the time the children entered primary school, those who had been in the early education program were again randomized into two groups, one of which received no further intervention. The other group received continued intervention in the form of a home-school resource teacher. Data on children were collected at ages 3, 5, 12, 15, and 21. The data showed that children who participated in the early education program from birth to age 5 had higher scores on achievement tests and fewer grade repetitions and special education than children who did not participate in the program. At age 21, individuals who had participated in the early education program had higher average test scores and were twice as likely to remain in school or to have attended a four-year college than young adults who had not benefited from the program (Pia Rebello. Britto et al., 2013).

Another small-scale program that demonstrated positive impacts on childhood development outcomes was the *Chicago Child Parent Program*. The program offered preschool and family support services to low-income children aged 3 or 4 years in 22 centers located in Chicago public schools. The centers offered teaching basic language and readings skills, as well as social and psychological development programs, and encouraged parental involvement in classroom activities, field trips, and adult education classes. The centers also provided health services and free breakfast and lunch. Thirteen of these centers provided additional educational services through the third grade. Data on children in treatment and control groups were collected periodically, with some studies collecting data until the children where 22 years old (Lynch, 2004). These data showed that participation in the program was associated with positive behavioral outcomes, including higher cognitive skills, greater educational attainment and achievement, lower use of remedial services, higher school completion rates by age 20, and lower rates of juvenile arrest at age 18 (Reynolds et al., 2002). *The Chicago Longitudinal Study* followed nearly 1,150 students who attended the Child Parent centers from 1983 to 1986 and compared them to a control group of 389 children of the same age who met the eligibility criteria for participation in the program. The study found that children who participated in the program had higher achievement test scores at ages 5, 6, 9, and 14, and spent less time on special education through age 18. They also had lower grade repetition rates than children who did not participate in the program. Moreover, delinquency rates among participants were significantly lower, and high school graduation rates were higher than for nonbeneficiary children (McCartney & Phillips, 2008).

The Head Start Program was introduced in 1965 to provide children aged 3 to 5 years with comprehensive support services, including early childhood education, development, health, and nutrition services. The program also offered educational services for the parents of these children. Between 2001 and 2007 the program covered over 900,000 children every year; they were serviced in 2007 by over 18,000 local centers.1 Although the program is large, it serves only approximately 35 percent of all eligible children aged 3 to 4 years. Local programs can opt for center- or home-based delivery, or a combination of both. There is tremendous variation in how the program has been implemented across time and sites. Yet all programs must comply with specific performance standards that ensure a minimum level of quality. Compliance is assessed every three years by federal monitors (J. J. Heckman, 2011).

These interventions highlight several ECD programs in developed countries that have been shown to have positive short- and long-term impacts on the cognitive, behavioral, and economic outcomes of at-risk children from disadvantaged neighborhoods.

In the context of multidimensional crisis, such as the COVID-19 pandemic, these ECD programs are especially important. The pandemic has exacerbated existing inequalities, including those related to access to quality ECD services, and has resulted in the closure of many ECD centers. This has led to a significant loss of learning and developmental opportunities for young children, which can have long-lasting consequences.

The ECD programs presented, provide examples of evidence-based interventions that can help mitigate the negative effects of the pandemic on young children's development. By investing in ECD programs, policymakers and practitioners can provide support to children and families who are facing multiple crises, including health, economic, and social challenges.

Interventions in developing countries

Developed countries are not alone in recognizing that ECD interventions can have lasting positive results. Evidence on the effectiveness of ECD programs in the developing world is growing. In 1999, for example, the Philippine government launched a five-year ECD project in three southern regions that encompassed roughly 2.2 million households. In 2002, the project became part of a broader governmental program that was formally established by the Early Childhood Care and Development Act.

A study in Uganda tracked the progress of participants in the *Uganda Nutrition and Early Child Development Program*. Initiated in 1998, the program consisted of pilot ECD services in selected sub-counties in more than 30 districts of the country. Activities included child health fairs organized at the parish level every six months, together with community growth promotion activities and community-based grants for food security or ECD programs. The project was found to have had a positive impact on the nutritional status of children under 1 year old, with effects of one-half of a standard deviation.

In terms of the impact on cognitive development, the project only had a positive effect on children of the age of 3 with regard to their facility with number concepts (Alderman 2007). The services in the Uganda project were neither as intensive nor comprehensive as those in the Philippines project, which may perhaps explain why it had smaller estimated effects on child developmental outcomes.

The Turkish Early Enrichment Project set out to assess the impact of an optimal combination of educational preschool care and home intervention on the overall development of socioeconomically disadvantaged urban children in Istanbul. The program offered both early childhood enrichment and training of mothers in low-income areas of the city. Both

center- and home-based enrichment services were studied separately and in combination. The study followed 255 low-income children of the age of 3 to 5 and their mothers. Some families participated in center-based and some in home-based enrichment interventions. A third group received a combination of both interventions for a period of two years. Mothers attended group meetings to enhance parenting practices, which trained them to promote child language development and problem-solving skills. In a 10-year follow-up study, 86 percent of the children in the program were still in school, compared to 67 percent of the children in the control group. Child participants also had higher school grades and greater self-confidence (Vegas & Santibanez, 2009).

t. Overview of ECD indicators and initiatives in the Middle East and North Africa (MENA) region.

The MENA region is a diverse region with a wide range of economic and demographic indicators affecting ECD services. Recent up-to-date demographic and economic indicators that are relevant to ECD in the MENA region include:

- Population growth: The MENA region has experienced significant population growth in recent years, with an estimated population of over 558 million in 2020. This growth has placed a strain on resources and infrastructure, including ECD services.
- Urbanization: The MENA region is highly urbanized, with over two-thirds of the population living in urban areas. Rapid urbanization has resulted in a growing need for ECD services in urban areas, including daycare centers and preschools.
- Economic inequality: The MENA region has some of the highest levels of economic inequality in the world, with significant disparities between rich and poor. This has led to unequal access to ECD services, with children from low-income families less likely to have access to quality ECD services.
- Refugees and displaced populations: The MENA region has a large number of refugees and displaced populations, with over 18 million refugees and 10 million internally displaced people in 2020. These populations often face significant challenges accessing ECD services, including language barriers, cultural differences, and limited resources.
- Investment in ECD: While there has been some investment in ECD services in the MENA region, funding levels remain low compared to other regions. This has led to a shortage of trained ECD professionals, inadequate facilities, and limited access to quality ECD services for many children.
- Gender inequality: Gender inequality remains a significant challenge in the MENA region, with women and girls often facing limited access to education and other resources. This can have a significant impact on ECD, with girls less likely to have access to quality ECD services and more likely to face discrimination and disadvantage (El-Kogali & Krafft, 2015).

Main ECD initiatives and programs

While access to ECD services and programs varies across the world, the Arab region faces unique challenges due to conflicts, displacement, and poverty, which hinder the provision of quality ECD services. Here are some examples of ECD programs and initiatives in Arab countries:

Lebanon: The Early Childhood Education Program (ECEP) is a project that aims to improve access to quality ECD services for Syrian refugees and vulnerable Lebanese children. The program works with local NGOs and community-based organizations to provide early learning opportunities for children aged 3-5.

The Children's Learning Center (CLC) is a non-profit organization that provides early childhood education to children in marginalized communities in Lebanon. The CLC also offers training to parents and caregivers on how to support children's early learning.

Jordan: The Madrasati project is a joint initiative between the government of Jordan, the private sector, and civil society organizations. The program aims to improve the learning environment for children in public schools, including ECD centers. As of 2021, the program has improved more than 1,000 schools, benefiting over 500,000 students.

The Queen Rania Foundation for Education and Development (QRF) has an early childhood development program that works to improve the quality of early childhood education in Jordan. The program provides training for early childhood educators, develops curricula and assessment tools, and advocates for policies that support young children.

Palestine: The Ministry of Education and Higher Education (MOEHE) in Palestine has launched several initiatives to promote ECD, including the National Early Childhood Care and Development (ECCD) Strategy. The strategy aims to improve the quality of ECD services and to provide better support to parents and caregivers.

Egypt: The Ministry of Education in Egypt has launched the "ECD Across Egypt" initiative, which aims to improve access to quality ECD services for children in underserved areas. The initiative focuses on developing and implementing ECD programs, building the capacity of ECD practitioners, and raising awareness among parents and caregivers.

The Egyptian Foundation for Advancement of Childhood Conditions (EFACC) provides early childhood education and care for children in underprivileged areas of Egypt. They also offer training for early childhood educators and advocate for policies that support young children and their families.

Saudi Arabia: The King Abdulaziz Center for World Culture (Ithra) has an early childhood development program that focuses on promoting early learning and creativity. The program includes a variety of activities and resources for children,

parents, and educators, including an interactive exhibition, workshops, and online resources.

United Arab Emirates: The Dubai Cares Early Childhood Development program works to improve access to quality early childhood education in the UAE and in developing countries around the world. The program supports the development of early childhood education policies, provides training for early childhood educators, and develops and implements early childhood education programs.

Yemen: The Early Childhood Development Programme in Yemen is a collaboration between UNICEF and the government of Yemen. The program aims to improve access to quality ECD services for children aged 0-3, and to provide support to parents and caregivers. The program has established ECD centers in several regions of the country and has trained over 1,000 ECD practitioners.

While there are many initiatives to promote ECD in Arab countries, there is still a lot of work to be done to ensure that all children have access to quality ECD services. The ongoing conflicts and crises in the region pose significant challenges to ECD efforts, and require sustained support from the international community.

Survival, health care, and nutrition in the MENA region

The first step in healthy ECD is simply surviving early childhood. In MENA, a region reputed for instability, conflicts, tensions, poor governance, economic failures, and political divisions, around one in every 40 children dies in the first year of life. Although there have been improvements over time, too many children still die of preventable causes. Numerous dimensions of a country's development and children's experiences shape early mortality. Many different inputs to children's early development can affect early mortality, including health and health services, nutrition, caregivers' child-rearing knowledge, birth timing and spacing, and access to clean water and sanitation (Naudeau et al., 2011).

Early death represents the ultimate loss of all a child's development potential and the compounded effects of malnutrition and diseases. MENA's infant mortality rate (dying in the first year of life) of 24 deaths per thousand births is lower than the world average of 35 deaths per thousand births (Figure 2); however, it is higher than in East Asia and the Pacific (17 deaths per thousand births) and Latin American and the Caribbean (16 deaths per thousand births) - regions with income levels similar to MENA. Most of infant mortality is composed of neonatal mortality (dying in the first month of life). MENA has fewer deaths in

the first month of life than the world average, but its rate of 15 deaths per thousand births means that 1 in every 67 children dies in the first month of life.

Addressing both early mortality and ECD begins during pregnancy. In MENA, 83 percent of births receive prenatal care. While this is the same as the world average, it is substantially lower than regions with similar income levels, such as East Asia and the Pacific and Latin America and the Caribbean, where over 90 percent of births receive prenatal care. MENA has only a 5-percentage-point higher rate of prenatal care than Sub-Saharan Africa. Delivery with a skilled attendant is also an important component of reducing newborn mortality and illness. At 79 percent, the rate of deliveries handled by a skilled attendant in MENA is substantially higher than the world average of 68 percent, but below Latin America and the Caribbean and East Asia and the Pacific. The full immunization of children plays an important role in reducing child mortality - diseases such as measles are a major cause of child mortality. MENA is approaching high immunization coverage, with 89 percent of children fully immunized against diphtheria, pertussis, and tetanus (DPT) (UNICEF, 2014). Malnutrition, which impairs the growth of almost a fifth of children, is a major challenge for MENA. Stunting - being more than two standard deviations below the height of a healthy reference child of the same age and gender - has been connected to decreased cognition, poorer school performance, decreased productivity later in life, and decreased income. Almost a fifth (18 percent) of children in MENA are stunted. As a result of being stunted, children in MENA will accumulate less health and human capital and face lower wages later in life (El-Kogali & Krafft, 2015).

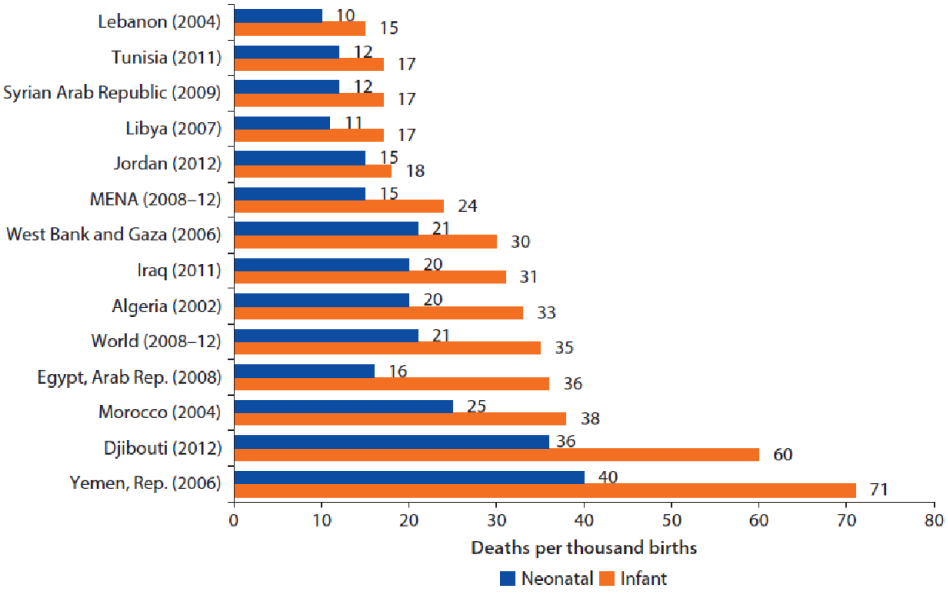

Figure 2: Neonatal and Infant Mortality by Country or Territory Deaths per Thousand Births (World Bank)

MENA has the fewest households with adequately iodized salt of any region, putting children at great risk for impaired cognitive development. Micronutrients such as Iron, vitamin A, Zinc, and Iodine, play an important role in both physical and cognitive development. Iodine-deficient individuals average 10-point-lower IQs than non-deficient individuals (Molina 2012). Iodized salt is the primary means for delivering iodine to children. At a rate of 48 percent of households with adequately iodized salt, MENA is lower than Sub-Saharan Africa (53 percent) and South Asia (55 percent) and falls well below the world average of 71 percent of households having adequately iodized salt (El-Kogali & Krafft, 2015).

Social, Emotional, and Cognitive Development in the MENA region

Although it has been proven that play and interaction are important components of ECD, children in MENA are missing out on important opportunities to develop socially and emotionally and are at a substantial disadvantage compared to other regions. Parents' engagement in activities that promote learning is an important support of cognitive development, and an important indicator of parenting practices and the social-emotional engagement of parents with their children (El-Kogali & Krafft, 2015).

Early childhood education and early learning play an important role in school success. However, the MENA region is substantially underinvesting in this important stage of education. Despite evidence that early childhood care and education (ECCE) improves cognition and socioemotional development and endows lifetime benefits, pre-primary gross enrollment in MENA is almost half that of the world average. MENA's rate of pre-primary enrollment is lower than all other regions except Sub-Saharan Africa and is about one-third the rate of Europe and Central Asia and Latin America and the Caribbean.

Another challenge that risks hindering the healthy development of children is violent discipline. Violent child discipline is widespread in MENA, negatively impacting children's physical, psychological, and social development. Comparing MENA countries with available data and countries in other regions shows that MENA countries have the highest percentage of children aged 2–14 years who are violently disciplined. Yemen and the West Bank and Gaza have the highest rates of violent discipline (out of 50 countries), with 95 percent of children violently disciplined. Tunisia, Iraq, Algeria, Syria (pre-conflict), Morocco, and the Arab Republic of Egypt all have high rates of violent discipline, between 79 and 93 percent. Tunisia has the 5th highest rate of violent discipline, Egypt the 8th highest, Morocco the 11th highest, Syria the 14th highest, Algeria the 17th highest, and Iraq the 26th highest. Only Djibouti has a lower rate, around 38 percent and ranks 49th in violent child discipline among the 50 countries (World Bank, 2015).

The Arab region, including Lebanon, has experienced a range of unique circumstances that have had significant impacts on ECD. Some of these circumstances include ongoing conflicts and political instability, economic challenges, and natural disasters. Here are some specific examples of how these circumstances have affected ECD in the region:

Conflict and political instability: Ongoing conflicts and political instability in many Arab countries have had a devastating impact on ECD. Children in these contexts are exposed to violence, displacement, and trauma, which can lead to toxic stress and long-term developmental challenges. For example, according to UNICEF, in Yemen, over 12 million children require humanitarian assistance due to the ongoing conflict, and an estimated 2 million children are out of school. This has significant implications for their development and future opportunities.

Economic challenges: Many Arab countries, including Lebanon, have faced economic challenges in recent years. These challenges can impact ECD in several ways. For example, families may struggle to provide for their children's basic needs, including food, shelter, and healthcare. Children may also be forced to work to help support their families, which can impact their educational opportunities and overall development.

Natural disasters: The Arab region has also experienced a range of natural disasters, including earthquakes, floods, and droughts. These events can have significant impacts on ECD, including disruptions to education, displacement, and trauma. For example, in Lebanon, the 2020 Beirut port explosion destroyed or damaged many schools, leaving thousands of children without access to education.

There have been a number of recent research studies on ECD under crisis situations in Arab countries. Here are some key findings from a few of them:

A study conducted in Lebanon found that exposure to violence during the Syrian crisis was associated with lower cognitive and language development in young children. The study recommended the provision of targeted ECD services to support the development of affected children (Bouchane et al., 2018).

A review of ECD programs in Palestine found that despite the challenges of ongoing conflict, there have been some successful initiatives, such as home visiting programs and psychosocial support for parents and caregivers. The review recommended the expansion of these programs and increased investment in ECD (Awwad et al., 2017).

A study in Yemen found that malnutrition and exposure to violence were major risk factors for poor ECD outcomes and recommended the integration of ECD services into nutrition and child protection programs (UNICEF, 2020b).

A study in Iraq found that parenting programs that promote positive discipline and parental mental health were effective in improving ECD outcomes, particularly for children who had experienced trauma (SABER, 2016).

Samara et al. (2020) conducted a research study on the prolonged exposure of children to the toxic stress of war trauma in the Middle East. The study aimed to investigate the impact of war trauma on the mental health of children and the protective factors that might reduce its impact. The study findings indicated that war trauma resulted in toxic stress that impacted the mental health and well-

being of children, leading to increased rates of anxiety, depression, and behavioral problems.

Save the Children's research in 2017 on toxic stress and the impact of six years of war on the mental health of Syria's children found that the conflict in Syria has caused high levels of trauma and toxic stress among children, which has had a severe impact on their mental health and well-being. The report stated that children in Syria have experienced high levels of exposure to violence, loss, and displacement, which have resulted in increased rates of anxiety, depression, and other mental health problems.

UNICEF's report on the status of children in Yemen, Iraq, Syria, and Lebanon found that children in these countries have been exposed to high levels of violence, displacement, and conflict, resulting in significant psychosocial distress and mental health problems. The report highlighted the need for urgent interventions and programs to address the mental health and well-being of children affected by the crisis (UNICEF, 2023).

Overall, this brief overview of these studies highlight the importance of targeted ECD interventions in crisis situations, particularly those that address the needs of both children and their caregivers. They also underscore the need for continued investment in ECD programs in Arab countries affected by conflict and crisis.

6. Overview of ECD in Lebanon

a. Country's demographic and economic indicators

Lebanon is currently amid an escalating humanitarian emergency arising from the compounding effects of three concurrent crises: massive economic collapse, the August 4 ammonium nitrate blast at the Port of Beirut, and the COVID-19 pandemic. These crises come in the background of a complex local and regional geopolitical context, including a confessional political establishment characterized by endemic corruption and generating entrenched structural inequalities; a long history of foreign occupations and recurrent incursions that have had lasting impacts on critical infrastructures and stability; ongoing foreign influences that have rendered Lebanon a proxy battleground and continue to destabilize; the issue of over 540,000 Palestinian refugees in Lebanon, highly vulnerable and denied the most basic of rights, continuing to fuel social tensions; and the effects of a decade-long conflict in neighboring Syria, which has seen the influx of over 1.5 million refugees into Lebanon, straining services and infrastructures and exacerbating an already tense social environment in the country.

With more than half the population now living in poverty, a generation of children are among those at risk. UNICEF has warned that children are the worst hit, with every aspect of their lives including health and safety at risk and their futures at stake. Urging immediate action, Save the Children recently warned that with the

complex humanitarian crisis in Lebanon worsening by the day, “time is running out” for Lebanon’s children (Save the Children, 2023).

Demographic and economic indicators that are directly affecting ECD services in the country:

1. Population growth: Lebanon has experienced steady population growth over the past decade, with an estimated population of 6.5 million in 2021. This growth has placed a strain on resources and infrastructure, including ECD services.
2. Economic crisis: Lebanon is facing an ongoing economic crisis, with high inflation, unemployment, and a significant decline in the value of the local currency. This crisis has led to a shortage of funding for ECD services, and many families are struggling to provide basic needs for their children.
3. Political instability: Lebanon is facing a prolonged period of political instability, which has had a significant impact on the provision of ECD services. The lack of a stable government has made it difficult to implement policies and programs that support ECD.
4. Refugee crisis: Lebanon is home to over 1.5 million refugees, including over 900,000 Syrian refugees. This crisis has placed a significant strain on resources, including ECD services, and has led to overcrowding in schools and daycare centers.
5. Gender inequality: Gender inequality remains a significant challenge in Lebanon, with women and girls often facing limited access to education and other resources. This can have a significant impact on ECD, with girls less likely to have access to quality ECD services and more likely to face discrimination and disadvantage.
6. COVID-19 pandemic: The COVID-19 pandemic has had a significant impact on ECD services in Lebanon, with many centers and schools closing down temporarily or permanently. This has led to a significant disruption in early childhood education and care.

These changes, in addition to the 4th of August historical blast, have had a profound impact on children's lives in Lebanon, with many experiencing poverty, food insecurity, lack of access to education and healthcare, and trauma. The challenges have been compounded by the COVID-19 pandemic, which has disrupted education and other services for children. Many children are at risk of falling behind academically, experiencing emotional and behavioral difficulties, and suffering from physical and mental health problems. The ongoing economic and political challenges facing Lebanon make it difficult to address these issues effectively and ensure that all children have access to the resources and support they need to thrive (UNICEF, 2020a).

Demography

The main demographic data for Lebanon are as follows (World Bank, 2022):

Population: According to the World Bank, the estimated population of Lebanon in 2021 is 6.5 million.

Age structure: The age structure of Lebanon's population is relatively young, with a median age of 31 years. The percentage of the population under 15 years old is 23.5%, while the percentage over 65 years old is 9.8%.

Gender: The population is nearly evenly split between males and females, with females accounting for 49.5% of the population.

Ethnicity: Lebanon has a diverse population, with no official census on ethnicity. However, estimates suggest that the population is roughly divided into 4 main groups: Sunni Muslims, Shia Muslims, Maronite Christians, and Greek Orthodox Christians.

Religion: Lebanon has 18 officially recognized religious groups. The majority of the population is split between Christianity and Islam, with smaller minority groups such as Druze and Jews.

It is important to note that demographic data in Lebanon can be difficult to accurately measure due to the country's history of political and social conflict, as well as the lack of recent official census data.

Economic trends

Up until 2019, Lebanon was an upper-middle-income country with a gross domestic product per capita of about 51.99 billion USD in 2019 and decreasing to $21.8 billion in 2021 (in current US Dollars). (Statista, 2021). The average life expectancy at birth in 2021 was 79 years, which was a substantial improvement over the 1990's life expectancy of 70 years. Overall, Lebanon ranks 92 out of 189 countries with comparable data in the 2021 Human Development Index (United Nations Development Reports, 2021).

Since then, the economic situation in Lebanon has become challenging, with high inflation, currency devaluation, high unemployment, and widespread poverty. These factors have had a significant impact on the lives of many Lebanese people, including children and families, and have made it more difficult to support early childhood development.

Some of the key economic trends in Lebanon include:

Inflation: Lebanon has experienced high inflation, with an annual rate of inflation of around 84% in 2020. This has led to a significant increase in the cost of living for many Lebanese people.

Currency devaluation: The Lebanese pound has lost around 90% of its value since the crisis began in late 2019. This has made it much more difficult for Lebanese people to access foreign currency and has led to shortages of basic goods.

Unemployment: The unemployment rate in Lebanon has risen significantly since the start of the crisis. According to the World Bank, the unemployment rate was around 35% in 2020.

Poverty: The economic crisis has pushed many Lebanese people into poverty. According to the United Nations, the poverty rate in Lebanon rose from 28% in 2019 to over 55% in 2020.

External debt: Lebanon has one of the highest external debt levels in the world, with external debt estimated to be around 180% of GDP in 2020 (UNICEF, 2022a).

b. Educational overview in recent years

Education has been significantly impacted by the changes and challenges in Lebanon in recent years. The key aspects of the current education sector are school closures, funding shortages, refugee education, education quality and brain drain (Government of Lebanon and the United Nations, 2022).

1. School closures: Due to the COVID-19 pandemic, schools in Lebanon were closed for an extended period, and students had to switch to remote learning. This disruption has affected children's learning outcomes and has highlighted disparities in access to technology and resources.
2. Funding shortages: The economic crisis in Lebanon has led to funding shortages for education, including a lack of resources for schools and low pay for teachers. This has led to overcrowded classrooms and limited access to quality education.
3. Refugee education: Lebanon is home to a large number of refugees, including many children, who face significant barriers to accessing education. Many refugee children are out of school or have limited access to education due to financial, logistical, and legal barriers.
4. Education quality: Even before the recent crises, Lebanon faced challenges in providing quality education to all students, including outdated curriculum, inadequate facilities, and limited access to technology.
5. Brain drain: Many Lebanese teachers and educators have left the country in recent years, seeking better opportunities abroad. This has contributed to a shortage of qualified teachers and has further impacted the quality of education.

These factors have contributed to a challenging education landscape in Lebanon, with many children facing barriers to accessing quality education. There is a need for increased investment in education, improved infrastructure and resources, and targeted interventions to address the specific needs of marginalized and vulnerable children, including refugees.

Many international organizations have conducted several studies on education in Lebanon in recent years, highlighting the challenges and opportunities facing the education sector.

For instance, "Education and Fragility in Lebanon: Addressing the Challenges of Access, Quality and Relevance" is a report that was jointly authored by the United

Nations Children's Fund (UNICEF), UNESCO Beirut, and the World Bank. The report was published in 2016 and provides an analysis of the challenges facing the education system in Lebanon, with a focus on the impact of the Syrian refugee crisis on access, quality, and relevance of education. The report identifies key challenges and provides recommendations for improving the education system in Lebanon, particularly in the context of fragility and conflict. "The Status of Girls' Education in Lebanon" is a report that was jointly authored by the United Nations Children's Fund (UNICEF) and the United Nations Girls' Education Initiative (UNGEI). The report provides an analysis of the challenges facing girls' education in Lebanon, including barriers to access and completion of education, as well as gender-based violence in schools.

"Early Childhood Education in Lebanon: Status, Challenges and Opportunities" is a report that provides an overview of the state of early childhood education (ECE) in Lebanon. The report was published by the Issam Fares Institute for Public Policy and International Affairs at the American University of Beirut in collaboration with the UNICEF Lebanon Country Office in 2015.

The main aspects tackled in these studies can be listed as follow:

1. Access to education: Despite efforts to improve access to education, there are still significant disparities in access, particularly for vulnerable and marginalized children, including refugees and children with disabilities.

2. Quality of education: The quality of education in Lebanon is affected by several factors, including inadequate infrastructure, outdated curriculum, a shortage of qualified teachers, and insufficient resources.

3. Gender disparities: While girls' education has improved in recent years, there are still significant gender disparities in access to education, particularly in rural areas.

4. Early childhood education: There is a need for greater investment in early childhood education, particularly for disadvantaged children who are at risk of falling behind in their cognitive and social development.

5. Higher education: While Lebanon has a relatively high level of higher education enrollment, there are concerns about the relevance and quality of higher education, particularly in terms of preparing graduates for the job market.

UNESCO continues to monitor and report on education in Lebanon, particularly in light of the ongoing crises affecting the country. UNESCO's recent reports on

education in Lebanon focus on the impact of the COVID-19 pandemic on education, including school closures, remote learning, and the challenges faced by vulnerable and marginalized children. UNESCO also provides technical assistance and support to the Lebanese government in strengthening the education system and improving access, quality, and relevance (UNESCO, 2021a).

All these studies and others, suggest that there is a need for increased investment in education in Lebanon, particularly in improving access, quality, and relevance. There is also a need for targeted interventions to address the specific needs of vulnerable and marginalized children, and to ensure that education is inclusive and equitable.

c. Main ECD players

In Lebanon, there are various social protection services and actors involved in providing ECD services to children and families. Some of these actors include:

1. Government: The Lebanese government plays a role in providing social protection services to children and families, including those related to ECD. The Ministry of Social Affairs is responsible for implementing social welfare policies and programs in the country, including early childhood development programs.
2. NGOs: Non-governmental organizations (NGOs) also play a significant role in providing ECD services to children and families in Lebanon. These NGOs include organizations such as UNESCO, Save the Children, UNICEF, and Caritas, among others. They provide a range of ECD services, including parenting support, child protection, and early childhood education.
3. Municipalities: Municipalities in Lebanon also have a role to play in providing ECD services. They can support ECD programs by providing access to community spaces, such as parks and community centers, and by partnering with NGOs and other organizations to provide ECD services.
4. Local communities: Local communities and families play a crucial role in supporting ECD in Lebanon. They can provide support to parents and caregivers, share knowledge and resources related to ECD, and help create a supportive environment for young children.

d. ECD research

There has been significant efforts conducted by funded programs and NGOs on ECD in Lebanon over the past few years.

1. The Arab Network for Early Childhood Development (ANECD) conducted a study on the "State of Early Childhood Development in Lebanon" in 2018, which examined the policy and programmatic landscape for ECD in Lebanon, as well as the challenges and opportunities for promoting ECD.

2. The American University of Beirut (AUB) has conducted several research projects on ECD in Lebanon, including studies on the impact of early childhood education programs on children's cognitive and socio-emotional development, the effects of parental involvement on children's school readiness, and the role of ECD programs in promoting gender equality.
3. UNICEF Lebanon has conducted a study on "Child Poverty and Deprivation in Lebanon," which examined the extent and nature of poverty and deprivation among children in Lebanon, as well as the impact on children's health, education, and well-being.
4. The International Rescue Committee (IRC) has conducted a study on "Early Childhood Development in Emergencies: Lessons from the Lebanon Crisis," which examined the challenges and opportunities for promoting ECD in the context of the Syrian refugee crisis in Lebanon.
5. The Higher Council for Childhood (HCC) which operates under the wings of the Ministry of Social Affairs and is responsible for the protection and promotion of the rights of children in the country. According to the HCC's 2020 report on the impact of the economic crisis on children, the crisis has led to reduced access to health care for many children in Lebanon, particularly in rural areas. The report also noted that malnutrition rates among children have increased, with around 30% of children under the age of five in Lebanon experiencing stunted growth.
6. UNICEF and UNESCO have produced several reports on the struggles with accessible services to health, social, education, and child protection services for both Lebanese children and Syrian refugee children in Lebanon. Here are some of the key findings:
7. UNICEF's "Back to School" report for 2020-2021 found that approximately 354,000 children (36% of school-aged children) were out of school in Lebanon, with Syrian refugee children being the most affected. Barriers to education include poverty, lack of documentation, distance to school, language barriers, and discrimination.
8. UNICEF's "Humanitarian Action for Children" report for 2021 highlights the challenges facing children's health and nutrition in Lebanon. The report notes that 30% of children under the age of five suffer from stunting, and access to basic health care remains limited for many vulnerable children.
9. UNICEF's "Child Protection in Emergencies" report for 2020 highlights the high prevalence of child marriage and child labor in Lebanon, particularly among Syrian refugee children. The report also notes that children are at risk of abuse, exploitation, and violence, with limited access to child protection services.
10. UNESCO's "Social Protection for All" report for 2020 highlights the need for greater investment in social protection programs in Lebanon, particularly for vulnerable and marginalized children. The report notes that poverty rates are high among both Lebanese and Syrian refugee children, with limited access to social safety nets.

    It's worth noting that the data and statistics available on childhood issues in Lebanon may be limited or outdated, due in part to the challenges of collecting and analyzing data in the country's complex and often volatile context.

Overall, these reports highlight the challenges facing vulnerable children in Lebanon, particularly in terms of access to education, health care, child protection, and social protection services. The reports also emphasize the urgent need for increased investment and support to address these challenges and promote the well-being of all children in Lebanon.

Lebanon's figures of some ECD indicators [box]

- 6 per 1000 infant mortality rate
- 4 per 1000 neonatal mortality rate
- 7 per 1000 of under-five mortality rate
- 62 percent of children aged 36-59 months attending an early childhood education program
- 29 percent of children under age 5 who have 3 or more children's books
- 16 percent of children under age 5 who play with 2 or more types of playthings
- 9 percent of children under age 5 left alone or under the supervision of another child younger than 10 years of age for more than 1 hour at least once per week
- 41 percent early initiation of breastfeeding
- 11 percent continued breastfeeding (20-23 months)

(Lebanon - Demographics, Health & Infant Mortality - UNICEF DATA)

e. Child prenatal care, health and nutrition overview

Household wealth and mother's and father's education are strongly associated with births having prenatal care in Lebanon. Births in the poorest fifth of households have an 89 percent chance of prenatal care, while births in the richest fifth of households have a 100 percent chance. There are large differences based on mother's education. While a birth to a mother who is illiterate has an 80 percent chance of receiving prenatal care, a mother even just being able to read and write increases the chance to 91 percent, and secondary or higher educated mothers have a 99 percent chance of receiving prenatal care. There are similar differences based on the father's education as well. After accounting for multiple characteristics, births in the third through richest fifth of households are more likely to receive prenatal care than births in the poorest fifth of households. Having a mother with primary or greater education increases the chance of a birth receiving prenatal care, as does having a father who can read or write or who has preparatory or greater education. Given the nearly universal prevalence of skilled attendants at delivery, it is neither necessary nor possible to identify factors affecting access to these services (El-Kogali & Krafft, 2015).

In Lebanon, almost all births received prenatal care and were attended by a skilled health professional. Addressing both early mortality and ECD begins during pregnancy. Around 95 percent of births received prenatal care from a health professional, and 98 percent of births were attended by a health professional (Figure 3). Lebanon has been doing well on delivery care for decades; in 1995, the rate was already at 98 percent (World Development Indicators). Lebanon is well above the current regional average for delivery care of 79 percent (UNICEF 2014).

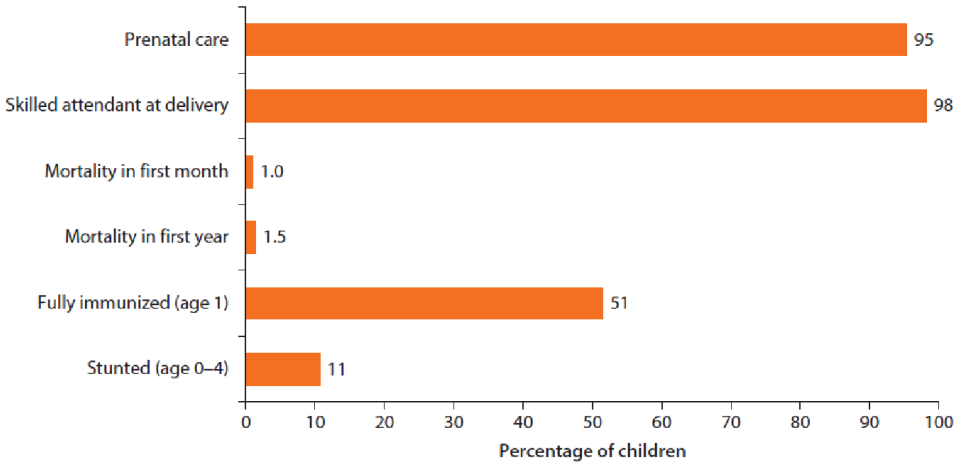

Figure 3: Selected ECD indicators' rates for Lebanon

The immunization of children plays an important role in preventing illnesses and reducing mortality (Molina, 2012). Yet Lebanon is far from full immunization coverage. Children are considered fully immunized if they have received immunizations for all six major preventable childhood diseases: tuberculosis, diphtheria, whooping cough, tetanus,5 polio, and measles. Data were not available in the PAPFAM (Pan Arab Survey for Family Health) survey on tuberculosis vaccine coverage, so the rate of full immunization is calculated based on the other immunizations. Children should be fully immunized by 12 months of age; this analysis focuses on children 12–23 months to allow for optimal parental recall. In Lebanon, only 51 percent of children 12–23 months are fully immunized. Measles, in particular, has a low coverage rate at only 51 percent. Additionally, 80 percent of children 12–23 months have received the third DPT (diphtheria, pertussis, tetanus) dose, and 83 percent have received the third polio dose. Looking at more recent (2010) data, vaccination rates have, if anything, deteriorated: only 74 percent of children received the third polio or DPT doses, and 53 percent received the measles vaccine (World Development Indicators).

Nutrition plays an important role in children's healthy development. In Lebanon, 16 percent of children are stunted (Global Nutrition Report, 2020). In terms of weight-for-age, 4 percent of children in Lebanon are underweight (–2 standard

deviations or lower). In terms of weight-for-height, 6 percent of children are wasted (–2 standard deviations or lower). Ninety-two percent of children under the age of five live in a household with sufficiently iodized salt (World Development Indicators). Micronutrients such as Iron, vitamin A, Zinc, and Iodine play an important role in both physical and cognitive development. Reaching the remaining 8 percent of children can save them from the risk of impaired cognitive development due to the absence of iodine in their diets.

Female and male children have similar chances of being stunted. However, stunting is higher in the poorest (15 percent) and second poorest wealth quintiles of households (12 percent) than in the third, fourth, and richest wealth quintiles (8–9 percent).

f. Children's screen time

A local study (Samaha & Hawi, 2017) shows that more than half of the Lebanese children from 6 to 11 years (59.3 percent) exceeded the recommended daily screen time. Within their cohorts, more boys exceeded the recommended screen time (63.5 percent) than girls (54.7 percent). Also, more children enrolled in the English-based educational curriculum (67.7 percent) exceeded the two hours limit in comparison with children enrolled in French based educational curriculum (56.3 percent).

The prevalence of exceeding the two hours of recommended screen time per screen media parenting practice and non-electronic activities. For instance, about one fifth of parents (20.4 percent) reported that they reward their child's good achievement by allowing screen media use and 64.1 percent of the children of this category of parents exceeded 2 h per day of screen time compared to 35.0 percent of parents who reported they "sometimes" reward their child with 62.5 percent of the children of this category of parents exceeding the recommendation. Only 29.5 percent of households do not punish their child's bad achievement/behavior by prohibiting screen media use. These two disciplinary parenting practices had positive relationship with screen media use. For non-electronic activities, 55.1 percent of parents reported that their child did not meet the recommendation of at least one hour of physical activity per day and 57.5 percent of the children of this category exceeded the recommended daily screen time (Samaha & Hawi, 2017).

g. Children with special needs

In 2000, Lebanon passed Law 220 that, among other things, guaranteed disabled individuals the right for an education free from discrimination, as well as equal opportunities within private and public educational institutions. Yet, in the near two decades since the law was passed, an implementation decree has not been developed or agreed on by relevant ministries. While there are signs that this

could change in the future, current progress is slow, and on a structural level, the educational system in Lebanon continues to exclude and discriminate against special needs students. For students who do manage to enroll in schooling, and whose families can afford the added costs imposed on them, there is an additional barrier to face: the lack of accommodation in the Lebanese national curriculum for special needs students. It is up to the schools themselves to adapt the curriculum to suit specific needs.

Due to the lack of data on the overall number of children with disabilities in Lebanon, it is impossible to give a scale to this problem. By the World Bank's estimate, worldwide at least 5 percent of children aged between one and 14 have a disability; using that metric, Human Right Watchestimates that, on the conservative side, there could be around 45,000 disabled children in Lebanon. However, the government agency charged with registering people with disabilities have just 8,558 children on file - perhaps because Lebanon does not consider some conditions - such as high-functioning autism, misophonia, and pathological demand avoidance - as disabilities.

The Ministry of Social Affairs (MOSA), NGOs, and INGOs have been joint reports and studies conducted in Lebanon on children with disabilities:

1. MOSA and the United Nations Development Programme (UNDP) conducted a study on "Mapping of Social Protection Schemes for Persons with Disabilities in Lebanon" in 2021. The study aimed to identify gaps and challenges in the provision of social protection services for persons with disabilities in Lebanon.
2. The Lebanese Physical Handicapped Union (LPHU) conducted a study on "Access to Education for Children with Disabilities in Lebanon" in 2020, which examined the challenges and barriers to accessing education for children with disabilities in Lebanon, as well as the policies and programs in place to support their inclusion in mainstream schools.
3. Handicap International (now known as Humanity & Inclusion) conducted a study on "Barriers to Accessing Health Care for Persons with Disabilities in Lebanon" in 2019, which examined the challenges and barriers faced by persons with disabilities in accessing health care services in Lebanon.
4. World Vision Lebanon conducted a study on "Inclusion of Children with Disabilities in Early Childhood Development Programs in Lebanon" in 2018, which examined the extent to which ECD programs in Lebanon are inclusive of children with disabilities, as well as the barriers and challenges to their inclusion.

Special needs students in Lebanon continue to face social, financial, and physical barriers to education. Changing this is important, as investment into special education leads to positive spillovers, through job creation and increasing the opportunity for children with special needs to reach their full potential as adults. All in all, greater efforts should be made to promote an

inclusive education system for all children in Lebanon (Darwich-Houssami, 2019).

h. Total kindergarten enrollment rates

Early Childhood Care and Education (ECCE) is provided by a mix of public and private nurseries and kindergartens. Nurseries are primarily private, while pre-primary school is a mix of public and private (Kaloustian, 2012).

Percentage of enrolment in pre-primary education in private institutions in Lebanon was reported at 74.7 % in 2019, according to the World Bank collection of development indicators, compiled from officially recognized sources.

Total kindergarten enrollment rates for three-to six-year-olds are 96 percent in Mount Lebanon, 85 percent in Beirut, and 83 percent in Bekaa; however, they are 71 percent in the North, 73 percent in Nabatieh, and 61 percent in the South. This generally coincides with rates of poverty and income; the South and North have the highest poverty rates. In brief, children in Lebanon have high chances of early health care (prenatal and delivery care) and low chances of dying in the first month or year of life. However, as they grow older, children face several threats to their development, including low immunization rates and a substantial chance of being stunted. Additionally, children face unequal chances of healthy early development based on their circumstances, with the poorest children and those with the least educated mothers particularly at risk. Children are also likely to face unequal chances to be school-ready, given differences in access to ECCE. More needs to be done to ensure that children can develop successfully and equitably throughout their early years. Additional and more frequent data on children's development in Lebanon could also play a crucial role in assessing other areas where children's development is threatened and tracking progress in addressing these gaps (UNICEF, 2022b).

i. The situation in Lebanon since late 2019

Lebanon is in the throes of an overt humanitarian emergency, the impacts of which will be felt for generations.

Economic Crisis

The current situation is widely described as the worst economic crisis in Lebanon's turbulent modern history. The World Bank has reported that the economic and financial collapse is among the most severe globally since the mid-19th century. The World Bank has warned that poverty in Lebanon will continue to worsen, likely surpassing half of the population by mid-2021, and that the country faces an arduous and prolonged recession. Many report that the current situation is worse than experiences during Lebanon's 15-year civil war. Food and medication shortages are now widespread. Many subsidized goods, including medications, are reportedly being smuggled out of Lebanon, further

exacerbating supply-chain shortages. The oil and gas sector is nearing collapse. Petrol is scarce and the black-market price soaring (ESCWA, 2021).

Imminent lifting of subsidies on essential items, combined with ongoing currency devaluation, will see further diminishing of purchasing power. Lifting of subsidies on fuel has also sparked concerns that Lebanon will soon literally be left in the dark, with electricity supplies at risk. As of July 2021, fuel shortages have led to widespread power blackouts, with ongoing electricity cuts lasting up to 22 hours per day affecting all the sectors of the country (ESCWA, 2021).

The healthcare system has been ravaged, and further compromised by brain drain. One in five doctors are believed to have either already left the country or intend to do so. Oxygen to support patients on breathing aid was in short supply in hospitals, and tons of oxygen had to be shipped in from Syria. Social tensions have soared, and violence and petty crimes have increased. Mental health professionals describe a collective psychological trauma.

Due to sensitivities around sectarianism and population demographics, Lebanon has not conducted a national census since 1932. The World Bank estimates that of Lebanon's population (estimated at 6.85 million in 2021), 1.75 million are children aged 0–14 years. Hosting the largest number of refugees per capita, United Nations High Commissioner for Refugees (UNHCR estimates that Lebanon houses around 488,000 school-aged (3–18 years old) Syrian refugee children, around 121,380 Palestinian children (0–17 years old), and more than 5,000 Iraqi children, in addition to children of other nationalities, such as Sudanese and Ethiopian. Lebanese, refugee, and migrant children alike have been impacted by the recent crises in the country (UNICEF, 2023).

Covid19: A stress over stress

Following the first documented COVID-19 case on 21 February 2020, Lebanon implemented early and aggressive strategies that, until mid-2020, generally succeeded in containing COVID- 19 spread. Lebanon imposed several short partial lockdowns in late 2020 which were poorly enforced, had poor compliance and met with strong resistance from businesses and lobby groups. With no social security benefits or income support, informal workers, who comprise an estimated 55 percent of the overall workforce and 95 percent of the non-Lebanese workforce, were unable to earn a wage, causing unprecedented hardships. In a bid to boost the economy and encourage expatriate return and spending over the end of year holiday period, Lebanon eased restrictions and opened up on 17 December 2020, several days before a nationwide lockdown was due to end. Early 2021 consequently saw a massive resurgence in COVID-19 case numbers, with Lebanon reporting at the time the Eastern Mediterranean region's highest daily case numbers per million population and record daily

death tolls. PCR test costs and accessibility reportedly generated significant social disparities in test uptake, with official case statistics believed not to be reflective of the true disease burden and distribution. A strict 6-week total lockdown, including a national 24-h curfew, was imposed to control the outbreak. COVID- 19 vaccination commenced on 14 February 2021, with first vaccines administered to priority groups, including healthcare workers and the elderly. Despite close coordination between the Lebanese Ministry of Public Health and WHO-Lebanon to centralize management of the COVID-19 vaccination program, corruption has also plagued the vaccine rollout, with reports of politicians securing and unofficially importing vaccines into the country for distribution to their loyalists and sectarian constituencies (Abouzeid et al., 2021; Yoshikawa et al., 2020).

The situation drastically reflected on nurseries, kindergartens and schools who were obliged to close for several weeks and thus face budgetary problems due to the concurrent steep money devaluation of families' income and power purchase, which severely declined to nearly 10% of its original value in 2019 (Prensa Latina, 2022).

The synergy of Covid 19 spread and fiscal crisis led to the deterioration of health services in Lebanon. Hospitals and healthcare facilities are only accepting patients in need of emergency care and delaying routine operations. The situation compromises children's timely and appropriate access to health services and increases their risk of morbidity and mortality (Hamadeh et al., 2021).

Beirut Blast

The Beirut Port blast on 4 August 2020 occurred due to the explosion of up to 2,750 tons of highly explosive ammonium nitrate that was illegally stored at the port, and which senior government figures had reportedly known of for years. The largest non-nuclear explosion in the 21st century, the blast left over 200 dead and around 6,500 injured, and it severely damaged around 40 percent of Beirut, crippled businesses and destroyed lives and livelihoods. With extensive damage to health infrastructures, the already stretched health system and its health workers were overwhelmed. In the absence of state support or a coordinated government response, the Lebanese population were left to drive clean-up efforts themselves - including many young people taking to the streets with brooms and dustpans to remove debris - and left grappling with the psychological impacts of yet another crisis. Psychologists reported that the explosion triggered memories of the 1975-1990 civil war among older Lebanese, many of whom had never dealt with their traumas and hence did not know how to support their children following the blast. Humanitarian needs have since increased across the country, including in areas not directly affected by the explosion but experiencing the compounding impacts of the economic collapse, COVID-19, and port disruption. Needs have also soared among already

vulnerable groups, including Syrian refugee households, nine out of ten of which reportedly now live in extreme poverty, and other foreign nationals (Abouzeid et al., 2021).

j. The impact of the complex crises on Lebanon's children schooling

Even prior to the Beirut blast, which left at least 183 schools damaged and is estimated to have affected access to learning and education support for more than 85,000 children and youth, it was reported that 1,600 schools would close due to the economic crisis and many children had been withdrawn from schools due to economic hardship (ACAPS, 2022).

COVID-19 has further impacted educational access and uptake, with school closures in March 2020 estimated to have interrupted the education of more than 1.2 million children enrolled in private, public and United Nations Relief and Works Agency for Palestine Refugees. (UNRWA) schools and ~30,000 children and youth enrolled in non-formal education. A remote online learning strategy was implemented by the Ministry of Education and Higher Education for all private and public schools. It is estimated that in 2019–20, children received a maximum of 11–18 weeks of schooling delivered by any modality (of 31–33 weeks in a traditional school year), and this figure is lower for Syrian children. Remote learning participation rates have varied considerably across governorates, grade levels and student populations, mirrored by inequities in access to internet, computer facilities and electricity. It is estimated that at least one in four children in Beirut are now at risk of dropping out of school and 40 percent of school aged Syrian refugee children are not enrolled in any type of learning.

It is reported that as of March 2021, 15 percent of 1,244 households surveyed by United Nations Children's Fund (UNICEF) had stopped their children's education. Access to education is further threatened by the imminent lifting of subsidies, with many children likely to either be transferred from private to public schools and others likely to forgo education completely as spending on food is prioritized over schooling, and as others are forced into child labor to support household incomes (Abouzeid et al., 2021).

k. Health and nutrition

The direct health impacts of Lebanon's multiple crises on children are pronounced and include an increased number of children aged under 5 years with acute malnutrition. UNICEF reported that in March 2021, 30 percent of families in 1,244 households, had at least one child who skipped a meal or went to bed hungry, and 77 percent of all households indicated that they did not have enough food or enough money to purchase food (UNICEF, 2023).

Access to safe water is increasingly an issue, with 20 percent of households reporting insufficient drinking water. There have also been marked reductions in uptake and coverage of routine child immunizations, with a 43 percent decrease reported in private clinics, a 31 percent decrease at the national level, and 77 percent of pediatricians reporting a decrease in routine immunization between October 2019 and April 2020 compared with the same period in the preceding year. UNICEF reported that 30 percent of children are not receiving the primary health care they require, and 76 percent of households are impacted by soaring medication prices. “Period poverty” is also increasing with two-thirds of adolescent girls having no means of purchasing sanitary products, and many resorting to other measures to manage their periods, including newspaper, old rags, baby diapers or not leaving the house (Hamadeh et al., 2021).

The health impacts of the Beirut blast on children are profound: more than 1,000 children were injured, 100,000 had their homes either completely or partially destroyed, and children from areas both near and far from the blast epicenter are experiencing psychological impacts related to trauma from the blast. Physical and mental health problems are projected to continue to increase among children in Lebanon. Refugee and vulnerable children experience additional and psychosocial concerns, including, among Syrian refugee boys, a fear of violence and being targeted by the Lebanese authorities and surrounding communities and fear about their future in Lebanon given the political and economic breakdown. Among working refugee boys of school age, the stress of being the sole breadwinners and fears that the economic situation may force them to engage in illegal activities such as drug dealing, and weed cultivation are described. Negative coping mechanisms pose further health risks, with reports of alcohol and drug misuse among children of all nationalities in Lebanon, adopted as strategies to relieve the pressures of the pandemic and the economic crisis (Abouzeid et al., 2021).

In sum, the socioeconomic environment is a fundamental determinant of ECD and, in turn, ECD is a determinant of health and well-being across the balance of the life course. The current crises engulfing Lebanon present a range of health, economic and social challenges that threaten the well-being of a generation of children.

These crises are not expected to be rapidly resolved due to the dysfunctional power sharing, deep-seated sectarian divides, and the scars of Lebanon’s history of conflict and its ongoing leaders’ abuses.

The Lebanese people, and in particular the children of Lebanon, can be rescued only through rigorous political reform that demands merit-based and transparent governance and a political agenda that strengthens institutions and

infrastructures, allows a life of dignity, and protects the rights and well-being of all.

Early Childhood Development Index 2030 [box]

In 2015, early childhood development became part of the Sustainable Development Goals (SDGs). These global goals include a commitment to ensure that, by the year 2030, all children will have equitable access to quality early childhood development and early learning opportunities.

SDG indicator 4.2.1 was chosen to specifically monitor the impact of government action towards this target, and UNICEF was tasked to lead the development of a measure to track progress.

That same year, UNICEF initiated a process of methodological development that involved extensive consultations with experts, partner agencies and national statistical authorities. Over the following five years, a sequence of carefully planned technical activities were executed, incorporating both qualitative and quantitative methods to identify the best items to measure indicator 4.2.1. This process led to the development of the ECDI2030.

The ECDI 2030 captures the achievement of key developmental milestones by children between the ages of 24 and 59 months. Mothers or primary caregivers are asked 20 questions about the way their children behave in certain everyday situations, and the skills and knowledge they have acquired.

The ECDI 2030 addresses the need for nationally representative and internationally comparable data on early childhood development, collected in a standardized way. The module can be integrated into existing national data collection efforts. It is accompanied by standard guidance and a framework for technical assistance to support implementation. And because the data can be disaggregated by key demographics and subnational areas, the use of this measure can also help advance the SDG commitment to leave no one behind.

The ECDI 2030 questionnaire has been translated into multiple languages and, in addition to English, is available in Arabic and French.

Source: https://data.unicef.org/resources/early-childhood-development-index-2030-ecdi2030/

7. Research design of the study

a. FGD from the 5 Governorates

The FGD conducted in each of the five Governorates where experts interviewed five caregivers, five parents, and five teachers from different areas. Before each 25-to-30-minute interview, consents and discussions on the interview's objectives were discussed with the interviewees. Thus, three FGDs were conducted in each Governorate where set of guided interview questions were prepared ahead of time

focusing on assessing the status of ECD in Lebanon. The interviews, conducted in Arabic language, were recorded, coded, and transcribed (check appendix 4). In the following section, a summary of each interview is discussed. The researcher made sure not to ask questions about information that might embarrass the interviewees. As mentioned in Hajal (2018), Creswell provided the researchers several ethical issues. A summary of the ethical issues was as follow:

-don't push participants at risk;

-gain the permission of individuals in authority;

-respect research sites so that the sites are left undisturbed after research study;

-collect data so that all participants and not only an experimental group, benefit from the treatment;

-means such as authority need to be considered for reciprocating between the research and the participants;

-anticipate the possibility of harmful information being disclosed during the data collection process such as parental abuse.

b. Analyses of the Interviews

The data collected from the discussions were manually coded and categorized. The researcher started analyzing the discussions from each transcription. Transcriptions from the field notes in separate centers were thoroughly studied and chunks of coded sections were grouped. Thus, the researcher coded all the common characteristics observed in the discussion from each of the FGD.

Therefore, data was gathered from the comparison between what was reported by each of the teachers, parents, and healthcare givers in each of the 5 governorates. All these helped in fulfilling the purpose of the research which was to assess the early childhood care and development situation of young children and their families during the multi-dimensional crisis in Lebanon.

c. Teachers Interview

The group members were forced to make changes to their teaching methods in the recent years because the crisis reflected significantly on the parents and students. The online teaching method made the students more dependent on their parents. The utilization of teaching videos was both time consuming and counterproductive due to the difficulty in finding content that best clarifies the concept being explained. Another issue with the migration to online teaching was the failure to achieve full

quorum on time because students found numerous excuses to justify their delay or absence. Moreover, it became difficult to evaluate competencies given that parents were the ones solving tasks rather than students. There was a difficult learning curve for teachers who relied on teaching methods that did not incorporate such technologies. The length of the Zoom session was far less than the actual class session. The students were not serious in their approach to online learning. The challenge was close to impossible for Syrian students given the unavailability of laptops and the dependency of the entire family on the same smartphone. The crisis imposed many restrictions on what was before abundantly available for students. This lack of leisure exercises and activities produced more passive, lazy, and angry individuals than what used to be observed before. Competencies that require in-person supervision were not acquired. The number of students exhibiting learning difficulties increased significantly after students got back to school following months of online learning. The teachers suggested a reformation in the adopted curriculum that takes into consideration the challenges that Lebanese students might face throughout the school year (power cuts, internet loss, paper shortage, behavioral changes…) and provide ways to navigate these difficulties beforehand.

d. Parents Interview

The economic crisis affected the individual's personal income whether it was a deduction in the salary itself or the devaluation of the currency which rendered parents unable to meet the basic needs of their offspring. The concern shifted from a healthy diet to hunger-evasion. Children were confronted with issues such as the availability of basic needs, and other ones with which children were not supposed to be concerned. Even learning freely became a luxury when students were forced to share the internet bandwidth and to compromise the quality of learning in favor of allowing the largest number of individuals in the family to learn online. The quality of learning was more affected in public schools than private schools. Nevertheless, the overall experience that schools provide from making friends to other social interactions was severely affected. The quality of food that the parents were able to provide shifted from meat and poultry to beans and lentils, and even with that they could not splurge. Concerning basic health provisions, the challenge was not just the incomprehensible increase in prices, but the unavailability of simple over-the-counter medication, which forced parents to search far and wide to be able to provide these necessities. As parents, a definite need for financial support is needed if life is to continue in any form of normality and needs are to be met.

e. Healthcare Providers Interview

A severe shortage has developed in both healthcare providers, who migrated to countries where a higher income and medication itself could be secured. Children did not receive vaccines and basic provisions like milk per se either due to unavailability or due to high prices. This contributed to an increase in medical cases that were

considered quite rare like meningitis. The confinement forced a regression in the children's ability to adapt to outdoor and group activities. Higher rates of students with gastroenteritis were observed; this increase could be attributed to inadequate heating. Children need support from governmental and non-governmental organizations to meet their basic medical needs.

8. Findings of the report

A. Summary of Bekaa FGD

a. Teachers' FGD

The convener asked the teachers about the challenges they faced, how they faced these emerging issues, and what factors helped them in handling the tough situations during the last two years. Also, he asked the teachers about the activities and techniques used to facilitate their teaching process. In turn, all the teachers agreed that the remote teaching was ineffective and inefficient since it impacted the education in a negative way. They claimed that the two years the students spent at home didn't allow them to receive the appropriate education; the matter that created lazy, stressed, and unmotivated generation. The teachers used constructive techniques to bring back the students' spirit in the children in their classrooms. They used several interactive teaching techniques to attract the students' attention that was captured by the electronic devices they used for the whole two years. The teachers worked as well on the psychomotor skills, discipline, and appropriate acquiring knowledge techniques. During the remote teaching/learning period, the teachers used to videotape the lectures and send them to the students and parents as well. Not only that, but also, they recorded the lectures as voice messages and sent them to the parents who, in turn, explained them to their children. When the convener asked about the psychological effects of that unusual situation, the teachers agreed on the fact that the stress was obvious through the students' behavior. The tough financial situation has laid its weight on the parents and children as well. Parents have hard times keeping their jobs and living standards. They fell behind all their duties towards their children who were fully conscious of what was happening around. Parents are now struggling to get food and medicine to their children. Parents are now unable to pay the school tuition, buy books and copybooks, ensure transportation, and even make the house warm during the cold weather in Bekaa. The schools and teachers as well can't keep their feet stable in such a tough crisis. They can't survive in the absence of the parents and government support. They are left for their dark destiny awaiting help from an NGO.

b. *Parents' Focus Group Report*

The convener asked the parents whether their social, economic, and financial status has changed and affected their life quality, how they have faced and dealt with these challenges, what factors helped them to adapt to these difficult emerging life patterns, what unusual behavior the children developed, and what difficulties they have had to keep living standards and academic stability. All the parents agreed that the emerging situation affected their income in a major way. Parents are not able to keep the living standards, buy food, fuel, or other necessities. In addition to that, mothers have got very busy teaching their children; the matter that didn't allow them to specify even few times to their husbands. All these tipped their daily stress. The most devastating reason is that in Bekaa during winter, the weather gets too cold; however, unfortunately, so many people could afford buying fuel to heat up their houses, so some switched into using wood and others ended up using blankets to warm up their children. Staying home for two years, the children got bored, lazy, disrespectful, and unfocused. Also, spending time on social media taught them about some things that don't even exist in our culture and society. In addition to that, the food quality has dropped to the high prices. People eliminated so many essential nutrients like chicken and meat from their daily meals. Also, parents stooped buying bottled drinking water and replace it by the tap water. The saddest part is that the parents don't have the ability to buy medicine and get good treatments. They even stopped vaccinating their children due to the lack of the vaccines and their high prices.

c. *Healthcare Focus Group Bekaa Report*

The convener asked how the focus group participants describe the provision of child health care and access to medical services over the past two years, the challenges in accessing the resources, equipment, and care tools needed for medical services such as vaccinations and examinations, How to deal with these challenges and what the intervention plans that have been implemented are, the main effects of the challenges on children's health and development as well as educational and psychological growth, and in addition to Corona, what the main medical conditions that have been raised in the field of pediatric health care in the past two years would be. All the participants agreed that the current difficult financial, economic, social, and medical situation affected all the families and especially children in a radical way. The lack of medicine or the high prices hindered the appropriate medical procedures and so many families focused only on the very urgent and essential cases. However, the neglected medical cases have become very serious and current cases affected the children from all sides. Experienced specialists are leaving and many unexperienced one are taking over; the matter that lessens the medical standards. The participants added that the experienced specialists for disabilities are very rare to exist. All these reasons made the parents disregard the psychological cases and all what is related to it. What made the parents disregard their children's mild cases was the expensive doctors' fees and medications. In some times, parents went to unspecialized clinics and the treatments were not effective. Buying medical tools

was another problem emerged by the difficult current situation and that contributed to making the problems even worse. Moreover, COVID-19 has created a confusing milieu for people, so any symptom, no matter what it was, has been considered COVID-19 symptoms; the matter that screened all other illnesses symptoms. Lack of vaccination and proper medication has brought to light some old illnesses that existed a decade before. Lack of money, medication, medical resources developed an intensive increase in stress, medical and learning illnesses and difficulties, and loose life.

B . Summary of Mount Lebanon FGD

a. Teachers Focus Group Mount Lebanon Report

The participants claimed that they were forced to make changes to their teaching methods in the recent years because the crisis reflected significantly on the parents and students. The online teaching method made the students more dependent on their parents. The utilization of teaching videos was both time consuming and counterproductive due to the difficulty in finding content that best clarifies the concept being explained. Another issue with the migration to online teaching was the failure to achieve full quorum on time because students found numerous excuses to justify their delay or absence. Moreover, it became difficult to evaluate competencies given that parents were the ones solving tasks rather than students. There was a difficult learning curve for teachers who relied on teaching methods that did not incorporate such technologies. The length of the Zoom session was far less than the actual class session. The students were not serious in their approach to online learning. The challenge was close to impossible for Syrian students given the unavailability of laptops and the dependency of the entire family on the same smartphone. The crisis imposed many restrictions on what was before abundantly available for students. This lack of leisure exercises and activities produced more passive, lazy, and angry individuals than what used to be observed before. Competencies that require in-person supervision were not acquired. The number of students exhibiting learning difficulties increased significantly after students got back to school following months of online learning. The teachers suggested a reformation in the adopted curriculum that takes into consideration the challenges that Lebanese students might face throughout the school year (power cuts, internet loss, paper shortage, behavioral changes…) and provide ways to navigate these difficulties beforehand.

b. Parents Focus Group Mount Lebanon Report

The economic crisis affected the individual's personal income whether it was a deduction in the salary itself or the devaluation of the currency which rendered parents unable to meet the basic needs of their offspring. The concern shifted from a healthy diet to hunger-evasion. Children were confronted with issues such as the availability of basic needs, issues with which children are not supposed to be concerned. Even

learning freely became a luxury when students were forced to share the internet bandwidth and to compromise the quality of learning in favor of allowing the largest number of individuals in the family to learn online. The quality of learning was more affected in public schools than private schools. Nevertheless, the overall experience that schools provide from making friends to other social interactions was severely affected. The quality of food that the parents were able to provide shifted from meat and poultry to beans and lentils, and even with that they could not splurge. Concerning basic health provisions, the challenge was not just the incomprehensible increase in prices, but the unavailability of simple over-the-counter medication which forced parents to search far and wide to be able to provide these necessities. As parents, a definite need for financial support is needed if life is to continue in any form of normality and needs are to be met.

c. Healthcare providers Focus Group Mount Lebanon Report

A severe shortage has developed in both healthcare providers, who migrated to countries where a higher income and medication itself could be secured. Children did not receive vaccines and basic provisions like milk per se either due to unavailability or due to high prices. This contributed to an increase in medical cases that were considered quite rare like meningitis. The confinement forced a regression in the children's ability to adapt to outdoor and group activities. Higher rates of students with gastroenteritis were observed; this increase could be attributed to inadequate heating. Children are in need of support from governmental and non-governmental organizations to meet their basic medical needs.

C. Summary of South FGD

a. Parents Focus Group South Report

The convener asked the parents whether their social, economic, financial status has changed and affected their life quality, how they have faced and dealt with these challenges, what factors helped them to adapt to these difficult emerging life patterns, what unusual behavior the children developed, and what difficulties they have had to keep living standards and academic stability. All the parents agreed that the emerging situation affected their income in a major way. Parents are not able to keep the living standards, buy food, fuel, or other necessities. Most of them have moved out their children from private schools and enrolled them in public ones where the teaching and learning quality is very poor. So, some students have quit their long-life majors and moved into local institutions because they can't afford paying bus fees. They switched buses and car by motorcycles. Many parents have reduced the meals into two and offer the lunch very late in the afternoon, so their children stay a bit satisfied till evening. Even parents complained about the quality of food they are putting on their tables. One parent said that she has had a spaghetti farm in their stomachs. Another major problem is the medicine and the medical cases. They can't afford going to doctors and buying medicine and in case of emergency, they only buy the necessary medicine because they

can't afford doctor and medicine together. The parents seem and sound very frustrated because they see their children's future in stake. Instead of seeing their children playing, learning, and enjoying life, they see them loaded with life burdens at very early ages. Parents wish death of living such a miserable life where the schooling, hospitalization, medical, nutritional, social, economic, and financial systems are collapsed.

b. *Healthcare providers Focus Group South Report*

The convener asked how the focus group participants describe the provision of child health care and access to medical services over the past two years, the challenges in accessing the resources, equipment, and care tools needed for medical services such as vaccinations and examinations, How to deal with these challenges and what the intervention plans that have been implemented are the main effects of the challenges on children's health and development as well as educational and psychological growth. In addition to COVID-19, what the main medical conditions that have been raised in the field of pediatric health care in the past two years would be. All the participants agreed that the current difficult financial, economic, social, and medical situation affected all the families and especially children in a radical way. The lack of medicine or the high prices hindered the appropriate medical procedures and so many families focused only on the very urgent and essential cases. However, the neglected medical cases have become very serious and current cases affected the children from all sides. They also added that they replaced the medicine with made-home herbs due to the unavailability and high prices of the medicine What made the parents disregard their children's mild cases was the expensive doctors' fees and medications. In some times, parents went to unspecialized clinics and the treatments were not effective. Buying medical tools was another problem emerged by the difficult current situation and that contributed to making the problems even worse. Moreover, COVID-19 has created a confusing milieu for people, so any symptom no matter what it was, has been considered COVID-19 symptoms; the matter that screened all other illnesses symptoms. Lack of vaccination and proper medication has brought to light some old illnesses that existed a decade before. Lack of money, medication, medical resources developed an intensive increase in stress, medical and learning illnesses and difficulties, and loose life.

They added that there should be an identification card that allows individuals to receive free hospitalization and medication. Also, they mentioned about the passive role of the municipalities and NGO in distributing hand sterilizers. So many people donated money to help patients with diabetes and heart diseases and others left money at pharmacies to help those who can't afford buying medicine. In addition to so many doctors who dedicated one day per week to check people for free.

c. *Teachers Focus Group South on Report*

The convener asked the teachers about the challenges they faced, how they faced these emerging issues, and what factors helped them in handling the tough situations during

the last two years. Also, he asked the teachers about the activities and techniques used to facilitate their teaching process. In turn, all the teachers agreed that the remote teaching was ineffective and inefficient since it impacted the education in a negative way. They claimed that the two years the students spent at home didn't allow them to receive the appropriate education; the matter that created lazy, stressed, and unmotivated generation. Some schools had the system and were ready to start directly teaching remotely, but other schools were not capable at all even to have a remote teaching platform. Those schools used the WhatsApp application to teach their students; the matter that didn't help the students at all. Those who were able used constructive techniques to bring back the students' spirit in the children in their classrooms. They used several interactive teaching techniques to attract the students' attention that was captured by the electronic devices they used for the whole two years. During the remote teaching/learning period, the teachers used to videotape the lectures and send them to the students and parents as well. Not only that, but also, they recorded the lectures as voice messages and sent them to the parents who, in turn, explained them to their children.

When the convener asked about the psychological effects of that unusual situation, the teachers agreed on the fact that the stress was obvious through the students' behaviors. The tough financial situation has laid its weight on the parents and children as well. Parents have hard times keeping their jobs and living standards. They fell behind all their duties towards their children who were fully conscious of what was happening around. Parents are now struggling to get food and medicine to their children. Parents are now unable to pay the school tuition, buy books and copybooks, and ensure transportation. The schools and teachers as well can't keep their feet stable in such a tough crisis. They can't survive in the absence of the parents and government support. One teacher mentioned that remote teaching was a chance for all the teachers and students to learn how to deal with news matters that would be important in the future.

D. Summary of transcripts of Beirut

a. Teachers Focus Group Beirut Report

The participants faced tremendous challenges with online learning because children at a young age need to have their hand held and to be cared for in person. And even when in person learning was allowed again, the children had a lot of deficits in terms of what was supposed to be acquired by that time of the year. The achievement of a full column in classrooms was hard, so some students learned while others were not, which posed as another obstacle for teachers. As for the secondary section, we faced the difficult task of providing content that would attract the students to remain in the Online class and for that part, we mostly failed because many students did not attend most of the sessions. They remained connected but turned their cameras off to provide the illusion that they were attending the session when they were nowhere near the laptops most of

the time. This problem was translated back to the classroom when in-person teaching was established again, and students still found it very difficult to focus or to become engaged and teachers found a lot of difficulty teaching the way they used to teach because students were not as receptive. Student were unable to adapt to a learning environment where they were supposed to do a lot of the work on their own because they were not used to that in the classroom. The method of teaching was also affected by the crisis because online learning requires a lot of engaging exercises, so we were forced to look into games and websites that you have not been introduced to before this time. The teacher also faced the challenge of proving that they can adapt to changes and able tackle different issues easily. In addition to that, the isolation of teachers that the pandemic forced made them more stressed on a psychological level because the active interaction and the work dynamic between them and the students was gone, and they were left with housework and teaching which it was already challenging and stressful. Teachers felt that they were sometimes inadequate because they failed at coping with some of the students' needs who were sitting in online classes but acquiring very little. Also, that problem was also translated back to in person teaching because of the deficit of information. Students became passive and lazy. Most were excited to come back to school not because they were eager to learn, but because they enjoyed meeting their fellow classmates. They enjoyed the social interaction that the school provided. Moreover, issues arising while lessons were explained were that teachers failed to anticipate while preparing the lesson before the class met. That was probably because they did not been evaluating the students alone, but the parents were shadowing while exams were held and that gave the false impression that skills were required. The students had to deal with a lot of stress: the stress of isolation, the stress of living without internet and electricity for most of the time, etc… they had to cope with a severe downgrade in their quality of life and spending habits. They were forced to think about life as a difficult task rather than enjoying time with their friends at school and living like normal kids and teenagers. Some students preferred the less formal environment that online learning provided because they could stay at home all day in their pajamas without having to deal the formalities of going to school, but many others felt that they didn't want to go back to online learning because it reminded of confinement. Learning remains a crucial part of the child's developmental process because it is not only about information but about shaping a person as well. The curriculum must be adjusted to cope with the new era of learning and the new type of students that has emerged. That means adopting new technologies and adjusting the content to better meet the interests of modern learners.

b. Healthcare providers Focus Group Beirut Report

The crisis along with the COVID-19 pandemic affected healthcare providence, especially for children and newborn babies, who were forced to skip vaccines or settle for products that were not regulated by the ministry of health. Parents had to downgrade from specialists to public clinics and generic medicine because of the shortage in healthcare providers that left the country coupled with the insane expenses of doing so.

The shortage of supplies and medical equipment forced hospitals to request tests from other labs when they were able to perform them. Some tests became foreign to the entire country and had to be sent abroad like the autism test and others. UNICEF along with NGOs must support healthcare in the area coupled with team effort can help children sustain their health. The ministry of health must monitor expired and/or fake medication as this problem is arising with the crisis.

c. Parents Focus Group Beirut Report

We Face tremendous challenges with online learning because children at a young age need to have their hand held and to be cared for in person. Even when in person learning was allowed again, the children had a lot of deficits in terms of what was supposed to be acquired by that time of the year. The achievement of a full column in classrooms was hard, so some students were learning, while others were not, which not which posed another obstacle for teachers. As for the secondary section, we faced the difficult task of providing content that would attract the students to remain in the online class, and for that part we mostly failed because many students did not attend most of the sessions. They remained connected but turned their cameras off to provide the illusion that they were attending the session when they were nowhere near the laptops most of the time. This problem was translated back to the classroom when in-person teaching was established again, and students still found it very difficult to focus or to become engaged and teachers found a lot of difficulty teaching the way they used to teach because students were not as receptive. Students were unable to adapt to a learning environment where they were supposed to do a lot of the work on their own because they were not used to that in the classroom. The method of teaching was also affected by the crisis because online learning requires a lot of engaging exercises, so we were forced to look into games and websites that you have not been introduced to before this time. The teacher also faced the challenge of proving that they were able to adapt to changes and tackle different issues easily. In addition to that, the isolation of teachers that the pandemic forced made them more stressed on a psychological level because the interaction and the work dynamic was gone, and they were left with housework and teaching which it was already challenging and stressful. Teachers felt that they were sometimes inadequate because they were failing at coping with the needs of some of the students who were sitting in online classes but acquiring very little. And that problem was also translated back to in person teaching because of the deficit of information. Students became passive and lazy. Most were excited to come back to school but not because they were eager to learn, but because they enjoyed meeting their fellow classmates. They enjoyed the social interaction that the school provided. Moreover, issues were arising while lessons were explained that teachers failed to anticipate while preparing the lesson before the class met. That was probably because they have not been evaluating the students alone, but the parents were shadowing while exams were held and that gave the false impression that skills were required. The students had to deal with a lot of stress: the stress of isolation, the stress of stress of living without internet and electricity for most of the time, etc... they had to cope with a

severe downgrade in their quality of life and spending habits. They were forced to think about life as a difficult task rather than enjoying time with their friends at school and living like normal kids and teenagers. Some students preferred the less formal environment that online learning provided because they could stay at home all day in their pajamas without having to deal with the deal the formalities of going to school, but many others felt that they didn't want to go back to online learning because it reminded them of confinement reminded of confinement. Learning remains a crucial part of the child's developmental process because it is not only about information but about shaping a person as well. The curriculum must be adjusted to cope with the new era of learning and the new type of students that has emerged. That means adopting new technologies and adjusting the content to better meet the interests of modern learners.

E. Summary of transcriptions of North

1. Teachers Focus Group North Report

The participants agreed that the distance teaching was ineffective and inefficient since it impacted the education in a negative way. They claimed that the two years the students spent at home didn't allow them to receive the appropriate education; the matter that created lazy, stressed, and unmotivated generation. They faced from electricity problems in addition to their ignorance of utilizing platforms such as Microsoft teams. When the convener asked about the psychological effects of that unusual situation, the teachers agreed on the fact that the stress was obvious through the students' behaviors. The tough economic situation has laid its weight on the parents and children as well. Parents have hard times keeping their jobs and living standards. They fell behind all their duties towards their children who were fully conscious of what was happening around. Parents are now struggling to get food and medicine to their children. The schools and teachers as well can't keep their feet stable in such a tough crisis. They can't survive in the absence of the parents and government support. One teacher mentioned that remote teaching was a chance for all the teachers and students to learn how to deal with news matters that would be important in the future.

2. Healthcare providers Focus Group North Report

Almost all the participants agreed that the current difficult financial, economic, social, and medical situation affected all the families and especially children in a radical way. The lack of medicine or the high prices hindered the appropriate medical procedures and so many families focused only on the very urgent and essential cases. However, the neglected medical cases have become very serious and current cases affected the children from all sides. They also added that they replaced the medicine with made-home herbs due to the unavailability and high prices of the medicine. Parents had to go to unspecialized clinics and the treatments were not effective. Buying medical tools was another problem emerged by the difficult current situation and that contributed to making the problems even worse.

Moreover, COVID-19 has created a confusing milieu for people, so any symptom no matter what it was, has been considered COVID-19 symptoms; the matter that screened all other illnesses symptoms. Lack of vaccination and proper medication has brought to light some old illnesses that existed a decade before. Lack of money, medication, medical resources developed an intensive increase in stress, medical and learning illnesses and difficulties, and loose life. Many people helped by providing money to help patients in addition to so many doctors who dedicated one day per week to check people for free.

3. Parents Focus Group North Report

All the parents agreed that the situation affected their income in a major way. Parents are not able to keep the living standards, buy food, fuel, or other necessities. Most of them moved out their children from private schools and enrolled them in public ones where the teaching and learning quality is very poor. So have students have quit their long-life majors and moved into local institutions because they can't afford paying bus fees. Many parents have reduced the meals into two and offer the lunch very late in the afternoon, so their children stay a bit satisfied till evening. Even parents complained about the quality of food they are putting on their tables. Another major problem is the medicine and the medical cases. They can't afford going to doctors and buying medicine and in case of emergency, they only buy the necessary medicine because they can't afford doctor and medicine together. The parents seem and sound very frustrated because they see their children's future in stake. Instead of seeing their children playing, learning, and enjoying life, they see them loaded with life burdens at very early ages. Parents wish death of living such a miserable life where the schooling, hospitalization, medical, nutritional, social, economic, and financial systems are collapsed.

I. Cross sectional analysis between the 5 governorates

A. Teachers FGD

The focus groups in all 5 governorates found online learning to be the main challenge through which they were forced to navigate. Members of each focus group expressed total agreeability whenever the opinions and frustration of any of these members were brought to the discussion. The sequence of which issues were being discussed seemed to vary for each governorate where the teachers of mount Lebanon seemed to focus more on conduct while the rest of the focus groups prioritized issues concerning education and its delivery.

The deprivation of students of their ability to interact physically with their teachers seemed to diminish their learning capacity especially in younger age-groups. The issue was exacerbated by parents who aided their kids on evaluations. Power cuts and internet bandwidth issues along with the unavailability of enough or any suitable electronic devices inhibited access to online learning on top of adding the stress of the daily life of students who found themselves in such a predicament;

this issue was highlighted more intensely in poorer areas of the country like the Bekaa governorate. A word that was repeated by lower elementary teachers was “attached”, denoting the crucial role of the feeling of connection to the teacher in acquiring information.

The latest crisis impacted the wellbeing of the students negatively in all parts of the country. Words like “stressed”, “anxious”, “lonely”, and “aggressive” circulated among teachers. Students were confronted with the pressure of online learning while dealing with a severe downgrade in the quality of their daily lives. It should be noted that a more detailed description of the student’s psychological state was described by teachers of private schools. Nevertheless, the teachers used terms like “lazy” and “dependent” that are considered to be personal and inflict shame upon whoever is on the receiving end of that kind of talk.

The biggest concerns on ECD were addressed in an educational context only; the answers were concerned with the gap that students had to overcome when they returned to in-person learning. There was consensus on the fact that education remains an important component in the ECD because it is about character building and not just acquiring information. The teachers suggested a reformation in the adopted curriculum that takes into consideration the challenges that Lebanese students might face throughout the school year (power cuts, internet loss, paper shortage, behavioral changes…) and provide ways to navigate these difficulties beforehand.

B. Parents FGD

Almost all participants from the 5 Governorates claimed that the crisis affected the individual’s personal income whether it was a deduction in the salary itself or the devaluation of the currency which rendered parents unable to meet the basic needs of their offspring in all 5 governorates. The concern shifted from a healthy diet to hunger-evasion. There was evident frustration in the tone of voice that the parents used. There was clear harmony in the voicing of these issues which clearly affected them all.

Children were confronted with issues such as the availability of basic needs, issues with which children are not supposed to be concerned. Even learning freely became a luxury when students were forced to share the internet bandwidth and to compromise the quality of learning in favor of allowing the largest number of individuals in the family to learn online, an issue that was voiced more readily in poorer governorates like Bekaa, public schools, and Syrian refugee camp parents.

The quality of learning was more affected in public schools than private schools. Nevertheless, the overall experience that schools provide from making friends to

other social interactions was severely affected. The quality of food that the parents were able to provide shifted from meat and poultry to beans and lentils, and even with that they could not splurge. Concerning basic health provisions, the challenge was not just the incomprehensible increase in prices, but the unavailability of simple over-the-counter medication which forced parents to search far and wide to be able to provide these necessities.

Parents suggested a definite urgency for financial support if life is to continue in any form of normality and needs are to be met, and that was a commonality among all governorates.

C. Healthcare providers FGD

Across all 5 governorates, severe shortage has developed in both healthcare providers, who migrated to countries where a higher income and medication itself could be secured.

Children did not receive vaccines and basic provisions like milk per se either due to unavailability or due to high prices. Different governorates reported the resurfacing of medical cases that were considered quite rare like meningitis, and they all seemed quite surprised while reporting this incident.

The confinement forced a regression in the children's ability to adapt to outdoor activities and in the ability of these students to find a place in any group-based game. Words like "isolation" and "antisocial" were used to describe the situation.

Higher rates of students with gastroenteritis were observed; this increase could be attributed to inadequate heating especially in colder parts of the country like the Bekaa and Mount Lebanon governorates. Children are in need of support from governmental and non-governmental organizations to meet their basic medical needs.

8.1 Quantitative methodology

For the final data, we started the execution of the results using the descriptive statistics to present generally the results using the appropriate tables and figures in addition to Mean and Standard deviation as statistical indicators for central tendency and dispersion. In the next step, we used the inferential statistics to study the association between the

demographic information and the items of ECDI. Various statistical tests were applied like Chi-square, T-test, Anova, and Correlation.

Based on the results, further statistical tests were used such as Anova to study the relations between items or indicators based on other indicators called Moderator or Mediation. At the end, we applied the Structural Equational Modeling (SEM) to test and evaluate multivariate causal relationships between the indicators of ECDI.

A. Information about the participants

This section of the report is prepared to study the results of the survey that was conducted with 1379 families online or Face to Face in different areas in Lebanon

This analysis is divided into two parts: 1. Descriptive statistics to generally present the results of the questions in the survey using the appropriate tables and figure, 2. Correlational or inferential statistics in order to study the important relationships between the questions or the indicators.

1. Descriptive Statistics

Section 1: Demographics

A. Information about the participants

The results in Table 1 demonstrate that 47.93% of the participants are the mothers, 46.34% are the fathers, 3.77% are the relatives, while 1.96% of the participants are the caregivers. For the gender of the participants, 52.14% are females, 47.28% are males; however, 0.58% of the participants preferred not to give information about their gender. 62.07% of the participants are Lebanese, 30.31% are Syrian and 7.54% are Palestinian.

For the age, 39.16% of the participants are aged between 36 and 45 years, 29.44% between 31 and 35 years, 17.33% between 23 and 30 years, 8.27% between 46 and 55 years, 2.32% between 19 and 22 years, 1.96% between 15 and 18 years, while 1.52% of the participants are aged 56 years and above.

A. Information about the participants

Concerning the marital status, the results reveal that the majority of the participants are married (92.75%), 3.84% are single, 1.96% are divorced or separated, 1.31% are widowed, though, 0.15% (2 participants) are missing their partners.

For the education level, 24.66% of the participants have university degree, 21.17% can read and write, 15.66% have finished the elementary level, 14.79% the complementary level, and 14.36% the secondary level, while 9.35% of the participants are illiterate.

Table 1: Information about the participants

		Frequency	Percent
Respondent	Mother	661	47.93%
	Father	639	46.34%
	Relative	52	3.77%
	Caregiver	27	1.96%
Gender	Female	719	52.14%
	Male	652	47.28%
	No information	8	0.58%
Nationality	Lebanese	856	62.07%
	Syrian	418	30.31%
	Palestinian	104	7.54%
	Other	1	0.07%
Age	15- 18 years	27	1.96%
	19-22 years	32	2.32%
	23-30 years	239	17.33%
	31-35 years	406	29.44%
	36-45 years	540	39.16%
	46-55 years	114	8.27%
	56 and above	21	1.52%
Marital Status	Married	1279	92.75%
	Single	53	3.84%
	Divorced / Separated	27	1.96%
	Widowed	18	1.31%
	Missing partner	2	0.15%
Education	Illiterate	129	9.35%

	Can read and write	292	21.17%
	Elementary	216	15.66%
	Complementary	204	14.79%
	Secondary or equivalent	198	14.36%
	University	340	24.66%

B. Information about the family

The results in Table 2 indicate that 22.26% of the families are living in Mount Lebanon, 20.96% in Bekaa, 18.85% in North, 18.78% in Beirut, 11.24% in Nabatieh, while 7.90% of the families are living in South. 55.98% of these families are living in houses, 32.63% in apartments, 6.89% in shared rooms, 3.70% in tents, 0.44% in studio, while 0.36% of the families are living in other places

		Frequency	Percent
Governorate of residency	Mount Lebanon	307	22.26%
	Beqaa	289	20.96%
	North	260	18.85%
	Beirut	259	18.78%
	Nabatieh	155	11.24%
	South	109	7.90%
Type of household	House	772	55.98%
	Apartment	450	32.63%
	Shared room	95	6.89%
	Tent	51	3.70%
	Studio	6	0.44%
	Other	5	0.36%

Table 2 Governorate of residency and Type of household

For the number of people who are living in the household, the results indicate that 30.96% of the households are consisting of 4 peoples, 25.67% 5 peoples, 15.74% 7 peoples and more, 14.94% 6 peoples, 12.04% 3 peoples, and 0.96% of the households are consisting of 2 peoples. Concerning the number of children under 8 years, 40.90% of the households have 2 children under 8 years, 31.54% one child, 17.33% 3 children, 5.80% 4 children, 2.54% 7 children and more, 1.02% 5 children, whereas 0.87% of the households have 6 children under 8 years.

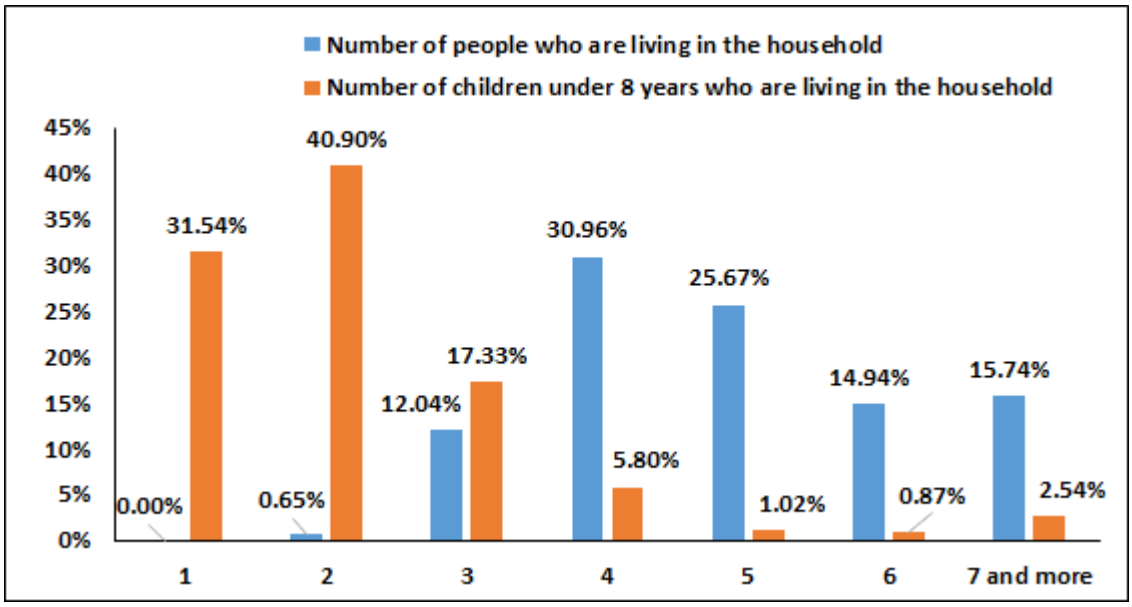

Figure 1 Number of people and children under 8 years who are living in the household

C. Family financial Information

The results in Table 3 demonstrate that 32.34% of the respondents are not employed, 28.79% are full time employees, 16.24% are part time employees, 15.74% are self-employed, 4.28% are temporary employees, while 2.61% of the participants are seasonal employees. The results also show that 67.08% of the participants didn't have to separate from the family because of work, 21.75% the father, 4.86% preferred not to answer, 3.26% the mother, 2.47% the father and the mother at the same time, while 0.58% of the participants indicate that the caregivers had to separate from the family because of work.

Concerning the family income last month, 30.75% of the families have earned between 1'000'000 - 2'000'000 LBP, 27.92% between 2'000'000 - 4'000'000 LBP, 16.17% between 500'000 - 1'000'000 LBP, 11.09% between 4'000'000 - 7'800'000 LBP, 7.98% between 0 - 500'000 LBP, while 6.09% of the families have earned more than 7'800'000 LBP last month.

The results reveal that 69.54% of the participants didn't receive any monetary contributions or gifts that included rent or utility payments from someone who does not live with them, 27.48% have received this kind of help, while 2.97% of the participants preferred not to answer.

	Frequency	Percent

Employment status	Not employed	446	32.34%
	Full time employee	397	28.79%
	Part time employee	224	16.24%
	Self-employed	217	15.74%
	Commission and piece rate employee / temporary employee	59	4.28%
	Fixed term employee/ Seasonal employee	36	2.61%
Parents have to separate from the family because of work	No	925	67.08%
	Father	300	21.75%
	Prefer not to answer	67	4.86%
	Mother	45	3.26%
	Father and Mother	34	2.47%
	Caregiver	8	0.58%
Family income last month	0 - 500'000 LBP	110	7.98%
	500'000 - 1'000'000 LBP	223	16.17%
	1'000'000 - 2'000'000 LBP	424	30.75%
	2'000'000 - 4'000'000 LBP	385	27.92%
	4'000'000 - 7'800'000 LBP	153	11.09%
	More than 7'800'000 LBP	84	6.09%
Receiving any monetary contributions or gifts	Yes	379	27.48%
	No	959	69.54%
	Prefer not to say	41	2.97%

Table 3 Family financial Information

D. Information about the child in question

The results in Table 4 reveal that 55.18% of the children in question are boys, while 44.82% are girls. Regarding the nationality, 62.22% of the children are Lebanese, 29.73% are Syrian, 7.69% are Palestinian, while 0.36% of the children are from other nationalities (4 from Jordan and 1 from Oman).

For the age, 41.19% of the children are aged between 5 and 8 years, 30.75% between 4 and 5 years, 9.21% between 3 and 4 years, 7.32% between 2 and 3 years, 3.84% between 1 and 2 years, 2.54% between 4 and 6 months, 2.03%

between 0 and 3 months, 1.96% between 7 and 9 months, while 1.16% of the children are aged between 10 and 12 months.

		Frequency	Percent
Gender	Boy	761	55.18%
	Girl	618	44.82%
Nationality	Lebanese	858	62.22%
	Syrian	410	29.73%
	Palestinian	106	7.69%
	Other	5	0.36%
Age	0 to 3 months	28	2.03%
	4-6 months	35	2.54%
	7-9 months	27	1.96%
	10-12 months	16	1.16%
	1 to 2 years	53	3.84%
	2 to 3 years	101	7.32%
	3 to 4 years	127	9.21%
	4 to 5 years	424	30.75%
	5 to 8 years	568	41.19%

Table 4 Information about the child in question

Section 2: Information about the early childhood development milestones

A. Beginning (0) to 3 months' age range (Frequency = 28)

The results in table 5 show the following:

- 53.57% of the babies between 0 and 3 months can't lift their heads to the left and the right while lying on his/her stomach, whereas 46.43% of the babies can.

- 71.43% of the babies can't roll onto their backs when placed on their side, while 25.00% of the babies can, also 3.57% of the participants answered that they don't know.
- 53.57% of the babies can wave and kick using their arms and legs, while 46.43% of the babies can't.
- 64.29% of the babies watch their parents' face and look at objects, while 35.71% don't.
- 67.86% of the babies show reaction when loud sounds pop, while 28.57% don't, also 3.57% of the participants answered that they don't know.
- 60.71% of the babies bring their hands together, 32.14% can't, while 7.14% of the participants answered that they don't know.
- 71.43% of the babies calm down when they hear their parents' voice, 21.43% don't, while 7.14% of the participants answered that they don't know.
- 78.57% of the babies coo and make sounds, 17.86% don't, while 3.57% of the participants answered that they don't know.
- 53.57% of the babies swipe at dangling objects, 42.86% don't, while 3.57% of the participants answered that they don't know.
- 60.71% of the babies can't grasp and shake a rattle, while 39.29% of the babies can.
- 53.57% of the babies sleep between 14-17 per day, 32.14% don't, while 14.29% of the participants answered that they don't know.

	Yes	No	Don't know
While lying on his/her stomach, can the baby lift his/her head to the left and the right?	46.43%	53.57%	0.00%
When placed on his/her side, can the baby roll onto his/her back?	25.00%	71.43%	3.57%
While lying on his/her back, can the baby wave and kick using his/her arms and legs?	53.57%	46.43%	0.00%
Does the baby watch your face and look at objects?	64.29%	35.71%	0.00%
Does the baby show reaction when loud sounds pop?	67.86%	28.57%	3.57%
Does the baby bring his/her hands together?	60.71%	32.14%	7.14%
Does the baby calm down when he/she hears your voice?	71.43%	21.43%	7.14%
Does the baby coo and make sounds?	78.57%	17.86%	3.57%
Does the baby swipe at dangling objects?	53.57%	42.86%	3.57%
Does the baby grasp and shake a rattle?	39.29%	60.71%	0.00%
Does your baby sleep between 14-17 per day?	53.57%	32.14%	14.29%

Table 5 Information about the early childhood development milestones (Babies between 0 and 3 months)

B. 4 to 6 months' age range (Frequency = 35)

The results in table 6 indicate the following:

- 65.71% of the babies between 4 and 6 months can sit for at least 8 seconds when their hands are placed in front of them on the floor, 31.43% can't, whereas 2.86% of the participants answered that they don't know.
- 48.57% of the babies can hold their feet when they are lying on their backs, 34.29% can't, while 17.14% of the participants answered that they don't know.
- 68.57% of the babies can hold up their head for at least 15 seconds, 17.14% can't, while 14.29% of the participants answered that they don't know.
- 62.86% of the babies do push up on their arms, 22.86% don't, while 14.29% of the participants answered that they don't know.
- 85.71% of the babies follow the toy with their eyes when their parents move it in front of them, 11.43% don't, while 2.86% of the participants answered that they don't know.
- 68.57% of the babies purposefully reach towards toys, 28.57% don't, while 2.86% of the participants answered that they don't know.
- 57.14% of the babies hold their bottles during feedings, 40.00% can't, while 2.86% of the participants answered that they don't know.
- 65.71% of the babies sleep 12-15 hours per day, 28.57% don't, while 5.71% of the participants answered that they don't know.
- 77.14% of the babies react differently when their parents change their voice, 14.29% don't, while 8.57% of the participants answered that they don't know.
- 77.14% of the babies laugh and babble when they are happy, 14.29% don't, while 8.57% of the participants answered that they don't know

	Yes	No	Don't know
Can the baby sit for at least 8 seconds when their hands are placed in front of them on the floor?	65.71%	31.43%	2.86%
While lying on his/her back, does the baby hold his/her feet?	48.57%	34.29%	17.14%
While lying on his/her tummy, does the baby hold up their head for at least 15 seconds?	68.57%	17.14%	14.29%
While lying on their tummy, does the baby push up on their arms?	62.86%	22.86%	14.29%
When you move a toy in front of the baby, will he/she follow it with their eyes?	85.71%	11.43%	2.86%
Does the baby purposefully reach towards toys?	68.57%	28.57%	2.86%
Does the baby hold their bottles during feedings?	57.14%	40.00%	2.86%
Does the baby sleep 12-15 hours per day?	65.71%	28.57%	5.71%
Does the baby react differently when you change your voice?	77.14%	14.29%	8.57%
Does the baby laugh and babble when he/she is happy?	77.14%	14.29%	8.57%

Table 6 Information about the early childhood development milestones (Babies between 4 and 6 months)

C. 7 to 9 months' age range (Frequency = 27)

The results in table 7 show the following:

- 70.37% of the babies between 7 and 9 months can pull themselves to sit when their backs, while 29.63% can't.
- 92.59% of the babies can roll onto their tummy, while 7.41% can't.
- 92.59% of the babies can play with objects around them while sitting, 3.70% can't, while 3.70% of the participants answered that they don't know.
- 51.85% of the babies are able to rock back-n-forth while on their hands/knees, 37.04% can't, while 11.11% of the participants answered that they don't know.
- 88.89% of the babies can reach with one hand to get a toy, while 11.11% of the participants answered that they don't know.
- 88.89% of the babies look around to see where a loud sound came from when they hear it, 3.70% don't, while 7.41% of the participants answered that they don't know.
- 62.96% of the babies use gestures to point on objects they want, 25.93% can't, while 11.11% of the participants answered that they don't know.
- 85.19% of the babies respond to words with sounds and gestures, 11.11% can't, while 3.70% of the participants answered that they don't know.
- 70.37% of the babies eat from a spoon, 25.93% can't, while 3.70% of the participants answered that they don't know.
- 77.78% of the babies pick up food and bring it to their mouth, 18.52% can't, while 3.70% of the participants answered that they don't know.
- 81.48% of the babies consistently babbling during the day, 14.81% can't, while 3.70% of the participants answered that they don't know.
- 77.78% of the babies sleep 12-15 hours per day, 14.81% don't, while 7.41% of the participants answered that they don't know.
- 55.56% of the babies can't engage in peek-a-boo games, 40.74% can't, while 3.70% of the participants answered that they don't know.

	Yes	No	Don't know
While lying on his/her back, can the baby pull himself/herself to sit?	70.37%	29.63%	0.00%
When laying on their back, can the baby roll onto their tummy?	92.59%	7.41%	0.00%
Can the baby play with objects around him/her while sitting?	92.59%	3.70%	3.70%
Is the baby able to rock back-n-forth while on their hands/knees?	51.85%	37.04%	11.11%
While on their tummy, can the baby reach with one hand to get a toy?	88.89%	0.00%	11.11%

If the baby hears a loud sound, will they look around to see where it came from?	88.89%	3.70%	7.41%
Do the baby use gestures to point on objects they want?	62.96%	25.93%	11.11%
Does the baby respond to words with sounds and gestures?	85.19%	11.11%	3.70%
Can the baby eat from a spoon?	70.37%	25.93%	3.70%
Can the baby pick up food and bring it to their mouth?	77.78%	18.52%	3.70%
Is the baby consistently babbling during the day?	81.48%	14.81%	3.70%
Does the baby sleep 12-15 hours per day?	77.78%	14.81%	7.41%
Can the baby engage in peek-a-boo games?	40.74%	55.56%	3.70%

Table 7 Information about the early childhood development milestones (Babies between 7 and 9 months)

D. 10 to 12 months' age range (Frequency = 16)

The results in table 8 indicate the following:

- 75.00% of the babies between 10 and 12 months can get into sitting from their backs and tummy, 18.75% can't, while 6.25% of the participants answered that they don't know.
- 75.00% of the babies sit for several minutes on the floor without support, 18.75% can't, while 6.25% of the participants answered that they don't know.
- 56.25% of the babies can pull up into standing on a sturdy object, 31.25% can't, while 12.50% of the participants answered that they don't know.
- 81.25% of the babies can roll themselves in both directions, 12.50% can't, while 6.25% of the participants answered that they don't know.
- 75.00% of the babies can pick up a small item by using their thumb and fingers, 12.50% can't, while 12.50% of the participants answered that they don't know.
- 43.75% of the babies can drop objects into a container, 31.25% can't, while 25.00% of the participants answered that they don't know.
- 56.25% of the babies feed themselves using their hands, 25.00% can't, while 18.75% of the participants answered that they don't know.
- 43.75% of the babies can imitate the use of toys in the manner their parents displayed, 31.25% can't, while 25.00% of the participants answered that they don't know.
- 68.75% of the babies can't play "peek-a-boo" or "pat-a-cake", 25.00% can, while 6.25% of the participants answered that they don't know.
- 43.75% of the babies don't understand words for common objects, 25.00% do understand, while 6.25% of the participants answered that they don't know.
- 68.75% of the babies can wave "hi" and "bye", 25.00% can't, while 6.25% of the participants answered that they don't know.

- 62.50% of the babies aren't beginning to use words, 18.75% are using words, while 18.75% of the participants answered that they don't know.
- 62.50% of the babies can't understand simple commands or questions, 25.00% can, while 12.50% of the participants answered that they don't know.
- 68.75% of the babies sleep 12-16 hours per day, 18.75% don't, while 12.50% of the participants answered that they don't know.

	Yes	No	Don't know
Can the baby get into sitting from his/her back and tummy?	75.00%	18.75%	6.25%
Can the baby sit for several minutes on the floor without support?	75.00%	18.75%	6.25%
Can the baby pull up into standing on a sturdy object?	56.25%	31.25%	12.50%
Can the baby roll himself/herself in both directions?	81.25%	12.50%	6.25%
Can the baby pick up a small item (Cheerio/Puff) by using his/her thumb and fingers?	75.00%	12.50%	12.50%
Does the baby drop objects into a container?	43.75%	31.25%	25.00%
Does the baby feed himself/herself (cookie, cracker, fruits, etc.) using his/her hands?	56.25%	25.00%	18.75%
Does the baby imitate the use of toys in the manner you displayed?	43.75%	31.25%	25.00%
Does the baby play "peek-a-boo" or "pat-a-cake"?	25.00%	68.75%	6.25%
Does the baby understand words for common objects?	25.00%	43.75%	31.25%
Does the baby wave "hi" and "bye"?	68.75%	25.00%	6.25%
Is the baby beginning to use words? (end of 1st year)	18.75%	62.50%	18.75%
Does the baby understand simple commands or questions?	25.00%	62.50%	12.50%
Does the baby sleep 12-16 hours per day?	68.75%	18.75%	12.50%

Table 8 Information about the early childhood development milestones (Babies between 10 and 12 months)

E. 1 to 2 years' age range (Frequency = 53)

The results in table 9 demonstrate the following:

- 50.94% of the toddlers aged between 1 and 2 years can't walk for at least 8 feet independently, 47.17% can, while 1.89% of the participants answered that they don't know.
- 56.60% of the toddlers can lower themselves to the floor with control while holding onto a piece of furniture, 35.85% can't, while 7.55% of the participants answered that they don't know.
- 60.38% of the toddlers can scribble with a crayon, 35.85% can't, while 3.77% of the participants answered that they don't know.
- 60.38% of the toddlers can pretend to sleep and/or eat, 30.19% can't, while 9.43% of the participants answered that they don't know.

- 56.50% of the toddlers can't pull their socks off, 39.62% can, while 3.77% of the participants answered that they don't know.
- 62.26% of the toddlers share excitement/joy/objects with their parents, 32.08% can't, while 5.66% of the participants answered that they don't know.
- 66.04% of the toddlers can follow simple commands such as "give me"," point to", etc., 32.08% can't, while 1.89% of the participants answered that they don't know.
- 58.49% of the toddlers can't use 1-8 simple words, 39.62% can, while 1.89% of the participants answered that they don't know.
- 73.58% of the toddlers can shake their heads, 22.64% can't, while 3.77% of the participants answered that they don't know.
- 67.92% of the toddlers sleep 11-14 hours per day, 30.19% don't, while 1.89% of the participants answered that they don't know.

	Yes	No	Don't know
Can the toddler walk for at least 8 feet independently?	47.17%	50.94%	1.89%
Does the toddler lower himself to the floor with control while holding onto a piece of furniture?	56.60%	35.85%	7.55%
Can the toddler scribble with a crayon?	60.38%	35.85%	3.77%
Does the toddler pretend to sleep and/or eat?	60.38%	30.19%	9.43%
Can the toddler pull his/her socks off?	39.62%	56.60%	3.77%
Does the toddler share excitement/joy/objects with you?	62.26%	32.08%	5.66%
Does the toddler follow simple commands such as "give me"," point to", etc.?	66.04%	32.08%	1.89%
Does the toddler use 1-8 simple words?	39.62%	58.49%	1.89%
Does the toddler shake his/her head no?	73.58%	22.64%	3.77%
Does the toddler sleep 11-14 hours per day?	67.92%	30.19%	1.89%

Table 9 Information about the early childhood development milestones (Toddler aged between 1 and 2 years old)

F. 2 to 3 years' age range (Frequency = 101)

The results in table 10 reveal the following:

- 57.43% of the toddlers aged between 2 and 3 years old can't walk up and down at least 4 stairs continuously without holding on, 40.59% can, while 1.98% of the participants answered that they don't know.
- 51.49% of the toddlers can run well without losing their balance, 45.54% can't, while 2.97% of the participants answered that they don't know.
- 56.44% of the toddlers can't jump up and down with 2 feet, 36.63% can, while 6.93% of the participants answered that they don't know.

- 55.45% of the toddlers can't catch a ball tossed to them from 3-5 feet away by encircling it with their arms/hands, 36.63% can, while 7.92% of the participants answered that they don't know.
- 60.40% of the toddlers can't imitate a vertical and horizontal line, 27.72% can, while 11.88% of the participants answered that they don't know.
- 74.26% of the toddlers can't take off their clothes independently without any fasteners, 20.79% can, while 4.95% of the participants answered that they don't know.
- 50.50% of the toddlers can't brush their teeth with assistance, 45.54% can, while 3.96% of the participants answered that they don't know.
- 87.13% of the toddlers can't put on their coat independently, 10.89% can, while 1.98% of the participants answered that they don't know.
- 73.27% of the toddlers can't pull up their pants, 22.77% can, while 3.96% of the participants answered that they don't know.
- 67.33% of the toddlers can't use 2-3 word phrases and use approximately 300 words, 21.78% can, while 10.89% of the participants answered that they don't know.
- 46.53% of the toddlers can't follow 2-step directions and understand simple concepts of "in/on/under", "big/little", 45.54% can, while 7.92% of the participants answered that they don't know.
- 55.45% of the toddlers can imitate play sequences and play next to other children, 37.62% can't, while 6.93% of the participants answered that they don't know.
- 63.37% of the toddlers can use "me" when referring to them, 29.70% can't, while 6.93% of the participants answered that they don't know.
- 53.47% of the toddlers understand and answer simple questions, 37.62% can't, while 8.91% of the participants answered that they don't know.
- 75.25% of the toddlers sleep 12-13 hours per day, 20.79% don't, while 3.96% of the participants answered that they don't know.

	Yes	No	Don't know
Can the toddler walk up and down at least 4 stairs continuously without holding on?	40.59%	57.43%	1.98%
Does the toddler run well without losing their balance?	51.49%	45.54%	2.97%
Can the toddler jump up and down with 2 feet?	36.63%	56.44%	6.93%
Can the toddler catch a ball tossed to them from 3-5 feet away by encircling it with their arms/hands?	36.63%	55.45%	7.92%
Can the toddler imitate a vertical and horizontal line?	27.72%	60.40%	11.88%
Can the toddler take off his or her clothes independently without any fasteners?	20.79%	74.26%	4.95%
Can the toddler brush his/her teeth with assistance?	45.54%	50.50%	3.96%
Can the toddler put on their coat independently?	10.89%	87.13%	1.98%
Can the toddler pull up his/her pants?	22.77%	73.27%	3.96%

Does the toddler use 2-3 word phrases and use approximately 300 words?	21.78%	67.33%	10.89%
Can the toddler follow 2-step directions and understand simple concepts of “in/on/under”, “big/little”?	45.54%	46.53%	7.92%
Can the toddler imitate play sequences and play next to other children?	55.45%	37.62%	6.93%
Does the toddler use “me” when referring to him/her?	63.37%	29.70%	6.93%
Does the toddler understand and answer simple questions?	53.47%	37.62%	8.91%
Does the toddler sleep 12-13 hours per day?	75.25%	20.79%	3.96%

Table 10 Information about the early childhood development milestones (Toddler aged between 2 and 3 years old)

G. 3 to 4 years’ age range (Frequency = 127)

The results in table 11 indicate the following:

- 62.99% of the kids aged between 3 and 4 years old can form lines, a circle, and a cross, 34.65% can’t, while 2.36% of the participants answered that they don’t know.
- 56.69% of the kids can walk up and down 4 stairs with one foot on each step, 33.86% can’t, while 9.45% of the participants answered that they don’t know.
- 65.35% of the kids can climb up a ladder to go down a slide, 32.28% can’t, while 2.36% of the participants answered that they don’t know.
- 60.63% of the kids can stand on one foot for at least a few seconds without holding on, 27.56% can’t, while 11.81% of the participants answered that they don’t know.
- 71.65% of the kids can jump forward with two feet for at least 15 centimeters, 22.05% can’t, while 6.30% of the participants answered that they don’t know.
- 54.33% of the kids can walk on their tip toes for 3-5 feet, 33.07% can’t, while 12.60% of the participants answered that they don’t know.
- 63.78% of the kids can kick a ball forward using opposite arm/leg motion, 22.83% can’t, while 13.39% of the participants answered that they don’t know.
- 55.12% of the kids can’t string small beads, 26.77% can, while 18.11% of the participants answered that they don’t know.
- 44.88% of the kids can complete simple puzzles, 38.58% can’t, while 16.54% of the participants answered that they don’t know.
- 67.72% of the kids do hold a pencil/crayon with their thumb, index finger, and middle finger, 29.92% don’t, while 2.36% of the participants answered that they don’t know.
- 84.25% of the kids can point to several body parts, 13.39% can’t, while 2.36% of the participants answered that they don’t know.

- 64.57% of the kids can't button buttons of his clothes or the toy's clothes, 29.13% can, while 6.30% of the participants answered that they don't know.
- For 68.50% of the kids, the speech is understandable while they use 4-5 word sentences, while it's not understandable for 28.35% of the kids, also 3.15% of the participants answered that they don't know.
- 57.48% of the kids do understand the concepts on, off, in/out, and one, some/all, rest, and few, 36.22% don't, while 6.30% of the participants answered that they don't know.
- 62.20% of the kids can follow 3 step commands, 29.13% can't, while 8.66% of the participants answered that they don't know.
- 48.82% of the kids can't retell a story, 44.88% can, while 6.30% of the participants answered that they don't know.
- 56.69% of the kids do understand others feelings and respond appropriately, 36.22% don't, while 7.09% of the participants answered that they don't know.
- 72.44% of the kids sleep 10-13 hours per day, 22.83% don't, while 4.72% of the participants answered that they don't know.
- 83.46% of the kids have begun to play and share with others, 13.39% haven't, while 3.15% of the participants answered that they don't know.

	Yes	No	Don't know
Can the kid form lines, a circle, and a cross?	62.99%	34.65%	2.36%
Can the kid walk up and down 4 stairs with one foot on each step?	56.69%	33.86%	9.45%
Can the kid climb up a ladder to go down a slide?	65.35%	32.28%	2.36%
Can the kid stand on one foot for at least a few seconds without holding on?	60.63%	27.56%	11.81%
Can the kid jump forward with two feet for at least 15 centimeters?	71.65%	22.05%	6.30%
Can the kid walk on their tip toes for 3-5 feet?	54.33%	33.07%	12.60%
Can the kid kick a ball forward using opposite arm/leg motion?	63.78%	22.83%	13.39%
Can the kid string small beads?	26.77%	55.12%	18.11%
Can the kid complete simple puzzles?	44.88%	38.58%	16.54%
Does the kid hold a pencil/crayon with their thumb, index finger, and middle finger?	67.72%	29.92%	2.36%
Can the kid point to several body parts?	84.25%	13.39%	2.36%
Can the kid button buttons of his clothes or the toy's clothes?	29.13%	64.57%	6.30%
Are the kids speech understandable while he/she uses 4-5 word sentences?	68.50%	28.35%	3.15%
Does the kid understand the concepts on, off, in/out, and one, some/all, rest, and few?	57.48%	36.22%	6.30%
Can the kid follow 3 step commands?	62.20%	29.13%	8.66%
Can the kid retell a story?	44.88%	48.82%	6.30%
Does the kid understand others' feelings and respond appropriately?	56.69%	36.22%	7.09%

Does the kid sleep 10-13 hours per day?	72.44%	22.83%	4.72%
Have the kid begun to play and share with others?	83.46%	13.39%	3.15%

Table 11 Information about the early childhood development milestones (Kids aged between 3 and 4 years old)

H. 4 to 5 years' age range (Frequency = 424)

The results in table 12 demonstrate the following:

- 67.69% of the kids aged between 4 and 5 years old can perform 1-2 sit-ups, 19.81% can't, while 12.50% of the participants answered that they don't know.
- 74.06% of the kids can jump over a 30 cm. object using two feet at the same time, 17.69% can't, while 8.25% of the participants answered that they don't know.
- 65.80% of the kids can throw a ball overhand for 12 cm and hit a target while using opposite arm/leg movements, 20.28% can't, while 13.92% of the participants answered that they don't know.
- 77.12% of the kids can stand on one foot for at least 9 seconds, 13.44% can't, while 9.43% of the participants answered that they don't know.
- 85.14% of the kids can run quickly, 11.08% can't, while 3.77% of the participants answered that they don't know.
- 75.24% of the kids can pedal a tricycle or bike with training wheels, 19.81% can't, while 4.95% of the participants answered that they don't know.
- 67.22% of the kids can dress and undress themselves, 29.25% can't, while 3.54% of the participants answered that they don't know.
- 61.79% of the kids can cut out simple shapes such as a circle, square, and triangle, 31.13% can't, while 7.08% of the participants answered that they don't know.
- 73.82% of the kids can form a vertical line, horizontal line, circle, and other shapes, 20.75% can't, while 5.42% of the participants answered that they don't know.
- For 77.59% of the kids, the speech is understandable most of the time, while it's not for 18.16% of the kids, also 4.25% of the participants answered that they don't know.
- 69.81% of the kids do use full sentences when speaking, 26.65% don't, while 3.54% of the participants answered that they don't know.
- 81.60% of the kids can name at least 4 colors and 3 shapes, 15.09% can't, while 3.30% of the participants answered that they don't know.
- 78.54% of the kids can count at least 10 objects, 16.75% can't, while 4.72% of the participants answered that they don't know.
- 49.06% of the kids do use pronouns such as he, she, me, I, her, him, we, 43.63% don't, while 7.31% of the participants answered that they don't know.
- 52.83% of the kids can follow 3-step directions and retell a story from memory, 37.50% can't, while 9.67% of the participants answered that they don't know.

- 48.35% of the kids do take turns and stay on topic during a conversation, 41.98% don't, while 9.67% of the participants answered that they don't know.
- 82.31% of the kids sleep 10-12 hours per day, 13.68% don't, while 4.01% of the participants answered that they don't know.
- 82.78% of the kids do play with a group of friends, 15.80% don't, while 1.42% of the participants answered that they don't know.
- 64.62% of the kids are eager to please and make others happy, 21.46% aren't, while 13.92% of the participants answered that they don't know.

	Yes	No	Don't know
Can the kid perform 1-2 sit-ups	67.69%	19.81%	12.50%
Can the kid jump over a 30 cm. object using two feet at the same time?	74.06%	17.69%	8.25%
Can the kid throw a ball overhand for 12 cm and hit a target while using opposite arm/leg movements?	65.80%	20.28%	13.92%
Can the kid stand on one foot for at least 9 seconds?	77.12%	13.44%	9.43%
Can the kid run quickly?	85.14%	11.08%	3.77%
Can the kid pedal a tricycle or bike with training wheels?	75.24%	19.81%	4.95%
Can the kid dress and undress himself/herself?	67.22%	29.25%	3.54%
Can the kid cut out simple shapes such as a circle, square, and triangle?	61.79%	31.13%	7.08%
Can the kid form a vertical line, horizontal line, circle, and other shapes	73.82%	20.75%	5.42%
Is the kid's speech understandable most of the time?	77.59%	18.16%	4.25%
Does the kid use full sentences when speaking?	69.81%	26.65%	3.54%
Can the kid's name at least 4 colors and 3 shapes?	81.60%	15.09%	3.30%
Can the kid count at least 10 objects?	78.54%	16.75%	4.72%
Does the kid use pronouns such as he, she, me, I, her, him, we?	49.06%	43.63%	7.31%
Can the kid follow 3-step directions and retell a story from memory?	52.83%	37.50%	9.67%
Does the kid take turns and stay on topic during a conversation?	48.35%	41.98%	9.67%
Does the kid sleep 10-12 hours per day?	82.31%	13.68%	4.01%
Does the kid play with a group of friends?	82.78%	15.80%	1.42%
Is the kid eager to please and make others happy?	64.62%	21.46%	13.92%

Table 12 Information about the early childhood development milestones (Kids aged between 4 and 5 years old)

I. 5 to 8 years' age range (Frequency = 568)

The results in table 13 show the following:

- 89.08% of the kids aged between 5 and 8 years old can acquire new motor skills such as football, 5.63% can't, while 5.28% of the participants answered that they don't know.
- 83.45% of the kids can throw and catch a ball and hit a target, 10.21% can't, while 6.34% of the participants answered that they don't know.
- 91.90% of the kids can run fast, 5.28% can't, while 2.82% of the participants answered that they don't know.
- 76.23% of the kids can tie their shoelaces, 20.07% can't, while 3.70% of the participants answered that they don't know.
- 74.65% of the kids can demonstrate competence with writing letters/words/sentences/compositions, 22.01% can't, while 3.35% of the participants answered that they don't know.
- 84.51% of the kids can speak what is on their minds using correctly structured sentences, 13.38% can't, while 2.11% of the participants answered that they don't know.
- 73.42% of the kids do use precise vocabulary to question and offer opinions, 21.30% don't, while 5.28% of the participants answered that they don't know.
- 65.32% of the kids can understand opposites, 26.06% can't, while 8.63% of the participants answered that they don't know.
- 72.71% of the kids can understand time intervals and the concept of time, 22.36% can't, while 4.93% of the participants answered that they don't know.
- 54.05% of the kids do read appropriate texts with ease, 40.85% don't, while 5.11% of the participants answered that they don't know.
- 77.64% of the kids can pay attention to details, 15.32% can't, while 7.04% of the participants answered that they don't know.
- 84.86% of the kids do follow instructions and finish their schoolwork, 12.32% don't, while 2.82% of the participants answered that they don't know.
- 79.05% of the kids do understand the consequences of their own actions, 17.25% don't, while 3.70% of the participants answered that they don't know.
- 84.68% of the kids sleep 9-12 hours per day, 12.15% don't, while 3.17% of the participants answered that they don't know.

	Yes	No	Don't know
Can the kid acquire new motor skills such as football…	89.08%	5.63%	5.28%
Can the kid throw and catch a ball and hit a target?	83.45%	10.21%	6.34%
Can the kid run fast?	91.90%	5.28%	2.82%
Can the kid tie his shoelaces?	76.23%	20.07%	3.70%

Can the kid demonstrate competence with writing letters/words/sentences/compositions?	74.65%	22.01%	3.35%
Can the kid speak what is on his/her mind using correctly structured sentences?	84.51%	13.38%	2.11%
Does the kid use precise vocabulary to question and offer opinions?	73.42%	21.30%	5.28%
Can the kid understand opposites?	65.32%	26.06%	8.63%
Can the kid understand time intervals and the concept of time?	72.71%	22.36%	4.93%
Does the kid read appropriate texts with ease?	54.05%	40.85%	5.11%
Can the kid pay attention to details?	77.64%	15.32%	7.04%
Does the kid follow instructions and finish his/her schoolwork?	84.86%	12.32%	2.82%
Does the kid understand the consequences of his/her own actions?	79.05%	17.25%	3.70%
Does the kid sleep 9-12 hours per day?	84.68%	12.15%	3.17%

Table 13 Information about the early childhood development milestones (Kids aged between 5 and 8 years old)

Section 3: Information about the early childhood education

Information about the child's access to learning

Has the kid had access to education (remote or face to face) the year (2021-2022)?

The results in Figure 2 show that 53.08% of the kids had access to education remotely or face to face, 20.01% didn't have access to education, 12.26% of the kids had partially access to education, while this question was not applicable for 14.65% of the kids.

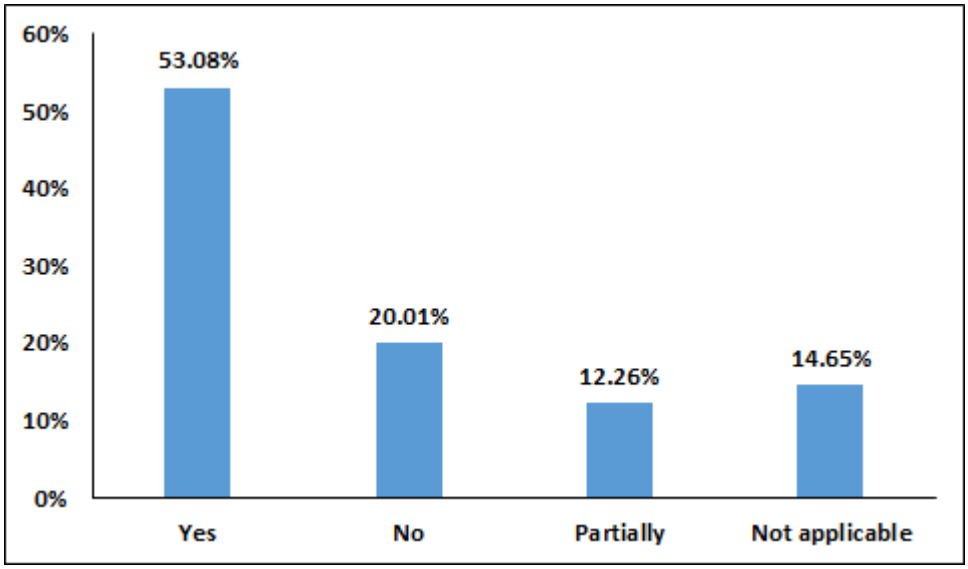

Figure 2 kids had access to education

42.62% of the kids who had access to education (Yes or Partially) are attending the day care/kindergarten/school on daily basis, 34.52% 2 to 3 times per week, 14.65% based attendance requirements, while 8.21% of the kids are attending the day care/kindergarten/school a couple of times per month.

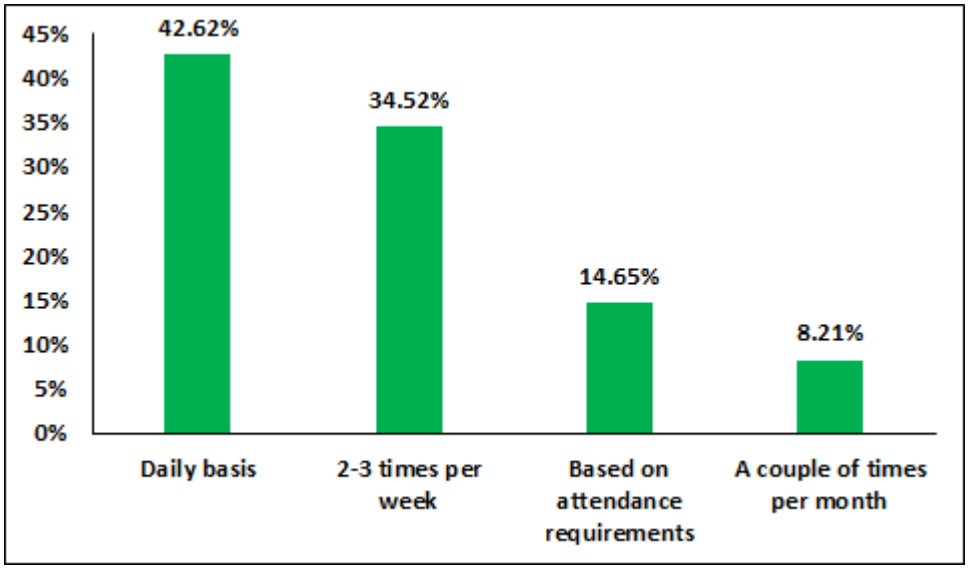

Figure 3 Frequency of attending the day care/kindergarten/school.

29.20% of the kids didn't have access to education (No or Partially) because their families did not have the ability to cover the transportation fees, 24.30% because the schools closed, 22.70% of the respondents said other reasons, the main answer because their babies are under age, 21.60% because the family did not have the ability to cover the tuition fees, 17.30% because of the increase in COVID-19 cases or other infectious diseases, 10.10% for the inability to access the internet and electricity for online learning and 8.50% for the inability to buy books and material to support the learning.

	Frequency	Percentage
The family did not have the ability to cover the transportation fees	130	29.20%
The school closed	108	24.30%
Other	101	22.70%
The family did not have the ability to cover the tuition fees	96	21.60%
Increase in COVID-19 cases or other infectious diseases	77	17.30%
Inability to access the internet and electricity for online learning	45	10.10%
Inability to buy books and material to support the learning	38	8.50%
Protests of teachers and educators	31	7.00%
Inability to access tools (laptop-phone-tablet, etc.) for online learning	29	6.50%
Lack of basic logistical means in schools (electricity, heating)	13	2.90%
In order to support the family and enter the labor market	13	2.90%

Table 14 Reasons for not attending the day care/kindergarten/school

Who is the caregiver responsible for following up on the learning process (duties / understanding of learning goals) for the kids?

For 66.60% of the kids, the mother is the caregiver responsible for following up on the learning process, 41.80% the father, while 6.20% of the respondents said brothers or sisters.

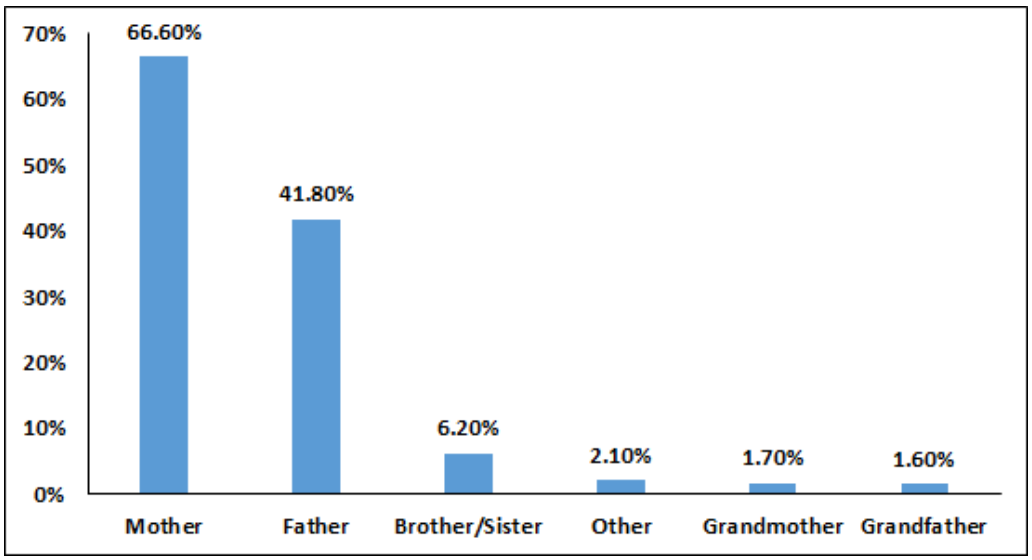

Figure 4 The caregiver responsible for following up on the learning process for the kids

Information about the child's learning facility

Concerning the day care/kindergarten/school, what is the type of the facility?

36.11% of the kids are attending private day care/kindergarten/school, 32.63% public facilities, 16.03% semi-private, while 15.23% said other answers (Mainly that the babies are still underage and not attending day care/kindergarten/school).

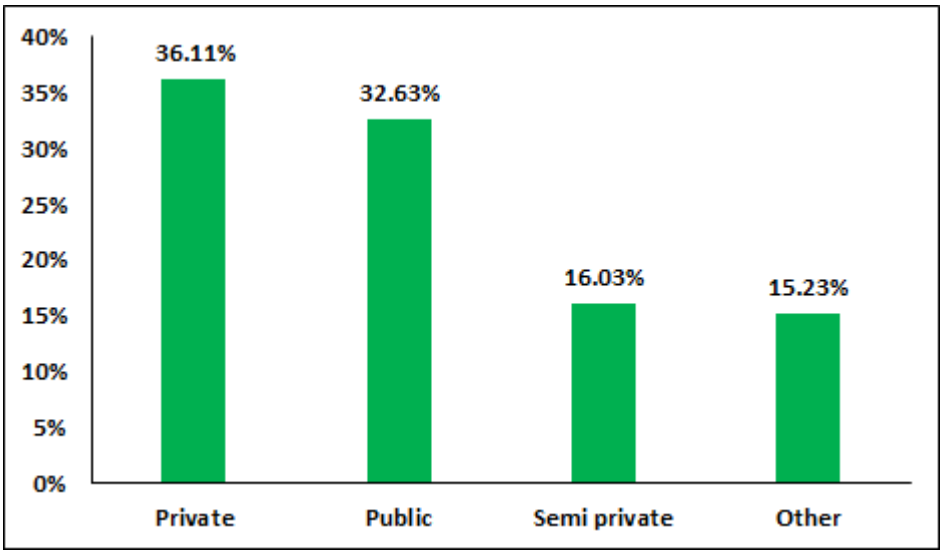

Figure 5 Type of the facility

The results also reveal that 33.94% of the participants can cover the full fees, 33.65% can partially cover the fees, while 32.41% can't cover the fees at all.

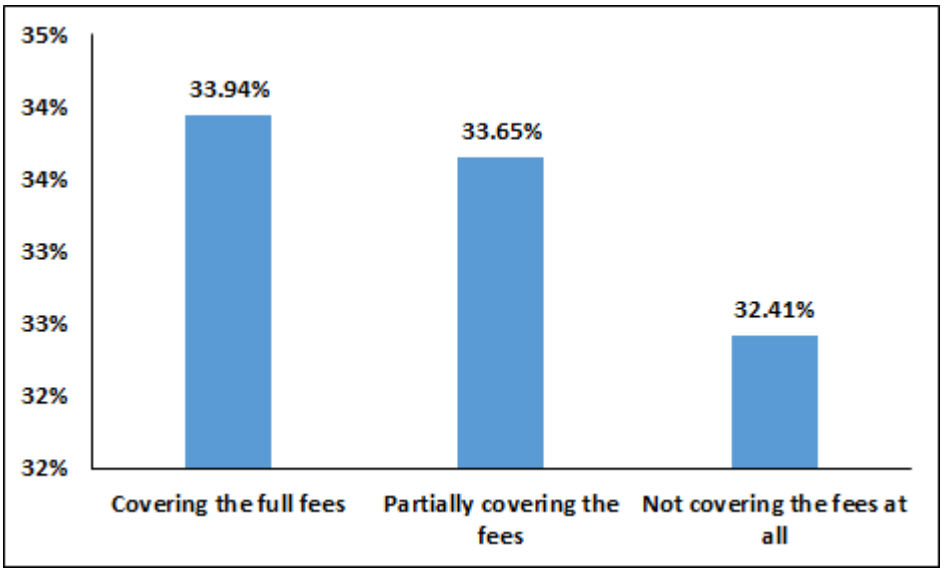

Figure 6 Ability to cover the fees

79.91% of the families who can't cover the fees or partially can are not receiving any external support to cover the fees, while 20.09% are receiving external support.

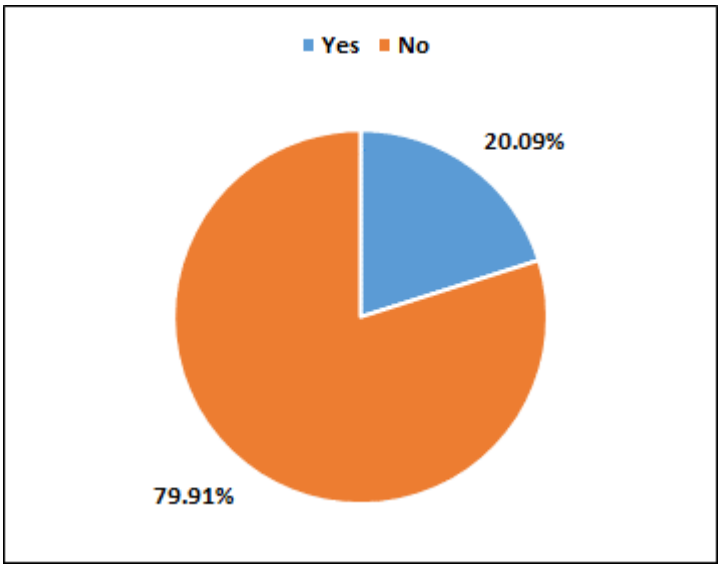

Figure 7 Receiving of external support to cover the fees

Out of the 20.91% of the families who are receiving external support, 31.69% receive the support from their relatives, 28.42% from organization: NGO - local organization – etc., 14.75% scholarships from the school and 12.02% are receiving external support from political parties.

	Frequency	Percent
Relatives	58	31.69%
Organization: NGO - Local Organization - etc.	52	28.42%
Scholarships from the school	27	14.75%
Political parties	22	12.02%
Other	16	8.74%
Religious Authorities	8	4.37%
Total	183	100.00%

Table 15 External support sources

Do you think you will be able to cover the fees of the daycare/kindergarten/school next year?

41.41% of the families won't be able to cover the fee at all next year, 31.91% will be able to cover the fees in full, while 26.69% will be able to partially cover the fees.

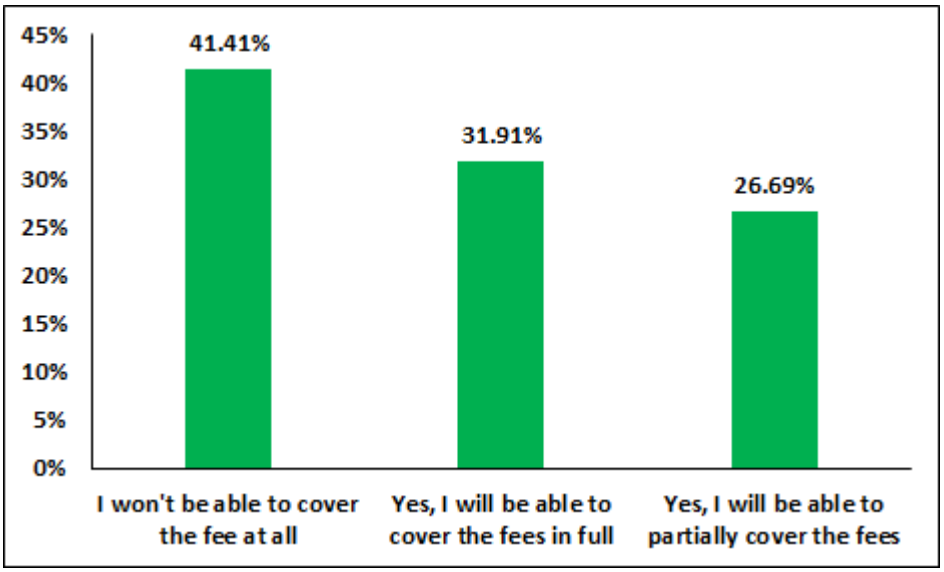

Figure 8. Ability to cover the fees next year

28.12% of the families who won't be able to cover the fee at all next year, or they can partially cover the fees, will move their kids to a semiprivate school, 22.90% will drop them out of school, 21.51% will move their kids to a public school and 17.68% will move their kids to a less expensive private school.

	Frequency	Percent
Move the kid to a semi-free school	264	28.12%
Drop the kid out of school	215	22.90%
Move the kid to a public school	202	21.51%
Move the kid to a less expensive private school	166	17.68%
Other	92	9.80%
Total	939	100.00%

Table 16 Decision of the family if they won't be able to cover the fees next year

For the transportation fees to the day care/kindergarten/school, 29.08% of the families are paying between 300 000 and 600 000 LBP per month, 22.41% between 0 and 300 000 LBP, 17.19% more than 900 000 LBP, 17.04% are not paying for the transportation (Don't have kids in the day care/kindergarten/school), while 14.29% of the families are paying between 600 000 and 900 000 LBP for the transportation per month.

	Frequency	Percent
0 LBP	235	17.04%
0 to 300 000 LBP	309	22.41%

300 000 to 600 000 LBP	401	29.08%
600 000 to 900 000 LBP	197	14.29%
More than 900 000 LBP	237	17.19%
Total	1379	100.00%

Table 17 Transportation fees to the day care/kindergarten/school per month

Information about the child's learning performance

Has the kids' performance changed negatively in comparison to classroom learning after the crisis? (Only for the kids who had access to education in 2021-2022)

For 48.06% of the families, their kids' performance didn't change in comparison to classroom learning after the crisis, 42.18% answered yes, while 9.77% of the families said that their kids' performance change partially negatively in comparison to classroom learning after the crisis.

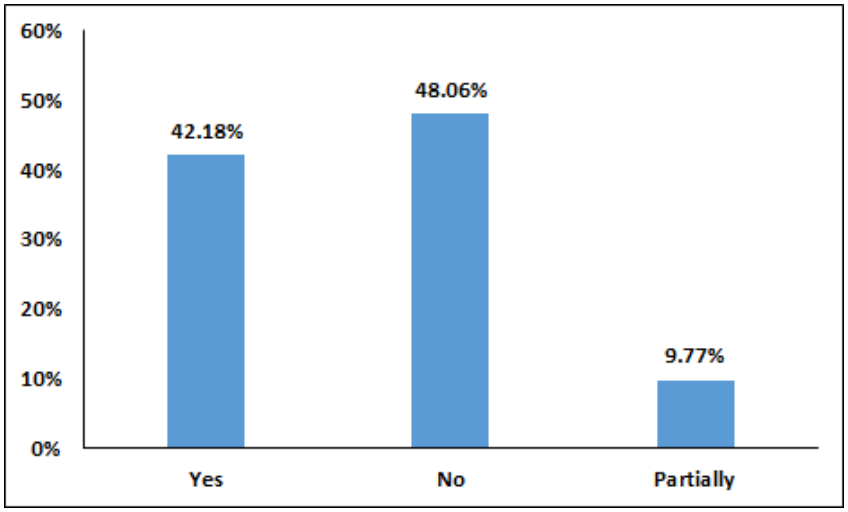

Figure 9 kids' performance changed negatively in comparison to classroom learning after the crisis

45.50% of the families who answered yes on the above question believed that having multiple interruption and school closures are the main reasons for the negative change in kids' performance after the crisis, 21.80% because of rushing to give the curriculum or putting a lot of pressure on finishing it, 19.50% lack of proper follow-up from the school's side, 18.90% decrease in the teachers' performance, 14.70% because the kids not having all the needed educational tools, 13.90% because of negative feelings experienced by the child recently, 12.40% lack of follow-up in the house and 10.80% lack of interactive learning.

	Frequency	Percent
Having multiple interruption and school closures	173	45.50%

Rushing to give the curriculum or putting a lot of pressure on finishing it	83	21.80%
Lack of proper follow-up from the school's side	74	19.50%
Decrease in the teachers' performance	72	18.90%
The kids not having all the needed educational tools	56	14.70%
Negative feelings experienced by the child recently	53	13.90%
Lack of follow-up in the house	47	12.40%
Lack of interactive learning	41	10.80%
Change in the educational institution norms	32	8.40%
Change the educational institution	26	6.80%
Failure to detect learning difficulties and needs	22	5.80%
Restricted interaction with friends	21	5.50%
Bullying or discrimination	16	4.20%
Other	8	2.10%

Table 18 Reasons for the negative performance of kids after the crisis

57.60% of these families noticed the changes in performance through the difficulty in assimilating the information, 31.30% lack of interest in school, 27.40% failure of kids to adapt and accommodate or other students to social norms, 16.10% difficulty to assimilate to classroom and peers' rhythm, 13.70% regressing grades and 9.70% difficulty to adhere to school norms (toilet breaks - snacks - talking - etc.).

	Frequency	Percent
Difficulty in assimilating the information	219	57.60%
Lack of interest in school	119	31.30%
Failure of kids to adapt and accommodate or other students to social norms	104	27.40%
Difficulty to assimilate to classroom and peers' rhythm	61	16.10%
Regressing grades	52	13.70%
Difficulty to adhere to school norms	37	9.70%
Other	10	2.60%

Table 19 How the families noticed the changes in performance

Section 4- Information about the early childhood health

Information about the medical checkups

The results in figure 10 reveal that 86.22% of the kids don't have any disability, 7.61% have disability, while 6.16% of the families preferred not to answer.

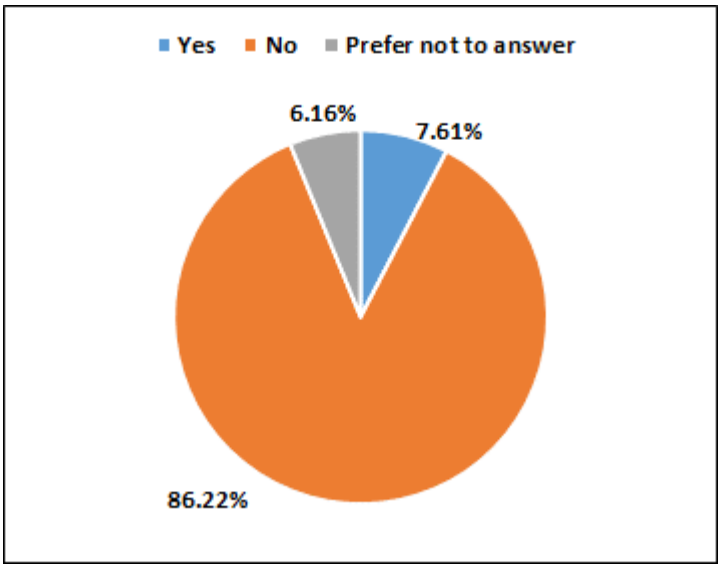

Figure 10 Kids have disability

Out of the 7.61% of kids who have disability, 35.20% of them have physical disability, 22.90% neurological disability, 21.90% preferred not to say, 20.00% sensory disability, while 9.50% have cognitive disability.

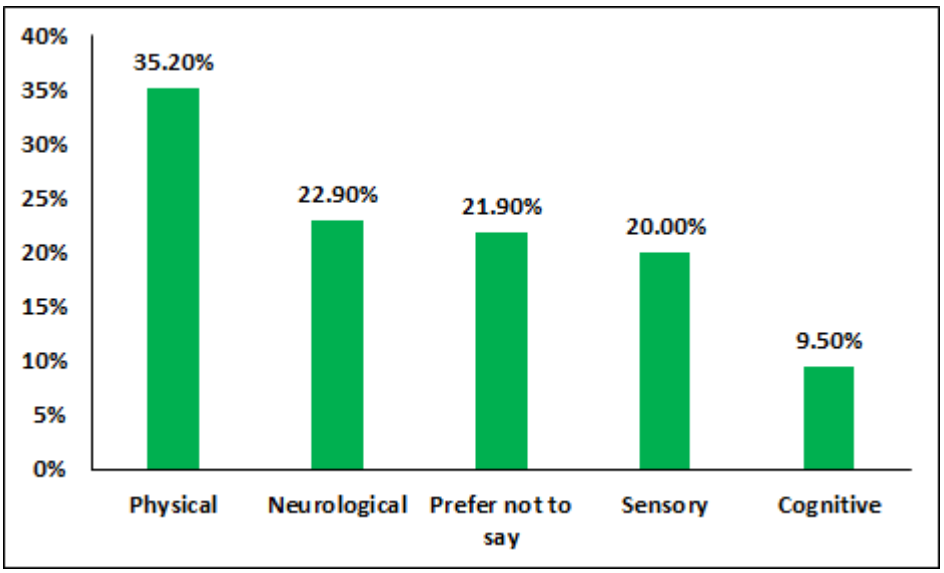

Figure 11 Type of disability

The results also demonstrate that 88.11% of the kids don't have any chronic disease, while 7.18% have chronic disease, and 4.71% preferred not to answer.

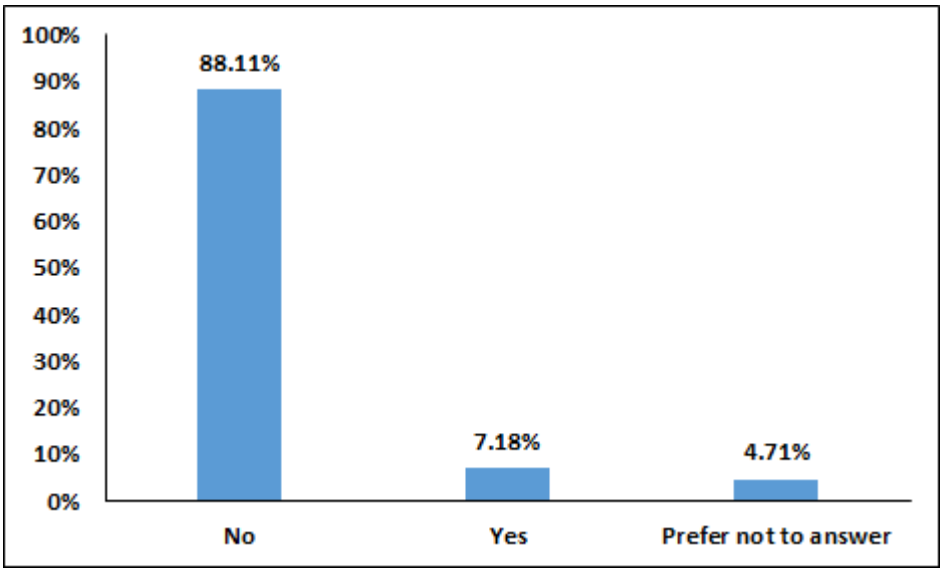

Figure 12. Kids have chronic disease

Following the Lebanese crisis, 50.04% of the kids were able with difficulties to receive appropriate medical follow-up, 28.14% weren't able, 17.26% easily, whereas 4.57% of the respondents preferred not to say.

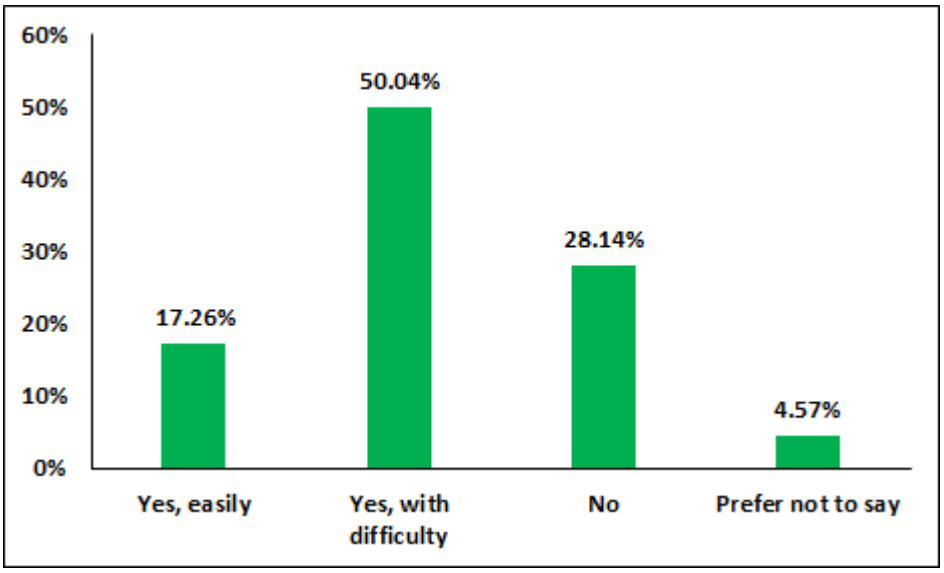

Figure 13. Ability for kids to receive appropriate medical follow-up

40.72% of the kids visit the pediatrician on the specified time depending on their ages, 35.33% of the kids were late, while 24.39% of the kids didn't go to any date (The 4.57% of participants who answered preferred not to say on the above question didn't answer this question).

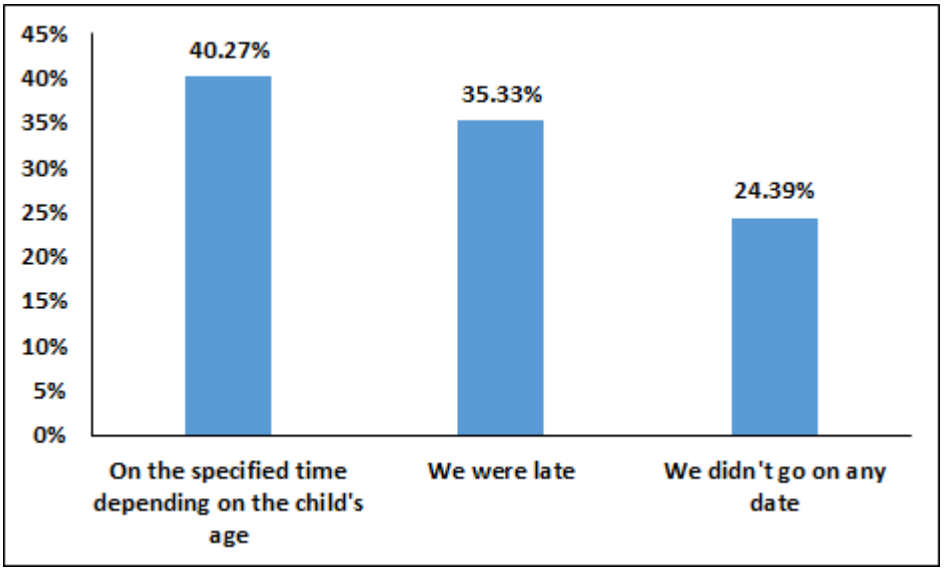

Figure 14. Time of visit to the pediatrician

For 76.40% of the kids who weren't able to receive appropriate medical follow-up or they received it with difficulties, the high fees were the most important reason for this, 20.60% Can't afford the transportation fees, 17.20% due to the Covid-19's restrictions, 14.20% Covid-19's anxiety and fear, 9.10% lack of professionals, due to their immigration, 9.00% of the kids are on waiting lists in organizations and health care centers, and 7.10% because of political situation.

	Frequency	Percent
High fees	824	76.40%
Can't afford the transportation fees	222	20.60%
Covid-19's restrictions	185	17.20%
Covid-19's anxiety and fear	153	14.20%
Lack of professionals, due to their immigration	98	9.10%
Waiting lists in organizations and health care centers	97	9.00%
Political situation	77	7.10%
Other	8	0.70%

Table 20 Difficulties faced ensuring the proper follow-up

The results also demonstrate that 71.07% of the parents had difficulties accessing medication to their kids, 13.85% didn't need any medicine, 11.39% didn't have any difficulties and 3.70% preferred not to say.

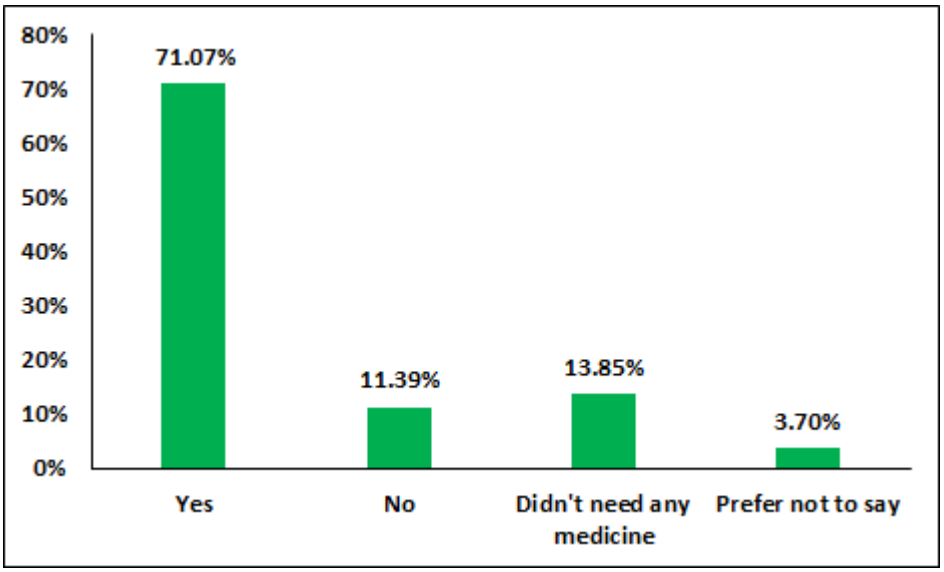

Figure 15 Difficulty accessing medication for kids

For the parents who had difficulties accessing medication to their kids, 83.20% couldn't afford medication because of high prices, 69.10% lack of medication in Lebanon, and 6.60% because electricity cuts affecting the storage of medication.

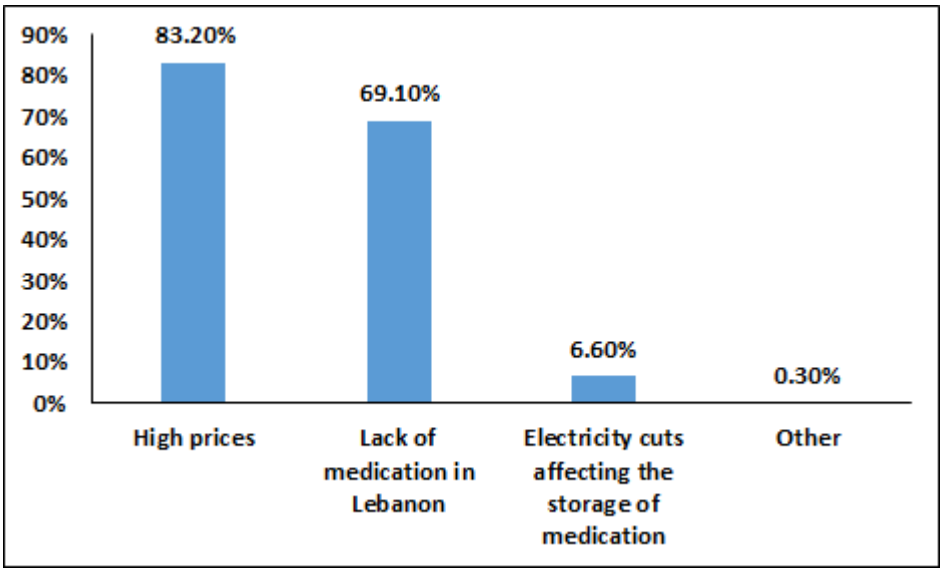

Figure 16. Type of the difficulties faced in order to insure the medication

For 41.10% of the parents who had difficulties accessing medication to their kids, the solution is waiting for donations, 34.20% receiving the medication from abroad relatives and friends, 23.70% buying the medication from outside Lebanon, 22.30% buying them from black market, and 11.80% of the parents didn't find any solution.

	Frequency	Percent
Waiting for donation	403	41.10%
Receiving the medication from abroad relatives and friends	335	34.20%
Buying the medication from outside Lebanon	232	23.70%
Buying them from black market	219	22.30%
Nothing	116	11.80%
Other	12	1.20%

Table 21 Solutions applied in order to insure the medication

The results indicate that 74.91% of the kids received their mandatory vaccine shots, 20.23% didn't, while 4.68% don't know.

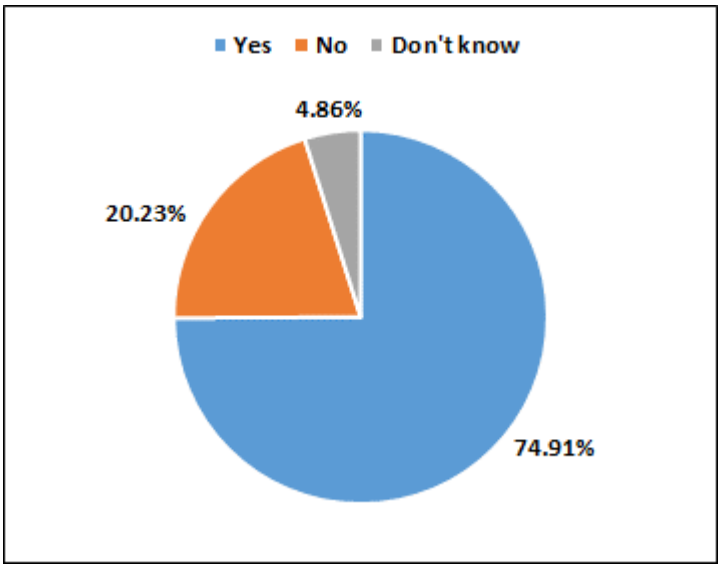

Figure 17. Kids received their mandatory vaccine shots

70.60% of the parents who their kids didn't receive the mandatory vaccine shots weren't able to pay for the shots, 36.20% because of the unavailability of shots in the nearest facility, 24.00% inability to reach the nearest medical facility, and 7.90% because of cultural or religious reasons.

	Frequency	Percent
Inability to pay for the shots	197	70.60%

Unavailability of shots in the nearest facility	101	36.20%
Inability to reach the nearest medical facility	67	24.00%
Cultural or religious reasons	22	7.90%
Other	9	3.20%

Table 22 Reasons for not taking the mandatory vaccine shots

Information about the Medical Team

The results illustrate that for 59.70% of the parents, the clinics of ministries of health and/or social affairs provide the medical checkups and shots for their kids, 29.00% the doctor at private clinic, 12.10% clinics of local actors or NGOs, 6.80% public hospital clinic, and 2.50% private hospital clinic.

	Frequency	Percent
Clinics of ministries of health and/or social affairs	823	59.70%
Doctor at private clinic	400	29.00%
Clinics of local actors or NGOs	167	12.10%
Public Hospital clinic	94	6.80%
Private Hospital clinic	35	2.50%
Other	14	1.00%
Community practitioner	6	0.40%

Table 23 Providers of the medical checkups and shots

The results also show that 65.60% of the kids doesn't need any specialized follow-up, 17.70% need doctor or medical specialist, 7.00% dental practitioner or dentist, 3.90% nurse, 3.50% nutritionist, while 3.00% of the kids need social worker.

	Frequency	Percent
Doesn't need any specialist help	905	65.60%
Doctor/medical specialist	244	17.70%
Dental practitioner/Dentist	96	7.00%
Nurse	54	3.90%
Nutritionist	48	3.50%
Social Worker	41	3.00%
Special Education Teacher	23	1.70%
Speech therapist	22	1.60%

Psychologist	21	1.50%
Psychomotor therapist	16	1.20%
Physical therapist	9	0.70%
Child and adolescent psychiatrist	8	0.60%
Other	7	0.50%

Table 24 Kids need specialized follow-up

55.27% of the kids who need specialized follow-up weren't followed up by specialists, while 44.73% were followed up by specialists.

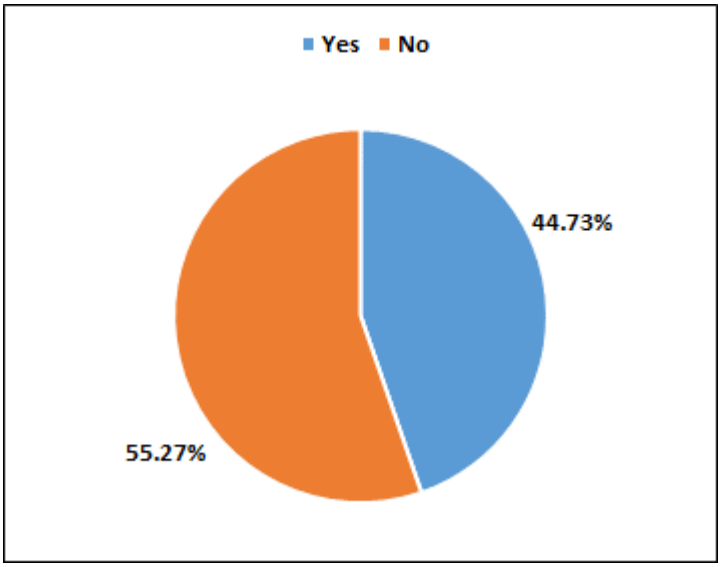

Figure 18. Kids who need specialized follow-up were followed up by specialists

Section 5: Information about the early childhood nutrition

55.00% of the babies under 2 years are not being breastfed, 37.31% are being breastfed, while 7.69% preferred not to answer. In average these babies are being breastfed 19 times per week

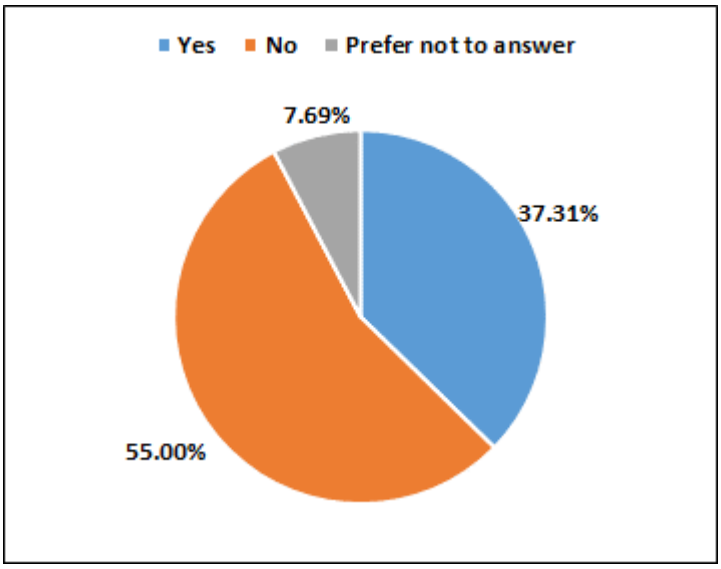

Figure 19. Babies under 2 years are being breastfed

The results also show that 75.20% of the kids didn't receive any fortified or special milk, 15.66% did receive fortified or special milk, while 9.14% of the participants preferred not to answer. In average these kids received fortified or special milk 6 times per week.

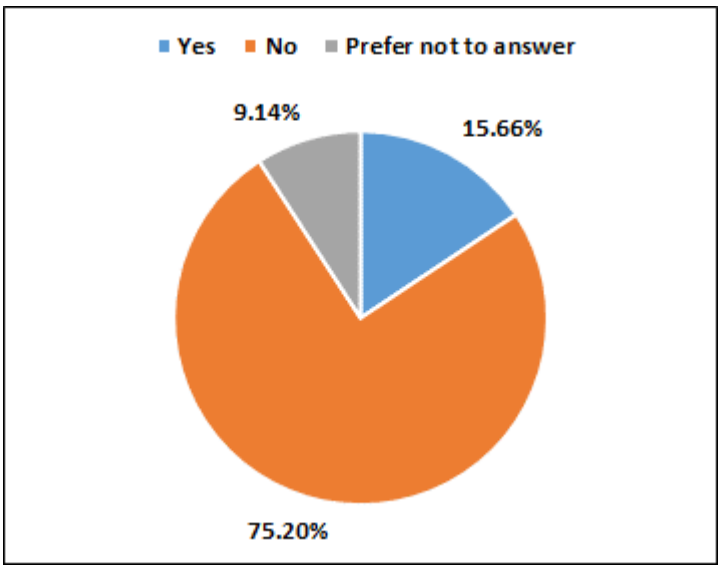

Figure 20. Kids received fortified or special milk

The results indicate that 77.59% of the kids are dinking clean water, 16.24% are not, while 6.16% of the participants preferred not to answer.

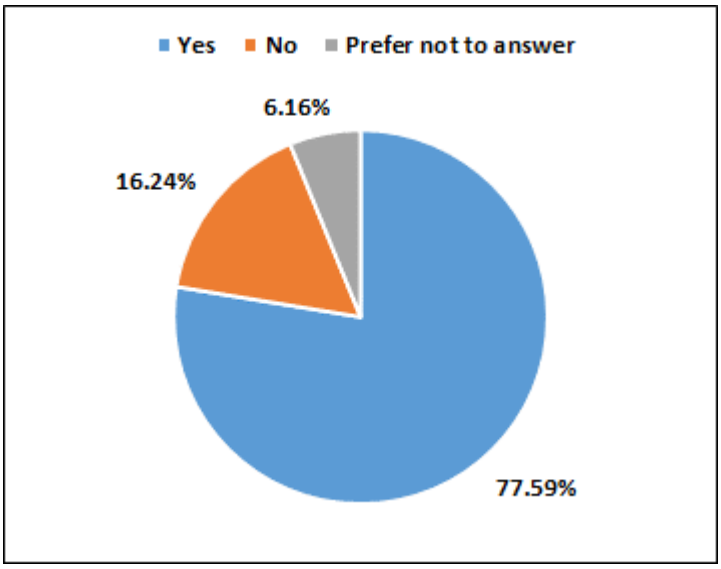

Figure 21. Kids are drinking clean water

35.20% of the kids are drinking bottled water, 30.30% from the local water source, 24.70% from the tap without filter, 14.70% from the tap with filter, while 2.20% don't know the source of the water.

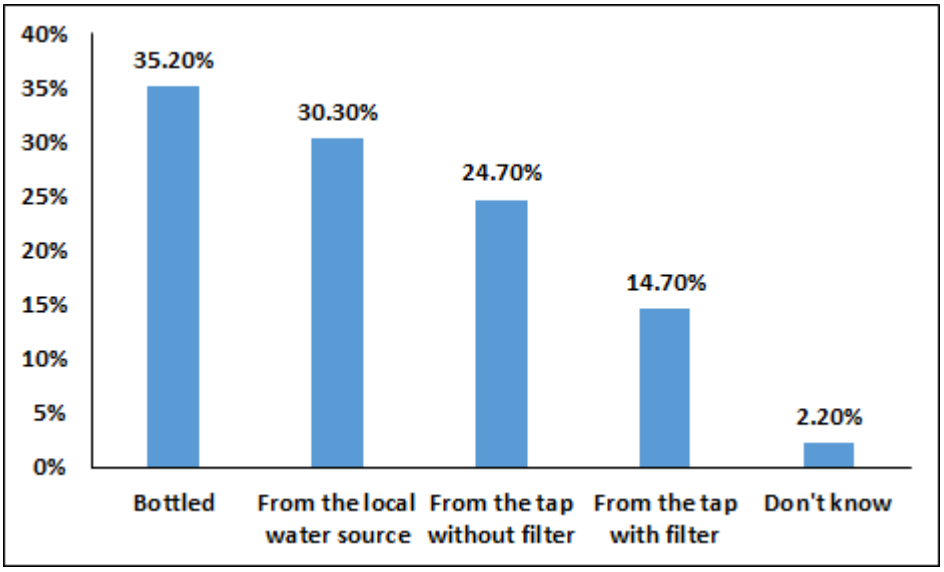

Figure 22. Source of the drinking water

The results also demonstrate that in the past year, the ability to eat enough have changed on daily basis for 52.86% of the kids, the ability didn't change for 39.01%, while 8.12% preferred not to answer. The number of daily meals has been reduced for 50.98% of the kids, it didn't change for 40.10%, while 8.92% preferred not to answer.

The quality of meals that the family consumes have been adjusted for 70.34% of the families, it didn't change for 22.34%, while 7.32% preferred not to answer.

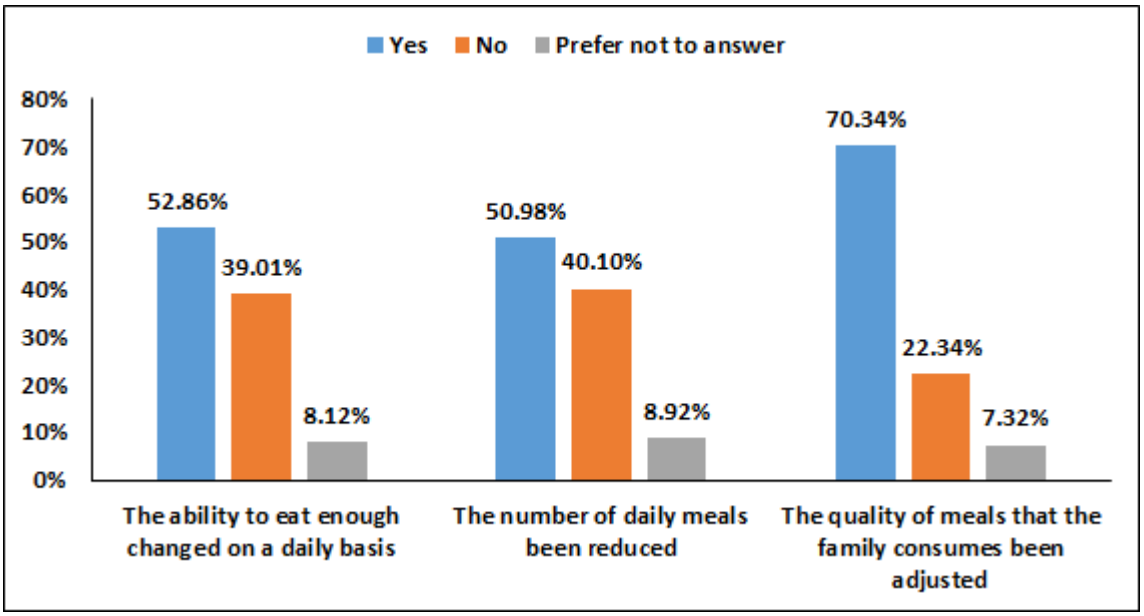

Figure 23. Change in food habits in the past year

58.45% of the households didn't receive food assistance during the last 3 months, 24.95% have received it once, while 16.61% did receive food assistance more than once the last 3 months.

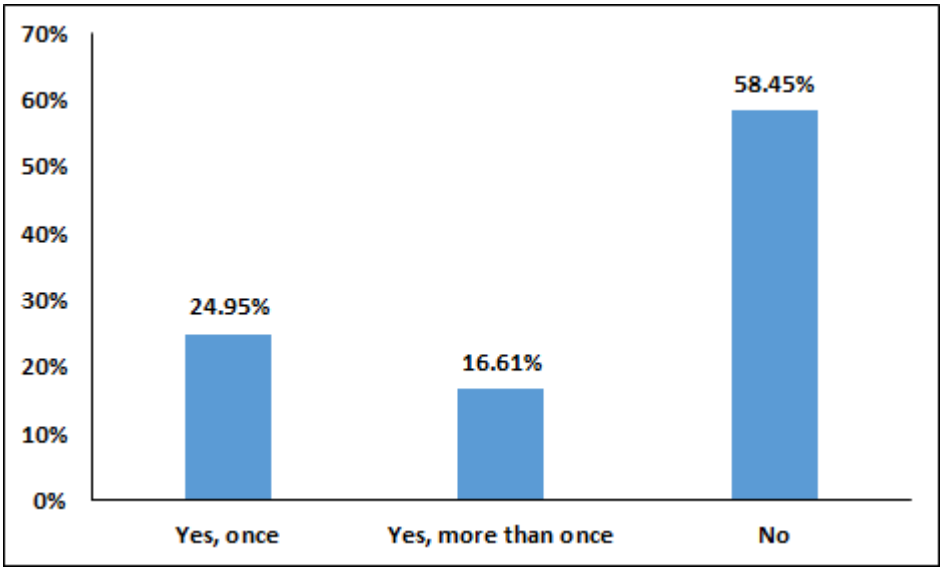

Figure 24. Household received food assistance during the last 3 months

Section 6: Information about the early childhood social and emotional development

Information about the Screen Time

The results in Table 25 indicate that 40.77% of the kids aged above 1 year spent between 2 and 3 hours per day using a screen (Includes computer, game consoles, cell phone, or TV), 28.04% between 0 and 1 hours, 16.34% doesn't spend time on screens, 13.75% between 4 and 6 hours, 0.86% between 7 and 10 hours, while 0.24% of kids spent 11 or more hours using a screen.

	Frequency	Percent
Doesn't spend time on screens	208	16.34%
0-1 hours per day	357	28.04%
2-3 hours per day	519	40.77%
4-6 hours per day	175	13.75%
7- 10 hours per day	11	0.86%
11 or more hours per day	3	0.24%
Total	1273	100.00%

Table 25 Time spent on screen (kids aged above 1 year)

39.04% of the kids spent the same time on the screen in the past 3 months, for 38.49% the time increased, while it decreased for 22.47% of the kids.

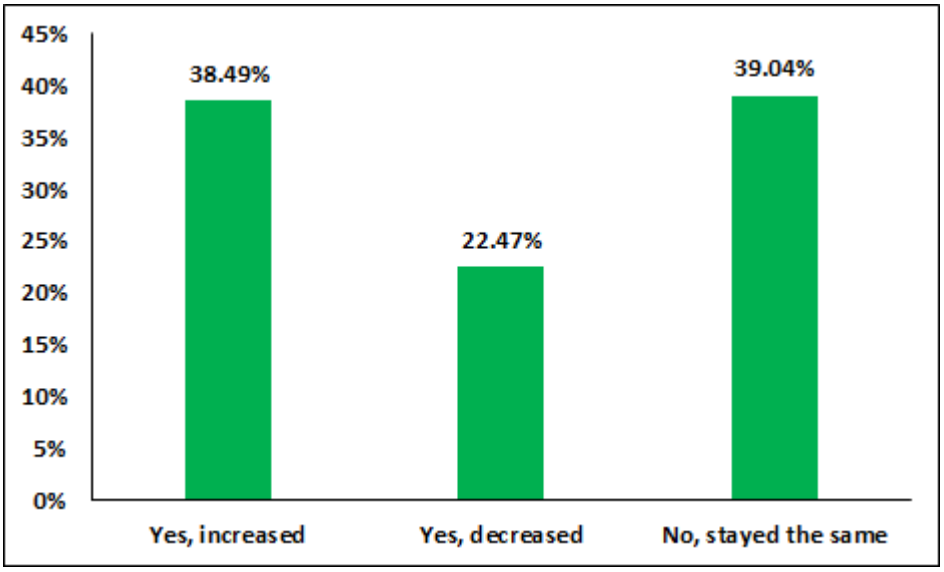

Figure 25. Change in time spent on screen in the last 3 months

The fact that 46.50% of the children spent more time on screen is attributed to having more free time and not having games to play, 46.10% due to the remote learning and school tasks

given online, 30.20% because they want to spend time on screen, and 12.20% due to unavailability of caregiver to take care of them.

	Frequency	Percent
More free time and no games to play	228	46.50%
Remote learning and school tasks given online	226	46.10%
They want to spend time on screen	148	30.20%
No caregiver available to take care of them	60	12.20%
Other	5	1.00%

Table 26 Reasons for the increased screen time consumption

The results demonstrate that 33.78% of the parents said that the screen sometimes affected in a negative way the mood and the behaviors of their kids, 24.90% never, 21.60% frequently, 15.48% don't know, while 4.24% of the parents answered always.

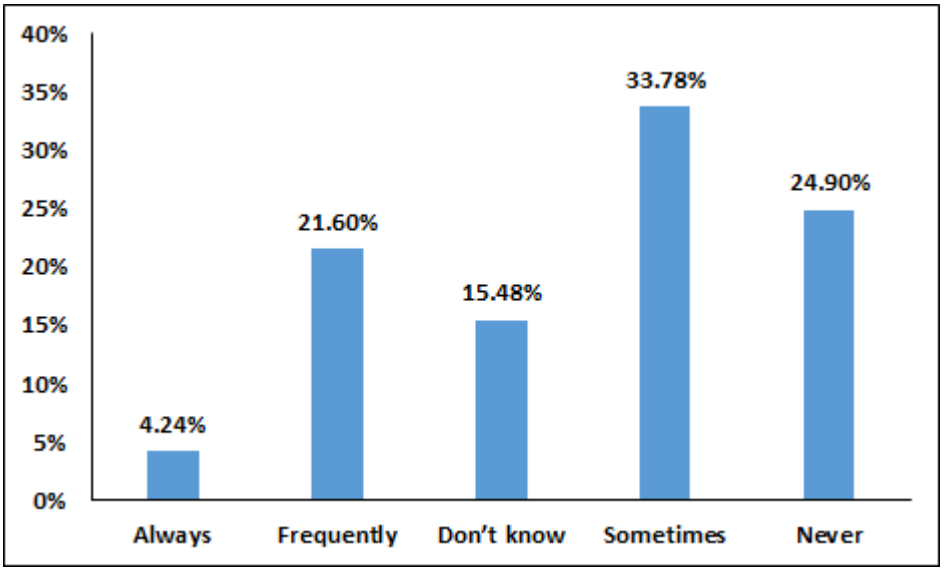

Figure 26. Screen affect in a negative way the mood and behaviors of the kids

For 62.20% of the parents, the content is supervised by them, 22.00% only setting the screen time limit, 19.20% don't supervise the content, while 9.30% don't know if the access and screen activities are supervised or not.

	Frequency	Percent
Yes, the content is supervised	792	62.20%
Only setting the screen time limit	280	22.00%
No supervision	245	19.20%

I don't know	119	9.30%

Table 27 Parents or caregiver supervise the access and screen activities

Information about the kids' play

The results indicate that 34.56% of the kids are some of the times playing alone, 32.29% most of the time, 11.23% less than half of the time, 10.76% more than half of the time, 7.07% at no time, while 4.08% of the parents said that their kids are playing alone all the total playing time.

However, 36.37% of the kids are most of the time playing with their peers or siblings, 28.52% some of the time, 16.10% more than half of the time, 8.48% less than half of the time, 6.91% all the time, while 3.61% of the kids are not playing with their peers or siblings.

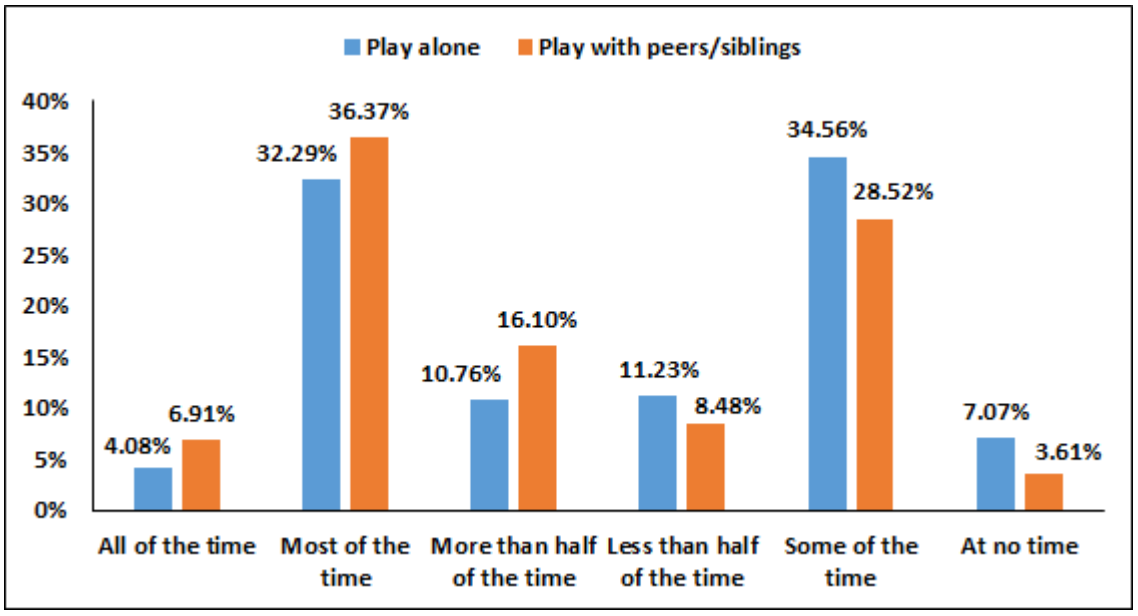

Figure 27. The time kids are playing alone or with peers and siblings.

For 41.79% of the kids, the outdoor play time was decreased comparing to before the crisis, it remained the same for 38.41% of the kids, while it was increased for 19.80% of the kids comparing to before the crisis.

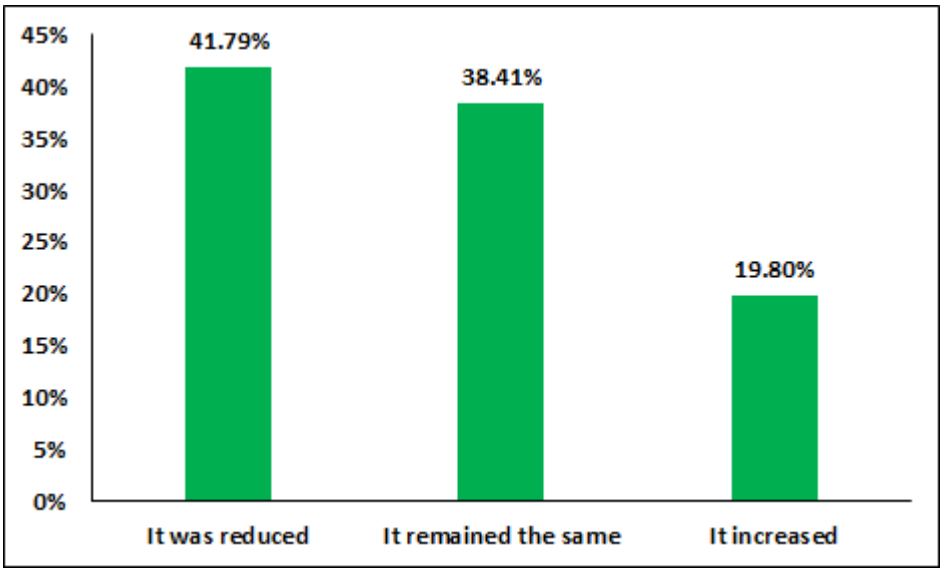

Figure 28. The outdoor play time of kids after the crisis

The results show that 67.01% of the kids have toys to play with, whereas 32.99% don't have.

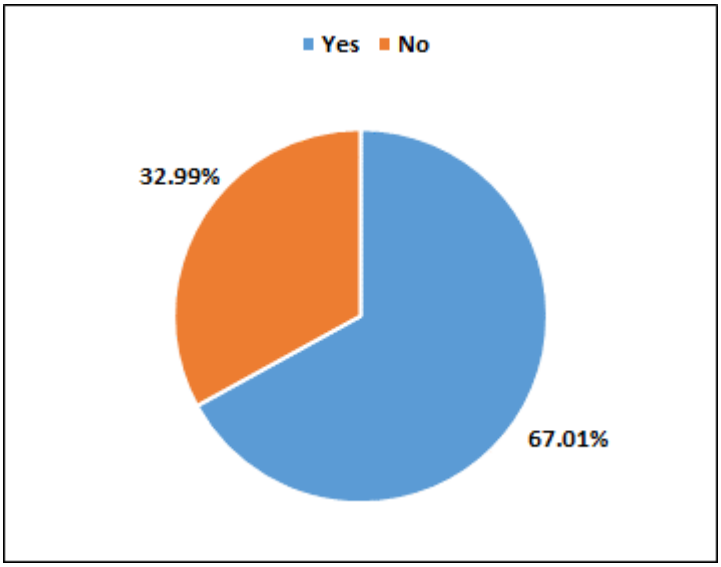

Figure 29. Kids have toys to play with

27.10% of the kids aged 1 year and above didn't receive a new toy since more than 1 year ago, 19.87% never received a new toy, 12.33% since the last three months, 11.78% last month, 10.21% since 3 to 6 months, also 10.21% since 6 to 12 months ago, while 8.48% of the kids have received new toy the last week.

	Frequency	Percent
Last week	108	8.48%
Last month	150	11.78%

Within the last three months ago	157	12.33%
3 to 6 months ago	130	10.21%
6 to 12 months ago	130	10.21%
More than a year ago	345	27.10%
Never	253	19.87%
Total	1273	100.00%

Table 28 The last time the kids have received a new toy

45.33% of the parents are playing between 0 and 1 hours with their kids per day, 23.88% don't play with them, 27.34% between 2 and 3 hours, 2.99% between 4 and 6 hours, while 0.47% of the parents play with their kids for more than 6 hours per day.

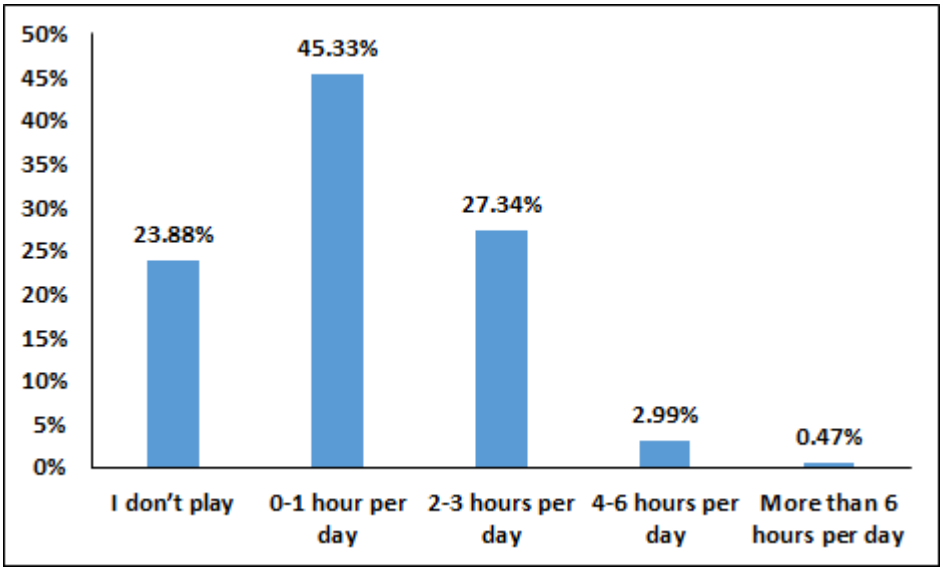

Figure 30. Time play with kids per day

33.54% of the parents said that due to the crisis in the last year, they are spending now less time playing with their kids, 28.20% partially less, the play time with kids was not affected by the crisis for26.39% of the parents, while 11.86% of the parents are spending more play time with their kids after the crisis.

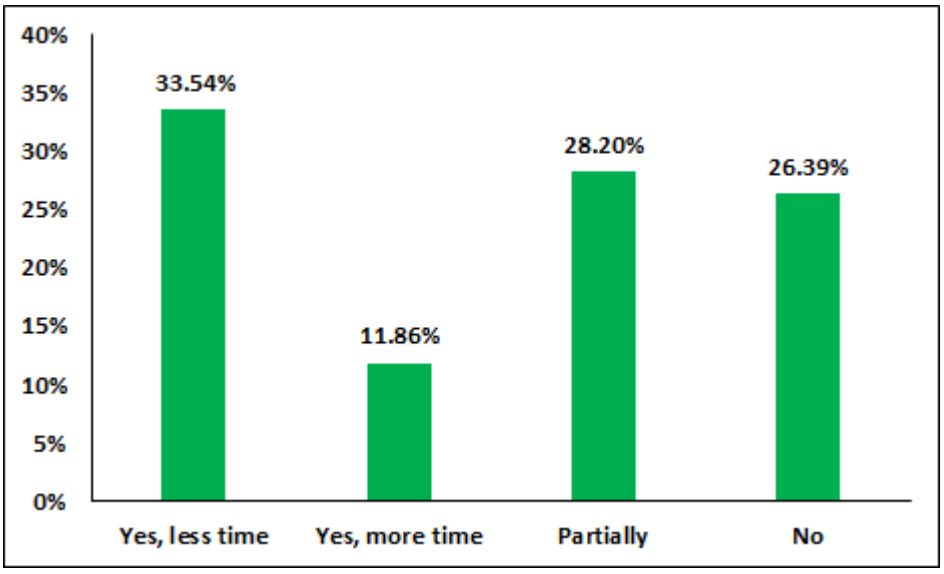

Figure 31. Play time with kids was affected in the last year due to the crisis

The results reveal that in the past month, 28.59% of the kids were spending between 15 minutes and hour per day to read books or stories, 12.25% between 2 and 3 hours, 1.89% between 4 and 6 hours, 0.31% more than 6 hours a day, while 56.95% of the kids doesn't read.

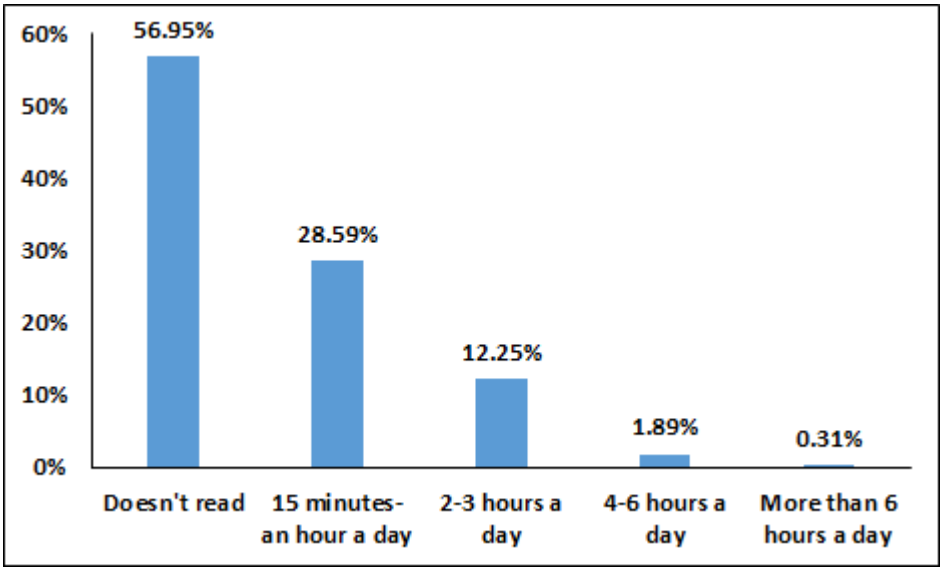

Figure 32. Time spent on reading books and stories in the last month

Section 7: Information about the changes brought by the pandemic/economic crisis

The results demonstrate that for 80.28% of the respondents the household income has decreased comparing to one year earlier, 16.53% answered no, while 3.19% of the respondents don't know whether the household income has decreased or not comparing to one year earlier.

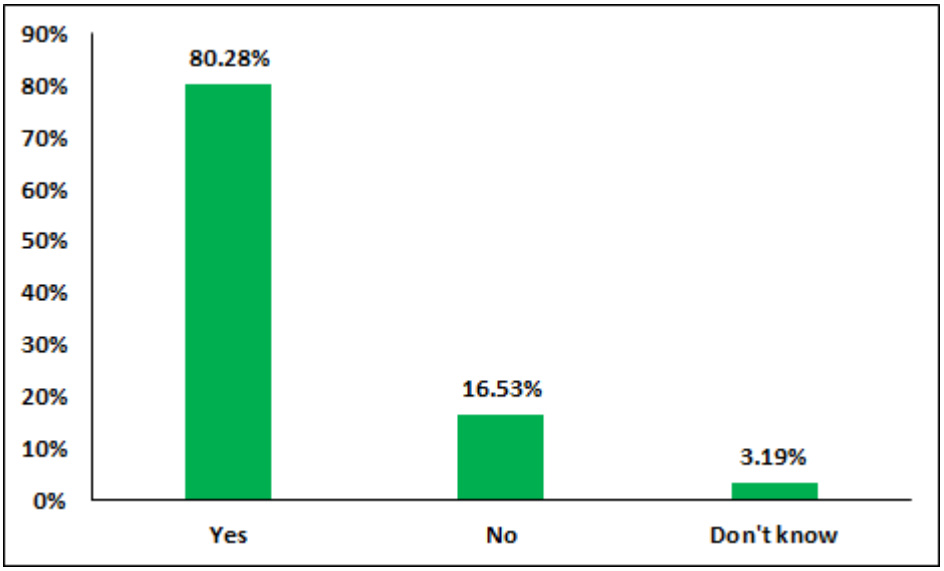

Figure 33. Household income undergone any decrease compared to one year earlier

The results also reveal that 66.72% of the respondents confirmed that the household lose one or more of the jobs since the outbreak of COVID 19 and the economic crisis, 28.86% answered no, while 4.42% of the respondents don't know whether the household lose one or more of the jobs since the outbreak of COVID 19 and the economic crisis or not.

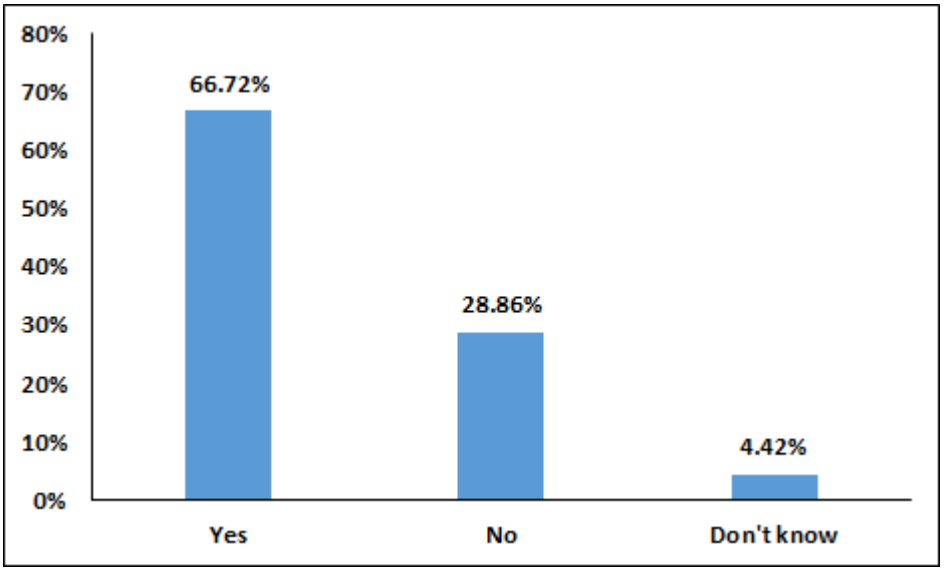

Figure 34. Household lose one or more of the jobs since the outbreak of COVID 19 and the economic crisis

64.97% of the respondents said that their households take debt in the past 30 days to cover basic needs, 28.57% answered no, while 6.45% preferred not to answer.

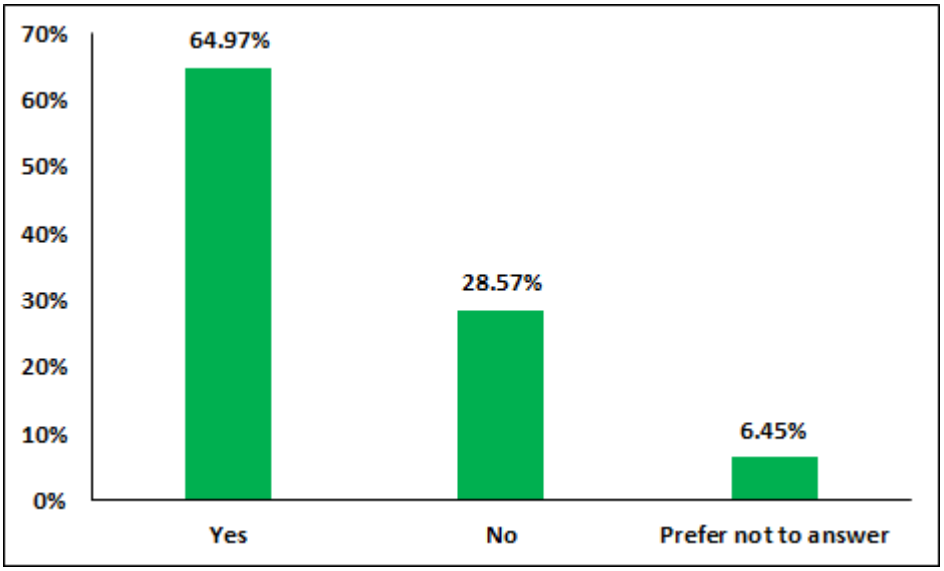

Figure 35. The household take debt in the past 30 days to cover basic needs

The results indicate that 52.43% of the respondents didn't have to sell a family inheritance or property over the past year, 38.94% had to, while 8.63% of the respondents preferred not to answer.

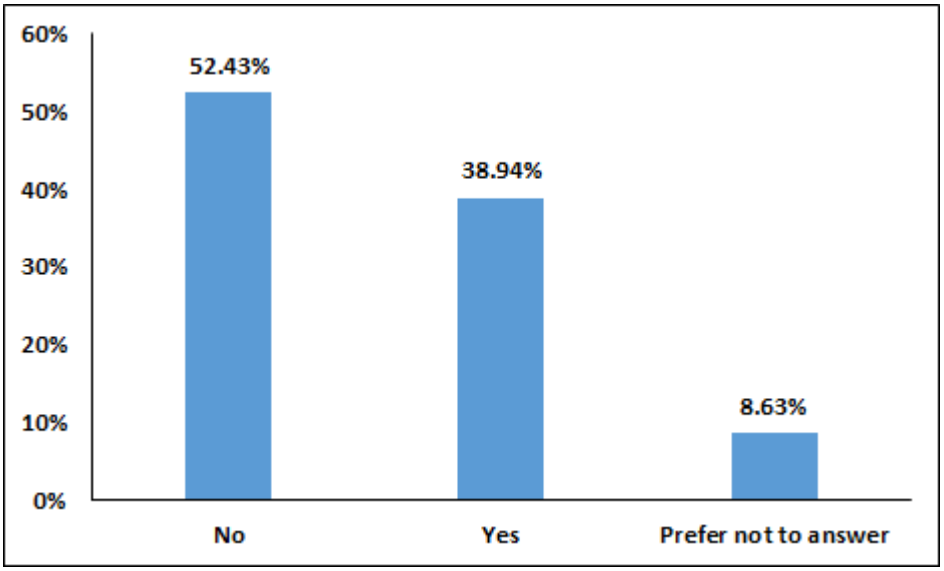

Figure 36. The family had to sell inheritance or property over the past year

80.30% of the respondents answered that no child stopped going to school to support their families, 14.40% to lower the costs of the school, 2.00% to take care of their brothers, and 1.80% to take care of their parents.

	Frequency	Percent

No child stopped going to school for these reasons	1107	80.30%
Lower costs	199	14.40%
Other	51	3.70%
Taking care of his brothers	27	2.00%
Taking care of his parents	25	1.80%

Table 29 Children under the age of eight stopped going to school this year to support the family

86.80% of the participants answered that their household location didn't undergo any changes in the last year, 10.80% said yes, while 2.39% don't know whether their household location undergone any changes in the last year or not.

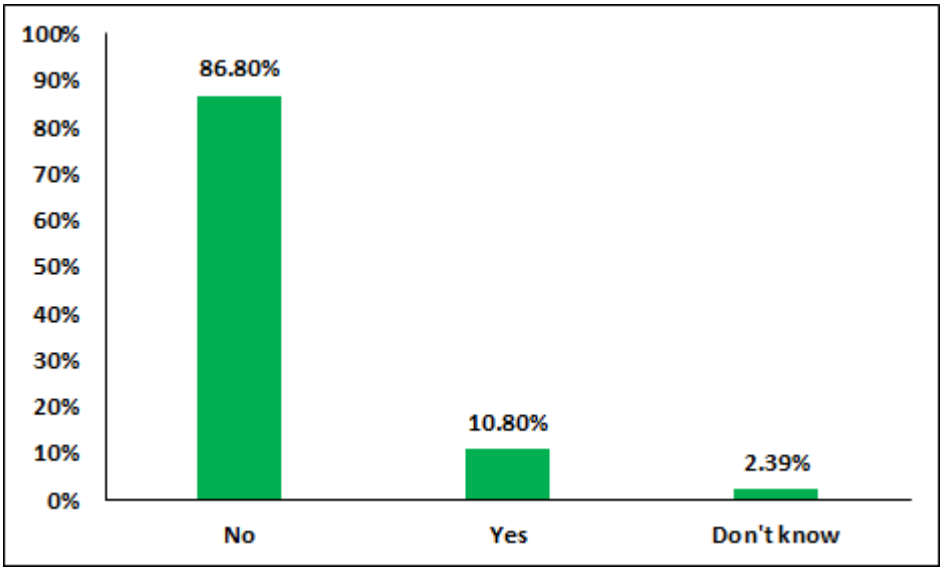

Figure 37. The household location undergone any changes in the last year

Out of the 10.80% of the respondents who answered yes, 45.60% have changed their households' location because the rent is too high, 22.10% they were forced to move, 13.40% to upgrade, 10.70% need more space, 8.10% because the contract was end, 8.10% were moved to other location close to job or school.

	Frequency	Percent
Rent is too high	68	45.60%
Forced to move	33	22.10%
Upgrade	20	13.40%
Need more space	16	10.70%
End of contract	12	8.10%
Closer to job or school	12	8.10%
Other	4	2.70%

Table 30 Reasons for changing the location of the household

The results show that 66.21% of the respondents agreed that the household reduced the expenses on Education/Food/Transportation during the last year, 27.99% answered no, while 5.80% of the respondents don't know whether these expenses were reduced or not.

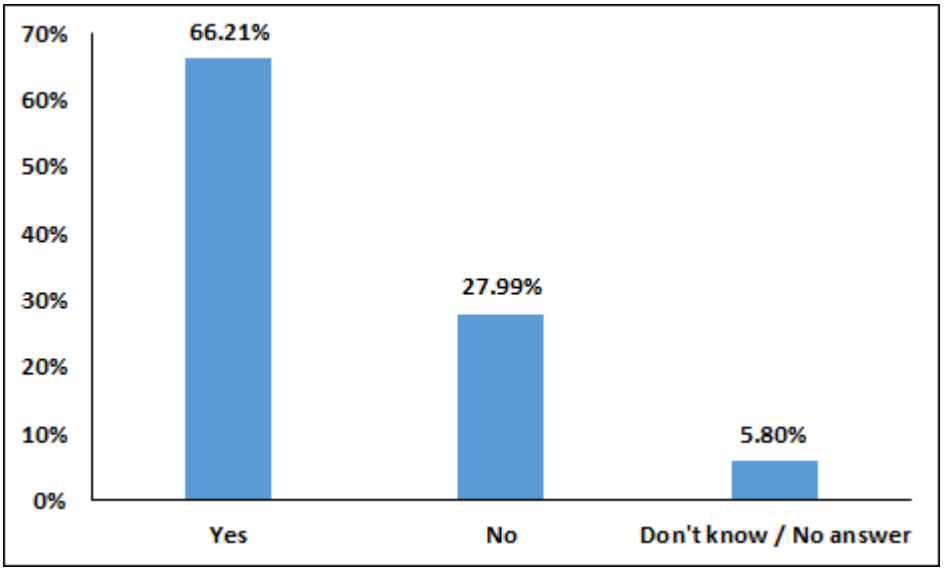

Figure 38. The household reduce the expenses on Education/Food/Transportation during the last year

85.58% of the respondents confirmed that the provision of clothes for the family members reduced during the last year, 10.44% answered no, while 2.97% don't know or preferred not to answer.

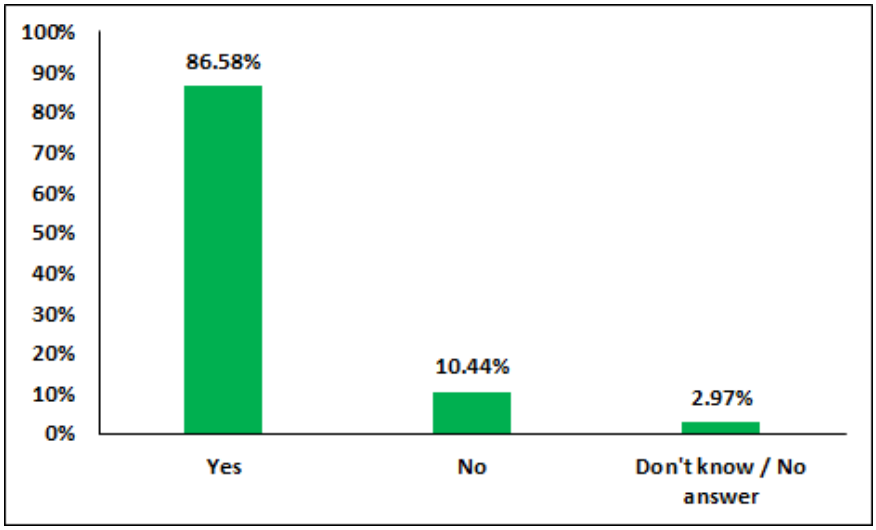

Figure 39. The provision of clothes for the family members reduced during the last year

The results also demonstrate that 80.49% of the respondents have access to sanitary items and hygiene material, 15.16% answered no, while 4.35% of the respondents don't know or preferred not to answer.

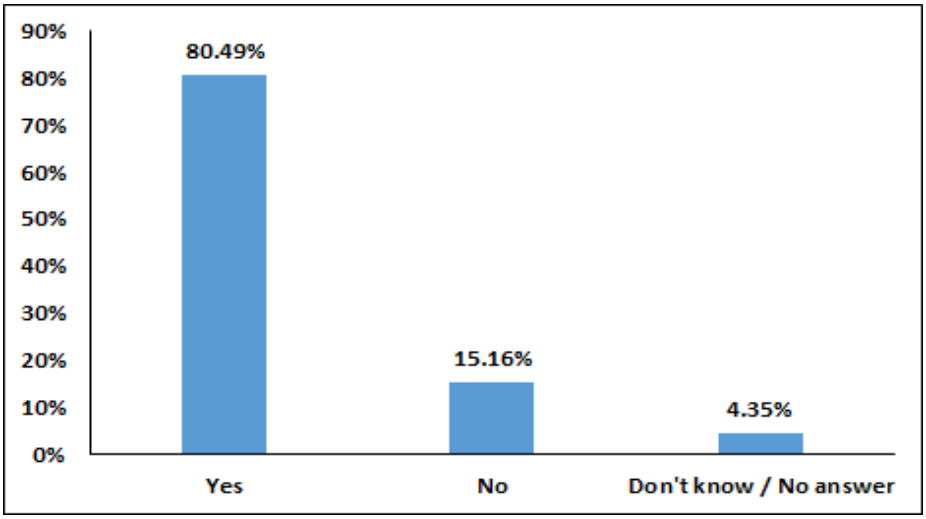

Figure 40. Families have access to sanitary items and hygiene material

80.78% of the respondents agreed that their ability to provide a heating or cooling system declined during cold and hot weather, 15.16% answered no, while 4.06% don't know or preferred not to answer.

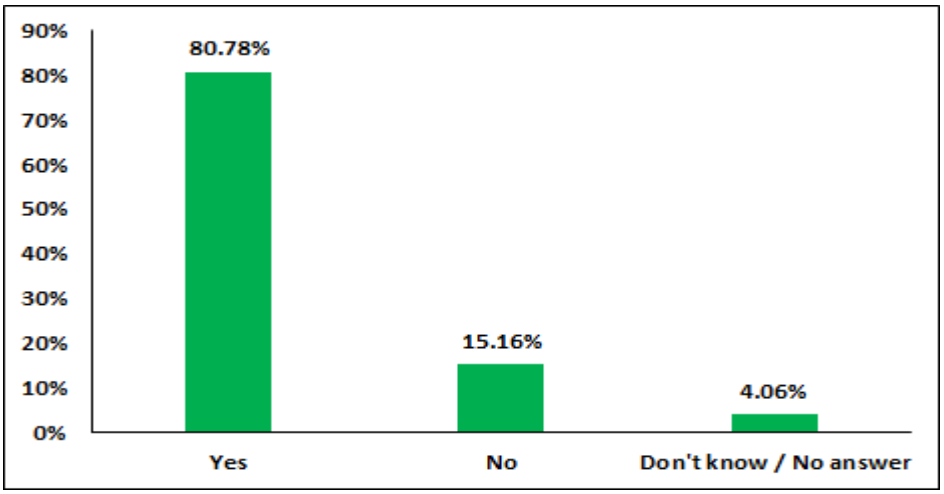

Figure 41. Family's ability to provide a heating or cooling system declined during cold or hot weather

The results reveal that 60.04% of the respondents didn't have to leave their kids alone at home or somewhere else to be able to attend work, 35.32% answered yes, while 4.64% of the respondents don't know or preferred not to answer.

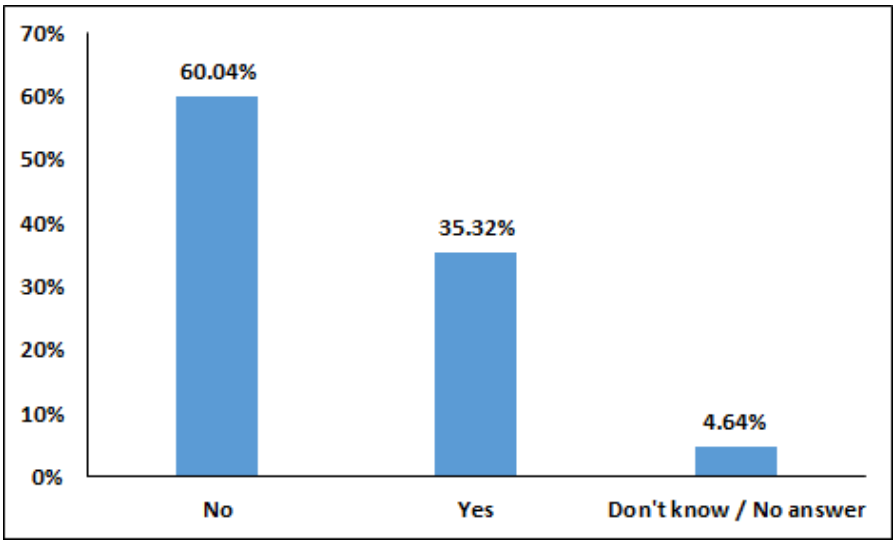

Figure 42. Participants had to leave their kids alone at home or somewhere else to be able to attend work

43.07% of the parents have used sometimes in the past year methods like shouting, hitting, spanking, or similar forms of disciplinary methods more than before when their kids misbehaved, 27.63% never used them, 16.82% said often, while 12.47% of the respondents believed that their kids didn't misbehave in the past year more than before.

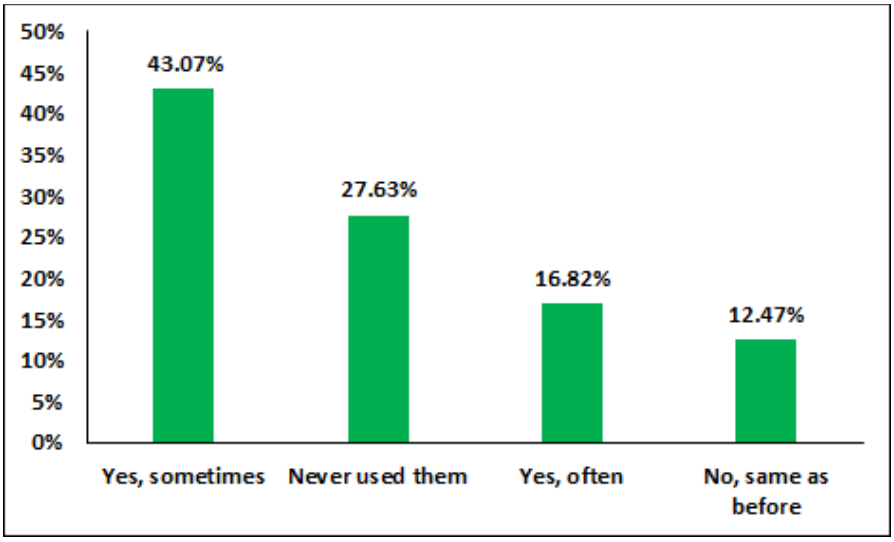

Figure 43. Parents used with their kids methods like shouting, hitting, spanking, or similar forms of disciplinary methods more than before

Section 8: Information about the child's mental health

The results in table 31 demonstrate the following:

- 54.92% of the kids above 2 years sometimes start asking more questions about the crisis in the past 6 months, 34.43% said never, while 10.66% of the participants answered often.
- 56.07% of the kids sometimes express more distress and nagging in the past 6 months in comparison to before, 32.54% said never, while 11.39% of the participants answered often.
- 52.21% of the participants sometimes notice that the kid's personality and behavior being affected by the crisis, 35.66% said never, while 12.13% of the participants answered often.
- 55.25% of the kids sometimes feel sad, unhappy, tearful in the past 6 months in comparison to before, 32.62% said never, while 12.13% of the participants answered often.
- 48.03% of the kids sometimes seem worried in the past 6 months in comparison to before, 38.61% said never, while 13.36% of the participants answered often.
- 49.92% of the kids sometimes seem to have less interest or pleasure in doing things in the past 6 months in comparison to before, 38.03% said never, while 12.05% of the participants answered often.
- 46.15% of the kids never seem to daydream more in the past 6 months in comparison to before, 44.51% said sometimes, while 9.34% of the participants answered often.
- 47.62% of the participants never noticed any changes in the kid's sleep in the past 6 months in comparison to before, 44.75% said sometimes, while 7.62% of the participants answered often.
- 55.25% of the participants never noticed any changes in the kid's sleep in the past 6 months in comparison to before, 37.70% said sometimes, while 7.05% of the participants answered often.
- 50.25% of the kids never seemed to feel tired or to have little energy in the past 6 months in comparison to before, 43.44% said sometimes, while 6.31% of the participants answered often.
- 53.61% of the kids never express feelings of insecurity and is easily scared in the past 6 months in comparison to before, 40.00% said sometimes, while 6.39% of the participants answered often. For the participants who answered sometimes or often, 73.50% attributed this to the economic crises, 57.20% to the covid-19's pandemic, 28.10% to the family situation, 15.70% because of 4th of August's Beirut's blast, and 5.50% to the abuse of the kids.
- 74.10% of the kids never have enuresis in the past 6 months in comparison to before, 21.39% said sometimes, while 4.51% of the participants answered often.
- 47.38% of the participants never noticed any change in the kid's appetite in the past 6 months in comparison to before, 44.84% said sometimes, while 7.79% of the participants answered often.
- 54.84% of the kids never have trouble with separation from their parents or any other caregiver in the past 6 months in comparison to before, 38.61% said sometimes, while 6.56% of the participants answered often.

- 49.10% of the kids' ability to regulate their emotions in a new situation never changed in the past 6 months in comparison to before, 44.92% said sometimes, while 5.98% of the participants answered often.

	Never	Sometimes	Often
Did the kid start asking more questions about the crisis in the past 6 months?	34.43%	54.92%	10.66%
Did the kid express more distress and nagging in the past 6 months in comparison to before?	32.54%	56.07%	11.39%
Did you notice the kid's personality and behavior being affected by the crisis?	35.66%	52.21%	12.13%
How much did the kid feel sad, unhappy, tearful in the past 6 months in comparison to before?	32.62%	55.25%	12.13%
How much did the kid seem worried in the past 6 months in comparison to before?	38.61%	48.03%	13.36%
Did the kid seem to have less interest or pleasure in doing things in the past 6 months in comparison to before?	38.03%	49.92%	12.05%
Did the kid seem to daydream more in the past 6 months in comparison to before?	46.15%	44.51%	9.34%
Have you noticed any changes in the kid's sleep in the past 6 months in comparison to before?	47.62%	44.75%	7.62%
Have you noticed an increase of nightmares or scary stories in the kid in the past 6 months in comparison to before?	55.25%	37.70%	7.05%
Has the kid seemed to feel tired or to have little energy in the past 6 months in comparison to before?	50.25%	43.44%	6.31%
Does the kid express feelings of insecurity and is easily scared in the past 6 months in comparison to before	53.61%	40.00%	6.39%
Did the kid have enuresis in the past 6 months in comparison to before?	74.10%	21.39%	4.51%
Have you noticed any change in the kid's appetite in the past 6 months in comparison to before?	47.38%	44.84%	7.79%
Did the kid have trouble with separation from you or any other caregiver in the past 6 months in comparison to before?	54.84%	38.61%	6.56%
Has the kid ability to regulate her/his emotions in a new situation changed in the past 6 months in comparison to before?	49.10%	44.92%	5.98%

Table 31 Information about the child's mental health

Section 9: Information about the respondent's mental health

The results in table 32 indicate the following:

- 46.63% of the participants sometimes have experienced more difficulty going to work in the past 6 months in comparison to before the crisis, 29.44% said often, while 23.93% of the participants answered never.
- 51.20% of the participants sometimes have experienced more difficulty taking care of things at home in the past 6 months in comparison to before, 32.92% said often, while 15.88% of the participants answered never.
- 51.05% of the participants sometimes have had trouble getting along with other people in the past 6 months after the crisis, 26.90% said often, while 22.04% of the participants answered never.
- 48.30% of the participants sometimes have felt less interest or no pleasure in doing activities in the past 6 months in comparison to before, 30.46% said often, while 21.25% of the participants answered never.
- 47.64% of the participants sometimes have felt down or depressed in the past 6 months in comparison to before, 38.07% said often, while 14.29% of the participants answered never.
- 46.63% of the participants sometimes have felt hopeless in the past 6 months in comparison to before, 39.38% said often, while 14.00% of the participants answered never.
- 48.73% of the participants sometimes have felt nervous in the past 6 months in comparison to before, 39.01% said often, while 12.26% of the participants answered never.
- 46.56% of the participants sometimes have felt anxious about daily life in the past 6 months after the crisis, 43.44% said often, while 10.01% of the participants answered never.
- 50.04% of the participants sometimes had changes in their sleep in the past 6 months in comparison to before, 26.98% said often, while 22.99% of the participants answered never.
- 50.62% of the participants sometimes have felt tired or have little energy in the past 6 months in comparison to before, 35.32% said often, while 14.07% of the participants answered never.
- 50.18% of the participants sometimes have experienced poor appetite or overeating in the past 6 months in comparison to before, 25.24% said never, while 24.58% of the participants answered often.
- 48.15% of the participants sometimes have felt that they are a failure or that they let themselves or their families down in the past 6 months in comparison to before, 29.15% said never, while 22.70% of the participants answered often.
- 53.01% of the participants sometimes had trouble concentrating on things in the past 6 months in comparison to before, 23.57% said often, while 23.42% of the participants answered never.
- 45.32% of the participants sometimes have experienced being slow in moving or speaking in the past 6 months in comparison to before, 35.75% said never, while 18.93% of the participants answered often.

- 48.59% of the participants sometimes have experienced being fidgety or restless in the past 6 months in comparison to before, 29.59% said never, while 21.83% of the participants answered often.
- 74.69% of the participants never have experienced harmful or suicidal thoughts in the past 6 months after the crisis, 18.42% said sometimes, while 6.89% of the participants answered often.
- 51.99% of the participants sometimes have taken less care of their hygiene and appearance in the past 6 months in comparison to before, 28.93% said never, while 19.07% of the participants answered often.
- 52.15% of the participants sometimes have felt less tolerant or communicative with their spouse in the past 6 months after the crisis, 29.79% said never, while 18.06% of the participants answered often.
- 48.63% of the participants sometimes have felt that the support they were receiving from their spouse was not enough in the past 6 months after the crisis, 35.81% said never, while 15.56% of the participants answered often.

	Never	Sometimes	Often
Did you experience more difficulty going to work in the past 6 months in comparison to before the crisis?	23.93%	46.63%	29.44%
Did you experience more difficulty taking care of things at home in the past 6 months in comparison to before?	15.88%	51.20%	32.92%
Did you have trouble getting along with other people in the past 6 months after the crisis?	22.04%	51.05%	26.90%
Did you feel less interest or no pleasure in doing activities in the past 6 months in comparison to before?	21.25%	48.30%	30.46%
Did you feel down or depressed in the past 6 months in comparison to before?	14.29%	47.64%	38.07%
Did you feel hopeless in the past 6 months in comparison to before?	14.00%	46.63%	39.38%
Did you feel nervous in the past 6 months in comparison to before?	12.26%	48.73%	39.01%
Did you feel anxious about daily life in the past 6 months after the crisis?	10.01%	46.56%	43.44%

Have you had changes in your sleep in the past 6 months in comparison to before? (Trouble sleeping, difficulty waking up, sleeping too much, or interrupted sleep, nightmares)?	22.99%	50.04%	26.98%
Did you feel tired or have little energy in the past 6 months in comparison to before?	14.07%	50.62%	35.32%
Did you experience poor appetite or overeating in the past 6 months in comparison to before?	25.24%	50.18%	24.58%
Did you feel that you are a failure or that you let yourself or your family down in the past 6 months in comparison to before?	29.15%	48.15%	22.70%
Did you have trouble concentrating on things in the past 6 months in comparison to before?	23.42%	53.01%	23.57%
Did you experience being slow in moving or speaking in the past 6 months in comparison to before?	35.75%	45.32%	18.93%
Did you experience being fidgety or restless in the past 6 months in comparison to before?	29.59%	48.59%	21.83%
Did you experience harmful or suicidal thoughts in the past 6 months after the crisis?	74.69%	18.42%	6.89%
Did you take less care of your hygiene and appearance in the past 6 months in comparison to before?	28.93%	51.99%	19.07%
Did you feel less tolerant or communicative with your spouse in the past 6 months after the crisis?	29.79%	52.15%	18.06%
Did you feel that the support you were receiving from your spouse was not enough in the past 6 months after the crisis?	35.81%	48.63%	15.56%

Table 32 Information about the respondent's mental health

Calculation of the scores

Early Childhood development

This component contains specific number according to each age category. If a participant answered Yes on 1 item, his score will be 1, while it will be zero when the participant answered "No" or "I don't know." The below table explains the scores for each age category.

Age category	Number of items	Min score	Max score	Mean	Mean %
0 to 3 months	11	0	11	6.14	55.82%
4-6 months	10	0	10	6.77	67.70%
7-9 months	13	0	13	9.81	75.46%
10-12 months	14	0	14	7.38	52.71%
1 to 2 years	10	0	10	5.74	57.40%

2 to 3 years	15	0	15	6.08	40.53%
3 to 4 years	19	0	19	11.34	59.68%
4 to 5 years	19	0	19	13.35	70.26%
5 to 8 years	14	0	14	10.92	78.00%

Mean % = Mean / Number of items

Table 33 Scores of ECD levels

The below table will be used for the interpretation:

Percentage	Interpretation
0-50 %	Very poor
51-60 %	Poor
61-70 %	Fair
71-80 %	Good
81-100 %	Very good

The mean in percentage was used to unify the mean since each age category has different number of items. The results show the following:

- 0 to 3 months: The mean equal 6.14 (Mean % = 55.82%), which indicates that the ECD level for this age category is poor.
- 4 to 6 months: The mean equal 6.77 (Mean % = 67.70%), which indicates that the ECD level for this age category is fair.
- 7 to 9 months: The mean equal 9.81 (Mean % = 75.46%), which indicates that the ECD level for this age category is good.
- 10 to 12 months: The mean equal 7.38 (Mean % = 52.71%), which indicates that the ECD level for this age category is poor.
- 1 to 2 years: The mean equal 5.74 (Mean % = 57.40%), which indicates that the ECD level for this age category is poor.
- 2 to 3 years: The mean equal 6.08 (Mean % = 40.53%), which indicates that the ECD level for this age category is very poor.
- 3 to 4 years: The mean equal 11.34 (Mean % = 59.68%), which indicates that the ECD level for this age category is poor.
- 4 to 5 years: The mean equal 13.35 (Mean % = 70.26%), which indicates that the ECD level for this age category is good.
- 5 to 8 years: The mean equal 10.92 (Mean % = 78.00%), which indicates that the ECD level for this age category is good.

Inferential Statistics

In this part the aim is to study the effect of the independent items or variables of the demographics and variables in other sections on the scores of ECD. Therefore, Independent sample t-test and ANOVA test are used to compare the ECD scores according to the independent items.

Normally, we compare Sig or P-value with Alpha which is the error rate, where Sig is a probability between 0 and 1, and Alpha (α) is a constant value equal to 0.05.

1. Demographics

A. Nationality

The results in below table indicate that nationality has significant effect on the following ECD scores:

- ECD for the category 4 to 6 months: The level of ECD for the Lebanese babies 73.46% is higher than the level of ECD for the Syrian babies 51.11%, *F = 4.194, Sig = 0.049 < 5%.*
- ECD for the category 1 to 2 years: The level of ECD for the Palestinian toddlers 73.33% is higher than the level of ECD for the Lebanese toddlers 67.59% and the Syrian toddlers 40.95%, *F = 5.422, Sig = 0.007 < 1%.*
- ECD for the category 2 to 3 years: The level of ECD for the Lebanese toddlers 52.75% is higher than the level of ECD for the Syrian toddlers 32.00% and the Palestinian toddlers 22.67%, *F = 12.365, Sig = 0.000 < 1%.*
- ECD for the category 3 to 4 years: The level of ECD for the Lebanese kids 68.22% is higher than the level of ECD for the Syrian kids 45.90% and the Palestinian kids 36.84%, *F = 18.194, Sig = 0.000 < 1%.*
- ECD for the category 4 to 5 years: The level of ECD for the Lebanese kids 74.17% is higher than the level of ECD for the Palestinian kids 71.35% and the Palestinian kids 61.50%, *F = 14.978, Sig = 0.000 < 1%.*
- ECD for the category 5 to 8 years: The level of ECD for the Lebanese kids 84.12% is higher than the level of ECD for the Palestinian kids 81.00% and the Palestinian kids 61.86%, *F = 61.427, Sig = 0.000 < 1%.*

Age category	Mean ECD %			F	Sig
	Lebanese	Syrian	Palestinian		
0 to 3 months	59.85%	59.50%	38.18%	1.129	0.339
4-6 months	73.46%	51.11%		4.194	0.049*
7-9 months	76.41%	80.00%	46.15%	3.038	0.067

10-12 months	59.74%	37.14%		2.779	0.118
1 to 2 years	67.59%	40.95%	73.33%	5.422	0.007**
2 to 3 years	52.75%	32.00%	22.67%	12.365	0.000**
3 to 4 years	68.22%	45.90%	36.84%	18.194	0.000**
4 to 5 years	74.17%	61.50%	71.35%	14.978	0.000**
5 to 8 years	84.12%	61.86%	81.00%	61.427	0.000**

* Significant at level 5%, ** Significant at level 1%

Table 34. Scores of ECD levels according to Nationality

B. Marital status

The results in table 35 indicate that marital status has significant effect on the following ECD score:

- ECD for the category 5 to 8 years: The level of ECD for the kids who their parents are married 79.12% is higher than the levels of ECD for the other kids (48.98% Single, 78.25% other), *F = 18.543, Sig = 0.000 < 1%.*

Age category	Mean ECD %			F	Sig
	Married	Single	Other		
0 to 3 months	57.34%		36.36%	0.961	0.336
4-6 months	68.82%	30.00%		1.716	0.199
7-9 months	75.96%	84.62%	65.38%	0.378	0.689
10-12 months	55.24%	14.29%		2.438	0.141
1 to 2 years	59.39%	43.33%	0.00%	2.085	0.135
2 to 3 years	40.14%	48.57%	20.00%	0.666	0.516
3 to 4 years	60.50%	31.58%	52.63%	1.760	0.176
4 to 5 years	70.25%	68.11%	74.09%	0.275	0.760
5 to 8 years	79.12%	48.98%	78.25%	18.543	0.000**

* Significant at level 5%, ** Significant at level 1%

Table 35 Scores of ECD levels according to Marital status

C. Education level

The results in below table indicate that education level has significant effect on the following ECD scores:

- ECD for the category 2 to 3 years: The level of ECD for the toddlers where the respondents have university degree was the highest (60.74%), while it was the lowest for the toddlers where the respondents can read and write (23.08%), *F = 8.588, Sig = 0.000 < 1%.*
- ECD for the category 3 to 4 years: The level of ECD for the kids where the respondents have secondary degree was the highest (71.58%), while it was

the lowest for the kids where the respondents can read and write (39.07%), *F = 8.970, Sig = 0.000 < 1%.*

- ECD for the category 4 to 5 years: The level of ECD for the kids where the respondents have university degree was the highest (83.00%), while it was the lowest for the kids where the respondents are illiterate (53.72%), *F = 13.588, Sig = 0.000 < 1%.*
- ECD for the category 5 to 8 years: The level of ECD for the kids where the respondents have university degree was the highest (89.13%), while it was the lowest for the kids where the respondents can read and write (65.41%), *F = 24.032, Sig = 0.000 < 1%.*

Age category	Mean ECD %						F	Sig
	Illiterate	Can read and write	Elementary	Complementary	Secondary or equivalent	University		
0 to 3 months	75.00%	43.18%	57.58%	47.27%	66.67%	51.52%	0.652	0.663
4-6 months	55.00%	55.00%	80.00%	80.00%	70.00%	62.86%	0.809	0.553
7-9 months	71.79%	63.74%	82.05%	92.31%	89.74%	66.67%	2.556	0.059
10-12 months		39.29%		67.86%	50.00%	52.86%	0.342	0.796
1 to 2 years	61.11%	42.78%	60.00%	46.00%	62.00%	75.71%	2.035	0.091
2 to 3 years	31.11%	23.08%	42.35%	43.59%	32.22%	60.74%	8.588	0.000**
3 to 4 years	54.25%	39.07%	56.29%	65.55%	71.58%	70.99%	8.970	0.000**
4 to 5 years	53.72%	63.39%	68.98%	69.62%	72.86%	83.00%	13.588	0.000**
5 to 8 years	66.71%	65.41%	72.81%	77.59%	87.46%	89.13%	24.032	0.000**

* Significant at level 5%, ** Significant at level 1%

Table 36. Scores of ECD levels according to Education level

D. Governorate of residence

The results in below table indicate that governorate of residence has significant effect on the following ECD scores:

- ECD for the category 4 to 5 years: The level of ECD for the kids who live in Nabatieh was the highest (79.88%), while it was the lowest for the kids who live in Mount Lebanon (63.16%), *F = 4.344, Sig = 0.000 < 1%.*
- ECD for the category 5 to 8 years: The level of ECD for the kids who live in Beirut was the highest (86.02%), while it was the lowest for the kids who live in Mount Lebanon (72.12%), *F = 4.344, Sig = 0.000 < 1%.*

Age category	Mean ECD %						F	Sig
	Beirut	Mount Lebanon	North	Beqaa	Nabatieh	South		
0 to 3 months	57.34%	81.82%	50.00%	69.70%	45.45%	9.09%	1.125	0.376
4-6 months	64.44%	45.00%	90.00%	65.83%		100.00%	2.660	0.052
7-9 months	66.15%	70.19%	92.31%	78.85%	73.08%	92.31%	1.033	0.424
10-12 months	60.20%	50.00%	7.14%	35.71%	78.57%		2.187	0.137
1 to 2 years	47.22%	58.89%	40.00%	66.36%	70.00%	73.33%	0.802	0.554
2 to 3 years	36.25%	37.71%	39.49%	52.82%	56.00%	44.44%	1.249	0.292
3 to 4 years	59.92%	53.91%	63.71%	66.80%	61.70%	36.84%	1.998	0.084
4 to 5 years	74.48%	63.16%	69.65%	68.09%	79.88%	67.22%	4.344	0.001**
5 to 8 years	86.02%	72.12%	77.20%	73.59%	89.48%	77.89%	8.551	0.000**

* Significant at level 5%, ** Significant at level 1%

Table 37. Scores of ECD levels according to Governorate of residence

E. Type of household

The results in below table indicate that governorate of residence has significant effect on the following ECD scores:

- ECD for the category 0 to 3 months: The level of ECD for the babies who live in shared room was the highest (81.82%), while it was the lowest for the babies who live in other types of households (9.09%), *F = 3.567, Sig = 0.021 < 1%.*
- ECD for the category 4 to 5 years: The level of ECD for the kids who live in apartments was the highest (78.61%), while it was the lowest for the kids who live in other types of households (50.00%), *F = 12.840, Sig = 0.000 < 1%.*
- ECD for the category 5 to 8 years: The level of ECD for the kids who live in apartments was the highest (83.00%), while it was the lowest for the kids who live in tents (52.92%), *F = 18.520, Sig = 0.000 < 1%.*

Age category	Mean ECD %					F	Sig
	Apartment	House	Shared room	Tent	Other		
0 to 3 months	65.15%	37.50%	81.82%	48.48%	9.09%	3.567	0.021*
4-6 months	72.50%	68.24%		40.00%	73.33%	1.027	0.394
7-9 months	78.63%	75.82%	73.08%	61.54%		0.414	0.745
10-12 months	53.57%	52.14%				0.010	0.921
1 to 2 years	60.38%	60.45%	28.00%			2.464	0.095
2 to 3 years	44.21%	41.45%	29.23%	15.56%	80.00%	2.236	0.071
3 to 4 years	63.27%	60.53%	44.50%	40.35%		2.652	0.052
4 to 5 years	78.61%	69.31%	53.57%	51.93%	50.00%	12.840	0.000**

5 to 8 years	83.00%	79.17%	55.80%	52.92%	71.43%	18.520	0.000**

* Significant at level 5%, ** Significant at level 1%

Table 38. Scores of ECD levels according to types of households

F. Number of people who live in the household

For the relation between the scores and the number of people who live in the household, Spearman rho correlation test is used to study these relationships. In the correlation, we recall that a Sig value less than 0.05 connotes a significant relationship between two variables and vice versa.

Correlation coefficients range in value from –1 (a perfect negative relationship) and +1 (a perfect positive relationship). A value of 0 indicates no linear relationship.

Correlation below 0.4 is considered Weak

Correlation between 0.4 and 0.6 is considered Moderate

Correlation above 0.6 is considered Strong

The results in below table indicate that number of people who live in the household has significant correlation with the following ECD scores:

- ECD for the category 10 to 12 months: The level of ECD for this age category is strongly and negatively correlated with the number people who live in the household, which indicates that the level of ECD decreases when the number of people who live in the household increases, *Correlation rho = -0.632, Sig = 0.009 < 1%.*
- ECD for the category 1 to 2 years: The level of ECD for this age category is weakly and negatively correlated with the number people who live in the household, which indicates that the level of ECD decreases when the number of people who live in the household increases, *Correlation rho = -0.375, Sig = 0.006 < 1%.*
- ECD for the category 3 to 4 years: The level of ECD for this age category is weakly and negatively correlated with the number people who live in the household, which indicates that the level of ECD decreases when the number of people who live in the household increases, *Correlation rho = -0.252, Sig = 0.004 < 1%.*
- ECD for the category 4 to 5 years: The level of ECD for this age category is weakly and negatively correlated with the number people who live in the household, which indicates that the level of ECD decreases when the number of people who live in the household increases, *Correlation rho = -0.165, Sig = 0.001 < 1%.*

- ECD for the category 5 to 8 years: The level of ECD for this age category is weakly and negatively correlated with the number people who live in the household, which indicates that the level of ECD decreases when the number of people who live in the household increases, *Correlation rho = -0.215, Sig = 0.000 < 1%.*

	Correlation Coefficient	Sig
0 to 3 months	0.160	0.417
4-6 months	0.072	0.680
7-9 months	-0.119	0.556
10-12 months	-0.632	0.009**
1 to 2 years	-0.375	0.006**
2 to 3 years	-0.165	0.099
3 to 4 years	-0.252	0.004**
4 to 5 years	-0.165	0.001**
5 to 8 years	-0.215	0.000**

* Significant at level 5%, ** Significant at level 1%

Table 39 Correlation between Scores of ECD levels and number people who live in the household

G. Number of people under 8 years' old who live in the household

The results in below table indicate that number of people under 8 years' old who live in the household has significant correlation with the following ECD scores:

- ECD for the category 1 to 2 years: The level of ECD for this age category is weakly and negatively correlated with the number people under 8 years' old who live in the household, which indicates that the level of ECD decreases when the number of people who live in the household increases, *Correlation rho = -0.325, Sig = 0.017 < 1%.*
- ECD for the category 4 to 5 years: The level of ECD for this age category is weakly and negatively correlated with the number people under 8 years' old who live in the household, which indicates that the level of ECD decreases when the number of people who live in the household increases, *Correlation rho = -0.146, Sig = 0.003 < 1%.*
- ECD for the category 5 to 8 years: The level of ECD for this age category is weakly and negatively correlated with the number people under 8 years' old who live in the household, which indicates that the level of ECD decreases when the number of people who live in the household increases, *Correlation rho = -0.218, Sig = 0.000 < 1%.*

	Correlation Coefficient	Sig

0 to 3 months	-0.112	0.569
4-6 months	0.147	0.398
7-9 months	0.098	0.628
10-12 months	-0.067	0.804
1 to 2 years	-0.325	0.017*
2 to 3 years	-0.037	0.711
3 to 4 years	-0.131	0.142
4 to 5 years	-0.146	0.003**
5 to 8 years	-0.218	0.000**

* Significant at level 5%, ** Significant at level 1%

Table 40. Correlation between Scores of ECD levels and number people under 8 years' old who live in the household

H. Disability

The results in below table indicate that disability has significant effect on the following ECD scores:

- ECD for the category 4 to 5 years: The level of ECD for the kids with disability 73.12% is higher than the level of ECD for the other kids (Kids with no disability = 71.38%, 54.33% for the kids who their parents preferred not to answer), *F = 9.170, Sig = 0.000 < 1%.*
- ECD for the category 5 to 8 years: The level of ECD for the kids with no disability 80.06% is higher than the level of ECD for the other kids (Kids with disability = 70.15%, 52.46% for the kids who their parents preferred not to answer), *F = 24.131, Sig = 0.000 < 1%.*

Age category	Mean ECD %			F	Sig
	Yes	No	No answer		
0 to 3 months	100.00%	54.18%	54.55%	1.209	0.315
4-6 months	85.00%	69.62%	44.00%	2.572	0.092
7-9 months	76.92%	76.22%	65.38%	0.285	0.755
10-12 months		56.63%	25.00%	2.771	0.118
1 to 2 years	74.00%	56.17%	30.00%	1.082	0.347
2 to 3 years	46.67%	40.15%	37.33%	0.272	0.763
3 to 4 years	46.71%	60.74%	57.89%	1.336	0.267
4 to 5 years	73.12%	71.38%	54.33%	9.170	0.000**
5 to 8 years	70.15%	80.06%	52.46%	24.131	0.000**

* Significant at level 5%, ** Significant at level 1%

Table 41 Scores of ECD levels according to Disability

The results demonstrate that kids between 4 and 5 years with sensory disability have lower score of ECD 51.32%, comparing with kids with no sensory disability (ECD = 75.76%), t = 2.184, Sig = 0.036 < 5%.

J. Chronic disease

The results in below table indicate that chronic disease of the kids has significant effect on the following ECD scores:

- ECD for the category 10 to 12 months: The level of ECD for the babies with no chronic disease 58.67% is higher than the level of ECD for the kids who their parents preferred not to answer 10.71%, *F = 8.572, Sig = 0.011 < 5%.*
- ECD for the category 5 to 8 years: The level of ECD for the kids with no chronic disease 79.35% is higher than the level of ECD for the other kids (Kids with chronic disease = 71.75%, 57.14% for the kids who their parents preferred not to answer), *F = 11.226, Sig = 0.000 < 1%.*

Age category	Mean ECD %			F	Sig
	Yes	No	No answer		
0 to 3 months	95.45%	54.91%		4.714	0.058
4-6 months	85.00%	67.67%	56.67%	0.538	0.589
7-9 months	73.08%	74.83%	100.00%	0.849	0.440
10-12 months		58.67%	10.71%	8.572	0.011*
1 to 2 years	46.67%	58.00%		0.352	0.556
2 to 3 years	48.00%	40.44%	34.67%	0.337	0.715
3 to 4 years	55.56%	59.96%	60.53%	0.146	0.865
4 to 5 years	70.24%	70.68%	64.91%	0.857	0.425
5 to 8 years	71.75%	79.35%	57.14%	11.226	0.000**

* Significant at level 5%, ** Significant at level 1%

Table 42 Scores of ECD levels according to chronic disease of the kids

K. Receiving appropriate medical follow-up

The results in below table indicate that receiving appropriate medical follow-up has significant effect on the following ECD scores:

- ECD for the category 4 to 6 months: The level of ECD for the babies who are receiving easily appropriate medical follow-up was the highest 94.00%, while it was the lowest for the kids who are not receiving appropriate medical follow-up (49.00%), *F = 3.596, Sig = 0.024 < 5%.*
- ECD for the category 3 to 4 years: The level of ECD for the kids who are receiving easily appropriate medical follow-up was the highest 71.17%, while it was the

lowest for the kids who their parents preferred not to answer (42.11%), *F = 3.276, Sig = 0.023 < 5%.*

- ECD for the category 5 to 8 years: The level of ECD for the kids who are receiving easily appropriate medical follow-up was the highest 85.85%, while it was the lowest for the kids who their parents preferred not to answer (64.84%), *F = 8.035, Sig = 0.000 < 1%.*

Age category	Mean ECD %				F	Sig
	Yes, easily	Yes, with difficulty	No	Prefer not to say		
0 to 3 months	43.43%	62.73%	60.61%		1.237	0.308
4-6 months	94.00%	72.22%	49.00%	55.00%	3.596	0.024*
7-9 months	77.88%	78.21%	68.13%		0.679	0.517
10-12 months	64.29%	62.24%	42.86%		1.111	0.359
1 to 2 years	62.00%	57.92%	55.00%	40.00%	0.195	0.900
2 to 3 years	56.19%	41.09%	34.41%	32.38%	2.685	0.051
3 to 4 years	71.17%	58.83%	56.73%	42.11%	3.276	0.023*
4 to 5 years	76.83%	69.59%	67.87%	71.68%	2.397	0.068
5 to 8 years	85.85%	77.68%	75.28%	64.84%	8.035	0.000**

* Significant at level 5%, ** Significant at level 1%

Table 43 Scores of ECD levels according to receiving appropriate medical follow-up

L. Difficulty accessing medication

The results in below table indicate that difficulty accessing medication has significant effect on the following ECD scores:

- ECD for the category 3 to 4 years: The level of ECD was the highest for the kids who didn't need any medicine 69.92%, while it was the lowest for the kids who their parents preferred not to answer (27.63%), *F = 4.260, Sig = 0.007 < 1%.*
- ECD for the category 4 to 5 years: The level of ECD was the highest for the kids who didn't need any medicine 79.33%, while it was the lowest for the kids who their parents preferred not to answer (65.33%), *F = 6.857, Sig = 0.000 < 1%.*
- ECD for the category 5 to 8 years: The level of ECD was the highest for the kids who didn't need any medicine 86.70%, while it was the lowest for the kids who their parents preferred not to answer (53.57%), *F = 11.893, Sig = 0.000 < 1%.*

Age category	Mean ECD %				F	Sig
	Yes	No	Didn't need any medicine	Prefer not to say		
0 to 3 months	56.64%	69.70%	40.91%	81.82%	1.499	0.240

4-6 months	72.86%	50.00%	50.00%	43.33%	1.511	0.231
7-9 months	74.77%		84.62%		0.477	0.496
10-12 months	54.76%	71.43%	28.57%	14.29%	1.443	0.279
1 to 2 years	58.16%	58.57%	55.00%	45.00%	0.116	0.950
2 to 3 years	40.46%	45.00%	45.19%	27.62%	0.802	0.496
3 to 4 years	58.13%	66.67%	69.92%	27.63%	4.260	0.007**
4 to 5 years	67.75%	77.94%	79.33%	65.33%	6.857	0.000**
5 to 8 years	76.56%	79.93%	86.70%	53.57%	11.893	0.000**

* Significant at level 5%, ** Significant at level 1%

Table 44 Scores of ECD levels according to difficulty accessing medication

M. Receiving the mandatory vaccine shots

The results in below table indicate that receiving the mandatory vaccine shots has significant effect on the following ECD scores:

- ECD for the category 4 to 5 years: The level of ECD for the kids who received their mandatory vaccine shots 71.83% is higher than the level of ECD for the other kids (Kids who didn't receive it = 64.68%, 67.37% for the kids where the respondents don't know if they did take it or not), *F = 3.492, Sig = 0.031 < 5%.*
- ECD for the category 5 to 8 years: The level of ECD for the kids who received their mandatory vaccine shots 80.72% is higher than the level of ECD for the other kids (Kids who didn't receive it = 73.60%, 47.52% for the kids where the respondents don't know if they did take it or not), *F = 27.872, Sig = 0.000 < 1%.*

Age category	Mean ECD %			F	Sig
	Yes	No	Don't know		
0 to 3 months	51.87%	60.00%	81.82%	0.639	0.536
4-6 months	69.58%	65.00%	50.00%	0.259	0.774
7-9 months	77.73%	72.53%	53.85%	0.837	0.445
10-12 months	58.44%	46.43%	14.29%	1.508	0.258
1 to 2 years	64.05%	41.54%	43.33%	2.894	0.065
2 to 3 years	43.79%	33.33%	39.17%	1.651	0.197
3 to 4 years	61.89%	50.69%	44.74%	2.678	0.073
4 to 5 years	71.83%	64.68%	67.37%	3.492	0.031*
5 to 8 years	80.72%	73.60%	47.52%	27.872	0.000**

* Significant at level 5%, ** Significant at level 1%

Table 45 Scores of ECD levels according to receiving the mandatory vaccine shots

9. Discussion of the Main Findings

Results of this report are aligned with previous research work done in Lebanon by academic researchers and international non-governmental organizations. In the next section, an overview analysis of the FGD and families' interview is presented.

a. Focus group discussion analysis

On the national level (5 governorates) the 5 FDG tendency was a major decline of educational ECD. Teachers found that the "online experience" was oppressive for students, parents, and the instructors while reducing mental and psychological performances of all parties. Parents and caregivers focused on the big regression of their economic power and income making it hard to meet the basic needs. Healthcare providers mentioned the resurfacing of medical cases that were considered quite rare like meningitis, along with gastroenteritis and medicine and baby milk shortages.

On governate level, the FDG inputs of parents, teachers, and healthcare givers, showed that none of the five governorates seems to be spared from the impacts of the dual crisis. All governorates are witnessing a rising deprivation in the areas of health care, medicines, services, education, employment, housing, and assets. The situation is similarly desperate on children in all governorates, and impacts are harsher on the poorest ones which are Bekaa and the North and where refugees' camps are numerous. Based on the discussions of the FDGs, even relatively richer governorates such as Beirut are affected by social and mental instability attacking adults and children. All governorates are experiencing interruptions that sometimes exceed 22 to 23 hours per day. The deteriorating economic and living conditions and increased poverty have exacerbated the brain drain of professionals, including healthcare providers and teachers.

Front of this situation, children of all regions are consciencely and unconsciously changing their behavior and temperament and stress management methods by being non interactive socially and prefer more screen time while reducing outdoor activities as reported by the FGDs.

b. Families' interviews analysis

The main results of the descriptive part of the 1379 interviews are analyzed according to the following sections: Demographics, early childhood development milestones, early childhood education, early childhood health, early childhood nutrition, early childhood social and emotional development, changes brought by the pandemic/economic crisis, child's mental health, and respondent's mental health.

c. Demographics

The nationalities mix of the families' sample represents an idea of the actual repartition of these nationalities across the nation. While Lebanese were the highest percentage (62%), the presence of Syrian (30%) and Palestinian refugees (8%) is not to be ignored when tackling ECD policies or action on the national level of Lebanon.

As mentioned in the literature review, the educational level of the parents or caregivers has a direct influence on children and the ECD. While 39% have had secondary and higher education, the majority 61% are of a complementary level education or below, of which 9% are illiterate.

The results in Table 1 demonstrate that 47.93% of the participants are the mothers, 46.34% are the fathers, 3.77% are the relatives, while 1.96% of the participants are the caregivers. For the gender of the participants, 52.14% are females, 47.28% are males, however, 0.58% of the participants preferred not to give information about their gender.

Regarding the nationality, the results show that 62.07% of the participants are Lebanese, 30.31% are Syrian, 7.54% are Palestinian, while one of the participants are from Jordan.

For the age, 39.16% of the participants are aged between 36 and 45 years, 29.44% between 31 and 35 years, 17.33% between 23 and 30 years, 8.27% between 46 and 55 years, 2.32% between 19 and 22 years, 1.96% between 15 and 18 years, while 1.52% of the participants are aged 56 years and above.

Concerning the marital status, the results reveal that most of the participants are married (92.75%), 3.84% are single, 1.96% are divorced or separated, 1.31% are widowed, though, 0.15% (2 participants) are missing their partners.

For the education level, 24.66% of the participants have university degree, 21.17% can read and write, 15.66% have finished the elementary level, 14.79% the complementary level, and 14.36% the secondary level, while 9.35% of the participants are illiterate.

The results in Table 2 indicate that 22.26% of the families are living in Mount Lebanon, 20.96% in Bekaa, 18.85% in North, 18.78% in Beirut, 11.24% in Nabatieh, while 7.90% of the families are living in South. 55.98% of these families are living in houses, 32.63% in apartments, 6.89% in shared rooms, 3.70% in tents, 0.44% in studio, while 0.36% of the families are living in other places.

For the number of people who are living in the household, the results indicate that 30.96% of the households are consisting of 4 peoples, 25.67% 5 peoples, 15.74% 7 peoples and more, 14.94% 6 peoples, 12.04% 3 peoples, and 0.96% of the households are consisting of 2 peoples. Concerning the number of children under 8 years, 40.90% of the households have 2 children under 8 years, 31.54% one child, 17.33% 3 children, 5.80% 4 children, 2.54% 7 children and more, 1.02% 5 children, whereas 0.87% of the households have 6 children under 8 years.

The results in Table 3 demonstrate that 32.34% of the respondents are not employed, 28.79% are full time employees, 16.24% are part time employees, 15.74% are self-

employed, 4.28% are temporary employees, while 2.61% of the participants are seasonal employees. The results also show that 67.08% of the participants didn't have to separate from the family because of work, 21.75% the father, 4.86% preferred not to answer, 3.26% the mother, 2.47% the father and the mother at the same time, while 0.58% of the participants indicate that the caregivers must separate from the family because of work.

Concerning the family income last month, 30.75% of the families have earned between 1'000'000 - 2'000'000 LBP, 27.92% between 2'000'000 - 4'000'000 LBP, 16.17% between 500'000 - 1'000'000 LBP, 11.09% between 4'000'000 - 7'800'000 LBP, 7.98% between 0 - 500'000 LBP, while 6.09% of the families have earned more than 7'800'000 LBP last month.

The results reveal that 69.54% of the participants didn't receive any monetary contributions or gifts that included rent or utility payments from someone who does not live with them, 27.48% have received this kind of help, while 2.97% of the participants preferred not to answer.

d. Early childhood development milestones

A common trait in the answers of this section is that there is a relatively high percentage of "Don't know" answers which reached on some questions related to the attention of the caregiver to the child more than, 14% for the 0-3 months stage, 17% for the 4-6 months stage, 11% for the 7-9 months stage, 31% in for the 10-12 months stage, 9% for the 1-2 years stage, 12% for the 2-3 years stage, 18% for the 3-4 years stage, 14% for the 4-5 years stage, and 9% for the 5-8 years stage. This is a delicate part of childhood when children need a lot of the care and nurturing of their caregivers. It was noticeable that the percentages of this answer are lower in the age groups of 4 to 5 years and 5 to 8 years. Despite few clear-cut answers (yes or no) over all the age groups, lack of knowledge and not paying enough attention among the sample (Do not know) reflects gaps in adult education and awareness on ECD.

Not all the children have access to education, especially because their families didn't have the ability to cover the tuition and the transportation fees, and most do not receive any external support to cover the fees. More than 50% of the families were paying more than 300 000 LBP as transportation fees to the day care/kindergarten/school per month.

Most of the families couldn't ensure appropriate medical follow-up for their kids due to high fees of the visits and the transportation.

The ability to have enough to eat daily has changed for half of the families, also the quality of meals that the family consumes has been adjusted for most of them. Most kids of all age groups didn't receive any new toy for more than 3 months.

For most of the families, the household income has decreased comparing to one year earlier as most of the participants confirmed that the household lost one or more of the jobs since the outbreak of COVID 19 and the economic crisis; and more than half took debts to cover their basic needs in the last 30 days from data collection, or reduced the

expenses on Education, Food, and Transportation during the last year. Most of the respondents confirmed that the provision of clothes for the family members reduced during the last year.

e. Early childhood education

An alarming 53% of children, of all age groups of the sample, had access to face to face or remote learning leaving a big gap to reach the target of quality education for all. In terms of advancing ECD on the national more effort is to be deployed to increase this percentage under multi-crisis environments.

The role of family structure and solidarity is essential in ECD as the highest percentage of educational fees aid comes from relatives followed by NGOs. In the coming academic year, things will get worse as fewer families reported being unable to cover the fees in full.

In the case of inability to cover the fees, an alarming 23% are ready to drop their kid out of school. This indicator is alarming and has a negative significance on the development of healthy ECD in education which leads to low expectations in all ECD domains.

Half of the kids of the sample had negative learning performance relatively to previous years. Different factors such as having multiple interruption and school closures, rushing to finish the curriculum, lack of proper follow-up from the school's side and decrease in the teachers' performance, were reported by the families leading to a difficulty of information assimilation and a general lack of interest in school.

f. Early childhood health

In early childhood, poor health, is associated in general with poorer cognitive development and negative long-term schooling outcomes. Following up with medical check-ups has become more difficult recently with the exacerbation of the economic crisis and the COVID-19 pandemic. Around 60% of the sample was late to the regular child medical check-ups or did not go on any checkup, suggesting a certain degree of indifference and low awareness of the caregivers despite the high fees of consultation and transportation. A child health should not be compromised due to financial incapability. On the other hand, a double barrier of price and accessibility to medicaments is being faced in Lebanon where more than 71% are facing difficulties accessing the right medication for their kids. More people are relying on extra national sources for their medication which may compromise the quality of the treatment.

The gap between fully vaccinated kids which represent 75% of the total and non-fully vaccinated ones show a poor performance of the health sector stakeholders on the national level such as the Ministry of Health, health related NGOs, local communities, etc.…

g. Early childhood nutrition

While it was proved that breastfeeding in infancy reduces children's risk for childhood obesity also points to the importance of early environmental experiences in physical development (the advancements and refinements of motor skills, or, in other words, children's abilities to use and control their bodies), 55% of babies under 2 years are not being breastfed compensating the nutritional values of mothers' milk by fortified or special pharmaceutical milks which are becoming rare and expensive.

Access to safe drinking water is a natural human right that must be met everywhere. Despite that, 78% believe that their children are drinking clean water, mainly from bottled water or local sources, while the rest are aware that this is not the case. Recently, in north Lebanon, massive water pollution has been reported and led to numerous child poisoning and death.

The results show a clear shift in the food regime accessibility, quantity, and quality. A major adjustment of meals quality has been noticed exposing children to higher risks of malnutrition, obesity or poisoning while the quantity and frequency of meals has been reduced in more than 50% of the families, especially that only a quarter of the families received food assistance recently.

h. Early childhood social and emotional development

Research has shown that longer hours of screen time are negatively associated with children's healthy development. For instance, too much screen time inhibits young children's ability to read faces and learn social skills. The children in the sample are moderately using technology screens. Although there are 16% of children of all ages of the sample who does not spend time on screen, and 41% who are in the limit of 2 hours daily (but prone to increase in 38% of the cases) a 15% exceeds daily limits and even reaches extremes such as 11 hours of screen time or more. The main two reasons for screen time increase are the remote learning tools and the availability of extra free time due to discontinuity of classes and decrease of outdoor activities due to financial crisis.

Another related danger on ECD is the quality of the material presented during these screen times, where only 62% of the content is monitored by caregivers, leaving the rest, vulnerable to various kinds of uncontrolled exposition of contents.

In comparison, the outdoor play time has been reduced (42%) in two folds the sample than it has increased (20%) and it has been noted that playtime can be variably distributed with friends (with an average of 1 hour and a half per day) or alone.

An alarming 57% of the children does not read which can have a serious repercussion on their cognitive abilities. Although heritable in a substantial proportion, promoting reading and learning is an important support of cognitive development, and an important indicator of parenting practices, despite their educational level.

i. Changes brought by the pandemic/economic crisis

The economic crisis coupled by the pandemic has been fatal on more than 80% of the sample who undergone a major income decrease or purchasing power compared to the previous year, especially with losing jobs in 67% of the cases and relying on credits and depts in 65% of the cases to cover their basic needs.

Although not sustainable, 39% were obliged to sell inheritance or property to fill the financial gap caused by the economic collapse, which appears to be worsening day after another putting more pressure of the financial capabilities of families and limiting educational, nutritional, and recreational budgets, thus jeopardizing children development under such conditions.

Often, families adapt to such situations by finding a second job or being far from home for a longer time due to more remuneration which pushed 8% of the sample to change their home location to be closer to work. All of this affects the ECD process and deprive the child from quality time with one or both of his parents at the expense of a higher purchasing power of essential needs.

In general, economic stressors affect parents, and children are affected by their parents. Children are not considered active in the model. Economical parental stress is exteriorized by an increase of 43% in violent behavior in their disciplinary methods used with their children and which involve shouting, hitting, spanking and other similar actions.

j. Child's mental health

If not mitigated, chronic stressful situations can become instantiated in parenting and child developmental trajectories that are maladaptive. Parenting stress transpires within parent–child dyads. The study focused on both sides to be able to assess specifically the consequences of stress on the developing child.

According to the interviews with parents and caregivers, the results reflect a general increase of 9% in the children's external stress behavior which reflected a change in the stability of their emotions and mental health. Although this percentage may

appear meagre, the researcher believes that all the crisis consequences and impacts are affecting much more than this proportion of children.

54.92% of the kids above 2 years sometimes start asking more questions about the crisis in the past 6 months, 56.07% sometimes express more distress and nagging in the past 6 months in comparison to before, 52.21% notice that the kid's personality and behavior being affected by the crisis, 55.25% sometimes felt sad, unhappy, tearful in the past 6 months in comparison to before. 49.92% sometimes seem to have less interest or pleasure in doing things, 50.25% never seemed to feel tired or to have little energy, 49.10% of the kids' ability to regulate their emotions in a new situation never changed in the past 6 months in comparison to before, 44.92% said sometimes, while 5.98% of the participants answered often.

Direct interviews with concerned children must be undertaken in future studies to be able to assess tangibly their mental and behavioral situation since a large part of the caregivers tend to hide their children's weaknesses and negative behavioral changes. Whether admitted or not by the parents, the current national situation of economic crisis and pandemic is affected child mental health and endangering a descent ECD path. Future studies can validate or dismiss this hypothesis.

k. Respondent's mental health

The sociocultural and physical environment in which the parent and child are embedded sets the stage for many aspects of the stress and coping parents will experience. The current report shows clearly that the parents' level of change in stressful behavior is three times (27%) in comparison with the change expressed in children. This reveal the internal stress management that the parents and care providers are trying to do by creating a buffering gap between the stressor and their children. Anxiousness was reported as the behavioral change that was most in increase, directly affecting child development care, personal health, work life, sleep time, energy, appetite, concentration, and social life.

For instance, comparing the past 6 months period to the period before the crisis the research reached the following findings:

46.63% of the participants have experienced more difficulty going to work, 51.20% have experienced more difficulty taking care of things at home, 51.05% have had trouble getting along with other people, 48.30% have felt less interest or no pleasure in doing activities, 47.64% have felt down or depressed in the past 6 months in comparison to before, 46.63% have felt hopeless, 48.73% have felt, 50.04% had changes in their sleep habits, 50.62% have felt tired or have little energy, 48.15% have felt that they are a failure or that they let themselves or their families down, 53.01% had trouble concentrating on things, 74.69% of the participants never have experienced harmful or suicidal thoughts, 51.99% have took less care of their hygiene and appearance, 52.15% have felt less tolerant or communicative with their spouse, 48.63% have felt that the support they were receiving from their spouse.

10. Final notes

On the educational level, the results of the different data collection tools showed that the impacts on families are harder to take in crisis times than in normal ones. The increase of unemployment in the sampled population along with family ongoing decrease of purchase power combined with weak distance learning practices and habits, led to a much less child interaction and learning potential than in normal times and conditions. Although many kids coped with this change and adapted suitably, others faced difficulties to follow on due to long screen concentration problems and technical issues. This also affected parents, were the aggravated situation at the household was translated through struggles in paying schools tuition or the day care center fees. Although teachers' performance in the distance learning experience varied depending on the grade and the techniques used, it was also a subject of criticism of ability to convey the quality and quantity of required information to the kids under crisis conditions.

As short-term health impacts of the multi-crisis situation, kids have been late for some of their mandatory vaccinations due to COVID19 confinement. In some cases, the immunization agenda can be adjusted when things get back to normal, unless the child caught the contaminating agent which vaccination was skipped or postponed. Health services degraded on the national level, putting all the population, mainly the most vulnerable ones (children and elderly), under critical situations. For technical and financial reasons, focus was on COVID19 treatment and other health subjects were not as prioritized unless it is extremely urgent. To uncover any health-related impacts on the long term, monitoring stress signs of children must be done by following their physical biometrics (overweight, sleep time, appetite, etc.…) learning abilities, their personality change, their self-blame, and other indicators.

Despite the high mobilization of food helps in the different regions and communities, the quantity and quality of food that children were receiving undertook a major change. This was reported by more than half of the families, despite that some were still receiving food donations and nutritional aids. Local water quality stays questionable even though it was bottled water, because not all companies have good standards in testing and filling. While most prefer to give their kids bottled water which is a safe choice, other (16%) are aware that the water they give to their kids is not clean but are obliged to compromise due to lack of accessibility to clean water or to its high price.

Regarding screen time where remote education techniques were applied, it was normal that it increased. On the other hand, some associated the reason of the increase not only to education but also to the fact that kids had more free time and no games to play other than on screen or watch television due to lockdown. This limited the human-to-human social interaction of the young kids and exposed them to increased digital environments. The impact of the screen on kids was reported to be negative in general with behavioral change as low hearing and attention levels. In general, since the outdoor play time was reduced because of the pandemic, many kids were forced to play alone coupled with less play time spent with parents.

Kids mental status is influenced by a crisis depending on their age and on the nature of the crisis. The level of worry has slightly increase in the last 6 months among kids, while asking

more question about the crisis increased more. This may be since kids at low age don't realize completely the full aspects of the consequences of the crisis. They expressed their feelings by an increase of distress, nagging and sadness, and lose of interest or pleasure in doing things. Enuresis rate during the previous 6 months of the survey was mainly reported as usual with no change. The observed mental health impacts can be temporary and reversable to a considerable extent but, depending on the duration of the actual crisis, monitoring kids' mental performance, personality and behavior can reveal other impacts resulting from the current national crisis.

11. Limitation of the study

The report embraced many limitations presented as follows:

- First, schools from the five Governorates closed their doors when the data collection process started. This made it hard to reach out more participants.
- Second, online centers did not reach out the targeted number for a reliable filled out online questionnaires.
- Third, the 0-3 years old age group was hard to reach out since we were not able to set agreements with day care centers.

Recommendations for future research to avoid the limitations.

- Collect data before the end of the academic year,
- Reach out more day care centers to have more samples from the 0-3 age group,
- Sign agreements with online centers for specifying the targeted number of online questionnaires.

12. Conclusion

The findings of the current assessment report lead to several conclusions.

Concerning the first and third research questions in relation to the challenges facing families of children under eight during the multidimensional crisis in Lebanon and the related issues that may affect young children under eight and their families during crisis.

A. Not all the children have access to education, especially because their families didn't have the ability to cover the tuition and the transportation fees.
B. The majority of the families who can't cover the fees or partially can are not receiving any external support to cover the fees
C. The majority of the families won't be able to cover the fees at all or partially next year
D. More than 50% of the families were paying more than 300 000 LBP as transportation fees to the day care/kindergarten/school per month
E. The majority of the families didn't have the ability for their kids to receive appropriate medical follow-up

F. The families weren't able to ensure appropriate medical follow-up for their kids due to high fees of the visits and the transportation
G. The majority of the families had difficulties accessing medication to their kids because of the high prices and the lack of medication in Lebanon
H. The ability to eat enough have changed on a daily basis for half of the families, also the quality of meals that the family consumes have been adjusted for the majority of them
I. The majority of kids didn't receive any new toy since more than 3 months.
J. For the majority of the families, the household income has decreased comparing to one year earlier
K. More than half of the participants confirmed that the household lose one or more of the jobs since the outbreak of COVID 19 and the economic crisis
L. More than half of the participants said that their households take debt in the past 30 days to cover basic needs
M. More than half of the households reduced the expenses on Education/Food/Transportation during the last year
N. The majority of the respondents confirmed that the provision of clothes for the family members reduced during the last year

As for the second research question concerning the status of young children under eight in Lebanon in each ECD domain,

A. The kids aged between 2 and 3 years had very poor level of ECD
B. The kids aged between 0 to 3 months, 10 to 12 months, 1 to 2 years, and 3 to 4 years had poor level of ECD
C. The kids aged between 4 and 6 months had fair level of ECD
D. The kids aged between 7 to 9 months, 4 to 5 years, and 5 to 8 years had good level of ECD

Thus, several recommendations are suggested and will be discussed in section 9 under policy suggestions.

13. Policy suggestions and recommendations

This study suggests the following policy recommendations to advance building a comprehensive response to the growing population of local young children living in crisis and conflict.

National unified strategy: There is an urgent need of a unified early childhood development national strategy for emergencies and disasters rather than scattered local and international NGOs initiatives.

Social support mechanism: Living conditions are primary in ECD. An operational social support system is a crucial tool during crisis time, in advancing the livelihood of families while increasing the chances of opportunities for ECD.

Crisis ready services: The national strategy can include building ECD-focused emergency services into existing ones, such as nurseries, schools, health centers, community groups, and food distribution centers, and integrate young children and families into community

services wherever possible and with access to services and benefits that comply with not only basic needs, but also human rights.

Health awareness stimulation: During crisis times when normal alignment of priorities fails, health awareness related to regular follow ups should be largely stimulated to limit spread of diseases and illnesses which peaks during disasters. For instance, awareness on vaccination should be raised in kindergarten, schools, hospitals, clinics, municipalities, and other public places to ensure a maximum of fully vaccinated children.

Crisis behavioral training: Increase access to specialized trainings and workshops for early childhood educators, health workers, caregivers and emergency practitioners in different sectors working with 0 to 8 years age group to be trained on how to deal with the kids under crisis situations. Also, building on existing delivery platforms to support parents' capacity to provide responsive stimulation.

Filling baseline data gaps: to fulfil missing data gaps, additional and more frequent data collection on children's development in Lebanon plays a crucial role in assessing other areas where children's development is threatened and tracking progress in addressing these gaps.

ECD research center: Establish a national ECD research center involving all ECD related entities, that promotes ongoing research to better inform early childhood practices affecting children and families and normalize the collection of data on both child development and quality of implemented services in normal and crisis settings.

Promote family cohesion: Give priority to establishing family-centered early childhood programs for all young children affected by crisis and disaster appropriate to each context through initiatives that prevent family separation and promote family cohesion.

Home visiting programs: Home visiting programs, led by social professionals, may be set, and conducted during the different stages of crisis and focused on integrated stimulation, learning, health, nutrition, and mental health for those families experiencing the highest levels of adversity or trauma enabling them to achieve positive parenting and child development outcomes. This comprehensive and coordinated assessment of the needs of young children and their families may be subject of referrals across sectors to available services, with follow-up.

Equal opportunities: Any foreign non-Lebanese children (0 - 8 years) should have early development rights in health, nutrition, and education, like Lebanese children of the same age. Concrete efforts from the state, INGO, and policymakers must be made to give children equal opportunities for healthy development.

ECD crisis fund: Establish, outside emergency times, an alliance composed of private and public stakeholders (World Bank, UNICEF, and other INGO, as well as bilateral assistance, and others) to finance solutions for early childhood development under emergency situations. ECD crisis fund can help to rapidly have an emergency ECD budget or increase funding for an explicit and targeted inclusion of early childhood development in humanitarian, fragile and crisis settings.

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Appendix 1: Arabic Questionnaires

القسم 1: التركيبة السكانية:

ينطبق على جميع المشاركين

1.1. معلومات حول مقدم الرعاية / المجيب:

1.1.1. أنت:
- أب
- أم
- قريب (أخ / أخت / عمة / عم / جدّة / جدّ / ابن العم او الخال
- مقدمو الرعاية الآخرون (شخص مسؤول عن تربية ورعاية الطّفل بدلًا عن الأم والأب لظروف معيّنة)

1.1.2. أنت:
- ذكر
- أنثى
- آخر
- أفضل عدم الإجابة

1.1.3. ما هي جنسيتك؟
- لبناني/ة
- سوري/ة
- فلسطيني/ة
- آخر يرجى التحديد

1.1.4. ما هو عمرك؟
- 15- 18 سنة
- 19 -22 سنة
- 23 -30 سنة
- 31- 35 سنة
- 36 -45 سنة
- 46 -55 سنة
- 56 وما فوق

1.1.5. ما هي وضعك الاجتماعية؟
- متزوج/ة
- أرمل/ة

- أعزب/عزباء
- منفصل/ة
- مطلق/ة
- الشريك/ة مفقود

1.1.6. ما هو مستواك التعليمي؟

- لا أقرأ ولا أكتب
- أقرأ وأكتب
- أنهيت سنوات الإبتدائي
- أنهيت سنوات التكميلي
- أنهيت سنوات الثانوي أو ما يعادلها مهني
- أنهيت الدراسة الجامعية
- آخر، يرجى التحديد

1.2 معلومات عن الأسرة:

1.2.1. في أي محافظة تقيم في لبنان؟

- بيروت
- جبل لبنان
- الشمال
- البقاع
- النبطية
- الجنوب

1.2.2. حدد نوع المسكن الذي تعيش فيه حاليًا:

- شقة
- منزل
- استوديو
- غرفة مشتركة
- خيمة
- آخر، يرجى التحديد

1.2.3. كم عدد الأشخاص الذين يعيشون في المنزل؟

- 1
- 2

- 3
- 4
- 5
- 6
- أكثر من 6

1.2.4. كم عدد الأطفال دون سن ال8 سنوات الذين يعيشون في المنزل؟

- 1
- 2
- 3
- 4
- 5
- 6
- أكثر من 6

1.3 المعلومات المالية للأسرة:

(في الأسئلة اللّاحقة نقصد بمقدّم الرعاية كل من يهتم بالطفل بدلًا من والديه أو أحد والديه وهو مسؤول بشكل تام عن تربية ورعاية الطّفل.)

1.3.1. ما هو وضعك الوظيفي الحالي؟

- موظّف بدوام كامل
- موظّف بدوام جزئي
- موظّف بعقد محدد المدة/موظّف موسمي
- موظّف على القطعة أو على العمولة/موظّف مؤقت
- أعمل لحسابي الخاص
- لا أعمل

1.3.2. هل اضطر أحد الأهل الانفصال عن العائلة بسبب العمل؟ (السفر أو العمل في منطقة بعيدة...)

- نعم، الأم
- نعم، الأب
- الأب والأم معا
- مقدّم الرعاية للطّفل (بديل عن الأم أو الأب)
- لا
- أفضّل عدم الإجابة

1.3.3. ما كان إجمالي دخل عائلتك الشهر الماضي؟
- 0 - 500000 ليرة لبنانية
- 500000 - 1000000 ليرة لبنانية
- 1000000 - 2000000 ليرة لبنانية
- 2000000 - 4000000 ليرة لبنانية
- 4000000 - 7800000 ليرة لبنانية
- أكثر من 7800000 ليرة لبنانية

1.3.4. هل تلقيت أي مساعدات مالية أو هدايا تضمّنت دفع إيجار أو منافع أخرى من شخص لا يعيش معك؟
- نعم
- لا
- أفضّل عدم الإجابة

1.4 معلومات عن الطفل المعني

اختر أحد الأطفال من الذين تقلّ أعمارهم عن 8 سنوات واملأ هذا الاستبيان نيابة عنه - إختر الطفل الأشدّ تأثرًا برأيك بالأزمات التي يمرّ فيها لبنان إذا كان ذلك ينطبق على أحد أطفالك.

ملأت استبياني نيابة عن طفلي:

1.4.1. اسم الطفل (يرجى كتابة الاسم باللغة العربية)

1.4.2. جنس (الاسم)
- ذكر
- أنثى
- أخرى

1.4.3. جنسيّة (الاسم)
- لبناني/ة
- سوري/ة
- فلسطيني/ة
- آخر، يرجى التحديد

1.4.4. تاريخ الميلاد اليوم/الشهر/السنة

القسم 2: معلومات عن تنمية الطفولة المبكرة

تنطبق على الفئة العمرية من البداية (صفر) حتى 3 أشهر

البيّنة	نعم	لا	لا أعرف
2-1 أثناء الاستلقاء على بطنه/ها، هل يستطيع/تستطيع (اسم الطفل/الطفلة) رفع رأسه/ها إلى اليسار واليمين؟			
2-2 عند وضعه/ها على جنبه/ها، هل يستطيع/تستطيع (الاسم) أن يقلب/تقلب على ظهره/ها؟			
2-3 أثناء الاستلقاء على ظهرها، هل تستطيع (الاسم) التلويح والركل مستخدمة يديها ورجليها؟			
2-4 هل يراقب (الاسم) وجهكم وينظر إلى الأشياء؟			
2-5 هل يُظهر (الاسم) ردة فعل عندما تندلع أصوات عالية؟			
2-6 هل يجمع (الاسم) يديه معا؟			
2-7 هل يهدأ (الاسم) عندما يسمع صوتكم؟			
2-8 هل يهدل (الاسم) ويصدر أصواتا؟			
2-9 هل يمد/تمد (الاسم) يده/ها باتجاه الأشياء المتدلية؟			
2-10 هل يمسك (الاسم) الخشخيشة ويهزها؟			
2-11 هل ينام/تنام (الاسم) ما بين 14 و17 ساعة في اليوم؟			

القسم 2: معلومات عن تنمية الطفولة المبكرة

تنطبق على الفئة العمرية من 4 إلى 6 أشهر

البيّنة	نعم	لا	لا أعرف
2-1 هل يستطيع/تستطيع (الاسم) الجلوس لمدة 8 ثوانٍ على الأقل عندما تكون يداه/ها أمامه/ها على الأرض؟			
2-2 أثناء الاستلقاء على ظهرها، هل تُمسك (الاسم) برجليها؟			
2-3 عنده استلقائه على بطنه، هل يرفع (الاسم) رأسه لمدة 15 ثانية على الأقل؟			
2-4 أثناء الاستلقاء على بطنه، هل يدفع (الاسم) بجسمه إلى الأعلى على ذراعيه؟			
2-5 عندما تحركون لعبة أمام (الاسم)، هل يتابعها بعينيه؟			
2-6 هل يتعمّد (الاسم) الوصول إلى الألعاب؟			
2-7 هل يمسك/تمسك (الاسم) زجاجاته/ها أثناء الرضاعة؟			
2-8 هل ينام/تنام (الاسم) ما بين 12 و15 ساعة في اليوم؟			
2-9 هل يتفاعل/تتفاعل (الاسم) بشكل مختلف عندما تغيرون صوتكم؟			
2-10 هل تضحك (الاسم) وتغمغم عندما تكون سعيدة؟			

القسم 2: معلومات عن تنمية الطفولة المبكرة

تنطبق على الفئة العمرية من 7 إلى 9 أشهر

البيّنة	نعم	لا	لا أعرف
2-1 أثناء الاستلقاء على ظهره/ها، هل يستطيع/تستطيع (الاسم) حمل نفسه/ها على الجلوس؟			
2-2 أثناء الاستلقاء على ظهره، هل يستطيع (الاسم) أن يقلب على بطنه؟			
2-3 هل يستطيع/تستطيع (الاسم) اللعب بأشياء حوله/ها عند الجلوس؟			
2-4 هل تستطيع (الاسم) التأرجح إلى الأمام والخلف عندما تكون على ركبتيها ويديها؟			
2-5 أثناء الاستلقاء على بطنه، هل يستطيع (الاسم) مد يد واحدة للحصول على لعبة؟			
2-6 إذا سمعت (الاسم) صوتًا عاليًا، هل تنظر حولها لترى من أين أتى الصوت؟			
2-7 هل يستخدم (الاسم) الإيماءات للإشارة إلى الأشياء التي يريدها؟			
2-8 هل يستجيب (الاسم) لكلمات عبر أصوات وإيماءات؟			
2-9 هل يستطيع (الاسم) أن يأكل من الملعقة؟			
2-10 هل يستطيع (الاسم) التقاط الطعام وجلبه إلى فمه؟			
2-11 هل يقوم (الاسم) بالمناغاة باستمرار أثناء النهار؟			
2-12 هل ينام/تنام (الاسم) ما بين 12 و15 ساعة يوميًا؟			
2-13 هل تستطيع (الاسم) الانخراط في لعبة "الغميضة"؟			

القسم 2: معلومات عن تنمية الطفولة المبكرة

تنطبق على الفئة العمرية من10 إلى 12 شهر

البيّنة	نعم	لا	لا أعرف
2-1 هل يتمكن/تتمكّن (الاسم) من الجلوس انطلاقا من استلقائه/ها على ظهره/ها وعلى بطنه/ها؟			
2-2 هل يستطيع (الاسم) الجلوس لدقائق عديدة على الأرض دون دعم؟			
2-3 هل يستطيع/تستطيع (الاسم) رفع نفسه/ها للوقوف على أرضية متينة؟			
2-4 هل تستطيع (الاسم) التدحرج في كلا الاتجاهين؟			
2-5 هل يستطيع (الاسم) التقاط غرضا صغيرا (حبوب تشيريوس أو قطعة فطيرة هشة) من خلال إبهامه وأصابعه؟			
2-6 هل يُسقط (الاسم) أغراضا في حاوية؟			
2-7 هل يُطعم (الاسم) نفسه (حلوى، مقرمشات، فواكه، إلخ) مستخدماً يديه؟			
2-8 هل تقلّد (الاسم) استخدام الألعاب بالطريقة التي تعرضونها؟			
2-9 هل يلعب (الاسم) لعبة الغميضة أو لعبة التصفيق حسب الإيقاع؟			
2-10 هل يفهم (الاسم) الكلمات التي تُطلق على الأشياء العامة؟			
2-11 هل يلوّح/تلوّح (الاسم) للترحيب (هاي) أو للتوديع (باي)؟			
2-12 هل بدأت (الاسم) في استخدام الكلمات؟ (نهاية أوّل سنة)			
2-13 هل يفهم (الاسم) الأوامر/الطلبات أو الأسئلة البسيطة؟			
2-14 هل ينام/تنام (الاسم) ما بين 12 و16 ساعة في اليوم؟			

القسم 2: معلومات عن تنمية الطفولة المبكرة

تنطبق على عمر السنة

البيّنة	نعم	لا	لا أعرف
2-1 هل يستطيع/تستطيع (الاسم) السير مترين ونصف على الأقل (8 أقدام) وحده/ها؟			
2-2 هل ينزل (الاسم) إلى الأرض بتحكّم حين يكون ممسكا بقطعة أثاث؟			
2-3 هل يستطيع/تستطيع (الاسم) الخربشة بقلم تلوين؟			
2-4 هل يدّعي/تدّعي (الاسم) النوم و/أو الأكل؟			
2-5 هل يستطيع (الاسم) خلع جواربه؟			
2-6 هل تتشارك (الاسم) الحماسة/الفرح/الأغراض معكم؟			
2-7 هل يتبع (الاسم) أوامر بسيطة مثل "أعطني" أو "أشِر إلى" أو ما إلى ذلك؟			
2-8 هل يستخدم/تستخدم (الاسم) ما بين كلمة وثماني كلمات بسيطة؟			
2-9 هل يهز/تهز (الاسم) رأسه/ها للإشارة إلى النفي (لا)؟			
2-10 هل ينام/تنام (الاسم) ما بين 11 و14 ساعة في اليوم؟			

القسم 2: معلومات عن تنمية الطفولة المبكرة

تنطبق على عمر السنتين

البيّنة	نعم	لا	لا أعرف
2-1 هل يستطيع/تستطيع (الاسم) صعود ونزول 4 درجات متواصلة دون التمسك بأي شيء/أحد؟			
2-2 هل يركض/تركض (الاسم) جيدا دون فقدان التوازن؟			
2-3 هل يستطيع/تستطيع (الاسم) القفز للأعلى والأسفل بالقدمين؟			
2-4 هل تستطيع (الاسم) التقاط كرة رُميت لها من مسافة تتراوح بين متر ومتر ونصف تقريبا عبر إحاطتها بالذراعين واليدين؟			
2-5 هل يستطيع (الاسم) محاكاة خط أفقي وخط عمودي؟			
2-6 هل يستطيع (الاسم) خلع ثياب دون سحابات وحده؟			
2-7 هل يغسل (الاسم) أسنانه مع مساعدة؟			
2-8 هل يستطيع (الاسم) ارتداء معطف وحده؟			
2-9 هل يستطيع/تستطيع (الاسم) رفع بنطاله/بنطالها؟			
2-10 هل تستخدم (الاسم) جُملا من كلمتين أو ثلاث، وهل تستخدم 300 كلمة تقريبا؟			
2-11 هل يستطيع (الاسم) اتباع تعليمات بخطوتين واستيعاب مفاهيم بسيطة مثل "في/على/تحت" و"كبير/صغير"؟			
2-12 هل يستطيع (الاسم) محاكاة تسلسل الألعاب واللعب قرب أطفال آخرين؟			
2-13 هل يستخدم/تستخدم (الاسم) "أنا" عند الإشارة إلى نفسه/ها؟			
2-14 هل يفهم (الاسم) أسئلة بسيطة وهل يجيب عنها؟			
2-15 هل ينام/تنام (الاسم) ما بين 12 و13 ساعة في اليوم؟			

القسم 2: معلومات عن تنمية الطفولة المبكرة

تنطبق على عمر الثلاث سنوات

البيّنة	نعم	لا	لا أعرف
2-1 هل يستطيع/تستطيع (الاسم) رسم خطوط ودوائر وصلبان؟			
2-2 هل يستطيع/تستطيع (الاسم) صعود أربع درجات ونزولها بقدم واحدة على كل درجة؟			
2-3 هل يستطيع/تستطيع (الاسم) تسلق سلم من أجل النزول على منزلق؟			
2-4 هل يستطيع/تستطيع (الاسم) الوقوف على قدم واحدة لبضع ثوان على الأقل دون التمسك بشيء أو أحد؟			
2-5 هل يستطيع/تستطيع (الاسم) القفز للأمام بقدميه/ها لمسافة لا تقل عن 15 سم؟			
2-6 هل يستطيع (الاسم) المشي على أطراف أصابعه لمسافة تتراوح بين متر ومتر ونصف؟			
2-7 هل يستطيع/تستطيع (الاسم) ركل كرة إلى لأمام باستخدام حركة الذراع/الساق المعاكسة؟			
2-8 هل يستطيع (الاسم) وضع حبات خرز صغيرة في خيط/سلك؟			
2-9 هل يستطيع/تستطيع إكمال ألعاب البازل البسيطة؟			
2-10 هل تُمسك (الاسم) قلم رصاص/تلوين بإبهامها وسبابتها وإصبعها الأوسط؟			
2-11 هل يستطيع/تستطيع (الاسم) الإشارة إلى عدة أجزاء من الجسم؟			
2-12 هل يستطيع (الاسم) تزرير ملابسه أو ملابس الألعاب؟			
2-13 هل كلام (الاسم) مفهوم عندما يستخدم/تستخدم جملا من 4 إلى 5 كلمات؟			
2-14 هل يستوعب (الاسم) مفاهيم التشغيل والإيقاف، وداخل/خارج، وأحد/بعض/كافة، والباقي والقليل؟			
2-15 هل يستطيع/تستطيع (الاسم) اتباع أوامر من 3 خطوات؟			
2-16 هل يستطيع (الاسم) إعادة سرد قصة؟			
2-17 هل يفهم/تفهم (الاسم) مشاعر الآخرين ويستجيب/تستجيب بشكل مناسب؟			
2-18 هل ينام/تنام (الاسم) ما بين 10 و13 ساعة في اليوم؟			
2-19 هل بدأ/ت (الاسم) باللعب مع الآخرين والتشارك معهم؟			

القسم 2: معلومات عن تنمية الطفولة المبكرة

تنطبق على الفئة العمرية من 4 إلى 5 سنوات

البيّنة	نعم	لا	لا أعرف
2-1 هل يستطيع/تستطيع (الاسم) القيام بتمرين المعدة لمرة أو اثنتين؟			
2-2 هل يستطيع/تستطيع (الاسم) القفز فوق غرض بطول 30 سم باستخدام القدمين في نفس الوقت؟			
2-3 هل يستطيع/تستطيع (الاسم) رمي الكرة من الأعلى على مسافة 12 سم وإصابة هدف ما مع استخدام حركة الذراع/الساق المعاكسة؟			
2-4 هل يستطيع/تستطيع (الاسم) الوقوف على قدم واحدة لتسع ثوان على الأقل؟			
2-5 هل يستطيع/تستطيع (الاسم) الركض سريعا؟			
2-6 هل تستطيع (الاسم) استخدام دراجة هوائية ثلاثية العجلات أو بعجلتين تدريبيتين؟			
2-7 هل يستطيع/تستطيع (الاسم) ارتداء ملابسه/ها وخلعها وحده/ها؟			
2-8 هل يستطيع (الاسم) قص أشكال بسيطة مثل الدائرة والمربع والمثلث؟			
2-9 هل يستطيع/تستطيع تشكيل خط عمودي وخط أفقي ودائرة وأشكال أخرى؟			
2-10 هل كلام (الاسم) مفهوم في معظم الأحيان؟			
2-11 هل يستخدم/تستخدم (الاسم) جملا كاملة عند التحدث؟			
2-12 هل يستطيع (الاسم) تسمية 4 ألوان و3 أشكال على الأقل؟			
2-13 هل يستطيع (الاسم) عد 10 أشياء على الأقل؟			
2-14 هل تستخدم (الاسم) ضمائر مثل هو، هي، أنا، لي، لها، له، نحن؟			
2-15 هل يستطيع/تستطيع (الاسم) اتباع توجيهات من 3 خطوات إعادة سرد قصة من الذاكرة؟			
2-16 هل يقوم/تقوم (الاسم) بالتناوب والبقاء في صلب الموضوع خلال محادثة ما؟			
2-17 هل ينام/تنام (الاسم) ما بين 10 و12 ساعة يوميا؟			
2-18 هل يلعب/تلعب (الاسم) مع مجموعة من الأصدقاء؟			
2-19 هل (الاسم) حريص/ة على إرضاء الآخرين وإسعادهم؟			

القسم 2: معلومات عن تنمية الطفولة المبكرة

تنطبق على الفئة العمرية من 6 إلى 8 سنوات

البيّنة	نعم	لا	لا أعرف
2-1 هل يستطيع/تستطيع (الاسم) اكتساب مهارة حركية جديدة مثل كرة القدم؟			
2-2 هل يستطيع/تستطيع (الاسم) رمي كرة والتقاطها وإصابة هدف؟			
2-3 هل يستطيع/تستطيع (الاسم) الركض بسرعة؟			
2-4 هل يستطيع/تستطيع (الاسم) ربط شريط حذائه/ها؟			
2-5 هل يُظهر/تُظهر (الاسم) مهارة في كتابة أحرف/كلمات/جمل/إنشاء؟			
2-6 هل يستطيع (الاسم) التحدث عمّا يدور في ذهنه مستخدما جملا مركبة بشكل صحيح؟			
2-7 هل تستخدم (الاسم) مفردات دقيقة لطرح الأسئلة وعرض الآراء؟			
2-8 هل يستطيع (الاسم) فهم الأضداد؟			
2-9 هل يستطيع/تستطيع فهم الفترات الزمنية ومفهوم الوقت؟			
2-10 هل يقرأ/تقرأ (الاسم) نصوصا ملائمة بسهولة؟			
2-11 هل يتمكّن/تتمكّن (الاسم) من الانتباه إلى التفاصيل؟			
2-12 هل يتبع (الاسم) التعليمات ويُنهي واجباته المدرسية؟			
2-13 هل يفهم/تفهم (الاسم) تبعات أفعاله/ها؟			
2-14 هل ينام/تنام (الاسم) ما بين 9 و12 ساعة يوميا؟			

القسم الثالث: معلومات عن تعليم الطفولة المبكرة

صالح لجميع الفئات العمرية

3.1. معلومات حول وصول الطفل إلى التعلم

3.1.1. هل حصل (الاسم) على تعليم (عن بُعد أو وجهاً لوجه) هذا العام (2021-2022)؟

- نعم
- لا
- جزئيا
- لا ينطبق

3.1.1.1. في حال الإجابة نعم أو جزئيًا، يذهب (الاسم) إلى الحضانة أو المدرسة:

- يوميًا
- 2-3 مرات في الأسبوع
- بضع مرات في الشهر
- بناءً على متطلبات الحضور

3.1.1.2. إذا كانت الإجابة لا أو جزئيًا، حدد الأسباب.

(إجابات متعددة) - (نستمع إلى إجابة المشارك(ة)، ثمّ ننتقل إلى الاحتمالات)

- عدم القدرة على تغطية رسوم المواصلات
- عدم القدرة على تغطية الرسوم الدراسية
- المدرسة مغلقة
- زيادة حالات الكوفيد أو غيرها من الأمراض المعدية
- عدم قدرة الوصول إلى الإنترنت والكهرباء للتعلم عبر الإنترنت/عن بعد
- عدم قدرة الوصول إلى الأدوات اللازمة (كمبيوتر محمول - هاتف - كمبيوتر لوحي ، إلخ) للتعلم عن بعد
- عدم القدرة على شراء الكتب والمواد التي تدعم التعلم
- عدم توفّر الخدمات اللوجستيّة في المدارس (تدفئة كهرباء)
- احتجاجات وإضرابات المعلمين والمربين
- من أجل دعم الأسرة و دخول سوق العمل
- آخر، حدد

3.1.2. من هو مقدم الرعاية المسؤول عن متابعة عملية التعلم (الواجبات/ استيعاب أهداف التعلم) لـ (الاسم)؟

(اختيارات متعددة)

- أب
- الأم
- جد
- جدة
- إخوة
- آخر

3.2. معلومات حول المؤسسة التعليميّة

3.2.1. ما هو نوع المؤسسة التعليمية التي يرتادها (الإسم)؟

- خاصة
- رسميّة - حكوميّة
- شبه مجّانيّة
- آخر، يرجى التحديد

3.2.2. هل أنت قادر/ة على تغطية رسوم الحضانة أو المدرسة؟

- نعم، قادر على تغطية الرسوم بالكامل
- نعم، قادر جزئيًا على تغطية الرسوم
- غير قادر على تغطية الرسوم على الإطلاق

3.2.2.1. إذا كان جزئيا أو غير قادر، هل تتلقى/ين أي دعم خارجي لتغطية الرسوم؟

- نعم
- لا

3.2.2.2. إذا كانت الإجابة بنعم، فمن أين الدعم؟

- منظّمة: منظّمة غير حكومية - منظّمة محلية - إلخ
- الجهات الدينية
- الأحزاب السياسية
- الأقارب
- مِنَح دراسية من المدرسة نفسها
- آخر

3.2.3. هل تعتقد/ين أنك ستكون/ين قادرًا/تا على تغطية رسوم الحضانة أو المدرسة العام المقبل؟

- نعم، سوف أكون قادراً على تغطية الرسوم بالكامل
- نعم، سوف أكون قادراً على تغطية الرسوم جزئياً
- لن أكون قادرًا على تغطية الرسوم على الإطلاق

3.2.3.1. إذا كان الجواب لا أو جزئيًا، فماذا ستفعل/ين؟
- نقل (الاسم) إلى مدرسة رسميّة - حكوميّة
- نقل (الاسم) إلى مدرسة خاصة أقل تكلفة
- نقل (الاسم) إلى مدرسة شبه مجانيّة
- ترك (الاسم) خارج المدرسة
- غير ذلك، (يرجى التحديد)

3.2.4. حول رسوم المواصلات إلى الحضانة أو الروضة أو المدرسة، ما هي التكلفة الشهرية؟
- 0 ليرة لبنانية
- من 0 ليرة لبنانية إلى 300000 ليرة لبنانية
- 300000 إلى 600000 ليرة لبنانية
- من 600.000 إلى 900.000 ليرة لبنانية
- فوق مليون ليرة لبنانية

3.3. معلومات حول أداء الطفل المدرسي

3.3.1. هل تغير أداء (الاسم) سلبًا مقارنة بالتعلم في الفصل الدراسي العام الماضي إثر الأزمات؟

(شرط إذا أجابوا بنعم أو جزئيًا في السؤال 3.1.1)
- نعم
- لا
- جزئيا

3.3.1.1. إذا كانت الإجابة نعم، فلماذا؟ الرجاء تحديد الأسباب لتراجع أداء طفلك (إجابات متعددة)

(نستمع إلى إجابة المشارك(ة)، ثمّ ننتقل إلى الاحتمالات)

9. تراجع أداء المعلمات/ين
10. عدم وجود متابعة مناسبة من جانب المدرسة
11. عدم وجود متابعة في المنزل
12. التعرّض للتمييز أو التنمّر
13. عدم توفّر الأدوات التعليمية اللازمة (كتب، إلخ)
14. الانتقال إلى مؤسسة تعليميّة جديدة
15. تغيّر في قواعد المؤسسة التعليمية
16. افتقار التعلم التفاعلي

17. عدم الكشف عن صعوبات التعلم والاحتياجات
18. تقييد التفاعل مع الأصدقاء
19. الانقطاع عن الدراسة والإغلاق المتكرر للمؤسسة التعليميّة
20. التسّرع في إعطاء المنهج أو وضع الكثير من الضغط على إنهاء المنهج
21. مشاعر سلبيّة يعاني منها الطفل مؤخرًا (شعور بانفصال أو حداد - زيادة القلق - خوف - إلخ)
22. آخر، الرجاء التحديد

3.3.1.2. إذا كانت الإجابة بنعم، فكيف تغيّر الأداء؟ الرجاء تحديد كل ما ينطبق: (إجابات متعددة)

- صعوبة استيعاب المعلومات
- عدم اهتمام الطفل بالمدرسة
- عدم التأقلم واستيعاب (الاسم) أو الطلاب الآخرين للقواعد الاجتماعيّة
- التراجع بالعلامات
- صعوبة الالتزام بالقوانين المدرسية (استراحات المرحاض - الوجبات الخفيفة - التحدث - إلخ.)
- صعوبة في الاندماج مع وتيرة الصفّ و/أو الأقران
- غير ذلك (يرجى التحديد)

القسم الرابع: معلومات عن صحة الطفولة المبكرة

ينطبق على جميع الفئات العمرية

4.1. معلومات عن الفحوصات الطبية:

4.1.1. هل يتعايش (الاسم) مع احتياجات خاصّة؟
- نعم
- لا
- أفضّل عدم الإجابة
-

4.1.1.1. إذا كان الجواب نعم، يرجى تحديد نوع الاحتياجات الخاصّة: (يمكن اختيار أجوبة متعددة)
- جسديّة
- حسّية-حركيّة
- عصبيّة
- ادراكيّة
- أفضّل عدم الإجابة

4.1.2. هل يتعايش) الاسم (مع أمراض مزمنة؟
- لا
- نعم، يرجى التحديد
- أفضّل عدم الإجابة

4.1.3. في أعقاب الأزمة اللبنانية، هل تمكّن (الاسم) من تلقّي المتابعة الطبيّة المناسبة؟
- نعم، بسهولة
- نعم، بصعوبة
- لا
- أفضّل عدم الإجابة

4.1.3.1. متى زرت طبيب الأطفال:
- في المواعيد المحدّدة بحسب عمر الطّفل
- تأخّرنا عن المواعيد المحدّدة
- لم نذهب إلى أي موعد

4.1.3.2. إذا نعم بصعوبة أو لا، يرجى تحديد الصعوبات التي تواجهها لضمان المتابعة الطبيّة السليمة ل (الاسم):
- رسوم مرتفعة
- نقص المهنيّين بسبب هجرتهم
- لا أستطيع تحمل رسوم النقل
- قيود كوفيد 19
- القلق والخوف بسبب كوفيد 19
- الوضع السّياسي
- لوائح الانتظار لدى المنظّمات ومراكز الرعاية الصّحية
- آخر، يرجى التحديد

4.1.4. بعد الأزمة، هل واجهتم صعوبة في تأمين الدواء ل(الاسم)؟
- نعم
- لا
- لم يحتاج أي دواء
- أفضّل عدم الإجابة

4.1.4.1. إذا كانت الإجابة نعم، يرجى تحديد الصّعوبات التي تواجهونها من أجل تأمين الدواء: (يمكن اختيار أجوبة متعددة)
- نقص الأدوية في لبنان
- أسعار باهظة
- تأثير انقطاع الكهرباء على تخزين الأدوية
- آخر، يرجى التحديد

4.1.4.2. إذا كانت الإجابة نعم، يرجى اختيار الحلول البديلة التي طبّقتموها من أجل تأمين الدواء: (يمكن اختيار أجوبة متعددة)
- شراء الدواء من خارج لبنان
- شراء الدواء من السّوق السوداء
- انتظار التبرعات
- استلام الدواء من الخارج أي من الأقارب والأصدقاء
- لا شيء
- آخر، يرجى التحديد

4.1.5. هل (الاسم) أخذ جرعات اللقاحات الإلزامية؟
- نعم
- لا
- لا أعلم

4.1.5.1. إذا كان الجواب لا، فلماذا؟

- عدم القدرة على دفع ثمن الجرعات
- عدم توفّر اللقاح في أقرب مرفق طبي
- عدم القدرة على الوصول إلى أقرب مرفق طبي
- لأسباب ثقافيّة، دينيّة، عرفيّة
- آخر، يرجى التحديد

4.2. معلومات عن الفريق الطبي

4.2.1. من يقوم بإجراء الفحوصات الطبية واللقاحات ل(الاسم)؟ (يمكن اختيار أجوبة متعددة)

- عيادة طبيب خاص
- عيادة وزارة الصحة أو الشؤون الاجتماعية/ مستوصف
- عيادة المنظمات غير الحكومية
- عيادة مستشفى عام
- عيادة مستشفى خاص
- الداية - ممرضة نقّالة
- آخر، يرجى التحديد

4.2.2. هل يحتاج طفلك إلى متابعة مختصّة من:

- طبيب/ة تخصص طبي
- ممرض/ة
- أخصائي/ة النفسي
- طبيب/ة نفسيّ للأطفال والمراهقين
- طبيب/ة أسنان
- اخصائي/ة تغذيه
- معالج/ة فيزيائي
- معالج/ة نفسي حركي
- معالج/ة نطق
- مدرّس/ة تربية متخصصة في المنزل
- عامل/ة اجتماعي/ة
- آخر، يرجى التحديد
- لا يحتاج مساعدة مختصّة

4.2.2.1. إذا كانت الإجابة نعم هل تم متابعة (الاسم) من قبل متخصصين:

- نعم

القسم الخامس: معلومات عن التغذية في مرحلة الطفولة المبكرة:

	نعم	كم مرة في الأسبوع	لا	لا أعلم/ لا يوجد جواب
يطبق على من هم أقل من سنتين هل (الاسم) يرضع/ترضع؟				
هل (...) تلقى/تلقت أي حليب مدعّم أو خاصّ؟				
يطبق على من هم أكثر من 6 أشهر هل (الاسم) يشرب/تشرب ماءً نظيفاً؟				
ما هو مصدر المياه الذي يشرب/تشرب منه (الاسم)؟	مياه معدنية (قنينة أو غالون مختومين) من الحنفية مع فلتر من الحنفية بدون فلتر من مصدر مياه محلي: العين - البئر لا أعرف			
هل تغيرت القدرة على تناول الطعام الكافي بشكل يومي في العام الماضي؟				
هل تم تخفيض عدد الوجبات اليومية خلال العام الماضي؟				
هل تمّ تعديل نوعية الوجبات التي تحصل عليها العائلة خلال العام الماضي؟ (من حيث استخدام اللحوم مثلا)				
هل تلقت الأسرة مساعدات غذائية خلال الأشهر الثلاثة الماضية؟	نعم، مرة واحدة نعم، أكثر من مرة كلا			

القسم السادس: معلومات عن النمو الاجتماعي والعاطفي في مرحلة الطفولة المبكرة

ينطبق على عمر سنة وما فوق

6.1. معلومات عن الوقت الذي يقضيه (الاسم) على الشاشة

6.1.1. خلال الشهر الماضي، كم كان عدد الساعات التي يقضيها/تقضيها (الاسم) يومياً في استخدام الشاشة (الكمبيوتر، التلفون، الالعاب الالكترونية، التلفزيون، الخ.)

- لا يقضي وقتا على الشاشات
- من 0-1 ساعة في اليوم
- من 2-3 ساعات في اليوم
- من 4-6 ساعات في اليوم
- من 7-10 ساعات في اليوم
- 11 ساعة أو أكثر في اليوم

6.1.2. هل الوقت الذي يقضيه/تقضيه (الاسم) على الشاشة قد ازداد أو انخفض في الأشهر الثلاثة الماضية؟

- نعم، ازداد
- نعم، انخفض
- كلا، لم يتغيّر

6.1.2.1. إذا ازداد، ما السبب؟

- التعلّم عن بعد والوظائف المدرسية المطلوبة عبر الانترنت
- ازدياد وقت الفراغ ونقص في الألعاب المتوفرة
- انشغال أو عدم وجود مقدم الرعاية للاهتمام به
- (الاسم) يريد قضاء الوقت على الشاشة
- سبب آخر (يرجى التحديد(

6.1.3. هل الوقت الذي يقضيه/تقضيه (الاسم) على الشاشة يؤثر سلباً على مزاجه/ا وتصرفاته/ا؟

- دائماً
- في كثير من الأحيان
- لا أعرف
- في بعض الأحيان
- أبداً

6.1.4. هل تُشرف أنت أو مقدم رعاية آخر على استخدام (الاسم) للشاشة؟ (مثلاً مراقبة مقاطع الفيديو والالعاب والصور والمحادثات؛ الحد من امكانية الوصول الى مواقع معينة من خلال إعدادات الجهاز)

- لا أشرف
- أشرف على المضمون
- أشرف لتحديد الوقت الذي يمضيه طفلي على الشاشة
- لا أعلم

6.2. معلومات عن اللعب لدى (الاسم)

6.2.1. كم من الوقت يقضي/تقضي (الاسم) في اللعب بمفرده/ا من إجمالي وقت اللعب بعد الأزمة؟

- كل الوقت
- معظم الوقت
- أكثر من نصف الوقت
- أقل من نصف الوقت
- بعض الوقت
- أبداً

6.2.2. كم من الوقت يقضي/تقضي (الاسم) في اللعب مع الأخوة والأصدقاء من إجمالي وقت اللعب بعد الأزمة؟

- كل الوقت
- معظم الوقت
- أكثر من نصف الوقت
- أقل من نصف الوقت
- بعض الوقت
- أبداً

6.2.3. بالمقارنة مع ما قبل الأزمة، كيف تغيّر وقت اللعب خارج المنزل ل(الاسم)؟

- نقص الوقت
- بقي الوقت كما هو
- ازداد الوقت

6.2.4. هل يملك/تملك (الاسم) ألعاب؟

- نعم
- كلا

6.2.5. متى كان آخر مرة تلقى/تلقت فيها (الاسم) لعبة جديدة؟

- الأسبوع الماضي
- الشهر الماضي
- خلال الثلاث أشهر الماضية
- منذ 3 إلى 6 أشهر
- منذ 6 إلى 12 شهر
- منذ أكثر من سنة
- لم يتلقى/تتلقى أبداً

6.2.6. كم من الوقت تقضيه أنت في اللعب مع (الاسم)؟

- لا ألعب مع (الاسم)
- من 0-1 ساعة في اليوم
- من 2-3 ساعات في اليوم
- من 4-6 ساعات في اليوم
- أكثر من 6 ساعات في اليوم

6.2.7. هل تغيّر وقت اللعب الذي تقضيه مع (الاسم) خلال السنة الماضية من بعد الأزمة؟ (مثلاً بسبب الحاجة لعمل إضافي، غياب مقدم الرعاية عن المنزل، غياب الطفل عن المنزل، الخ.)

- نعم - أقل وقت للعب
- نعم - أكثر وقت للعب
- تغيّر جزئياً
- لم يتغيّر

6.2.8. خلال الشهر الماضي، كم عدد الساعات التي كان يقضيها/تقضيها (الاسم) في استخدام الكتب وقراءة القصص؟

- لا يقرأ
- من ربع ساعة حتى ساعة في اليوم
- من 2-3 ساعات في اليوم
- من 4-6 ساعات في اليوم
- أكثر من 6 ساعات في اليوم

القسم السابع: معلومات حول التغييرات التي حدثت جراء الوباء / الأزمة الاقتصادية.

	نعم	لا	لا أعرف / لا إجابة

هل شهد دخل الأسرة أي انخفاض مقارنة بالسنة السابقة؟			
هل فقدت الأسرة مصدر واحد أو أكثر للدخل منذ بدء كوفيد أو الأزمة الاقتصادية؟			
هل اضطرت الأسرة الاستدانة في الأيام 30 الماضية لتغطية الاحتياجات الأساسية (الغذاء/الصحة/المأوى)؟			
هل اضطررت إلى بيع ميراث عائلي أو ممتلكات خلال العام الماضي؟ نعم لا أفضّل عدم الإجابة			
هل توقف أحد أطفال الأسرة دون عمر الثمانية سنوات عن الذهاب إلى المدرسة هذا العام من أجل دعم الأسرة عبر: ينطبق على سن 4 وما فوق لم يتوقف أي طفل من الذهاب للمدرسة لهذه الأسباب الاعتناء بأشقائه الاعتناء بوالديه تكاليف أقل غير ذلك، يرجى التحديد			
هل تغيير موقع السكن خلال العام الماضي؟			
إذا كانت الإجابة بنعم، فيرجى تحديد السبب		بحاجة إلى مساحة أكبر تحسين السكن نهاية العقد الإجبار على الانتقال الإيجار مرتفع أقرب إلى العمل أو المدرسة آخر، يرجى التحديد	
هل قامت الأسرة بتخفيض نفقات التعليم / الطعام / المواصلات خلال العام الماضي؟			
هل تمّ تخفيض شراء الملابس الجديدة لأفراد الأسرة خلال العام الماضي؟			
هل تراجعت القدرة على الحصول بسهولة على المواد الصحيّة ومواد النظافة مثل الأقنعة والمطهرات والمناديل والحفاضات والصابون وما إلى ذلك؟			
هل كانت تراجعت قدرة العائلة على توفير نظام تدفئة أو تبريد خلال الطقس البارد أو الحار؟			
هل كان عليك ترك (الاسم) بمفرده/ها في المنزل أو في مكان آخر لتتمكن من حضور العمل؟			

7.1. عندما أساء (الاسم) التصرف خلال العام الماضي، هل وجدت نفسك تستخدم طرقًا مثل الصراخ، أو الضرب، أو أي من أشكال التأديب المماثلة أكثر من قبل الأزمة؟

- نعم في كثير من الأحيان
- نعم احيانًا
- لا، لم أستخدمها قط

لا، كما كان من قبل

القسم الثامن: معلومات حول صحة الطفل النفسية

من عمر السنتين وما فوق

عن سلوكيات (الاسم)، ومشاعره/ا، ومواقفه/ا يرجى التفكير والإجابة خلال الأشهر الستة الماضية مقارنةً بالمرحلة ما قبل الأزمة	أبداً	بعض الأحيان	أغلب الأوقات
هل طرح/ت (الاسم) تساؤلات كثيرة فيما يتعلق بالأزمة خلال الأشهر السّتة الماضية؟			
هل عبّر/ت (الاسم) عن ضيق و تذمّر خلال الأشهر السّتة الماضية مقارنةً بما قبل؟			
هل لاحظت أنّ شخصية وسلوك (الاسم) قد تأثّروا جرّاء الأزمة؟			
إلى أي حدّ شعر (الاسم) بالحزن، وعدم السّرور، والبكاء، في الأشهر الستة الماضية مقارنةً بما قبل؟			
إلى أي مدى يبدو القلق على (الاسم) في الأشهر السّتة الماضية مقارنةً بما قبل؟			
هل ت/يظهر(الاسم) أقلّ إهتمام ومتعة في القيام بالأعمال التي كانت تثير اهتمامه/ا خلال الأشهر الستة مقارنةً بما قبل؟			
هل يبدو على (الاسم) أنه/ا يشرد أكثر خلال الأشهر السّتة الماضية مقارنةً بما قبل؟			
هل لاحظت بعض التغيّيرات في نوم (الاسم) خلال الأشهر السّتة الماضية (صعوبة في النوم / كثرة في النوم / صعوبة في الاستيقاظ / نوم متقطع) مقارنةً بما قبل؟			
هل لاحظت على (الاسم) كثرة في الكوابيس أثناء النوم، أو زيادة في القصص المخيفة لديه/ا، خلال الأشهر السّتة الماضية مقارنةً بما قبل؟			
هل ظهر على (الاسم) الشّعور بالتعب أو إنخفاض (قلة) في الحركة خلال الأشهر الستة الماضية مقارنةً بما قبل؟			

هل ت/يعبر (الاسم) عن مشاعره/ا بعدم الأمان، وهل صار تخويفه/ا أسهل عمّا مضى في السّابق خلال الأشهر الستة الماضية؟ ما هي الأسباب؟ يرجى تحديد كل الأجوبة المطابقة: · الأزمات الإقتصادية · جائحة كورونا · انفجار 4 آب في بيروت · التعرّض للإساءة · الوضع الأسري · آخر، الرجاء التحديد			
هل عانى/ت (الاسم) من التبول اللاإرادي خلال الأشهر السّتة الماضية مقارنةً بما قبل؟			
هل لاحظت أي تغيير في شهية (الاسم) خلال الأشهر السّتة الماضية مقارنةً بما قبل؟			
هل واجه/ت (الاسم) خوف من الانفصال عنك/كِ أو عن أي مقدم رعاية آخر خلال الأشهر السّتة الماضية مقارنةً بما قبل؟			
هل اختلفت قدرة (الاسم) على تنظيم مشاعره/ا وضبطها في المواقف الجديدة خلال الأشهر السّتة الماضية مقارنةً بما قبل؟			

القسم التاسع : معلومات حول الصحة النفسية للمجيب (صاحب الاستمارة)

يرجى التفكير مالياً والإجابة عن سلوكك ومشاعرك ومواقفك خلال الأشهر الستة الماضية، مقارنةً بما مضى:	أبداً	بعض الأحيان	أغلب الأحيان
هل شعرت بصعوبة أكثر في ذهابك/كِ للعمل خلال الأشهر الستة الماضية مقارنةً بما قبل الأزمة؟			
هل شعرت بصعوبة أكثر في الإعتناء (الإهتمام) بأمور المنزل خلال الأشهر الستة الماضية مقارنةً بما قبل؟			
هل شعرت بصعوبة في الانسجام مع أشخاص آخرين في الأشهر الستة الماضية مقارنةً بما قبل؟			
هل شعرتِ/ت بتدني الإهتمام أو الإستمتاع لديكِ/ك عند قيامكِ/ك بالنشاطات خلال الأشهر الستة الماضية مقارنةً بما قبل؟			
هل شعرتِ/ت بالإحباط أو الاستياء خلال الأشهر الستة الماضية مقارنةً بما قبل؟			
هل شعرتِ/ت باليأس مقارنةً بما كنتِ/ت سابقاً؟			
هل شعرتِ/ت بالتوتر مقارنةً بما كنتِ/ت سابقاً؟			
هل شعرتِ/ت بالقلق حول الحياة اليومية خلال الأشهر الستة الماضية مقارنةً بما قبل الأزمة؟			
هل طرأ أي تغييرات على نومكِ/ك (مشكلة في النوم / صعوبة في الاستيقاظ / كثرة في ساعات النوم / كوابيس) خلال الأشهر الستة الماضية مقارنةً بما سبق؟			
هل شعرتِ/ت بالتعب أو الإجهاد خلال الأشهر الستة الماضية مقارنةً بما قبل؟			
هل طرأ أي تغييرات في شهيّة الطعام (انخفضت الشهية أو الإفراط بتناول الطعام) خلال الأشهر الستة الماضية مقارنةً بما سبق؟			
هل شعرتِ/ت بالفشل أو أنكِ/ك خذلتِ/ت نفسك أو عائلتك خلال الأشهر الستة الماضية مقارنةً بما قبل؟			

هل واجهت صعوبة في التركيز خلال الأشهر الستة الماضية مقارنةً بما قبل؟			
هل شعرتِ/ت بصعوبة في الحركة أو التحدث خلال الأشهر الستة الماضية مقارنةً بما قبل؟			
هل شعرتِ/ت بالتململ أو الاضطراب (عدم القدرة على البقاء ثابتًا وهادءًا) خلال الأشهر الستة الماضية مقارنةً بما قبل؟			
هل اختبرت أفكاراً مؤذية أو انتحارية خلال الأشهر الستة الماضية بعد الأزمة؟			
هل اهتممت بنظافتك الشخصيّة ومظهرك الخارجي بشكل أقلّ خلال الأشهر الستة الماضية مقارنةً بما قبل؟			
هل واجهت صعوبة التواصل أو الاستيعاب مع الشريك خلال الأشهر الستة الماضية بعد الأزمة؟ (condition based on answer in question 1.1.5)			
هل شعرتِ/ت بأن الاهتمام (الدعم) الذي قدمه شريكك لم يكن كافياً خلال الأشهر الستة الماضية بعد الأزمة؟ (condition based on answer in question 1.1.5)			

Appendix2 : English Questionnaires

Section 1: Demographics

Applicable for all participants

1.1. Information about the caregiver/respondent:

1.1.1. You are a:

- o Father
- o Mother
- o Relative (Brother/ Sister/ Aunt/Uncle/ Grandmother/Grandfather/Cousin)
- ○ Others caregivers (ex: Neighbor/ Childminder)

1.1.2. You are a

- o Male
- o Female
- o Other
- o Prefer not to say

1.1.3. What is your nationality?

- o Lebanese
- o Syrian
- o Palestinian
- o Other

1.1.4. What is your age?

- o 15-18 years
- o 19-22 years
- o 23-30 years
- o 31-35 years
- o 36-45 years
- o 46-55 years
- o 56 and above

1.1.5. What is your marital Status?

- o Married
- o Widowed
- o Single
- o Separated
- o Divorced
- o Missing partner

1.1.6. What is your educational level?

- o Illiterate
- o Literate
- o Finished primary school
- o Finished elementary school
- o Finished secondary school or technical school
- o Finished university
- o Other

1.2 Information about the family:

1.2.1. In which Governorate do you reside in Lebanon?

- o Beirut
- o Mount Lebanon
- o North
- o Beqaa
- o Nabatiyeh
- o South

1.2.2. Select the type of household you currently live in:

- o Apartment
- o House
- o Studio
- o Shared room
- o Tent
- o Other

1.2.3. How many people live in the household?

- 1
- 2
- 3
- 4
- 5
- 6
- more than 6

1.2.4. How many children under 8 years old live in the household?

- 1
- 2
- 3
- 4
- 5
- 6
- more than 6

1.3 Financial Information of the family

(In the following questions, we mean by caregiver anyone who takes care of the child other than his/her parents or one of his/her parents and is fully responsible for the upbringing and care of the child.)

1.3.1. What is your employment status?

o Full time employee
o Part time employee
o Fixed term employee/ Seasonal employee
o Commission and piece rate employee / temporary employee
o Self employed
o Not employed

1.3.2. Have any of the parents had to leave the family because of work? (Travel or work in a remote area...)

- o Yes, the mother.
- o Yes, the father.
- o Father and mother together.
- o The Child's caregiver (alternative to mother or father)
- o No
- o Prefer not to say

1.3.3. What was your family's total income last month?

- o 0 - 500'000 LBP
- o 500'000 - 1'000'000 LBP
- o 1'000'000 - 2'000'000 LBP
- o 2'000'000 - 4'000'000 LBP
- o 4'000'000 - 7'800'000LBP
- o More than 7'800'000 LBP

1.3.4. Have you received any monetary contributions or gifts that included rent or benefits payments from someone who does not live with you?

- o Yes
- o No
- o Prefer not to say

1.4 Information about the child in question

Choose one of the children who is under 8 years old and fill this questionnaire on their behalf. Choose the most affected child by the crisis that Lebanon is going through if this applies to one of your children.

I filled my questionnaire on behalf of my child:

1.4.1. Name of the child (please write the name in Arabic)

1.4.2. Sex of (name)

- Male
- Female

- Other

1.4.3. Nationality of (name)

- Lebanese
- Syrian
- Palestinian
- Other, please specify

1.4.4. Date of birth DD/MM/YYYY.

Section 2: Information about the early childhood development milestones

Applicable for age group

Section 3: Information about the early childhood education

Applicable for all age groups

3.1. Information about the child's access to learning

3.1.1. Has (name) had access to education (remote or face to face) this year (2021-2022)?

- Yes
- No
- Partially
- Not applicable

3.1.1.1. (If yes or partially), how is the attendance of (name) to the day care/kindergarten/school, (name) is attending on:

- o Daily basis
- o 2-3 times per week
- o A couple of times per month
- o Based on attendance requirements

3.1.1.2.If No or Partially, why? Select all that applies. (multiple selection)

(First, we listen to the participant's answer, and then we give choices.)

- The family did not have the ability to cover the transportation fees
- The family did not have the ability to cover the tuition fees
- The school closed
- Increase in COVID-19 cases or other infectious diseases
- Inability to access the internet and electricity for online learning
- Inability to access tools (laptop-phone-tablet, etc.) for online learning
- Inability to buy books and material to support the learning
- Lack of basic logistical means in schools (electricity, heating)
- Protests of teachers and educators
- In order to support the family and enter the labor market
- Other - Please specify

3.1.2. Who is the caregiver responsible for following up on the learning process (duties/understanding of learning goals) for (name)? (Multiple choices)

- Father
- Mother
- Grandfather
- Grandmother
- Brothers
- other, please specify

3.2. Information about the child's learning facility

3.2.1. Concerning the day care/kindergarten/school, what is the type of the facility

o Private
o Public
o Semi-free
o Other, please specify.

3.2.2. Are you able to cover the fees of the daycare/kindergarten/school

o Yes, fully able to cover the fees

o Yes, partially able to cover the fees

o Not able to cover the fees at all

3.2.2.1.(Condition if partially or not able), are you receiving any external support to cover the fees?

- Yes
- No

3.2.2.2.If yes, from who?

- Organization (NGO - local organization - etc.)
- Religious entities
- Political parties
- Relatives
- The association (school) itself - (for ex scholarship)
- Others

3.2.3. Do you think you will be able to cover the fees of the daycare/kindergarten/school next year?

o Yes, will fully be able to cover the fees

o Yes, will partially be able to cover the fees

o Won't be able to cover the fees at all

3.2.3.1.If Not, will you:

- Move (name) to a public school
- Move (name) to a less expensive private school
- Move (name) to a semi-free school
- Drop (name) out of school
- Other, please specify

3.2.4. About the transportation fees to the day care/kindergarten/school, what is the cost per month?

- o 0 LBP
- o 0 LBP to 300,000 LBP
- o 300 000 to 600 000 LBP
- o 600,000to 900,000 LBP
- o Above 1 million LBP

3.3. Information about the child's learning performance

3.3.1. Has (name)'s performance changed positively or negatively in comparison to classroom learning after the crisis?

(conditioning if they answer yes or partially in question 3.1.1)

- Yes
- No
- Partially

3.3.1.1.If yes, why? Please select all that applies: (multiple answers)

(First, we listen to the participant's answer, and then we give the choices)

- Decrease in the teachers' performance
- Lack of proper follow-up from the school's side
- Bullying or discrimination
- (Name) not having all the needed educational tools (books, etc.)
- Change (name)'s educational institution
- Change in (name)'s educational institution norms
- Having multiple interruption and school closures
- Failure to detect learning difficulties and needs
- Restricted interaction with friends
- Rushing to give the curriculum or putting a lot of pressure on finishing it
- Negative feelings experienced by the child recently (separation or grief- increased anxiety - fear - etc.)
- Other, please specify

3.3.1.2.If yes the performance changed, how? Please select all that applies: (multiple answers)

- Difficulty in assimilating the information
- Lack of interest in school
- Regressing grades
- Failure of (name) to adapt and accommodate or other students to social norms
- Difficulty to adhere to school norms (toilet breaks - snacks - talking - etc.)
- Difficulty to assimilate to classroom and peers rhythm
- Other, please specify

Section 4- Information about the early childhood health

Applicable for all age groups

4.1. Information about the medical checkups:

4.1.1. Does (name) have any disability?

- Yes
- No
- Prefer not to say

4.1.1.1. If yes, please specify: (multiple choice)

- Physical
- Sensory
- Neurological
- Cognitive
- Prefer not to say

4.1.2. Does (name) suffer from any chronic diseases?

- No
- Yes, please specify
- Prefer not to say

4.1.3. Following the Lebanese crisis, was (name) able to receive appropriate medical follow-up?

- Yes, easily
- Yes, with difficulty
- No
- Prefer not to say

4.1.3.1. When did you visit the pediatrician?

- On the specified time depending on the child's age
- We were late
- We didn't go on any date

4.1.3.2. Kindly specify the difficulties faced ensuring the proper follow-up to (Name):

- High fees
- Lack of professionals, due to their immigration
- Can’t afford the transportation fees
- Covid-19’s restrictions
- Covid-19’s anxiety and fear
- Political situation
- Waiting lists in organizations and health care centers
- Other, please specify

4.1.4. Following the crisis, did you have difficulty accessing medication for (name)?

- Yes
- No
- Didn't need any medicine.
- Prefer not to say

4.1.4.1. If yes, kindly specify the difficulties faced in order to insure the medication? (Multiple choices)

- Lack of medication in Lebanon
- High prices
- Electricity cuts affecting the storage of medication
- Other, please specify

4.1.4.2. If yes, Kindly select solutions applied in order to insure the medication (multiple choices)

- Buying the medication from outside Lebanon
- Buying them from black market
- Waiting for donation
- Receiving the medication from abroad relatives and friends
- Nothing
- Other, please specify

4.1.5. Has (name) received their mandatory vaccine shots?

- Yes
- No
- I don't know

4.1.5.1.If not, why?

- Inability to pay for the shots
- Unavailability of shots in the nearest facility
- Inability to reach the nearest medical facility
- Cultural or religious reasons
- Other

4.2. Information about the Medical Team

4.2.1. Who provides the medical checkups and shots for (name): (multiple answers)

o Doctor at private clinic عيادة طبيب خاص
o Clinics of ministries of health and/or social affairs مستوصف
o Clinics of local actors or NGOs
o Public Hospital clinic
o Private Hospital clinic
o Community practitioner الداية
o Other, please specify

4.2.2. Does your child need specialized follow-up from:

- Doctor/medical specialist

- Nurse
- Psychologist
- Child and adolescent psychiatrist
- Dental practitioner/Dentist
- Nutritionist
- Physical therapist
- Psychomotor therapist
- Speech therapist
- Special Education Teacher
- Social Worker
- Other, please specify
- Doesn't need any specialist help.

4.2.2.1. If the answer is yes, has (name) been followed up by specialists:

- Yes
- No

Section 5: Information about the early childhood nutrition

Yes How many times per week No Don't Know/No response

Applicable for under 2 years

5.1. Is (….) being breastfed?

5.2. Did (…) receive any fortified or special milk?

Applicable for more than 6 months

5.3. Does (name) drink clean water?

5.3.1. Specify the source of the water (name) drinks? o Bottled

o From the tap with filter

o From the tap without filter

o From the local water source العين - البير

o Don't know

5.4. Has the ability to eat enough changed on a daily basis in the past year?

5.5. Have the number of daily meals been reduced over the past year?

5.6. Has the quality of meals that the family consumes been adjusted over the past year? (e.g. in terms of meat use)

5.7. Has the household received food assistance during the last 3 months?

- Yes, once.
- Yes, more than once.
- All of it

Section 6: Information about the early childhood social and emotional development

Applicable for above 1 year

6.1 Information about the Screen Time of (name)

6.1.1. In the past month, approximately how many hours per day has (name) spent using a screen? (Includes computer, game consoles, cell phone, or TV)

- Didn't spend time on screens
- 0-1 hours per day
- 2-3 hours per day
- 4-6 hours per day
- 7- 10 hours per day
- 11 or more hours per day

6.1.2. Did the time (name) spent on screen increase or decrease in the past three months?

- Yes, increased
- Yes, decreased
- No, stayed the same

6.1.2.1. If it increased, why?

- Remote learning and school tasks given online
- More free time and no games to play
- No caregiver available to take care of them
- They want to spend time on screen

- Other, please specify

6.1.3. Does the time spent by (name) on the screen negatively affect his mood and behaviors?

- Always
- Frequently
- Don't know
- Sometimes
- Never

6.1.4. Do you or another caregiver supervise the access and screen activities of (name)? (ex: watch the videos, games, pictures, conversations, limit the accessibility through the settings)?

- No supervision
- Yes, the content is supervised
- Only setting the screen time limit
- I don't know

6.2 Information about (name)'s play

6.2.1. How much time of his total playing time did (name) spend in playing alone following the crisis?

o All of the time
o Most of the time
o More than half of the time
o Less than half of the time
o Some of the time
o At no time

6.2.2. How much time of his total playing time did (name) spend in playing with his peers/siblings following the crisis?

o All of the time
o Most of the time
o More than half of the time
o Less than half of the time

o Some of the time

o At no time

6.2.3. In comparison to before the crisis, how was the outdoor play time of (name) affected?

- It was reduced
- It remained the same
- It increased

6.2.4. Does (name) have toys to play with?

- Yes
- No

6.2.5. When was the last time, (name) received a new toy?

o Last week

o Last month

o Within the last three month ago

o 3 to 6 months ago

o 6 to 12 months ago

o More than a year ago

o Never

6.2.6. How much time do you spend playing with (name)?

o I don't play with (name)

o 0-1 hour per day

o 2-3 hours per day

o 4-6 hours per day

o More than 6 hours per day

6.2.7. Was your play time with (name) affected in the last year due to the crisis? (Having to work extra - caregiver away from home - child away from home- etc.)

- Yes, less time
- Yes, more time

- Partially
- No

6.2.8. In the past month, approximately how many hours per day has (name) spent using books/stories?

- Doesn't read.
- 15 minutes- an hour a day
- 2-3 hours a day
- 4-6 hours a day
- More than 6 hours a day

Section 7: Information about the changes brought by the pandemic/economic crisis.

Yes No Don't Know/no response

7.1. Has the household income undergone any decrease compared to one year earlier?

7.2. Did the household lose one or more of the jobs since the outbreak of COVID 19 and the economic crisis?

7.3. Did the household take debt in the past 30 days to cover basic needs (food/health/shelter)?

7.4. Have you had to sell a family inheritance or property over the past year?

- Yes
- No
- I'd rather not answer.

7.5. Has a family child under the age of eight stopped going to school this year to support the family for:

Applies to age 4 and above

- No child stopped going to school for these reasons.
- Taking care of his brothers
- Taking care of his parents.
- Lower costs
- Otherwise, please specify

7.6. Has the household location undergone any changes in the last year?

7.6.1. If yes, precise the reason
- Need more space
- Upgrade
- End of contract
- Forced to move
- Rent is too high
- Closer to job or school
- Other, please specify

7.7. Did the household reduce the expenses on Education/Food/Transportation during the last year?

7.8. Was the provision of clothes for the family members reduced during the last year?

7.9. Has access to sanitary items and hygiene material such as masks, disinfectants, wipes, diapers, soap, etc., declined?

7.10. Has the family's ability to provide a heating or cooling system declined during cold or hot weather?

7.11. Did you have to leave (name) alone at home or somewhere else to be able to attend work?

7.12. When (name) misbehaved in the past year, did you find yourself using methods like shouting, hitting, spanking, or similar forms of disciplinary methods more than before?
- Yes, often
- Yes, sometimes
- Never used them
- No, same as before

Section 8: Information about the child's mental health

Applicable for 2 years and above

Please reflect on (name)'s behaviors, feelings, attitude within the past six months following the crisis in comparison to before. Never Sometimes Often

8.1. Did (name) start asking more questions about the crisis in the past 6 months?

8.2. Did (name) express more distress and nagging in the past 6 months in comparison to before?

8.3. Did you notice (name)'s personality and behavior being affected by the crisis?

8.4. How much did (name) feel sad, unhappy, tearful in the past 6 months in comparison to before?

8.5. How much did (name) seem worried in the past 6 months in comparison to before?

8.6. Did (name) seem to have less interest or pleasure in doing things in the past 6 months in comparison to before?

8.7. Did (name) seem to daydream more in the past 6 months in comparison to before?

8.8. Have you noticed any changes in (name)'s sleep in the past 6 months in comparison to before? (trouble sleeping, difficulty waking up, sleeping too much, or interrupted sleep)?

8.9. Have you noticed an increase of nightmares or scary stories in (name) in the past 6 months in comparison to before?

8.10. Has (name) seemed to feel tired or to have little energy in the past 6 months in comparison to before?

8.11. Does (name) express feelings of insecurity and is easily scared in the past 6 months in comparison to before?

8.11.1. What are the reasons, please select all that applies:

- Economic Crises
- Covid-19's pandemic
- 4th of August's Beirut's blast
- Abuse
- Family situation, please specify
- Other:

8.12. Did (name) have enuresis in the past 6 months in comparison to before?

8.13. Have you noticed any change in (name)'s appetite in the past 6 months in comparison to before?

8.14. Did (name) have trouble with separation from you or any other caregiver in the past 6 months in comparison to before? (e.g. cries out, feels anxious, etc.)

8.15. Has (name) ability to regulate her/his emotions in a new situation changed in the past 6 months in comparison to before?

Section 9: Information about the respondent's mental health

Please reflect on your own behaviors, feelings, and attitudes within the past six months in comparison to before Never Sometimes Often

9.1. Did you experience more difficulty going to work in the past 6 months in comparison to before the crisis?

9.2. Did you experience more difficulty taking care of things at home in the past 6 months in comparison to before?

9.3. Did you experience difficulty getting along with other people in the past 6 months after the crisis?

9.4. Did you feel less interest or no pleasure in doing activities in the past 6 months in comparison to before?

9.5. Did you feel down or depressed in the past 6 months in comparison to before?

9.6. Did you feel hopeless in the past 6 months in comparison to before?

9.7. Did you feel nervous in the past 6 months in comparison to before?

9.8. Did you feel anxious about daily life in the past 6 months after the crisis?

9.9. Have you had changes in your sleep in the past 6 months in comparison to before? (trouble sleeping, difficulty waking up, sleeping too much, or interrupted sleep, nightmares)?

9.10. Did you feel tired or have little energy in the past 6 months in comparison to before?

9.11. Did you experience poor appetite or overeating in the past 6 months in comparison to before?

9.12. Did you feel that you are a failure or that you let yourself or your family down in the past 6 months in comparison to before?

9.13. Did you have trouble concentrating on things in the past 6 months in comparison to before?

9.14. Did you experience being slow in moving or speaking in the past 6 months in comparison to before?

9.15. Did you experience being fidgety or restless in the past 6 months in comparison to before?

9.16. Did you experience harmful or suicidal thoughts in the past 6 months after the crisis?

9.17. Did you take less care of your hygiene and appearance in the past 6 months in comparison to before?

9.18. Did you feel less tolerant or communicative with your spouse in the past 6 months after the crisis?

(condition based on answer in question 1.1.5)

9.19. Did you feel that the support you were receiving from your spouse was not enough in the past 6 months after the crisis?

(condition based on answer in question 1.1.5)

Appendix 3: FGD Interview questions

Teachers' FG questions on the impact of Lebanese crisis on ECD

1- Did you face changes in your teaching modality during the last three years? If yes, what was the hard part for the students about this change? What was the challenge for the students in this switch?
2- How did the changes affect the students' access to Education/attendance, motivation to learning and engagement in the learning process?
3- Can you describe the impact of the latest crisis on the wellbeing of the students? Give examples on changed behaviors.
4- What are the biggest concerns in Education in the ECD context in the actual situation?
5- Do you think Education is still an important supported component in the ECD in Lebanon? If not, why?
6- What is the support you might suggest in order to enhance the quality of Education?
7-

Healthcare FG questions on the impact of Lebanese crisis on ECD medical services

1- How do you define the children healthcare provision and access to medical services during the last two years?
2- Are there any challenges in accessing the needed resources, devices and care tools needed for medical services (checks ups/shots…) for children in the last years? How these challenges are being handled? What were the intervention plans implemented?
3- What are the fundamental impact of these challenges on the children health and development?
4- Can you describe the impact of the latest crisis (exposure, crisis peak, long term effects) on the children wellbeing?
5- What are the main medical cases that raised in the domain of children healthcare in the last two years?
6- Did you experience changes in children access to healthcare services? What were these changes? Do you think it has an impact on their medical being? If yes, how?
7- What is the support needed in order to enhance the children access to medical services?

Parent FG questions on Impact of Lebanese crisis on ECD.

1- In the last two years, did your household undergo any changes on socioeconomic status (occupation, education, income, wealth and where your family lives)? If yes, on which level and how these changes impacted your child's life in general?

2- Which of these changes had the most impact on your child(ren) wellbeing? Give examples about the changes in your child(ren) behaviors.
3- Did you face barriers to enroll your child(ren) or one of your children in education setting/remote education? If yes, what are these barriers? How did you overcome it?
4- Did you face barriers to provide regular daily meals for your child(ren)? What is the reason behind these barriers? What are the changes in food provision? Could you mitigate these challenges?
5- How did the household cope with the increase in prices of primary medical services/medicines needed for children?
6- Do you think your household is in need for external financial support to guarantee a quality life for your child? If yes, on which level the financial support might be needed the most?

Parent FG questions on Impact of Lebanese crisis on ECD.

1- في العامين الماضيين ، هل واجهت أُسرتك أيّ تغييرات في الحالة الاجتماعيّة والاقتصاديّة (المهنة ،الحصول على التّعليم ، قيمة الدخل ، الثروة ، مكان الأقامة)؟ إذا كانت الإجابة بنعم ، على أي مستوى وكيف أثّرت هذه التّغييرات على حياة طفلك بشكل عام؟

2- أي من هذه التّغييرات كان لها الأثر الأكبر على رفاهية طفلك (أطفالك)؟ أعط أمثلة عن التّغييرات التي ظهرت في سلوكيات طفلك.

3- هل واجهت عوائق في تسجيل طفلك أو أحد أطفالك في اطار التّعليم / التّعليم عن بعد؟ إذا كانت الإجابة بنعم ، فما هي هذه العوائق؟ كيف تغلّبتم عليها؟

4- هل واجهت صعوبات في تقديم وجبات يوميّة مُنتظمة لطفلك (أطفالك)؟ ما سبب هذه الصعوبات؟ ما هي التّغييرات في امكانيتك لتوفير الغذاء؟ هل أمكنك التّخفيف من هذه التّحديات؟

5- كيف تعاملت الأسرة مع ارتفاع أسعار الخدمات الطبية الأوليّة / الأدوية اللازمة للأطفال؟

6- هل تعتقد أن أسرتك بحاجة إلى دعم مالي خارجي لِضمان حياة جيّدة لطفلك؟ إذا كانت الإجابة بنعم ، على أي مستوى قد تكون هناك حاجة ماسّة للدعم الماليّ؟

Healthcare FG questions on the impact of Lebanese crisis on ECD medical services

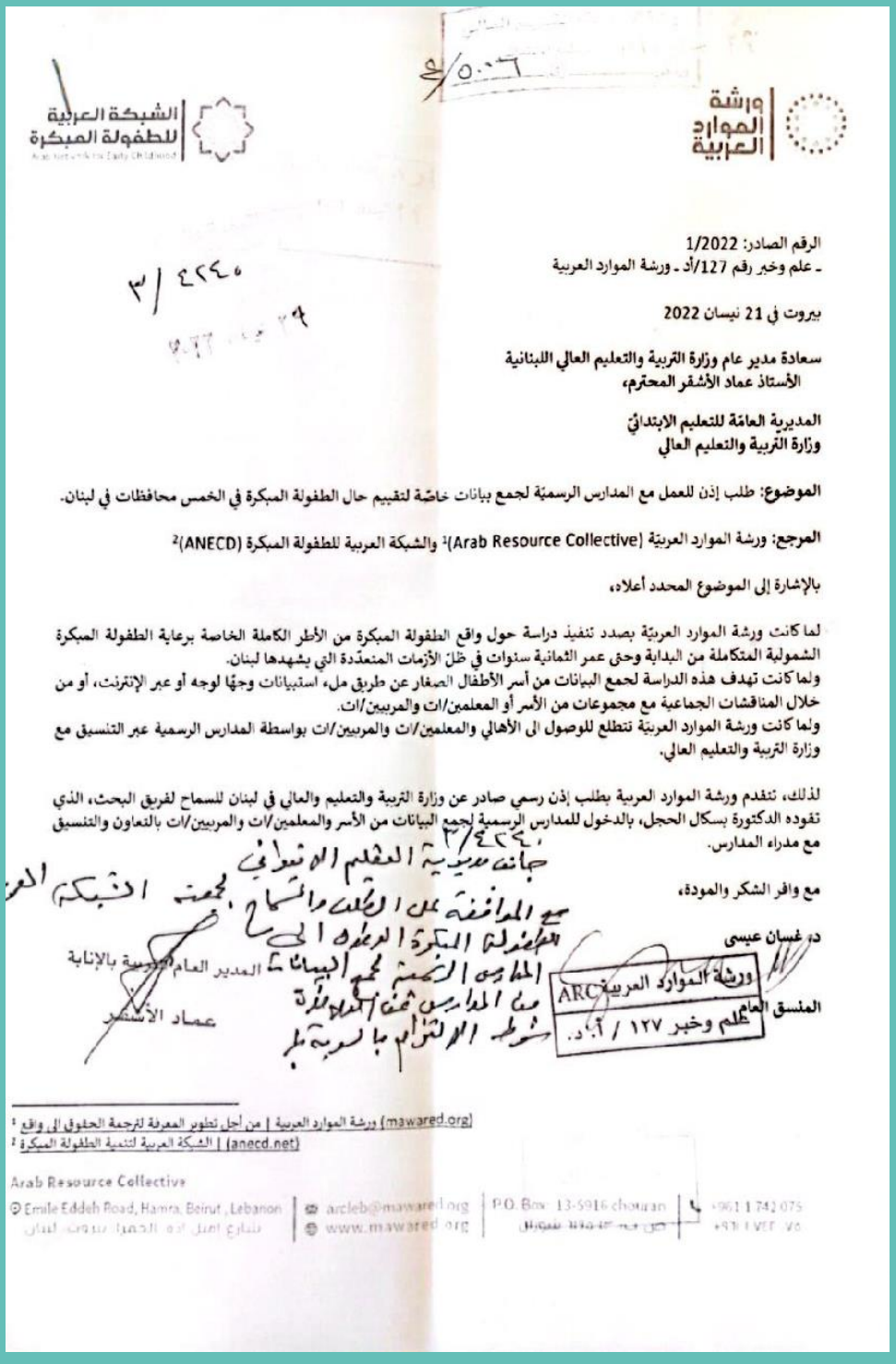
2. كيف تصنّف و تصف الرّعاية الصحيّة للأطفال والحصول على الخدمات الطبيّة خلال العامين الماضيين؟
3. هل هناك أي تحدّيات في الوصول إلى الموارد والأجهزة وأدوات الرّعاية اللّازمة للخدمات الطبيّة (فحوصات / لقاحات ...) للأطفال في السّنوات الماضية؟ ما هي؟ كيف يتم التّعامل مع هذه التحديات؟ ما هي خطط التّدخل التي تمّ تنفيذها؟
4. ما هو الأثر الأساسيّ لهذه التّحديات على صحّة الأطفال ونموّهم؟
5. هل يمكنك وصف تأثير الأزمات الأخيرة (اثر مباشر ،اثر غير مباشر ، الآثار طويلة المدى) على رفاهية الأطفال؟

6. ما هي أهمّ الحالات الطبّية التي ظهرت و استجدّت في مجال رعاية الأطفال في العامين الماضيين؟
7. هل لاحظت تغييرات في امكانيّة الأطفال الحصول على خدمات الرعاية الصحيّة؟ ما هي هذه التغييرات؟ هل تعتقد أن لها تأثير على وضعهم الطّبي و على رفاههم الصحّي؟ إذا كانت الإجابة نعم ، فكيف؟
8. ما هو الدّعم المطلوب لتعزيز حصول الأطفال على الخدمات الطبيّة؟

Teachers' FG questions on the impact of Lebanese crisis on ECD

9. هل واجهت تغييرات في طريقة التّدريس خلال السّنوات الثّلاث الماضية (تدريس عن بعد, تدريس حضوري) ؟ إذا كانت الإجابة نعم ، فما هو الجزء الصّعب على الطّلاب بشأن هذا التغيير؟ ما هو التّحدي الذي واجهه الطلاب جراء هذا التغيير؟
10. كيف أثّرت التّغييرات على حصول الطّلاب على الخدمات التعليميّة / على نسبة الحضور ، على الدافع للتعلّم والمشاركة في عملية التعلُّم؟
11. هل يمكنك وصف تأثير الأزمة الأخيرة على رفاهية الطلاب؟ أعط أمثلة على السلوكيات المتغيّرة.
12. ما هي أكبر تحديات التّعليم في الواقع الحالي؟
13. هل تعتقد أن التّعليم لا يزال مكوِّنًا مُهِمًا في مجال تنمية الطفولة في لبنان؟ إذا لم يكن كذلك ، فلماذا؟
14. ما هو الدّعم الذي قد تقترحه لتحسين جودة التّعليم؟

Appendix 4: Approval letter from MEHE



ورشة الموارد العربية

الشبكة العربية للطفولة المبكرة

الرقم الصادر: 1/2022
- علم وخبر رقم 127/أ - ورشة الموارد العربية

بيروت في 21 نيسان 2022

سعادة مدير عام وزارة التربية والتعليم العالي اللبنانية
الأستاذ عماد الأشقر المحترم،

المديرية العامّة للتعليم الابتدائي
وزارة التربية والتعليم العالي

الموضوع: طلب إذن للعمل مع المدارس الرسميّة لجمع بيانات خاصّة لتقييم حال الطفولة المبكرة في الخمس محافظات في لبنان.

المرجع: ورشة الموارد العربيّة (Arab Resource Collective)[1] والشبكة العربية للطفولة المبكرة (ANECD)[2]

بالإشارة إلى الموضوع المحدد أعلاه،

لما كانت ورشة الموارد العربيّة بصدد تنفيذ دراسة حول واقع الطفولة المبكرة من الأطر الكاملة الخاصة برعاية الطفولة المبكرة الشمولية المتكاملة من البداية وحتى عمر الثمانية سنوات في ظلّ الأزمات المتعدّدة التي يشهدها لبنان.
ولما كانت تهدف هذه الدراسة لجمع البيانات من أسر الأطفال الصغار عن طريق ملء استبيانات وجهًا لوجه أو عبر الإنترنت، أو من خلال المناقشات الجماعية مع مجموعات من الأمر أو المعلمين/ات والمربيين/ات.
ولما كانت ورشة الموارد العربيّة تتطلع للوصول الى الأهالي والمعلمين/ات والمربيين/ات بواسطة المدارس الرسمية عبر التنسيق مع وزارة التربية والتعليم العالي.

لذلك، تتقدم ورشة الموارد العربية بطلب إذن رسمي صادر عن وزارة التربية والتعليم والعالي في لبنان للسماح لفريق البحث، الذي تقوده الدكتورة بسكال الحجل، بالدخول للمدارس الرسمية لجمع البيانات من الأسر والمعلمين/ات والمربيين/ات بالتعاون والتنسيق مع مدراء المدارس.

مع وافر الشكر والمودة،

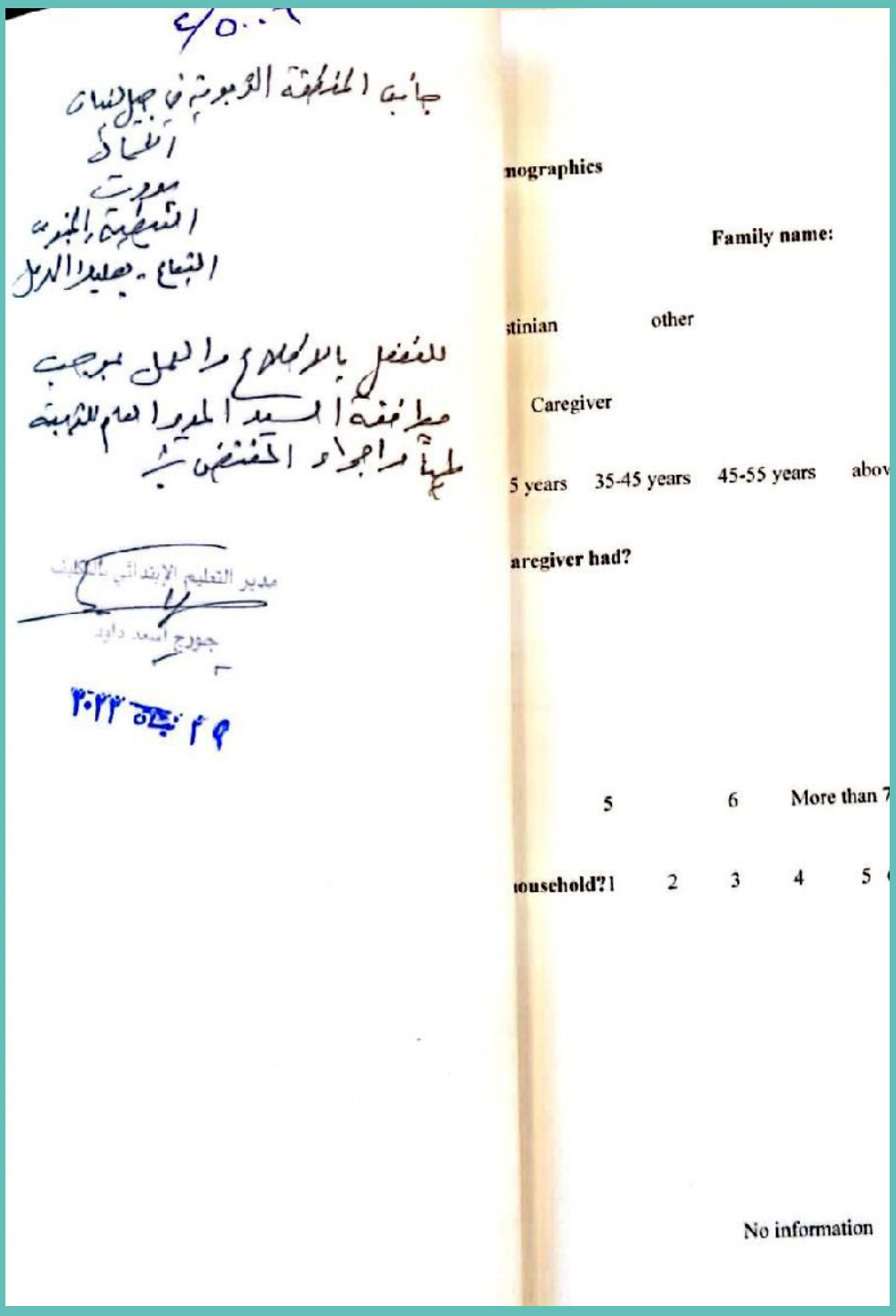
د. غسان عيسى
المنسق العام

ورشة الموارد العربية ARC
علم وخبر ١٢٧ / أ.د.

المدير العام للتربية بالإنابة
عماد الأشقر

[1] ورشة الموارد العربية | من أجل تطوير المعرفة لترجمة الحقوق إلى واقع (mawared.org)
[2] الشبكة العربية لتنمية الطفولة المبكرة | (anecd.net)

Arab Resource Collective
Emile Eddeh Road, Hamra, Beirut, Lebanon | arcleb@mawared.org | www.mawared.org | P.O. Box 13-5916 chouran | +961 1 741 075



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No information

Appendix 5: Coding

Parents	Bekaa	Beirut	Mount Lebanon	South	North
CSE*	/	/	/	/	/
CC**	/	/	/		
FH***	/			/	/
CSEWB****	/	/	/	/	/
PACH*****	/	/	/	/	/
*changes in Socio Economics					
**Cope with the Changes					
***Factors Helped					
****Childs Social and Economical Well being					
*****Barriers to Enroll Child					
******Crisis affecting Food and Water					
*******Prices affecting your Child Health					
Teachers	Bekaa	Beirut	Mount Lebanon	South	North
CO*	/	/	/	/	/
CCC**	/	/	/	/	/
FH***	/	/	/	/	/
SA****	/	/	/	/	/
StM*****	/	/	/	/	/
IS******	/	/	/	/	/
CC*******	/	/	/	/	/
SR********	/	/	/	/	/
*Challenges Online					
**Cope with the Changes/Challenges					
***Factors Helped					
****School Activities					
*****Students Motivation					
******Impact on Student					
*******Common Challenges					
********Support Received					
Health Cares	Bekaa	Beirut	Mount Lebanon	South	North
CH*	/	/	/	/	/
CF**	/	/	/	/	/
P***	/	/	/	/	/
FI****	/	/	/	/	/

MC*****	/	/	/	/	/
SN******	/	/	/	/	/
*Challenges Healthcare					
**Challenges Faced					
***Plans					
****Fundamental Impact					
*****Medical Cases					
******Support Needed					