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# Regional Baseline Study

MADAD Programme: 'Addressing vulnerabilities of refugees and host communities in five countries affected by the Syria Crisis'

# Final Report

Prepared for //
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# Contents

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# Acronyms

| | |
|---|---|
| CBHFA | Community-based Health and First Aid |
| DRC | Danish Red Cross |
| DRR | Disaster Risk Reduction |
| ERC | Egypt Red Crescent Society |
| EU | European Union |
| FGD | Focus Group Discussion |
| FRC | French Red Cross |
| FRIT | EU's Facility for Refugees in Turkey |
| GRC | German Red Cross |
| HIV | Human Immunodeficiency Virus |
| HNS | Host National Society |
| IDP | Internally Displaced Person |
| IFRC | International Federation of Red Cross and Red Crescent Societies |
| IRCS | Iraqi Red Crescent Society |
| JRCS | Jordanian Red Crescent Society |
| KII | Key Informant Interview |
| LRC | Lebanese Red Cross |
| M&E | Monitoring and Evaluation |
| MADAD | EU Regional Trust Fund in Response to the Syria Crisis |
| NCD | Non-Communicable Diseases |
| NLRC | Netherlands Red Cross |
| NorCross | Norwegian Red Cross |
| PRCS | Palestinian Red Crescent Society |
| PSS | Psychosocial Support |
| RCRC | Red Cross/ Red Crescent |
| SRC | Swedish Red Cross |
| SpRC | Spanish Red Cross |
| SwissRC | Swiss Red Cross |
| TOR | Terms of Reference |
| TRCS | Turkish Red Crescent Society |
| UNRWA | United Nations Relief and Works Agency for Palestine Refugees in the Near East |
| VCA | Vulnerability and Capacity Assessment |

# Introduction

## Background

The MADAD programme "Addressing vulnerabilities of refugees and host communities in five countries affected by the Syria Crisis" aims to provide a coherent, regional and coordinated response to the Syria crisis. The programme is implemented by a consortium led at the regional level by the Danish Red Cross (DRC), and in each country by IFRC or a European Red Cross partner working in conjunction with Host National Societies (HNS) and, in some cases, other Red Cross and Red Crescent (RCRC) partners. Activities are being implemented in Lebanon, Jordan, Egypt, Iraq and Turkey.

The overall objective of the programme, which aims to target one million beneficiaries, is to contribute to the wellbeing, resilience and peaceful coexistence among vulnerable refugees and host communities in countries affected by the Syria crisis. The intervention logic of the programme is two-fold: it has a focus on community development, health and livelihoods in relation to beneficiaries who are from host and refugee communities; and it also contributes to building RCRC capacity to identify and reach out to vulnerable groups.

The budget for the MADAD programme is €53 million. The programme will be implemented over 36 months (from December 2016), and it is funded under the European Union's MADAD Trust Fund. The Turkey component of the MADAD programme is managed by the EU's Facility for Refugees in Turkey.

IOD PARC was commissioned in June 2017 to carry out the MADAD regional baseline study. The aim of this consultancy was to undertake the baseline study in the five countries to operationalise and kick-start the programme's monitoring and evaluation system. The consultancy process focused on shared outcomes across the countries and complemented country-level processes such as labour market assessments and Vulnerability and Capacity Assessments (VCAs), as well as baseline country studies. IOD PARC was responsible for conducting the country baseline studies in Jordan and Turkey. Other country processes were undertaken by RCRC partners in Lebanon, Iraq and Egypt.

The regional baseline study focused on the outcome level (Specific Objectives) of the MADAD programme logical framework, which is consistent with the EU MADAD Trust Fund Results Framework:

- ***Outcome 1:*** *Refugees from Syria and host communities are more self-reliant and resilient to prevalent risks and local conflicts*
- ***Outcome 2:*** *Refugees from Syria and host communities have improved health and psychosocial well-being*
- ***Outcome 3:*** *RCRC Host National Societies in the region have strengthened their capacity and enhanced their ability to reach out to most vulnerable groups within the refugees and host communities*

This report presents the findings from the regional baseline study process. In the following sections, it sets out the methodology and limitations of the baseline. The report then outlines the demographic data of respondents, provides an overview of the main findings, and then moves on to present detailed findings on the two levels of inquiry for this study: in relation to beneficiaries on community development, health and livelihoods; and in terms of RCRC staff, focusing on capacity and training for delivering the MADAD programme. At the end of the report we offer some conclusions and recommendations for moving forward and for operationalising the programme's monitoring and evaluation (M&E) framework.

## Methodology

The consultancy was undertaken over a period of six months, and was divided into five main phases: inception, coordination between regional and national processes, data collection, data analysis, and reporting. Even though these were designed as distinct phases, some of them overlapped to ensure a participatory process between IOD PARC and the whole MADAD team.

During the **inception phase**, the IOD PARC team familiarised itself with the programme and existing material and produced an inception report together with an inquiry matrix. The inquiry matrix outlined specific areas of inquiry, parameters of the set indicators, points for clarification, and corresponding inquiry questions, including triangulation questions. These documents were shared with the MADAD team for comments and feedback. The inquiry matrix was further refined following on from a regional baseline inception workshop in early July, which helped to further focus the areas of inquiry and make the baseline exercise manageable within the resources available. During the inception phase we also launched **coordination between regional and national processes** through team visits to Lebanon, Jordan, and Iraq where the inquiry matrix was discussed in more detail, and focal points were identified for communication with IOD PARC throughout the baseline process. The Lebanon visit brought together all partners, and we also engaged with the Egypt and Turkey teams there.

Once the inquiry matrix was finalised (see Annex 5), the team designed the methodology for the baseline study, which included a baseline survey administered as a household survey, and focus group discussion (FGD) tool to engage with beneficiaries under Outcomes 1 and 2; and Key Informant Interview (KII) and FGD tools for RCRC staff and volunteers for Outcome 3. The survey and FGD tools were tailored to collect data from each country that was relevant to the intervention there; not all questions were applicable to all countries and locations.

We prepared a methodology manual that brought together the survey and FGD tools aimed at beneficiaries, and that provided guidance for enumerators and RCRC staff on the questions, as well as outlining a sampling strategy for each partner country (please see Annex 6 for data collection tools and sampling strategy). The methodology manual and tools were shared with partners for comment and feedback before being finalised, and the tools were then translated into Arabic and Turkish. Due to time constraints, we were unable to trial the tools prior to rolling out. The survey was uploaded in the three languages (English, Arabic and Turkish) into SurveyGizmo, the software that we used to roll out the survey.

The methodology manual was the basis for training enumerators and HNS staff involved in data collection to ensure common understanding of the data collection tools. Since IOD PARC carried out country baselines for Turkey and Jordan, the team visited both countries and was responsible for training enumerators and staff on the use of the data collection tools, which included both regional and country tools integrated together, and also on the use of the SurveyGizmo software. In other countries, the training of enumerators and HNS staff was undertaken in-house relying on the methodology manual, with remote support provided by IOD PARC where needed.

Each country team was responsible for undertaking **data collection** with beneficiaries for the baseline study. Data collection took place between August and October 2017. The baseline survey was administered by paper in Egypt, Turkey, Lebanon (PRCS) and Iraq, and responses were then uploaded onto the SurveyGizmo tool; and using tablets in Jordan and Lebanon (LRC), which collected data offline that was then uploaded onto the software. During this phase, IOD PARC provided remote support to the various country teams. We also collected data on Outcome 3 by conducting FGDs with staff and volunteers, and KIIs with IFRC/ European partners and HNS. Data collection for Outcome 3 was done remotely for Lebanon (LRC) and Iraq, and by the IOD PARC team during country baseline visits in Jordan and Turkey. Outcome 3 was not applicable to Egypt and Lebanon (PRCS).

We received 3,159 survey responses to the baseline survey on SurveyGizmo and retained 3,035. The remaining 124 responses were disqualified for being incomplete, for containing incomplete fields that were compulsory, or for being inconsistent with the answers expected for each context: for instance, a Jordanian respondent in Lebanon, and an Egyptian respondent in Iraq. We recognise the fluidity of the region, but including these inconsistent responses would not have enriched the analysis as they were

stand-alone responses for the most part and appear as outliers in graphs and figures. Cleaning the data did not significantly affect the samples for the countries.

The table below provides an overview of responses per country, providing detail of the breakdown where different RCRC partners were involved and/ or project components were implemented differently in various locations. Sampling strategies were tailored to accommodate these divergences, and the confidence level achieved with the responses received is detailed in the table too.

*Table 1: Number of responses per country and agency or location and confidence levels*

| Country | Agency/ location | Number of responses | Confidence levels |
|---|---|---|---|
| Lebanon | LRC: 353 | 679 | 90 percent, margin of error of 5 |
| | PRCS: 326 | | |
| Turkey | | 406 | |
| Jordan | | 414 | |
| Iraq | FRC: 272 | 716 | 90 percent, margin of error of 3 |
| | NorCross: 444 | | |
| Egypt | Alexandria: 303 | 820 | |
| | Cairo: 517 | | |
| | **Totals** | 3,035 | |

FGDs with beneficiaries were conducted in Lebanon, Jordan, Turkey and Iraq with host and refugee/ IDP communities, and disaggregated by age and gender. Each FGD was composed of eight participants, and notes were recorded using a standard template provided by IOD PARC. No FGDs were received from Egypt as these were not completed within the data collection timeframe.

- In Lebanon, LRC conducted a total of eight FGDs in Ghazieh, Kfar Chelane, Aamar Al Baykat, Hawouch El Rafika. PRCS conducted nine FGDs in Shatila, Burj El Barajneh and Qasmieh refugee camps.
- Eight FGDs were conducted in Turkey in the six locations where the survey was rolled out: Ankara, Mardin, Konya, Kayseri, Kahramanmaraş and Şanlıurfa.
- In Jordan, eight FGDs were conducted in two locations, Amman and Ajloun.
- A total of 13 FGDs were conducted in Iraq, divided between livelihood and health, in Erbil and Dohuk.

For Outcome 3, there are two indicators. Indicator 3.1 measures the increase in number of beneficiaries reached by HNS interventions by the end of the project. We have relied on figures of beneficiaries reached provided by HNS in 2016 to draw the baseline value for this indicator. We emphasised the need to ensure that the figures provided were counting people, not services; and that in recording this information for MADAD, there is a clear way of ensuring that it is possible to isolate beneficiaries being reached by the MADAD intervention.

Indicator 3.2 measures staff and volunteer improved competence and confidence in reaching out to vulnerable groups. Since it is not possible to baseline this value as it measures an improvement in competence and confidence, we instead conducted KIIs and FGDs to contextualise staff and volunteer capacity to implement the MADAD programme, and their ability to identify vulnerable beneficiaries. We conducted ten KIIs with IFRC/ European partners: two in Lebanon with NLRC and LRC; two in Turkey with IFRC and TRCS; two in Iraq with FRC and IRCS; and four in Jordan, two with IFRC and two with JRCS. We also conducted one FGD with HNS staff and/ or volunteers in Lebanon (LRC), Jordan, Turkey and Iraq. These KIIs and FGDs were helpful for contextualising training needs and capacity, ability to identify vulnerable populations, and challenges faced by HNS in relation to MADAD as well as more generally. Please see Annex 3 for a list of people interviewed.

Once we cleaned and organised the data, we conducted the **data analysis** and **reporting** phases simultaneously. For the analysis of the baseline survey and visualisation of results, we employed SurveyGizmo's analysis tools, as well as Tableau and Excel. For the qualitative data from FGDs and KIIs, we compared responses per intervention area and analysed key themes common to all groups and countries, as well as disaggregated per category (refugee/ IDP or host community, age and gender); and we triangulated responses against the baseline survey results.

The reporting phase included the drafting of this baseline study report, as well as filling out the country and regional logframes at outcome level, and preparing a presentation for a debriefing of partners in Copenhagen on 4-5 December 2017.

## Limitations

The consultancy team faced some limitations in conducting this baseline study, which we outline below:

- The MADAD programme is being implemented differently in each of the five countries with activities to fit each country context, and in some cases different parts of the intervention are applicable in each country and even within countries. This posed a challenge in designing the survey, in defining sample sizes, and in finding ways of ensuring that FGDs were representative enough to allow triangulation. We had very constructive exchanges with country teams, which allowed us to mitigate this limitation and sample sizes were appropriate; and we are overall satisfied with the spread of FGDs given the scope and time limitations of the baseline study. We also recognise that data collection was at times difficult, for instance in the Iraq context where it was dependent on the security situation.

- At inception, we outlined options for sampling and decided to go for a sample number that would be representative of the MADAD target in the country. We were unable to have a statistically significant sample for each of the disaggregated categories that are of interest to this study (host community, refugees and IDPs); this would have meant that the sample was considerably larger. We decided that we would sample a representative number in relation to the MADAD target, and then country teams would ensure that sample was representative of age, gender and host community/ refugee/ IDP breakdowns in the surveyed locations. This was not done in all cases due to the timeframe of delivery of the survey (daytime, data collection windows), as well as the need for some country teams to collect data that would be valuable for their intervention model. The final distribution of responses may have skewed some of our conclusions. This report is presented as findings on the sample, without a claim to represent the overall population in the surveyed countries.

- The IOD PARC team was unable to use responses from Palestinian refugees from Syria and Syrians who were living alongside Palestinian refugees in Lebanon. We received 29 and 15 responses from these groups, respectively, and we are unable to calculate baseline values for these groups based on the low level of response. As such, we have only calculated responses from Palestinian refugees in Lebanon for the figures related to the PRCS intervention there.

- Some of the FGD notes did not provide detailed answers to the questions, and in some cases only included yes/ no or one-sentence answers. This limited detail has meant that the IOD PARC team has faced constraints in triangulating survey answers, and had little qualitative material to understand the questions in depth. Some HNS teams reported that it was difficult to gather information in FGDs due to the reluctance of participants to elaborate on their answers, the size of FGD groups, the length of the FGD question list, and for FGDs conducted with women, the presence of children in the room.

- 46 focus groups were undertaken with beneficiaries as part of the baseline and these needed to consider the perspectives of men and women, age groups and community (host, IDP and refugee), and in some countries location of the intervention. It was not possible to conduct FGDs in all locations for all the groups of interest to this study; this would have been time

consuming and would have required considerable additional effort from RCRC staff involved in FGD data collection.

- We did not receive FGD material from Egypt. The Egypt country team provided a summary document outlining some of the key challenges faced in the Egypt context by beneficiaries, but we are unable to use these notes as triangulation. The FGD format template we provided had been linked with survey questions to allow triangulation. The notes provided by the Egypt team, while rich in detail, do not conform with the IOD PARC template.

- The data collection process relied on enumerators in each of the countries who had to be trained on data collection tools, both in terms of reaching a common understanding at regional level on the survey questions, as well as on the use of the survey software we employed. The process was lengthy but successful, which is reflected in the high number of valid responses we have recorded. HNS staff who were involved in collection of qualitative FGD data were also trained on the FGD tool.

- During IOD PARC meetings with the country teams, we occasionally faced communication barriers in countries where the consultancy team relied on a translator. A good translator was not always available, and this influenced the level of understanding between the HNS team staff and the consultant.

- Due to budget restrictions, the DRC MADAD team planned IOD PARC missions only to four countries instead of five. Egypt was deliberately not included in the plan because of the reduced size of the intervention. This limited IOD PARC's ability to support the Egypt team in the baseline process and meant that all communications were via email and Skype.

- The baseline study process was undertaken alongside the launch of the project, and recognising that country teams were engaged in preparatory work for the activities and, at times, for defining the locations where the intervention would be focused (e.g. VCAs, and labour market assessments). This is an understandable overlap, but one that required adaptation to these processes. This adaptation process meant that the timeline for completing the baseline was longer than expected, but it also ensured a more robust and relevant baseline was conducted.

- We defined categories for respondents that were in line with the MADAD intervention. This was necessary to facilitate the analysis and to allow us to draw on trends across the region and in countries. However, these categorisations at times also exposed some of the challenges of pre-establishing categories. For instance, the survey focuses largely on Syrians, but we received responses from Syrians who were habitually resident in some countries; and there is inter-marriage between communities predating the Syria crisis. Similarly, we received IDP responses in Turkey and Jordan where this category is not applicable to MADAD, but where there may be IDPs from areas bordering conflict zones. These outliers illustrate the fluidity of the region, but we did not account for them to present data in a way that is consistent with the intervention design.

# Demographic data and trends

Our analysis is based on 3,035 survey responses from the five MADAD countries, and 46 FGDs with beneficiaries in Lebanon, Jordan, Turkey and Iraq. The survey was administered in the following locations per country. In Lebanon, a smaller number of surveys was collected than targeted, and a slightly higher number of surveys were collected in Iraq.

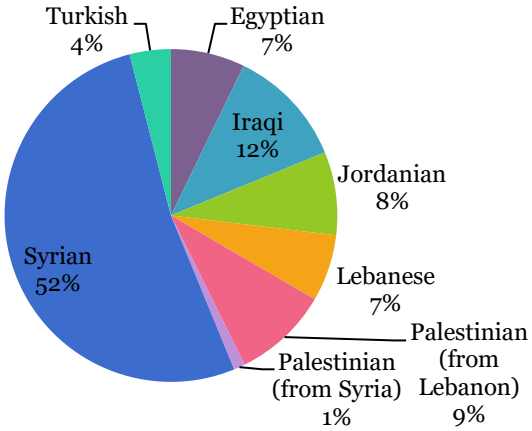
*Table 2: Percentage of total survey responses per country and sampling strategy target*

| Country | Survey locations | Percentage of total responses | Sampling strategy target percentage |
|---|---|---|---|
| Lebanon | **LRC:** Ghazieh, Kfar Chelane, Aamar Al Baykat, Hawouch El Rafika<br>**PRCS:** Ain El-Helweh, Burj El-Chemali, Nahr el Bared, Shatila, Rashidiyyeh, Baalbek, Burj El Barajneh and Qasmieh | 22 | 27 |
| Jordan | Amman and Ajloun | 14 | 13 |
| Turkey | Ankara, Mardin, Konya, Kayseri, Kahramanmaraş and Şanlıurfa | 13 | 13 |
| Iraq | Erbil and Dohuk | 24 | 20 |
| Egypt | Cairo and Alexandria | 27 | 27 |

The survey had **59 percent female** respondents and **41 percent male respondents**. This is somewhat different from census data for the various countries, where the breakdown is closer to 50:50.[1] Respondents were divided between the following age groups: 33 percent were 18-30, **60 percent were 31-59** years old, and seven percent were over 60. Most respondents were married (82 percent); ten percent were single, six percent were widowed, and two percent were divorced.

The **nationalities** of respondents included Syrian, Iraqi, Jordanian, Lebanese, Turkish, Egyptian, Palestinian from Lebanon and Palestinian from Syria.

*Figure 1: Nationalities of survey respondents*




When we break down data per **country, age group and gender**, we observe the following:

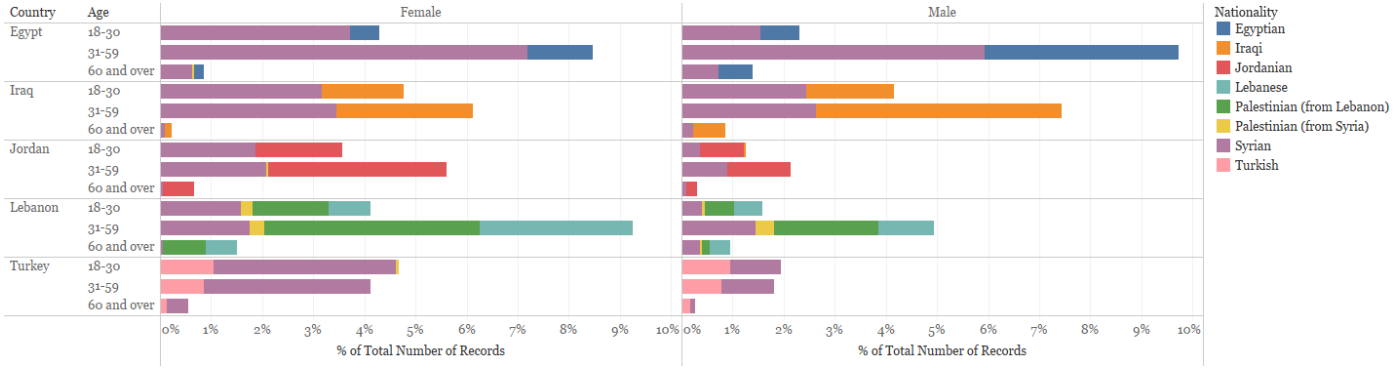
[1] Sources consulted for census/ population data include the CIA World Factbook, UNHCR for Syrian refugee data, and UNRWA for information on Palestinian refugees. References to population and census data in other parts of the texts are also from these sources.

- In **Lebanon, Turkey and Jordan** there is a **much higher percentage of female respondents than males** (67, 70 and 72 percent). Census and population data suggests that percentages in the population are closer to 50:50. This discrepancy could be expected given that the survey was administered to households during daytime. **In Iraq and Egypt, the breakdown is nearly 50:50**.

- In **Lebanon, Jordan, Iraq and Egypt**, the **most prominent age group** represented in the survey is the **31-59 age bracket**. In **Turkey** most responses were received from the **18-30 age group**. For all countries, the more prominent age group in data on populations is the 18-30 age bracket, so this would suggest the survey data is not representative in that respect.

- **In Turkey and Egypt, most respondents were Syrian. In Jordan, most respondents were from the host community, and in Iraq most respondents were Iraqi, which included both habitually resident and IDPs. In Lebanon, there was a higher number of responses received from the two host communities: Lebanese and Palestinians from Lebanon.** We had a low number of responses from Palestinians from Syria, which is one of the distinct refugee communities of interest to this study; we face limitations in the inferences we can make based on the responses we received for this group, and we have included them under the refugee rubric. However, it was noted by PRCS staff conducting FGDs that Palestinians from Syria tended to be in precarious conditions, either because they were not registered, because their papers were at General Security, or because they were unable to afford the costs of legalising their status. This may have affected their willingness to participate in the baseline survey.

*Figure 2: Respondents by age, nationality and gender in each country*




**Refugees** represented 60 percent of survey respondents. **Host communities**, or those who declared themselves to be habitually resident in the MADAD countries, made up 33 percent of survey responses. We also received seven percent of responses from **IDPs**, most of which were in Iraq. The most commonly recorded **household size** is five in all countries, although with high numbers of households that comprise of six or seven members in Iraq. Households of four members were also common in Turkey, Jordan, Egypt and Lebanon.

Of those who declared refugee or IDP status, **96 percent declared being registered**, and four percent stated they were not registered. Countries with higher levels of refugees who are not registered include Lebanon and Jordan (eight percent each) and Egypt (four percent). The most common number of **household members registered** is five in all countries except Egypt, where this figure is four.

In terms of **education levels**, **41 percent of respondents had completed primary education**, and 33 percent had completed secondary education. There were a further 11 percent of respondents who had a university degree, and six percent with a vocational/ technical training qualification. Only one percent of respondents possessed a postgraduate qualification. There were also eight percent of respondents who did not attend or left school before finishing primary.

When we disaggregate **education by country**, we observe the following patterns:

- **In Lebanon, Iraq and Egypt the most common level of education completed is primary; and in Jordan and Turkey it is secondary.** Lebanon and Turkey have the highest percentages regionally for respondents who did not attend or left school before finishing primary (14 and 19 percent, respectively).

- **Jordan and Lebanon have the highest levels of university education respondents**. Vocational training was under 10 percent for all countries, with higher scores in Lebanon, Jordan and Egypt. Postgraduate education was rarely recorded: 0.5 percent in Lebanon, two percent in Jordan and one percent in Egypt.

- **Males and females have comparable levels of education at primary, secondary, university and postgraduate levels**. Divergences are seen in vocational training, where males have higher percentages than females; and for responses that record not attending or leaving school before finishing primary, for which females record ten percent as opposed to six percent of males.

- The most common education level for the 18-30 age bracket is university, primary education for the 31-59 age bracket, and no school education for the over-60 age bracket.

*Figure 3: Education by sex, age and nationality in each country*[2]


**Most respondents were based in urban areas** (63 percent), and 14 percent lived in **rural areas**. There were also 23 percent of respondents who were based in **refugee camps**. However, it is important to disaggregate these figures per country:

- Refugee camp respondents were in Lebanon (in Palestinian refugee camps covered by PRCS, and in Ghazieh, Hawouch El Rafika and Aamar Al Baykat, covered by LRC) and in Iraq.

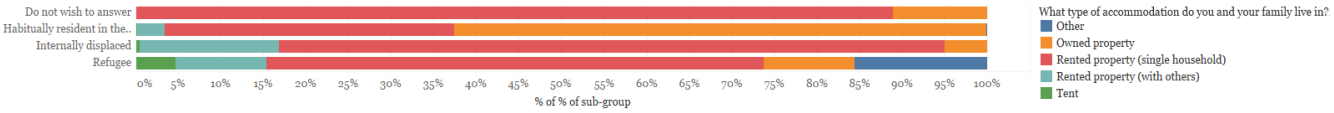
- All of Egypt's respondents were in urban areas, as were nearly all respondents from Turkey.

[2] As this table visualises responses as percentage of sub-group, please note that it may sometimes seem that an outlier represents 100 percent of a specific category. For example, we only had one Iraqi respondent in Jordan, and because the table is expressed as percentage of sub-group (Iraqi 18-30 years old), it appears as if it is 100 percent of that group.

- Most of Lebanon's respondents covered by LRC were in rural areas.
- In Jordan respondents were almost evenly divided between urban and rural areas (55:45).

In terms of **type of accommodation**, at regional level over half of respondents (52 percent) were living as a single household in rented accommodation, and 27 percent of respondents owned their property. Nine percent of survey respondents shared rented accommodation with others, and three percent stated that they lived in a tent. We also received a few qualitative responses for the 'other' option of this question, most of them from Iraq. These included respondents who lived in a warehouse, the mosque, parks, at their workplace, and at family members' households.

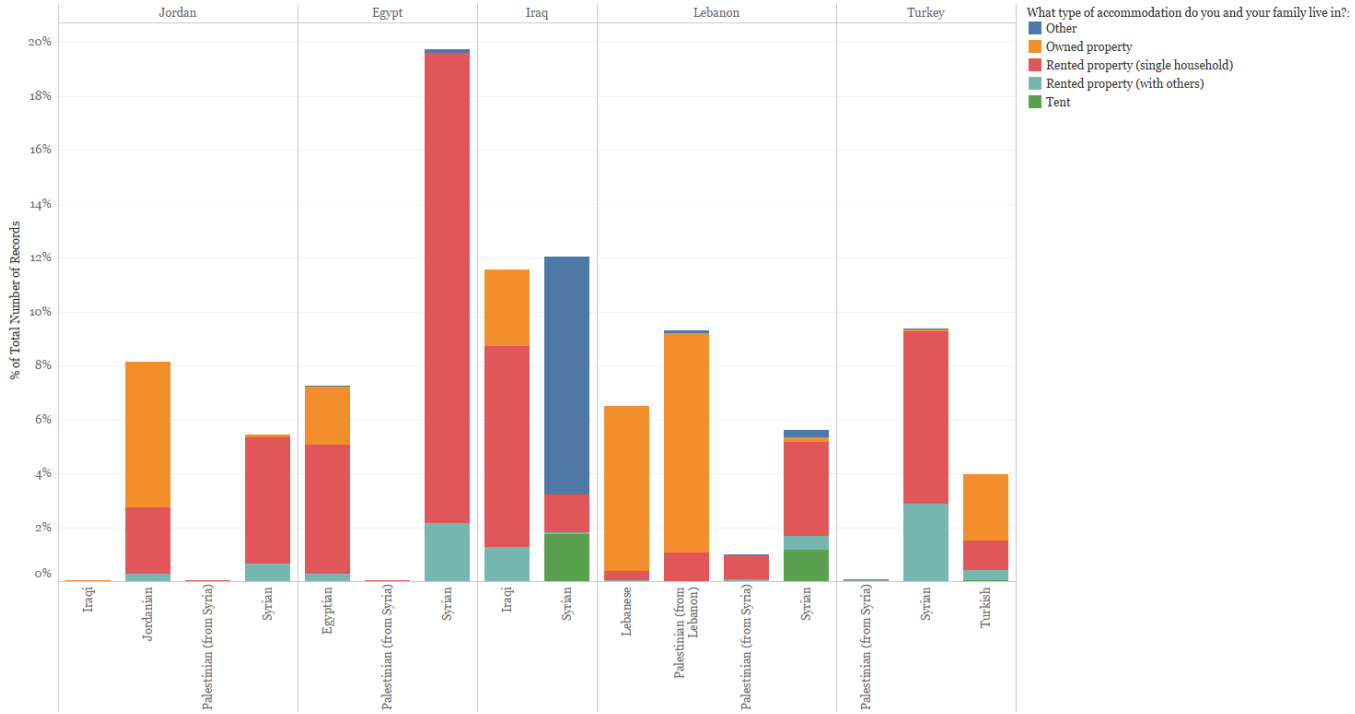
*Figure 4: Accommodation type per status*




Accommodation type patterns differ when the data is disaggregated by country, as can be seen in the figure below. The main points to highlight are:

- Percentages for **owned property tend to be higher for host community members**, although these are low in Egypt and Iraq compared with other countries.
- **The most common accommodation type for Syrians in all countries is renting property as a single household**. However, in Lebanon and Iraq there are incidences of respondents who were living in tents; and sharing households with others was more common in Turkey and Egypt.

*Figure 5: Accommodation type per country and nationality*



# Overview of findings per intervention area

## Community development

- **Most interaction between the communities targeted by MADAD happens in social settings, and least in social initiatives.** At regional level, the survey suggests that there is generally a **good or fair relationship between host communities and refugees/ IDPs**. Nonetheless, when disaggregated by country **Lebanon stands out as recording lower scores** in perceptions of the relationship between communities; and across countries **host communities tend to have poorer perception of their relations with refugees, except for Iraq** where relations are generally positive. Given that one of the key elements of the MADAD intervention is to incentivise interaction between host and refugee/ IDP communities by facilitating micro-projects or community development projects, it is important to take these perceptions into account.

- In all countries where FGDs were conducted, participants highlighted **main sources of tension between communities**, some of which are consistent regionally: **high rental prices, employers' favouring of refugees over host communities** because they can pay them less, **perceived cultural differences**, and issues related to **hygiene and cleanliness**, as well as the **use of common spaces and the environment**. Some of these tensions are **beyond the reach of MADAD** as they would, for instance, involve an intervention that tackles the regulation of rental housing and labour market. Other issues that are sometimes attributed to culture or hygiene, for instance, may be within the programme's reach. Hygiene promotion can tackle into some of the difficulties that beneficiaries face, but **most of the grievances expressed by participants in the baseline study have their root in their economic situation**.

- The manifestation of pressures faced by the various communities that participated in this study suggest that **mental health issues, gender based violence, violence against children, and more general physical and verbal abuse against refugee communities are a considerable source of stress and tension**. In some cases, particularly in Lebanon, these tensions seem to be leading to segregation between communities to avoid confrontation.

- Respondents overall had **low levels of participation in community development projects** in Lebanon and Jordan, where they are being implemented under MADAD, which is to be expected at baseline. Nonetheless, there are specific preferences that beneficiaries highlighted in different country contexts. In **Lebanon**, issues highlighted include lack of **infrastructure and hygiene/ cleanliness** concerns as areas where communities would like improvements to be made, as well as **facilities for children activities and interaction**. In **Jordan** there was also an interest in creating s**paces for children to play**, as well as **improvements to local schools**, initiatives to tackle **waste management**, and **community cleaning**.

- The MADAD intervention in Lebanon and Iraq includes training of community members to respond to threats, risks and hazards. **Health conditions and fires were the most prominent concerns** for baseline participants. **Responding to accidents and emergencies** were also of interest to FGD participants. **Refugee respondents** were more likely to be concerned with threats, risks and hazards; and they were also **more likely to have received information on them than host communities**. In **Iraq**, and particularly in refugee camps, the **most prominent risk identified** related to health conditions that stem from the **deterioration of hygiene conditions**.

- In Turkey, MADAD is being implemented through the provision of services in community centres. The project has taken over five existing community centres that were previously covered by other funders; the baseline study included data collection in three of these

locations. **The results of the baseline study suggest that nearly three quarters of participants did not go to community centres,** which supports the need for planned outreach activities to acquaint communities of the services offered in community centres.[3] **Of those who do use community centres, refugee and women respondents are more likely to use services there; and where they experience barriers, these are mainly related to cultural or communication barriers**. There is a perception in the Turkish host community that these centres are for Syrian refugees, and they are less likely to go there. It is not clear why men are less likely to attend, but the Turkey team has indicated that the time of day when activities are offered may be a factor. The two most used services were livelihoods; and child, youth and volunteer activities.

## Livelihoods

- The baseline study suggests that **livelihoods is the single most pressing issue in MADAD countries, including Lebanon where no livelihoods component is being implemented under MADAD.** Livelihoods are often cited in terms of being able to **meet living costs such as accommodation**. However, it is also an **underlying concern in relation to being able to access health services**, either because the **costs of healthcare or medicine cannot be met**, or because **beneficiaries cannot afford to go to the closest clinic or hospital**. This was most prominent in Iraq, Lebanon and Jordan. Lack of livelihood is also seen as a contributing factor in **mental health issues**, and in instances of domestic violence and violence against children.

- At overall regional level, **54 percent of respondents were in some sort of employment**; and **unemployment level is 35 percent**. Nonetheless, there are important variations when data is explored by gender and by community, as well as by country.

- **Refugees have the highest rate of unemployment at 43 percent – nearly double that of respondents who were habitually resident** in the countries covered by MADAD livelihoods interventions, who had an unemployment rate of 28 percent. The unemployment rate for IDPs surveyed is lower than the regional average for host communities at 21 percent.

- **Female unemployment is considerably higher than male unemployment: 42 percent to 15 percent, respectively.** FGDs suggest that women face social and cultural constraints in seeking employment.

- In some countries, the **reasons attributed to unemployment** are related to the **particularities of each labour marke**t (e.g. downsizing of businesses in Iraq, lack of employment opportunities compared with skills garnered through education in various countries).

- In **Turkey**, where **refugee unemployment is particularly high at 73 percent**, **language barriers** and the **lack of recognition of Syrian qualifications** act as a strong barrier for securing employment; and in J**ordan burdensome procedures for issuing work permits** to refugees are problematic.

- **Across the countries, there is reference to the importance of personal connections for finding a job (*wasta*)**. For host communities, there is consistent reference to employers favouring refugee employees because they can pay them lower salaries. This is supported by the baseline study, where **in most countries the average salary for refugees is half that of host communities**. **The exception is Egypt**,

[3] Strengthening the focus on outreach activities to acquaint communities with the services available in community centres was a recommendation that was emphasised in the Turkey country baseline study report of findings; and is an action area for the Turkey country team for going forward.

where salaries are similar for both; and Iraq, where the sample suggests that refugees have higher salaries.

- **Some of the difficulties faced in terms of access to income, for instance cash support, is attributed to agencies and organisations' changing their programming**. In all countries there is common reference to services that used to be available and no longer are, leaving a gap in addressing the needs of vulnerable communities.
- The most prominent **main source of income is from employment**, although **figures are higher for host communities** than refugees and IDPs. **Refugees and IDPs** are also **more likely**, based on the survey sample, **to not have a main source of income**.
- **Similar percentages of host and refugee communities receive support from friends and family as a main source of income.** Refugees also listed aid from international organisations and NGOs, cash transfers, and food vouchers and e-cards. All of these are also the most common secondary sources of income for respondents.
- **Food** was the most common household expenditure item that respondents **could afford**.
- **In Turkey, respondents were more likely than other countries to be able to afford health costs, which is to be expected as health is free**. Nonetheless, we note from qualitative data that there may sometimes be barriers to refugee access to healthcare if they have not undergone appropriate registration procedures.
- **The ability to afford accommodation costs differs between countries, with Iraq having the lowest scores**. Iraq also has lower scores relative to other countries in most of the other household expenditure items.
- **Host community members have consistently higher scores than other communities across all household expenditure options, except for food, where IDPs score higher in Iraq; and accommodation and utilities, where refugees score higher.** More than 75 percent of IDPs are not able to afford education, accommodation, household items, transportation, utilities and communication costs. Over half of refugee respondents are unable to afford education, health, clothing, hygiene items, transportation and communication costs.

## Health

- **Most survey respondents either had access to free healthcare (32 percent) or were able to access discounted or subsidised primary healthcare services (26 percent).**
- **The highest percentages for not being able to afford primary healthcare were found in Lebanon, Iraq and Jordan for the Syrian community**, and in **Lebanon for male Palestinians from Syria**, although the latter had **comparable levels to both male and female Palestinians from Lebanon** (noting that the sample of Palestinian refugees from Syria is small). This data is consistent with FGDs conducted in Lebanon.
- Those living in **refugee camps** were the group where the **highest number of respondents could access free health care**, and **receive discounted/ subsidised primary care compared to respondents in urban and rural areas**. FGD qualitative data from host community respondents in Lebanon suggests that Syrian refugees had easier access to healthcare through UNHCR than they did; while UNRWA/ PRCS covers some healthcare access for Palestinian refugees from Syria. However, beneficiaries from Syria noted that **where subsidised care is provided, they are not able to pay the difference**.

- **The highest percentage for both primary and secondary healthcare access is found in Turkey**, which is to be expected as healthcare is free for all. For secondary and specialised care, figures are significantly lower in all other countries.

- There were **42 percent of respondents who faced some barriers in accessing health services**, and **18 percent who faced many barriers**. There were also **28 percent of respondents who indicated they faced no barriers in accessing health services**. The types of barriers highlighted in each country, however, show some variation depending on context.

- The **most common barriers relate to financial constraints**, except for Turkey where this is not a prominent barrier. In **Turkey, the most common barrier by far was cultural- or communication-related**.

- **In both Jordan and Lebanon, the cost of accessing healthcare was highlighted as an issue, as well as quality of health services**. Although **LRC mobile clinics** were mentioned in FGDs in Lebanon, their **frequency was an issue**. For **Palestinian refugees in Lebanon and from Syria**, **security checks** and **surveillance** were an additional barrier.

- **In Iraq the lack of availability of health services, as well as transport costs required to be able to seek healthcare were highlighted. The cost and/ or availability of medicines was strongly highlighted too** by beneficiaries and by IRCS staff in FGDs. **Inability to pay for health services was the most common barrier in Egypt**.

- **Knowledge of how to access medical or health services and the availability of information on health conditions were not significant barriers for accessing health.** This was a finding from the survey and from FGDs conducted with beneficiaries.

- **Respondents were most knowledgeable about emergencies, maternal and child health, and immunisations.** However, host communities had higher percentages on knowledge of all medical services. **Lebanon scored higher** than other countries on knowledge of **blood transfusion services**. **Iraq had the lowest percentages** for knowledge of **emergencie**s.

- In Lebanon (LRC) and Turkey, the MADAD intervention has a psychosocial component. However, **psychosocial support is identified as a desired area of support even in contexts where no PSS is being implemented under MADAD**. In the survey, **the main stressors that emerged were money and living conditions**, with **health and family closely behind**. Overall, stress areas were higher in Lebanon than Turkey, except for money, which was a significantly higher stressor than in Lebanon. **Women also tended to score higher on most stressors than men.**

- In Lebanon (PRCS), Turkey and Iraq, MADAD is implementing **hygiene promotion** activities. **The areas where beneficiaries expressed most interest include positive behaviours to promote good health, and measures to prevent the deterioration of health conditions**. In FGDs the most prominent issues, particularly for Iraq, were related to sewerage, access to potable water and to running water in households, and collection of rubbish. These were also emphasised, although to a lesser extent, in Lebanon.

## RCRC Capacity

- **Host National Societies covered under Outcome 3 are confident in their ability to provide staff and volunteers with adequate training to implement the MADAD programme, and to be able to identify the most vulnerable beneficiaries to provide services to**. For some, such as LRC, the Lebanon MADAD component was designed with training that is available in mind.

- **In Turkey, TRCS received three types of training**: **must-have basic trainings**, **MADAD-specific training**, and **training based on needs identified**. TRCS can provide training in-house, and where it is not able to, it has appropriate mechanisms to request external support and/ or outsource training.

- **In Lebanon**, there is already **training available that is consistent with MADAD** in the **Medico-Social** and **Disaster Risk Reduction** departments. However, the **provision of specialised training**, for instance on GBV or child protection, is **dependent on the position held by staff and volunteers**.

- **Basic trainings have been provided to staff and volunteers in Iraq on PSS and hygiene, first aid and livelihoods. Trainings on gender and social inclusion are felt as a gap**.

- **In Jordan**, trainings have been provided on **gender, diversity, first aid, case management and referrals, NCDs, disaster management, Strengths, Weaknesses, Opportunities and Threats Analysis and Standard Operating Procedures, Community-based Health and First Aid (CBHFA) topics and training of volunteers to use assessment tools**. Training has also been received by some staff on **livelihoods.**

- There is a sense in some HNS that **specialised trainings need to be strengthened, for instance on gender-based violence**. These do not seem to be consistently rolled out to all staff involved in MADAD.

- **There are skills that are not MADAD-specific, but that staff in IRCS, JRCS, LRC and TRCS highlighted as of interest, and these relate to project management, administration and finance, monitoring and evaluation, and logistics.** Some HNS highlighted that it is more difficult to get funding for these kinds of trainings as it is expected that staff would be able to learn them on the job or know them already.

- **Some HNS face challenges related to retention of volunteers**, particularly in Jordan. Iraq had a strategy for relying on long-term volunteers to backstop potential turnover of volunteers. **Another challenge relates to the length of time that trainings take, which detracts from the time volunteers can spend in the field**. LRC seemed to have less concerns related to the latter as they adopt a gradual training approach to volunteers.

- **IRCS, LRC and JRCS have similar assessment criteria for identifying vulnerable beneficiaries**, which relate to their household, medical conditions, number of dependents, employment status, and so forth. **In Turkey, the community centre model was noted as a potential impediment for identifying vulnerable beneficiaries**; field staff note vulnerabilities, but the community centre model sometimes hinders being able to reach the most vulnerable.

- **LRC also noted challenges related to the political situation and tensions that at times reflect on their interventions; and in Iraq the security situation is a concern that staff must work around and may impact their ability to reach the most vulnerable**. Another issue in **Iraq** is that their **beneficiary population is mobile**: as the situation changes, people move between areas; the people they assist at times have **high turnover rates**.

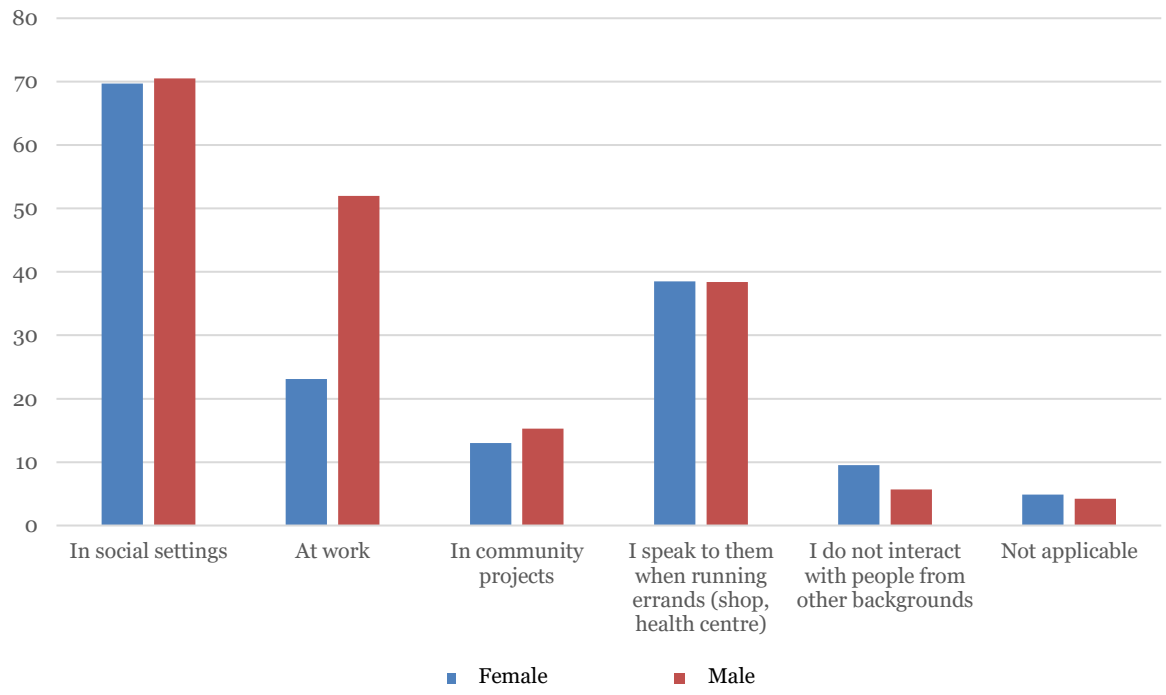
# Detailed findings: MADAD beneficiaries

## Community development

### *Social cohesion*

Respondents from all countries were asked about their interaction and relationship with other community members, i.e. host community, refugees and IDPs (where applicable) in relation to one another. **Respondents report that they interact with other members the most in social settings** (70 percent), and that **they speak to other members of the community when running errands** (39 percent). Interaction at work is reported by 35 percent; and **14 percent report that they interact as part of social or community initiatives and projects**. Eight percent report that they do not interact with people from other backgrounds.

*Figure 6: Interaction with other community members who are from the host community/refugees or IDPs by gender*




- When disaggregating by gender there is variation in more males interacting with members of other communities at work (52 percent) compared to females (23 percent).
- When asking about respondents' perception of the relationship between members of different communities, **most respondents (56 percent) report that the relationship is good** or fair (26 percent). Less than six percent report that the relationship is poor or hostile.
- When disaggregating by country, we see some variations for **Lebanon**, where the **rating of the relationship as good is significantly lower than in other countries at 35 percent**; and for Lebanon also respondents were much more likely than in other countries to rate the relationship as fair. This difference for Lebanon is also captured in FGDs with the Lebanese host community, with Syrian refugees, and with Palestinians from Lebanon and from Syria. Nearly all FGDs conducted with Lebanese participants, male and female, highlight that they do not accept the presence of Syrians, and in some groups they blame them for deteriorating conditions in Lebanon. Syrians living in Lebanese communities and in Palestinian refugee camps feel discriminated against, and report being verbally and physically abused. Palestinians from Syria note discrimination in the provision of services

inside Palestinian camps, but they highlight that at a social level they feel discriminated outside camps but not in their relationships with people inside the camps. Palestinians from Lebanon as a host community note that they also feel discriminated in Lebanon, both in accessing jobs and more generally as a community.

- **Iraq was the most likely to report a good relationship between communities at 67 percent.** This more positive perception is supported by FGD data. Host community, IDP and refugee participants all concur that there is generally a sense of solidarity between community members, and that for the most part they endeavour to support one another in what they see as problems that are common to all.

- **The FGDs in Jordan highlighted some of the issues that cause tensions between Jordanians and refugees.** Some Jordanians felt that Syrians were taking jobs away from them because they were willing to accept lower salaries from employers; and that they are being neglected because assistance is given to refugees when they face similar difficulties in accessing employment, for instance. Refugees, on the other hand, felt that they are helpless because they are not part of the community and cannot defend themselves; and that they are sometimes exploited, for instance by property owners who charge them higher rents and loan sharks. Women from both communities consistently highlight constraints they face due to social norms, for instance not being allowed to work even when they hold degrees; as well as being exposed to sexual harassment.

- In Turkey, the two FGDs with adult (male and female) Turkish respondents reported that the **social behaviour** of Syrians causes problems in the community. One of the FGDs with young Syrian males in Şanlıurfa explained that the locals accuse Syrians of dressing inappropriately; and that they felt there was a negative prejudice towards Syrians. Turkish female FGD participants also highlighted that their partners no longer allow them to use public spaces due to fears of them being harassed by refugees. Furthermore, the Turkish adult female respondents reported that, in addition to social behaviour, the presence of Syrians has also resulted in **inflated prices and increased cost of living**.

- There is an overall consistency in the factors that are seen to cause tensions between host and refugee communities in the different countries. **Lack of employment opportunities** is an issue that was consistently faced by all participants communities; unemployment is a source of tension. In all contexts where FGDs were conducted there is a **perception by host communities that refugees take their jobs away** because they accept lower salaries and livelihoods data supports this, with Syrians nearly across the board receiving about half of what host community members get in income. Another common source of tension was **rental prices**, which are perceived to have increased with refugee flows into countries neighbouring Syria.

- Other issues highlighted included **political and sectarian differences**, particularly in Lebanon; attribution of problems between communities to **cultural differences**, especially in Turkey; **competition for services and resources** in Lebanon and Iraq; and **sexual harassment of women** in Lebanon, Jordan, Iraq and Turkey.

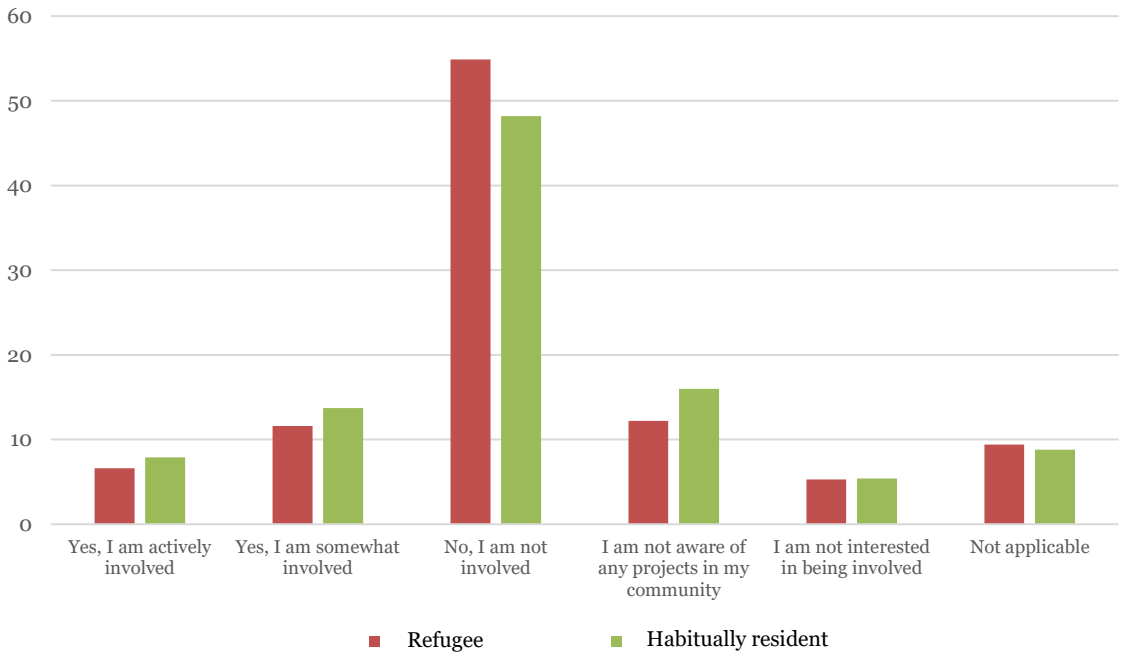
### *Community development projects*

In Lebanon and Jordan, community development projects are being implemented as part of MADAD. Respondents in these two countries were asked about their involvement in community development projects or initiatives. The number of **respondents who report that they are actively involved in social projects or initiatives in communities is only seven percent**. **The number of respondents who report that they have not been involved at all in social projects or initiatives is nearly 50 percent**. 13 percent are somewhat involved, 14 percent are not aware of any projects in their community, and five percent are not interested in being involved. FGDs conducted in Lebanon by PRCS indicated that in some cases participants were not involved in these projects because they perceived them as being dangerous to their health, for instance collecting rubbish.

The survey also asked respondents to detail what stage of implementation of community projects or initiatives they have been involved in: **62 percent are involved in implementation of projects, and almost 26 percent are involved in the identification and planning of projects**.

When disaggregating the survey data by country and age the percentage is similar, but when disaggregating by gender there is a variation; **more females (29 percent) have been involved in identification of community projects than males (19 percent) and for planning projects, more males (35 percent) have been involved than females (22 percent)**. The figure below shows involvement in community projects by status; for both host communities and refugees, the most prominent answer was that they were not involved in these.

*Figure 7: Involvement in community projects by status*




When disaggregating by area of living, **respondents living in urban areas or refugee camps were more actively involved in community projects** (nearly ten percent), whereas respondents living in rural areas were only three percent. Nonetheless, it is worth noting that overall there were few respondents who are based in rural areas in Lebanon; the figures are higher for Jordan where respondents based in rural areas represent 43 percent of survey respondents.

FGD data provides some insight into the perceptions of communities of potential social initiatives.

- In **Lebanon**, there was a strong emphasis from most Lebanese host community members that they had no interest in engaging in social initiatives that mixed host and refugee communities. Refugees, on the other hand, suggested that they preferred to stay out of the way to avoid tensions. Nonetheless, there was an **interest in social initiatives that were kept within the boundaries of each community**. Women FGDs emphasised activities for children, and men expressed an interest in leisure activities. Livelihoods was also referred to widely, but this is not a MADAD component in Lebanon.
- In **Jordan**, there was an interest in **creating spaces for children from both communities to interact with one another**, as well as support for local schools, initiatives to tackle waste management, and community cleaning.

*Threats, hazards and risks affecting communities*

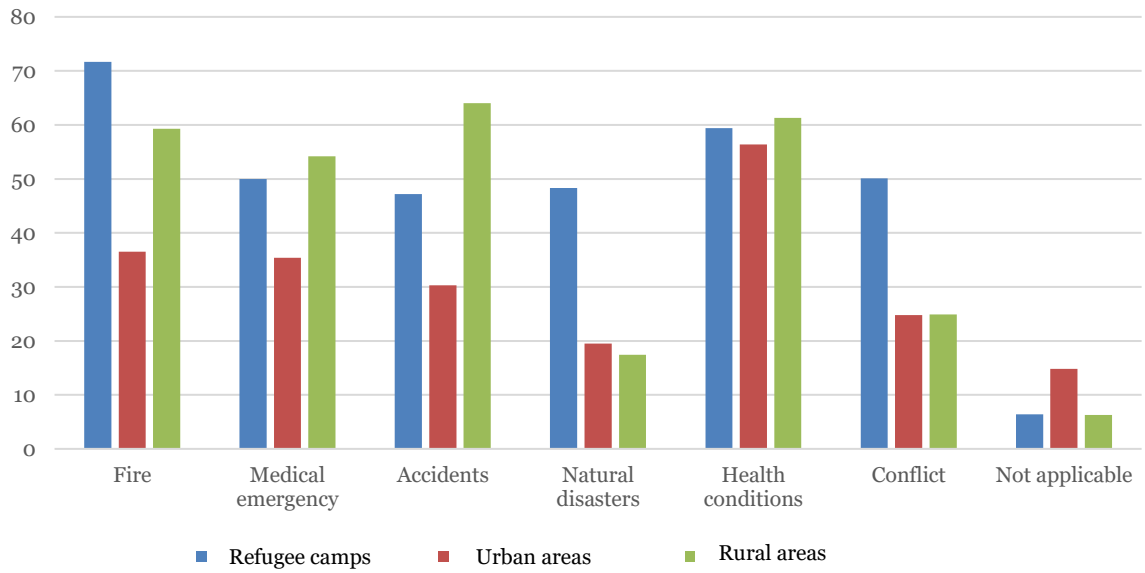
In Iraq and Lebanon, the MADAD programme is providing training to beneficiaries on the threats, hazards and risks they face in their communities. **Most respondents reported that the risk/hazards that most affect their community are health conditions** (59 percent) **and fire** (58 percent). The lowest percentages were for natural disasters (33 percent), and interestingly, conflicts (37 percent).

When disaggregating by country and gender the percentages are similar, but **there is variation when disaggregating by status.** Most respondents who are registered as refugees felt that the risk of fire mostly affects the community, possibly because their living conditions can be more precarious. Most respondents who are internally displaced, which would apply to Iraq, or habitually resident, which would apply to Iraq and Lebanon, report that health conditions are affecting the community most. FGDs in Lebanon with host community members consistently highlights road accidents as a big source of concern.

Other patterns identified when the data is disaggregated include the following:

- Most respondents based in **refugee camps** report that **fire is the threat/hazard that most affects the community** (72 percent) and accidents affect them the least, although at a relatively high frequency (47 percent).
- Most respondents from **rural areas** report that **accidents mostly affect the community** (64 percent) and natural disasters have the least effect (18 percent). The latter is similar for respondents from **urban areas**, where the risk that most respondents report as affecting the community is the one posed by **health conditions** (56 percent).
- When disaggregating by **age**, most respondents in the **younger age group (age 18-30) report that fire is the risk/hazard that affects the community** (63 percent), and most respondents in other age groups report that health conditions are affecting the community the most (near 60 percent).

*Figure 8: The level of hazards/risks affecting the community by area of living*

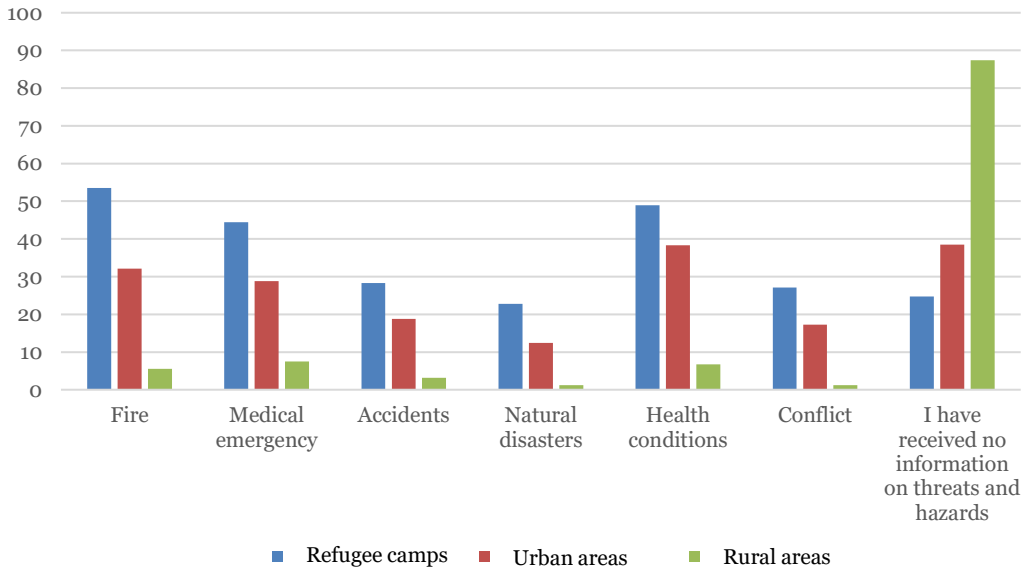



The respondents from Iraq and Lebanon were also asked if they have received information on how to respond to the listed threats/hazards. **Nearly 40 percent of the respondents report that they have not received any information at all on the listed hazards.** The subjects that the most respondents have received information on are health conditions and fire, both at 38 percent. The topics

that respondents have received least information on are natural disasters (16 percent), conflicts and accidents (nearly 20 percent). When disaggregating data, we get some interesting trends:

- There is a variation when desegregating by age. More respondents over the age of 60 report that they have not received any information at all (58 percent) compared to the younger age groups (less than 42 percent). **For those who have received information, percentages are evenly spread between age groups**.
- When examining data by status, more **respondents who are habitually resident in the country report that they have not received any information** on how to respond to the risks/hazards at all (56 percent), compared to 35 percent of refugees who have not received any information. In Iraq, the percentage for internally displaced respondents is 28.
- In terms of responses relative to the area where respondents live, **the highest percentage of respondents who have not received any information on threats and hazards are living in rural areas** (88 percent), compared to respondents living in urban areas (39 percent) and refugee camps (25 percent). The percentage of respondents who have received information on the different threats/risk topics is somewhat higher for respondents living in refugee camps than in urban areas.

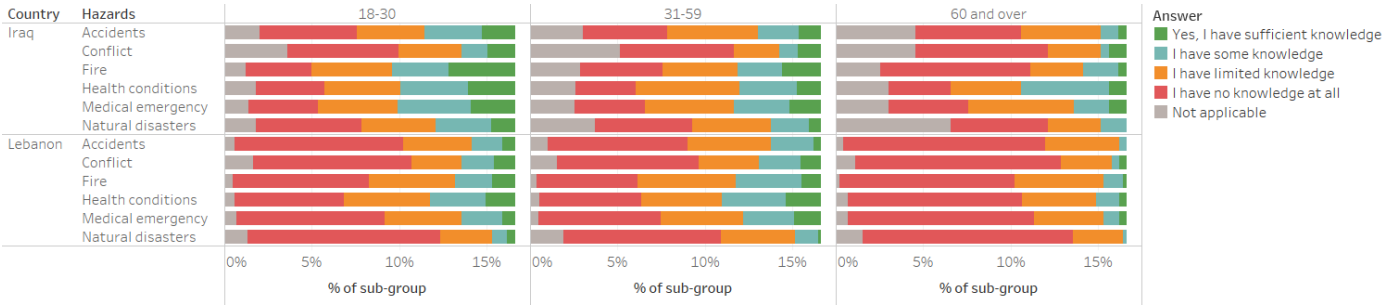
*Figure 9: Information received on how to respond to threats/hazards by area of living*




Respondents from Iraq and Lebanon were also asked if they feel that they have sufficient knowledge on the different subjects of risks and hazards. **40 percent of respondents report that they have no knowledge of risks and hazards.** The subject with the highest percentage for sufficient knowledge was fire and health conditions (nearly 11 percent), and the subjects with the lowest percentage were natural disasters (four percent) and accidents (seven percent).

When disaggregating by country, age, status and gender the percentages are similar, but when disaggregating by area of living, a higher percentage of **respondents who are living in rural areas reported having have no knowledge at all** on the topics (near 60 percent on average) compared to respondents living in urban areas of refugee camps (near 30 percent on average).

*Figure 10: Feeling of having sufficient knowledge on how to respond to threats and hazards by country and sex*



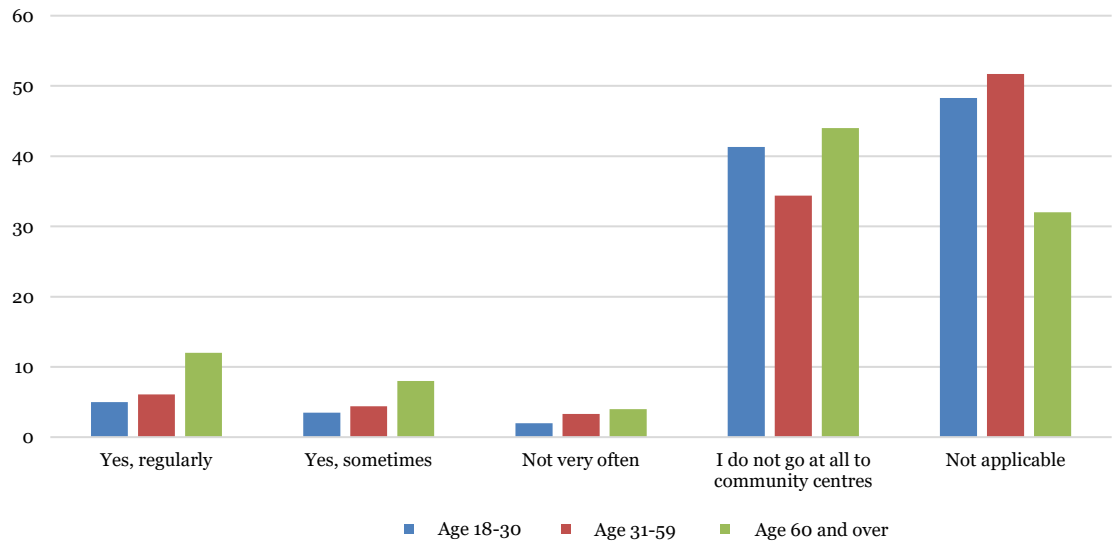

## *Use of community centres*

Programme implementation in Turkey is somewhat different from other countries in that it focuses on a community centre model. Ten centres will be supported by MADAD: five are already operational, since they have been taken over from other funders; two have opened at the end of 2017; and three are expected to be operational in the first quarter of 2018.

Respondents from Turkey who have access to the existing community centres are based in Ankara, Şanlıurfa or Konya. These respondents were asked about their use of the community centres. **74 percent report that they do not go to community centres at all**. 11 percent report that they use the centres regularly and less than 8 percent report that they use the centres sometimes or not very often.

- When disaggregating by age, **the percentage of respondents who use the centres regularly are highest for the age group 60 and over** (12 percent), although still low; the percentage is six for the age group 31-59, and only five percent from the youngest age group 18-31 use the centres regularly.
- When disaggregating by status, more respondents who are **habitually resident in the country report that they do not go at all to community centres (90 percent) compared to refugees (67 percent)**.
- For respondents who do go to community centres, **12 percent of refugees report that they go regularly and for habitually resident respondents the percentage is eight**.

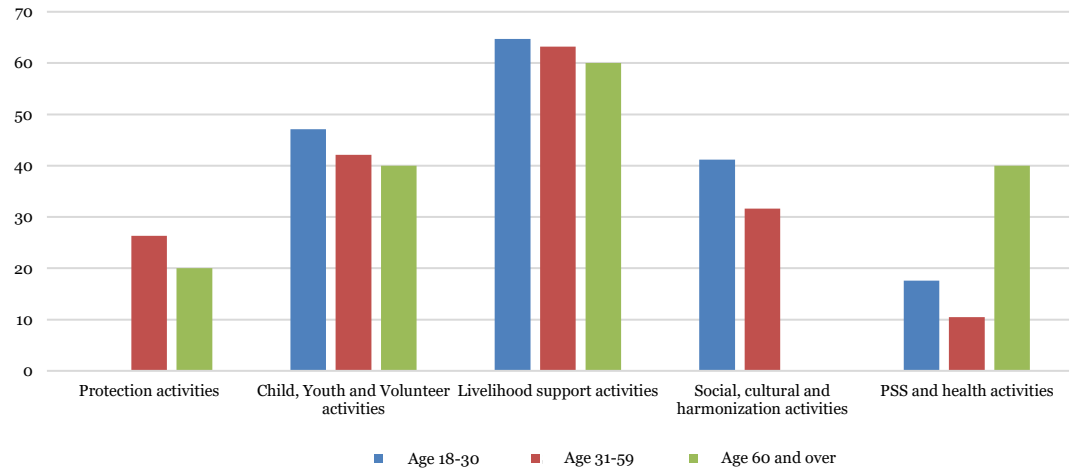
*Figure 11: Use of community centre by age*



The group of respondents who uses the centres report that **the services they access the most are livelihood support activities** (65 percent), and **child, youth and volunteer activities** (44 percent). 32 percent report that they access social, cultural and harmonization activities, and the service with the lowest percentage are protection activities, and psychosocial support (PSS) and health activities (near 15 percent).

- When disaggregating by age, **all age groups use livelihood support activities the most**. No one from the age group 60 and above accesses social, cultural and harmonisation activities; and no one from the age group 18-31 accesses protection activities. Interest in livelihoods is consistent with data received under the livelihoods section, which suggests unemployment is nearly 75 percent for refugee respondents.
- There is a variation when disaggregating by gender: **more females (46 percent) access child, youth and volunteer activities compared to males (37 percent), and more males (50 percent) access social, cultural and harmonization activities compared to females (27 percent)**. 18 percent of females access protection activities, while no males access this activity.
- **When disaggregating by status, only refugees access protection activities and child, youth and volunteer activities**. Both refugees and Turkish respondents access livelihood support activities, PSS and health activities, and social, cultural and harmonization activities.

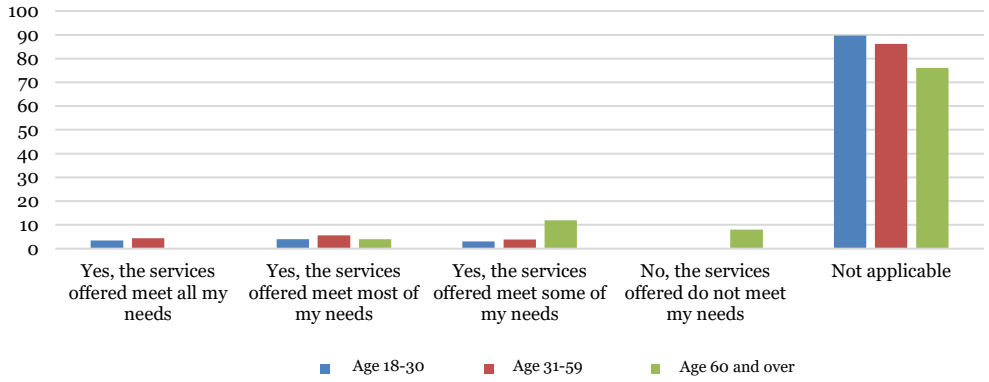
*Figure 12: Access of services in community centres by age*




When asking the respondents if the services respond to their needs, **seven percent report that the services respond to all their needs**, and nine percent report that the services respond to most of their needs. One percent of those who access services report that they do not meet their needs at all. When disaggregating by gender and status the percentage are similar, but when disaggregating by age there is a variation. No respondents from the over-60 age group feel that the services offered respond to all their needs. Nonetheless, it is worth noting that most respondents to this question marked is as not applicable.

Participants in the TRCS staff FGD reported that there are several **challenges to addressing the needs of beneficiaries**. For example, FGD respondents reported that Syrians are more likely to send their children out to work instead of sending them to school; and there is also a higher incidence of early marriage for their children. It was also reported that Syrians have larger families. Therefore, there are difficulties in implementing child planning and child rights projects.

*Figure 13: Services offered by community centres respond to their needs by age*



## Livelihoods

*The livelihoods section is not applicable to Lebanon or Alexandria in Egypt, and it is only applicable to the surveys collected by FRC in Iraq.*

There were **35 percent of respondents at regional level who reported being unemployed**; **eight percent marked this question as 'not applicable'**, and three percent were retired. The remaining **54 percent of respondents were in some sort of employment**: 18 percent were in formal employment, 17 percent in informal employment, 12 percent were self-employed, and seven percent were in temporary or casual employment.

These percentages are different when we disaggregate the data by status. **Refugees have the highest rate of unemployment (43 percent), compared with 28 percent of host communities, and 21 percent of IDPs in Iraq.**

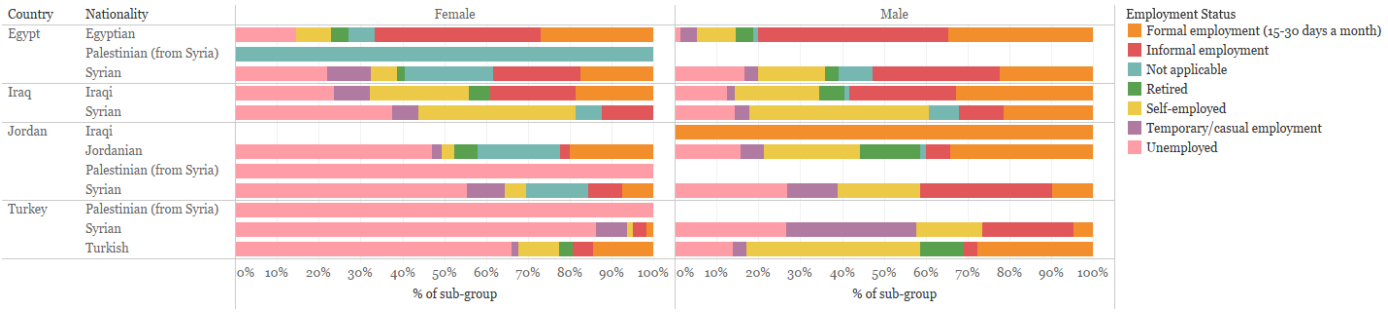
Unemployment levels also show divergences when disaggregated by gender. **Female unemployment is 42 percent, compared with 15 percent of male respondents who stated they were unemployed**. There were also nearly 12 percent of female respondents who marked the question on employment status as 'not applicable'. Male respondents were more likely to be in formal employment (26 percent), informal employment (24 percent) or self-employment (21 percent) than females for the same categories (13, 12 and six percent, respectively). **Male and female respondents had similar levels of temporary or casual employment** at nearly seven percent each.

These trends differ somewhat when we look at data for the MADAD countries separately:

- For **Turkey**, **refugee unemployment levels are very high at 73 percent, compared with 41 percent for Turkish respondents** (which includes three who listed themselves as IDPs). FGD data from Turkey suggests that the language barrier is a significant one for Syrians to secure employment, but more importantly the lack of recognition of Syrian qualifications in Turkey, which stops qualified individuals from seeking employment.
- In **Jordan**, unemployment levels for the host community are similar to Turkey (39 percent), but **unemployment amongst refugees is much lower than Turkey at 48 percent**. Beneficiaries who participated in FGDs highlighted that barriers to refugee employment included restrictions on the sectors they could seek work in; and KIIs conducted with IFRC highlighted that policies for Syrians to work are tight and cumbersome, and that obtaining a work permit usually constrains refugees by tying them to an employer.
- In **Iraq**, **refugee unemployment is 26 percent, compared with 19 percent of Iraqi IDPs and nine percent of Iraqis who were habitually resident** in the locations where the survey was rolled out. FGDs provided some insight into employment in Iraq. All FGD groups concurred that securing employment has become increasingly difficult, as companies have seen a general trend to downsize. IDPs and Syrian refugees are said to accept lower salaries. All community groups highlighted that it is easier to secure temporary or casual work than to start up a business, for example, as the latter would require licenses.
- In **Egypt**, unemployment levels for those surveyed in Cairo are lower than other countries: **20 percent for refugees**, and **nine percent for Egyptian respondents**. Egyptian respondents were most commonly either in formal employment (19 percent) or in **informal employment** (41 percent).
- In Iraq, Jordan and Turkey, **personal connections (wasta)** are a significant factor that consistently emerged in FGDs as a barrier for securing employment, and it was strongly highlighted by host communities. There was also mention of a mismatch between graduate skills and the jobs available in the market; people are completing their degrees and are unable to find employment in line with their skills.

The figure below illustrates employment status per country, nationality and gender:

*Figure 14: Employment status per country nationality of respondents*[4]




The main points to highlight are:

- Female respondents have higher levels of unemployment than men in all countries, and data from FGDs with beneficiaries suggest that they face social or cultural barriers to seeking employment; they also cite constraints regarding childcare or health conditions. When comparing between countries, however, female unemployment is lower in Egypt and Iraq than other countries. In Iraq women were also more likely than in other countries to be self-employed.
- Syrian women are more likely than their host community counterparts to be unemployed.
- The highest levels of formal employment for women in each country were found in Egypt for Egyptian women, and Jordan for Jordanian women. Formal employment is also high for men in the four countries relative to other groups.
- Both men and women in Egypt were more likely to be in informal employment than other forms of employment. Informal employment was also high for Syrian men in Jordan, and for both Iraqi men and women in Iraq.

The survey asked respondents to provide information of members of the household in employment per age group, and average monthly income in euros:[5]

- In Jordan, over half of the surveyed households only had one household member in employment and 16 percent did not have any household member in employment. The data also suggests that children and adolescent boys and girls in some households are working: one girl of the 12-17 age group; ten boys of the 12-17 age group; one girl of the 5-11 age group and one boy from the same age group; and four girls in the 0-4 age group. These figures suggest that it is a possibility that these children are working at the expense of going to school.

  **The average monthly income of respondents in Jordan was €405.** This figure differs when data was disaggregated by community: the average monthly income for **Jordanian respondents is of €487**, whilst the average income of **refugee respondents is €284.**

- In Turkey, for both refugee and host community respondents, there was most commonly only one person employed per household. Nonetheless, the average monthly salary does exhibit differences when it is disaggregated by community.

  **The overall average salary in Turkey per month was €336. The average salary for Turkish respondents is €459. For refugee respondents, the average is €272** – nearly half what Turkish respondents declared. This average would support qualitative

[4] Please note that this figure presents data as percentage of sub-group. As such, for groups where we received one response per country (Palestinian from Syria in Jordan, Egypt and Turkey), the respective categories look like they are 100 percent. We are unable to remove this series from the figure without removing it also from other figures linked to this dataset, but alternative figures are available where results are presented against the overall sample.

[5] Conversion rates from INFOREURO. Available here, accessed on 30 November 2017.

responses provided by beneficiaries in FGDs, as well as the FGD and KIIs with RCRC staff, that refugees tend to accept lower salaries than the host community, and that employers are opting for paying less to Syrians than they would do to Turkish workers.

- In Iraq, the most common response was for one household member to be in employment for all three communities: IDPs, habitually resident and refugee. There was one response reporting the employment of a boy in the 5-11 age bracket, and a girl in the same age group; a girl in the 12-17 age group; and three girls in the 0-4 age group.

  The **average monthly household income for the Iraq sample is €548**. The **highest income average was for refugees at €593**, followed by **Iraqis who were habitually resident in the survey locations at €248**. The lowest salaries were reported by **IDPs**, with an average of **€193**. These figures are not consistent with FGD data that suggests refugees tend to have lower salaries than host communities, although there were suggestions in FGDs that international organisations and NGOs employ Syrians. We do not have knowledge of salaries paid to Syrian refugees in these positions, but it may be that it has skewed results as otherwise FGDs would seem to suggest very precarious quality of life for Syrians in Iraq.

- In Egypt, the data suggests that for both refugee and host community households, most respondents report that there are four or five household members in employment. In Egypt there was one response suggesting that a boy in the 5-11 age group was employed, and two girls in the same age group.

  **The average monthly household income in Egypt for the sample is €107**. For **refugees**, the average income was of **€108**, and for the host community this figure was **€104**. These only apply to Cairo as the livelihoods section of the survey was not applicable to Alexandria, but they break the trend observed in other MADAD countries where there is a significant difference in salaries between those of refugees and the host community, with higher salaries usually reported for the latter.

*Figure 15: Average monthly income of respondents per country in euros*

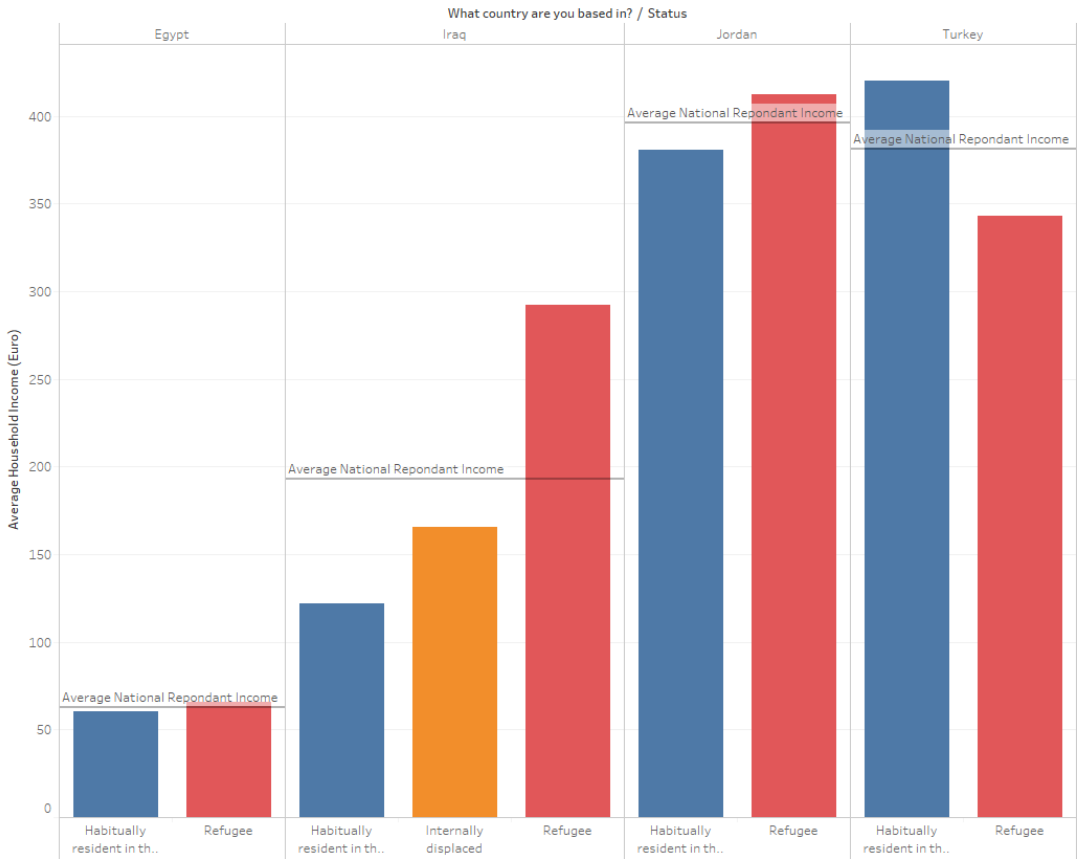
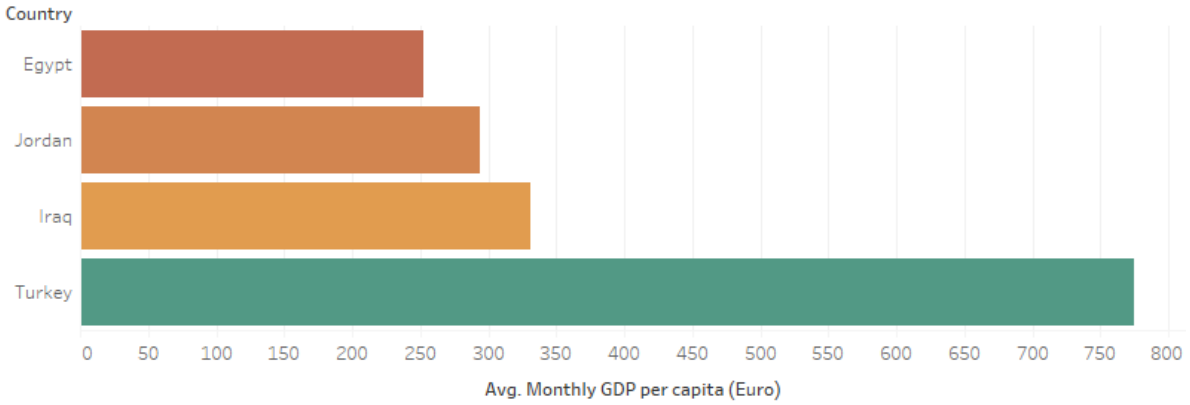


*Figure 16: Monthly GDP per capita in euros in Egypt, Iraq, Jordan and Turkey*[6]




### *Sources of income*

Most survey respondents (86 percent) did not have a bank, cooperative or other savings account. This figure is similar when disaggregated by gender and age group. However, these figures do differ somewhat when disaggregated by status: host community members are more likely to have an account (32 percent). **Nearly 98 percent of refugee respondents did not have an account, and 92 percent of IDPs in Iraq.**

All communities (host, IDP and refugees) listed **salary from employment or self-employment as their main source of income**, although percentages differed between these groups. Main sources of income for host communities were employment (62 percent) and self-employment (21 percent). These figures were 40 and 24 percent for refugees, respectively. IDPs in Iraq had employment and self-employment percentages of 36 and 37 percent, respectively. IDPs and refugees also listed having no source of income at 21 and 18 percent, respectively, whereas this category was only eight percent for host communities.

Most options provided in the survey for main source of income had low percentages, or were not chosen at all. **Similar percentages of host and refugee communities receive support from friends and family** as a main source of income (around four percent). **Refugees** also listed **aid from international organisations and NGOs** (six percent), **cash transfers** (three percent), and **food vouchers and e-cards** (three percent). Three percent of **IDPs in Iraq** also listed **agriculture, farming and livestock** as main sources of income. The following two figures provide detail of primary sources of income per nationality per country as percentages of each sub-group, and then as percentages in relation to the overall survey sample.

[6] Source: World Development Index (2015). Available here, accessed on 30 November 2017.

*Figure 17: Primary source of income per nationality in each country as percentage of sub-group*

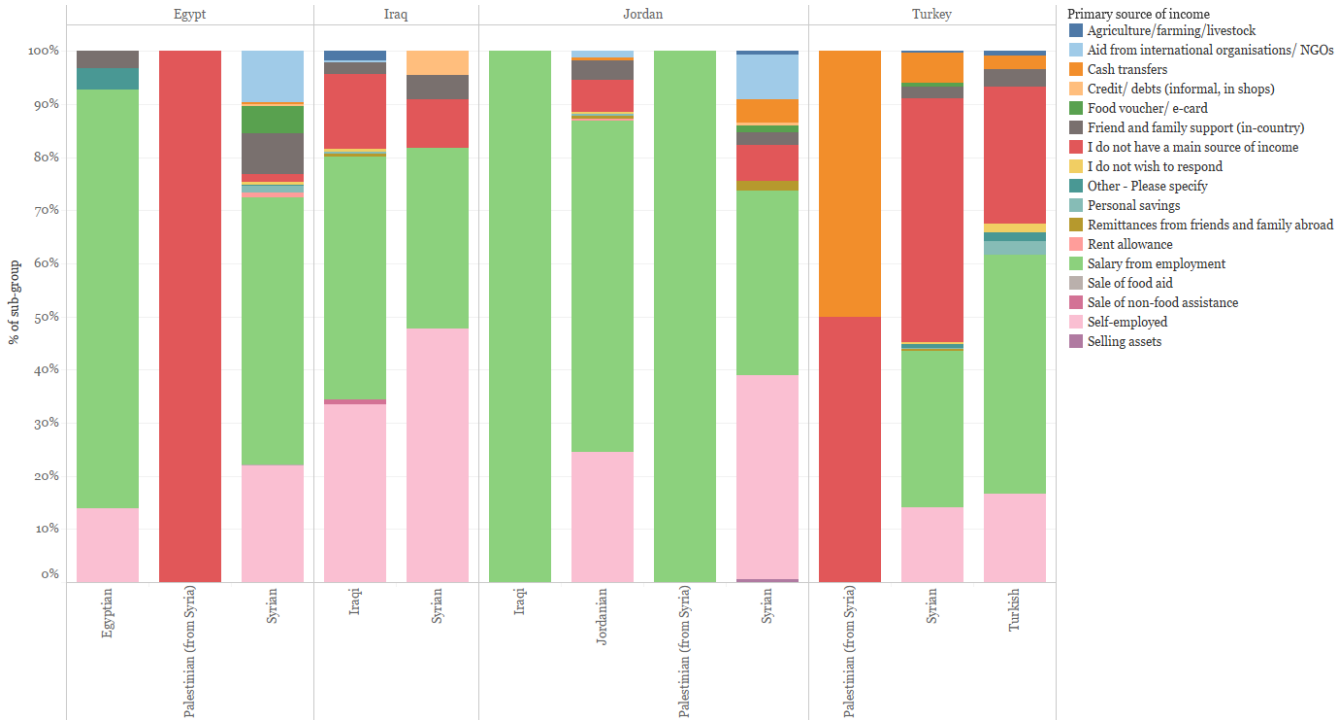



*Figure 18: Primary source of income per nationality in each country as percentage of overall sample*


There is some variation in responses for **secondary sources of income**: **57 percent of host community respondents had no secondary source of income**, compared with around 39 percent for both IDPs and refugees. For host communities, the most common secondary sources of income were employment, self-employment and friends and family support. There were qualitative answers provided under 'other', where respondents specified support from family members, as well as rent from property or commercial spaces and pensions.

For **refugees**, on the other hand, the **most common secondary sources of income** were **food vouchers and e-cards** (19 percent) and **cash transfers** (15 percent), followed by **aid from**

**international organisations and NGOs** (eight percent). 14 percent of refugee respondents also opted to fill in the 'other' qualitative response, but for the most part responses included reference to support from family members, as for the host community above, income from local authorities, and provision of private tuition as secondary sources of income.

Secondary sources of income for **IDPs** were highest for **self-employment** (nearly 33 percent) and employment (13 percent), followed by aid from international organisation and NGOs (12 percent) and friends and family support (nearly six percent).

Data from FGDs suggests that going into debt is a common coping mechanism across communities.

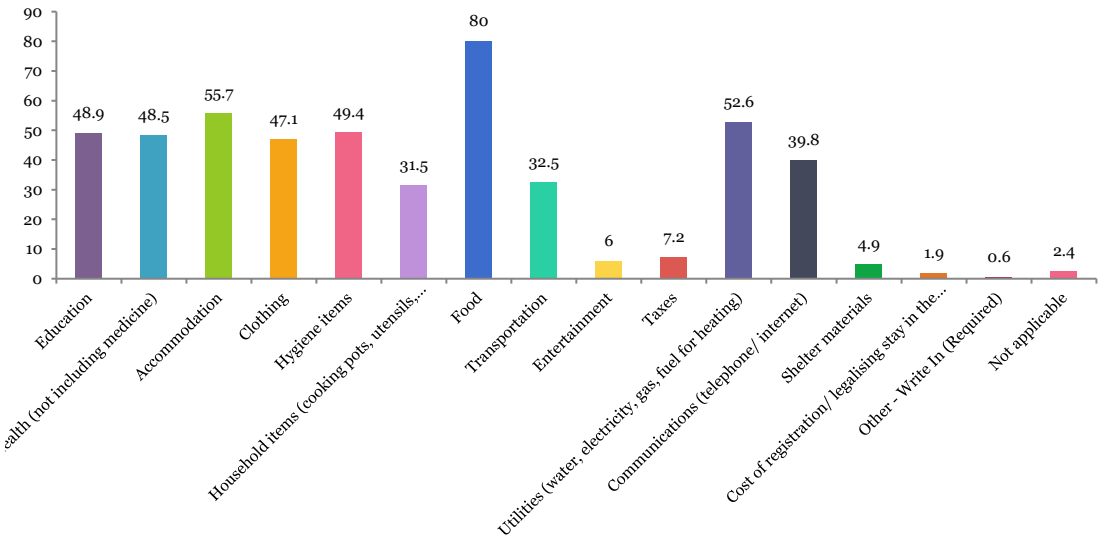
When looking at **secondary sources** of income per country, the following points are to note:

- **Cash transfers** are most common in **Turkey** (31 percent) as secondary sources of income.
- **Food vouchers/ e-cards** are common in **Jordan and Egypt** (18 percent in each).
- **Aid from international organisations/ NGOs** is mostly observed in **Jordan, Iraq and Egypt**, although figures for each remain below ten percent.
- In **Turkey**, 36 percent of respondents chose the qualitative 'other' option for this question, most commonly listing **family support** as a secondary source of income.
- Overall, however, in most countries **the highest chosen option for secondary sources of income in relation to other questions is for not having one**: 27 percent in Jordan, 43 percent in Turkey, 52 percent in Iraq and 61 percent in Egypt.

### *Household expenditure*

Most respondents stated that **they could meet food expenses** (80 percent). However, **just over half of respondents could afford accommodation and utility costs**. **Less than half of the respondents could meet expenses related to education, health and hygiene items**. When data is disaggregated by gender and age, patterns for household expenditure do not differ much.

*Figure 19: Ability to meet household expenditure*




When data is disaggregated by country, there are some divergences in the ability to meet household expenditure, although overall patterns are consistent with regional level. Some of the most significant divergences include:

- **Ability to afford accommodation costs differs between countries**: it is highest in Turkey (89 percent), followed by Egypt (58 percent) and Jordan (44 percent), and it is considerably lower in Iraq (19 percent). Nonetheless, in all countries (including Lebanon) a sharp increase in rental prices is noted as a difficulty, particularly for refugee communities.

- **Only in Egypt could more than half of respondents afford education costs** (59 percent). The percentage is 47 for Turkey, 43 for Jordan and 41 for Iraq.

- **Turkey ranks highest in being able to afford health costs at 61 percent,** but this is to be expected as healthcare is free for all. For Egypt, this figure is 52 percent, 44 percent in Iraq, and 36 percent in Jordan. In Jordan, this low percentage may be due to healthcare not being available free of cost. In Iraq, many financial barriers were noted in being able to afford health costs, which ranged from costs of medicines to transport costs as most locations where FGDs were held did not have clinics of hospitals nearby.

- **Iraq has considerably lower percentages than other countries in being able to afford household items, transportation and utilities**.

We also note interesting divergences in ability to afford household expenditure when data is disaggregated to examine respondents' status:

- **Host community members have consistently higher scores than other communities** across all household expenditure options, with the exception of food, where IDPs score higher in Iraq; and accommodation and utilities, where refugees score higher.

- **More than 75 percent of IDPs** are not able to afford education, accommodation, household items, transportation, utilities and communication costs.

- **Over half of refugee respondents** are unable to afford education, health, clothing, hygiene items, transportation and communication costs.

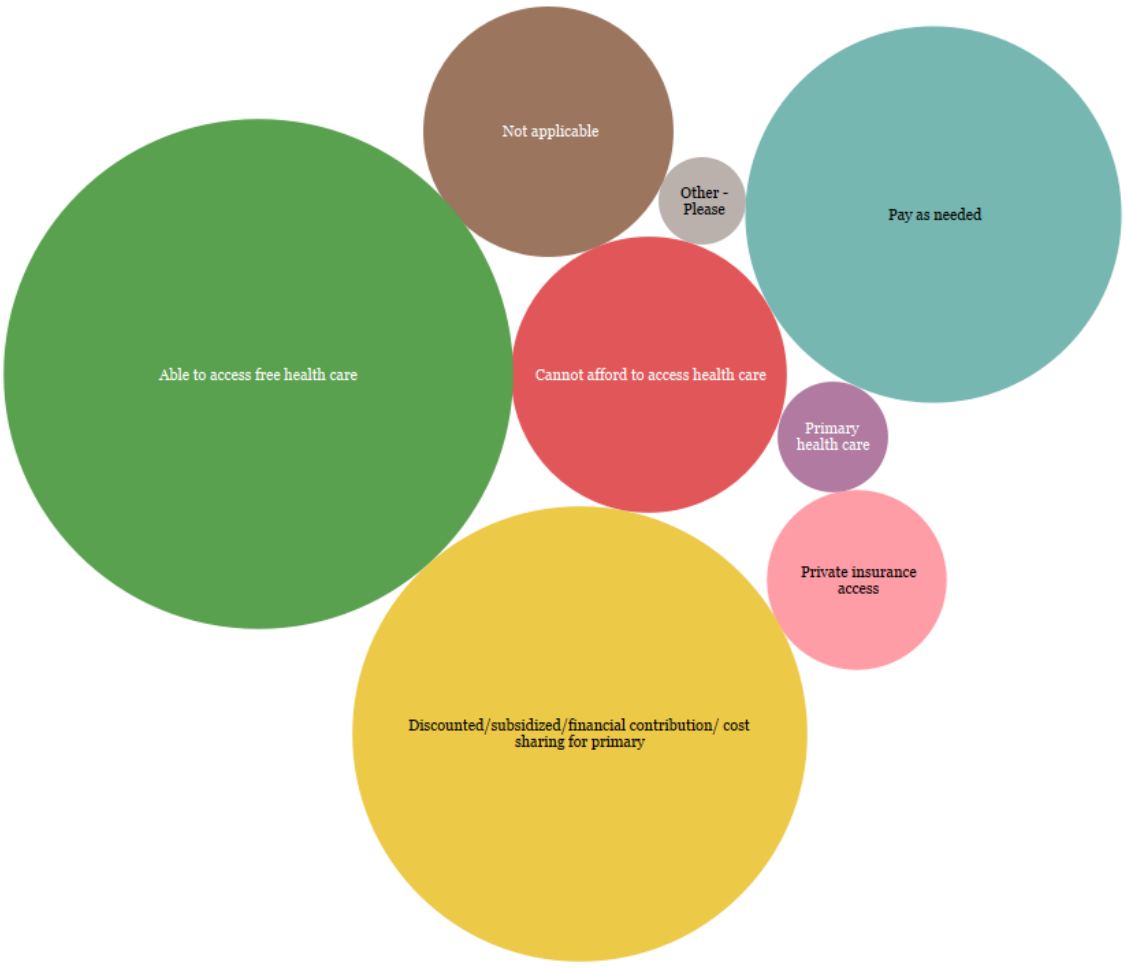
- Only **one percent of refugee and IDP respondents can afford entertainment costs**; this figure is also low for **host communities at 14 percent**. The desire for leisure activities was common in FGDs conducted with male participants from host communities in Lebanon.

## Health

*This section is not applicable to survey responses collected by FRC in Iraq.*

The survey asked respondents to provide details of their arrangements for primary health care access, and for this question respondents were able to select more than one option. For the overall survey at regional level, the **most selected option was that respondents were able to access free health care**, although the percentage of respondents was **just over 32 percent**; followed by **26 percent of respondents stating they had access to discounted/ subsidised/ financial contribution/ cost sharing for primary health care**; and 18 percent of respondents stated they paid as needed. Private health insurance, at four percent, was the least chosen option. There were nearly ten percent of respondents who stated they could not afford primary healthcare costs, and eight percent marked this question as not applicable.

*Figure 28: Primary healthcare access at regional level*

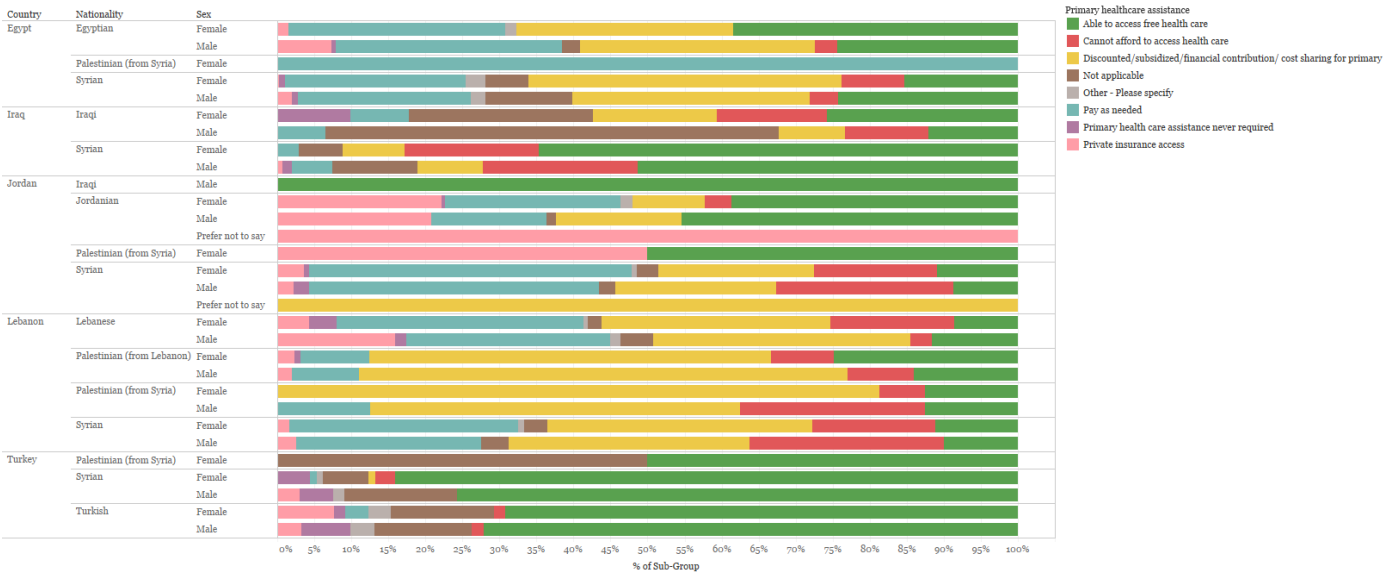



When data is disaggregated by country, community, gender and age, the picture that emerges is somewhat different to the regional trend:

- **Egyptian and Iraqi female respondents** were more likely than their male counterparts to be able to access free healthcare.

- **Syrian female refugees** in Turkey, Jordan and Syria also had higher percentages for being able to access free primary healthcare.
- In Egypt, **female Syrian refugee respondents were less likely than their male counterparts** to receive free primary healthcare, but they were more likely to have discounted/ subsidised health care.
- In Turkey and Jordan, **host community male respondents** were better able to access free healthcare than female counterparts.
- The highest percentages for **not being able to afford primary healthcare access were found in Lebanon, Iraq and Jordan for the Syrian community**, **and in Lebanon for male Palestinians from Syria, although the latter had comparable levels to both male and female Palestinians from Lebanon and the sample of Palestinian refugees from Syria is small**. This data is consistent with FGDs conducted in Lebanon: Lebanese host community members highlighted that they could not secure primary healthcare; Syrians stated that they could get some subsidised healthcare access, but they were unable to cover the difference; and Palestinians from Syria and from Lebanon both fall under PRCS and UNRWA, although not all services are covered by these organisations.
- When broken down by age, all **respondents in the 60 and over category said that they were able to access free health care**. The age group 18-30 were the group who were least able to afford access to primary health care.
- **Those living in refugee camps** were the group where the highest number of respondents for both being **able to access free health care**, and receiving **discounted/ subsidised primary care** compared to respondents in urban and rural areas. Respondents in rural areas were most likely to pay as needed.

*Figure 21: Primary healthcare access by country, nationality and gender*




For secondary healthcare access, **30 percent of respondents marked the question as not applicable**, and 15 percent stated they needed to pay in full for hospital care. There were **23 percent of respondents who were able to access free hospital or specialised care**, and **24 percent who received discounted/ subsidised care**. As above, when data is disaggregated, we observe some interesting trends:

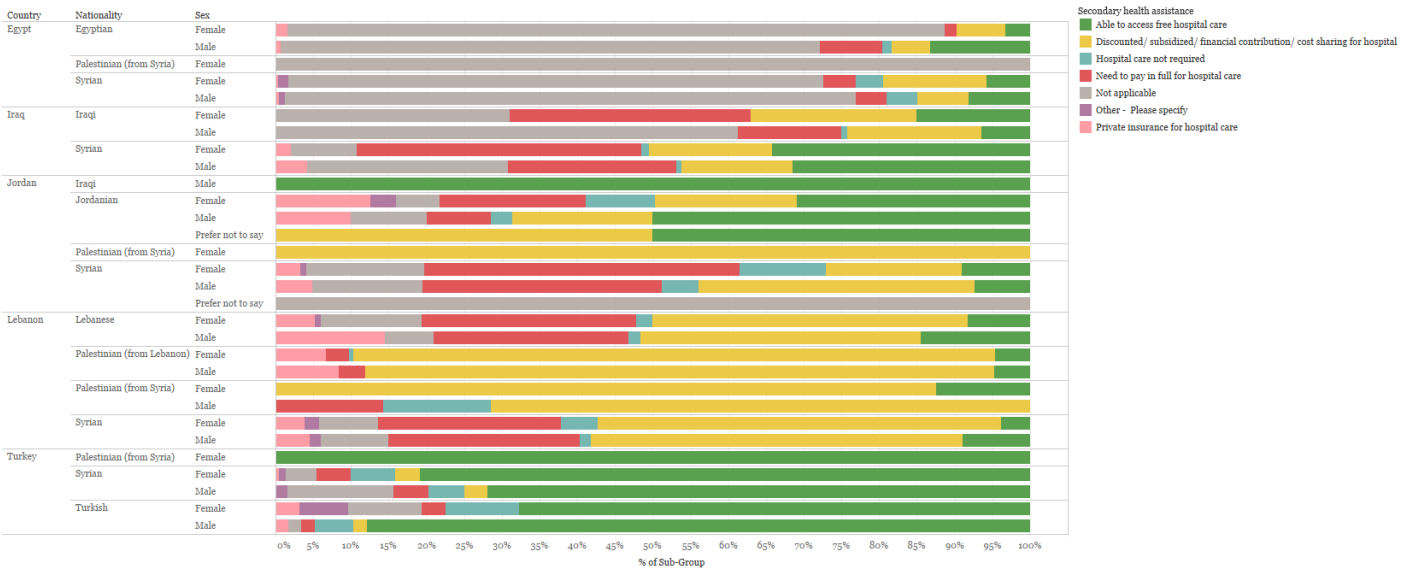
- In **Turkey, 79 percent of respondents stated that they were able to access free hospital care**; these figures are considerably lower for all other countries – just over 20

percent for Iraq and Jordan, and seven and eight percent in Lebanon and Egypt, respectively. However, it is important to note that in Turkey health is provided for free to everyone.

- Over **60 percent of respondents in Lebanon stated that they had discounted or subsidised secondary healthcare**. Percentages for this option are much lower in other countries: just over 20 percent in Iraq and Jordan, nine percent in Egypt and three percent in Turkey.

- **All countries had low levels of private insurance for hospital care**, and for not requiring hospital care. Egypt had 74 percent of respondents who marked this question as not applicable.

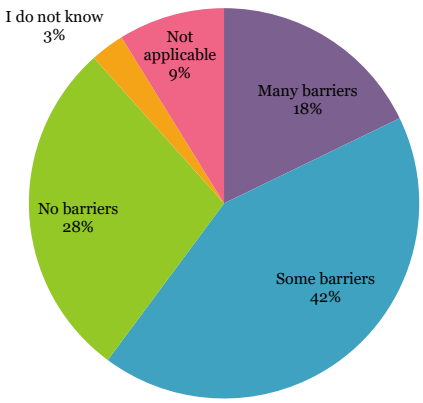
*Figure 22: Access to secondary healthcare by country, nationality and gender*




## *Access to health and medical services*

For the overall regional survey, 28 percent of respondents indicated that they faced no barriers to accessing health services. There were also nine percent of respondents who marked the question as 'not applicable', and three percent who answered that they did not know. The remaining responses indicated that respondents faced some (42 percent) or many (18 percent) barriers.

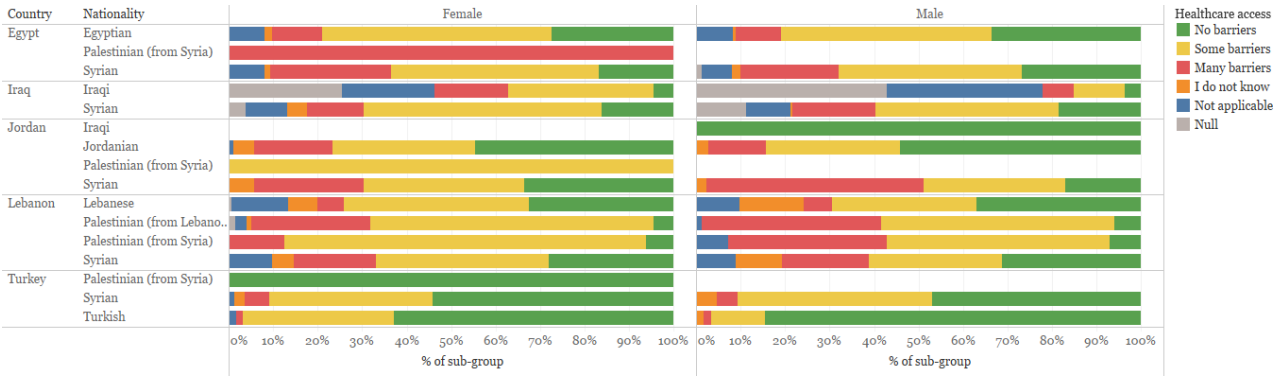
*Figure 23: Barriers to accessing health services*



When disaggregating by age, the perception of barriers is similar between age groups. Interesting divergences emerge when we disaggregate the data per country. The main points to highlight are the following:

- **In Turkey, most respondents indicated that they either faced no barriers** – by far the most common answer in relation to other countries – or that they faced some barriers.
- **Many barriers were mostly noted in Jordan and Lebanon**, particularly for **male respondents**.
- The **lowest scores for no barriers to healthcare access were in Iraq and Lebanon**, suggesting that it is in these countries where most barriers are experienced. In both countries, the costs of medicines and lack of availability of equipment were issues that were consistently highlighted. In Iraq, the most emphasised barriers were transportation costs that are incurred to be able to access health services, and lack of availability of medicines.

*Figure 24: Barriers to accessing healthcare by country, nationality and gender*




For respondents who noted that they did face barriers, **46 percent noted that the main barrier was the quality of health services**, and **51 percent suggested that it was inability to pay** that acted as the main barrier. Services not being available and inability to afford transport costs followed closely behind. As mentioned above, this finding is consistent with FGD data.

However, it is important to note that the detail of barriers differs between countries:

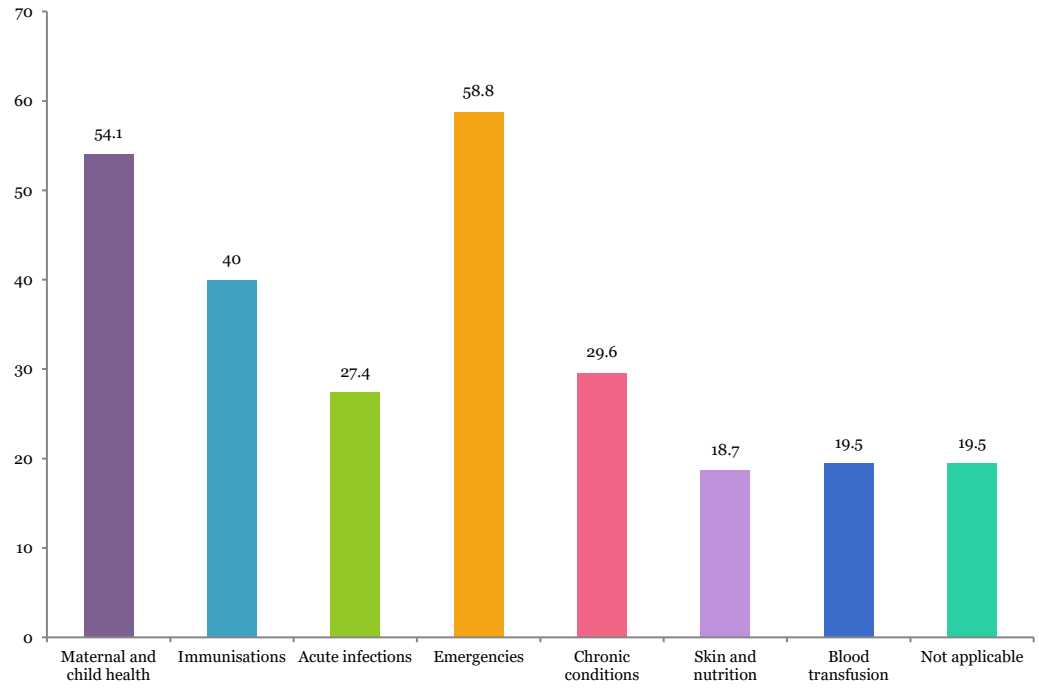
- In **Lebanon**, the main barriers are **inadequate or poor quality of services, inability to pay, and transportation barriers**.
- In **Turkey**, the most common barrier notes are **cultural or communication barriers**.
- In **Jordan**, inadequate or **poor quality, and inability to pay** were the most prominent barriers.
- In **Iraq**, the most significant barrier was the **cost of health services**, followed by **transport costs** and the **quality** of health services.
- In **Egypt**, the most significant barrier was the **ability to pay for health services**.

**The availability of information on health services does not seem to be a significant barrier at just over ten percent at regional level, and this finding is consistent with trends when data is disaggregated by country.** The data provided by respondents suggests that most of them would know how to access all or some medical services if someone in their household needed attention; only ten percent were unsure, and 11 percent did not know. FGD data supports this finding, with only one FGD with Syrian women in Lebanon indicating they were not sure how to access all health services.

Data on knowledge of how to access medical services suggests some divergences per country, although they are not dramatically different. **Turkey and Jordan have the highest percentages for knowing how to access medical services. Lebanon has the highest score for knowledge of how to access some health services. The highest percentage for lack of knowledge was found in Egypt, although it is low at 15 percent.**

The percentages for knowledge on how to access medical services also differ somewhat when disaggregated by gender, with **male respondents being more likely than females to know how to access these services**; and **women having higher percentages of responses for not knowing how to access medical assistance**.

*Figure 25: Knowledge of how to access specific health services at regional level*




**Knowledge on accessing health services was highest for emergencies and maternal and child health, followed by immunisations.** When disaggregated by gender, a greater proportion of male respondents were aware of how to access emergency services, and female respondents had higher scores than their male counterparts on maternal and child health, immunisations and acute infections.

When disaggregated by country and community:

- **Turkey, Jordan and Lebanon have high scores for knowledge on maternal and child health, immunisations and emergencies than other countries.** Turkey is also higher than all other countries on knowledge of acute infections, chronic conditions, and skin and nutrition.
- **Lebanon has the highest score for knowledge on blood transfusion services**, followed by Turkey and Jordan.
- **Iraq had the lowest score** relative to the other four countries on **knowledge of emergencies**.
- **Egypt was considerably lower than other countries on most areas** except for emergencies, where Iraq scored lower.

- **Host communities** scored highest on knowledge of all medical services. **Refugees** had the highest percentages for knowledge on maternal and child health, and emergencies, and these were also the two highest percentages for **IDPs** albeit somewhat lower than for refugees.

Focus group discussions were helpful for exploring the areas that beneficiaries are **most interested in receiving information on**. The two most prominent areas across all countries are **diabetes** and **blood pressure**. Other areas highlighted included **cancer**, particularly for Lebanese respondents living in the proximity of the Litani River; **chronic diseases**; **respiratory tract infections; skin conditions; kidney disease and dialysis**; and for women knowledge of **diseases and conditions specific to women**, as well as how to prevent them. In Iraq, **HIV** was also highlighted in several FGDs. Finally, in all countries there was an interest in **psychosocial services and mental health**, as well as dealing with **disabilities**.

### *Psychosocial health*

In Lebanon (LRC) and Turkey, the MADAD programme has a psychosocial health and wellbeing component. The baseline survey sought to collect information on the stressors that are affecting beneficiaries, as well as the support mechanisms they rely on or would like to have access to.

When we look at responses for both countries combined, the **most prominent stressors** are **money** (56 percent) and **living conditions** (52 percent). **Health** (34 percent) and **family** (31 percent) also scored high relative to other options. Two percent of responses indicate that domestic violence is a stressor. In both countries, community relations are expressed as a stressor, although percentages are low.

However, when we look at data by country, age, gender, and community, we note the following:

- **In Lebanon, individual stressors were all higher than for Turkey, except for money, for which Turkey scored higher.** The highest four stressors in Lebanon were family, money, health and living conditions, which received scores over 40 percent. The **most common coping mechanisms in Lebanon included talking to friends and relatives, and smoking**. **Desired support mechanisms** included **speaking to specialists, exercise, leisure activities and access to psychosocial support**.
- **In Turkey, money is the most prominent stressor, followed by living conditions.** Family, health, and study or work all score at around 20 percent. **Talking to friends and relatives** was by far the most prominent **coping mechanism**, as well as the most desired one. The other two most prominent **desired coping mechanisms** are **speaking to a specialist**, and speaking to **RCRC volunteers**.
- **Women have consistently higher percentages across stressors, except for political situation, community relations and security, where male respondents score higher.** Women are more likely to speak to friends and relatives as a coping strategy, and they also express most interest in this option and in speaking to a specialist as a desired support mechanism. Men also are more likely to speak to friends and relatives to cope, and to smoke; and their most desired support mechanisms include speaking to a specialist and leisure activities.
- **Money and living conditions are the most significant stressors for 18-30-year-olds and 31-59 age bracket.** In addition to these two stressors, health was also chosen as a prominent stressor for the 60 and over age group.
- **For refugees, the most prominent stressors are money (69 percent) and living conditions (61 percent). For host communities, family, money, health and living conditions are the highest-scoring stressors, although they all remain under 40 percent.** Speaking to friends and relatives is the most common coping option for both

communities; and desired support mechanisms include speaking to a specialist, to RCRC volunteers, and having access to leisure activities and to psychosocial support centres.

- Even though psychosocial services are not an intervention in all countries, it is worth nothing that **PSS was of interest in all countries where FGDs were conducted**. There is reference to lack of knowledge of how to deal with nervous breakdowns, for instance, and difficulties in facing stigma surrounding mental health issues.
- **Money as a stressor is prominent in all FGD data received from Lebanon and Turkey, and also Jordan and Iraq where no PSS activities are taking place.**
- FGD respondents, as well as some qualitative survey responses **suggest that beneficiaries are resorting to domestic violence, and in particular violence against women and children, as a way of releasing stress.**

### *Hygiene promotion activities*[7]

In Lebanon (PRCS), Turkey and Iraq, the MADAD programme is also covering hygiene promotion activities. These include: **positive behaviours to promote and protect good health, measures to prevent the deterioration of hygienic conditions**, use and maintenance of sanitation facilities, learning about harmful behaviours in relation to hygiene, water treatment, and solid waste disposal. The first two areas are the ones that attracted the larger number of responses.

*Table 3: Interest in learning about hygiene promotion activities*

| | Very interested | Somewhat interested | Not at all interested |
|---|---|---|---|
| Positive behaviours to promote and protect good health | 66.1% | 24.5% | 9.4% |
| Measures to prevent the deterioration of hygienic conditions | 62.3% | 27.3% | 10.4% |
| Use and maintenance of sanitation facilities | 57.1% | 28.7% | 14.2% |
| Learning about harmful behaviours in relation to hygiene | 58.5% | 31.1% | 10.4% |
| Water treatment | 49.5% | 31.1% | 19.3% |
| Solid waste disposal | 51.4% | 25.3% | 23.3% |

When disaggregated by country, gender and community, there are some commonalities and divergences with data at regional level:

- **In Turkey, the topics of least interest to respondents included solid waste disposal and water treatment**. Most respondents were very interested in positive behaviours to promote and protect good health, and measure to prevent the deterioration of hygienic conditions.
- **In Lebanon**, the two topics of highest interest were measures to prevent the deterioration of hygienic conditions, and learning about harmful behaviours in relation to hygiene, followed closely by water treatment and positive behaviours to promote and protect good health. All **four topics were in the high 60s in percentages for 'very interested'**.
- Survey results for Lebanon are consistent with data received in FGD notes, although the areas covered by LRC are not being targeted for hygiene promotion. **There is a consistent**

[7] The MADAD programme's outcome indicator for hygiene promotion aims to measure improvement in hygiene practices by the end of the intervention. At inception, the IOD PARC team noted that it would not be possible for us to measure hygiene knowledge as part of the baseline process and agreed to examine interest in hygiene promotion activity areas that MADAD is planning to implement. This section outlines the findings in this regard, but the outcome indicator will be baselined as zero.

**concern with open sewerage for Syrian participants,** and **rubbish collection as well as overcrowding** are highlighted in several FGDs.

- **In Iraq, the most popular health promotion topic was positive behaviours to promote and protect good health** (69 percent were 'very interested'). Water treatment was the option with least expressed interest. Nonetheless, **FGDs suggested that hygiene concerns are very prominent in Iraq, particularly in Syrian refugee camps,** where beneficiaries experience lack of water and electricity, and where rubbish collection is perceived not to happen often enough.
- When disaggregated by community, survey data suggests that all areas listed are of interest to respondents, with most responses received under 'very interested' for all options. **The two areas of most interest to host communities, refugees and IDP respondents alike were positive behaviours to promote and protect good health, and measures to prevent the deterioration of hygienic conditions.**
- **Women respondents were more interested than men in all hygiene promotion areas, except for water treatment and solid waste disposal**, where males recorded a higher number of responses under 'very interesting'.
- The **over-60s age bracket recorded the lowest level of interest in hygiene promotion activities relative to other age groups**. Levels of interest between the 18-30 and 31-59 age groups were similar across all hygiene promotion topics, except for positive behaviours to promote and protect good health, where 18-30-year-olds expressed stronger interest than the 31-59 age bracket.

# Detailed findings: RCRC staff and volunteers

The MADAD programme aims to strengthen the capacity of HNS staff and volunteers to support the implementation of the intervention. Outcome 3 of the MADAD programme focuses on building and strengthening the capacity of the host national societies to enhance their ability to reach out to the most vulnerable groups within the refugee and host communities.

Here, we provide a context for this outcome drawing from ten KIIs with IFRC/ European partners and HNS representatives with oversight of training; and four FGDs with staff and volunteers from national societies who have or will undertake MADAD-specific training, and who are involved in the implementation of the programme.[8]

*Identification of training needs*

In Turkey trainings offer a good theoretical basis that supports the work in the field. It is also highlighted that **building internal organisational, staff and volunteer, capacity is a priority**. It has been indicated that the **training** that TRCS staff and volunteers receive **is formed through three main avenues**: MADAD-specific trainings, must-have TRCS basic trainings, and trainings based on needs identified. It was also highlighted that staff capacity is also enhanced through **on-the-job experience,** and by **new staff and volunteers shadowing more seasoned staff,** as well as being **supervised by a senior staff member**.

- In **Lebanon** the FGD and KIIs highlight that MADAD is still new so **no training has taken place yet**. In the Medico-Social and Disaster Risk Reduction (DRR) departments, there is already training available that is coherent with MADAD; the project was designed in line with these available trainings and additional needs identified. Since the end of 2014, **there has been an effort to provide basic training** on PSS in DRR, psychosocial first aid and community PSS. However, the provision of specialty training depends on staff and volunteers' position, e.g. social workers who work with children will get child protection training. LRC are also developing a **customized self-training package** being piloted in the Emergency Medical Services department for practices, techniques and awareness.

- In **Iraq** the FGD with IRCS staff reports that before the start of MADAD, **staff have received training** on PSS and hygiene, and after the start of MADAD training on first aid. **No training has been received on gender and social inclusion**, but there is an interest in having more training. Training has also been received on livelihoods given this component of the MADAD intervention. **The next step will be** to do more technical training for volunteers, the staff also aim to strengthen the capacity of administration and logistics and give training in business management.

- KIIs and FGD conducted in **Jordan** report that **staff have already received training** in a number of areas of relevance to the MADAD programme as part of previous projects or programmes: these include gender, diversity, first aid, case management and referrals, NCDs, disaster management, Strengths, Weaknesses, Opportunities and Threats Analysis and Standard Operating Procedures, CBHFA topics and training of volunteers to use assessment tools. IFRC staff, on the other hand, have had less training on gender and diversity. On livelihoods specifically, as part of the Cash Transfer project, **ten JRCS staff and 20 volunteers were provided with specific training** to then provide to beneficiaries. Staff also mentioned that IFRC have a compendium of trainings online that host national society and volunteers can undertake. Since the start of MADAD, JRCS and IFRC staff have not had any further training.

[8] The MADAD logframe's Outcome indicator 3.2 aims to measure improved competence and confidence of staff in using their skills to reach out to vulnerable individuals. As outlined at inception, the baseline cannot test the competence and confidence or staff, and we have instead provided here context of staff capacities and training available.

In Jordan, **the training needs** for staff and volunteers are **established somewhat organically in working with vulnerable groups**. JRCS resource the training internally or ask IFRC for support and training is commissioned from external providers where necessary. There are also online training resources for staff and volunteers to access as needed. Although staff appreciated the availability of the online training, they found **face-to-face training and learning by doing are more effective** in improving their work than online trainings. It was also noted by staff that volunteers on average volunteer for eight hours a month and that some of the trainings they are expected to go on are as long as five days; this then limits the extent to which the 'work' with beneficiaries can be delivered.

*Gaps and challenges related to staff and volunteer capacity*

- For the FGD and KIIs in **Turkey no gaps were mentioned,** but the training officer reported that the trainings that TRCS provided and those offered through other agencies are sufficient to address the needs of the field staff and the additional activities of MADAD. Financially, trainings can also draw on budgets from other projects, if necessary. The training department can develop new trainings depending on the need of the staff and courses can be offered very quickly. However, **a challenge was noted** in terms of being understaffed and not having the time to participate in the training in a sufficient way.

- Participants in KIIs and the FGD in **Lebanon** report that the training is provided and are perceived fit for purpose for dealing with vulnerable groups. However, they also mentioned **some gaps in the training;** it would be useful to have training on how to monitor activities of micro-projects in communities, and child protection is another issue they would like to have training on. However, volunteers struggle to find the time for training, and there is a **gap in the quality of training**, especially in training on sensitive topics.

  In the FGD with staff in Lebanon it was also mentioned that some aspects of the MADAD intervention do not allow for engaging with cases that require more specialised skills. For instance, Central Dispatch for emergency services gets calls for domestic violence, but they **cannot help with these cases** as they are outside their remit (they can only deal with emergencies), and they have to collaborate with the security services. Another gap that was mentioned is that there is **no training for monitoring.** Training on reporting system for the project coordinator was ongoing at the time of conducting the FGD. Blood transfusion services are directly monitored through data input, but there is no related training being provided so far.

- KIIs and FGD with staff in **Iraq** report a view that the general technical knowledge of staff is good, but **there are gaps in terms of administration and finance, management, logistics and sustainability**. It was also mentioned that there is also a lack of training on **health and livelihoods, gender, hygiene promotion and disabilities**. IRCS **relies on long-term volunteers**. They often receive expressions of interest from new volunteers, but they rely mostly on a cohort of volunteers who have been with them for a long time.

- The FGD and KIIs conducted in **Jordan** report examples of **internal challenges,** like a shortage of staff and internal HNS capacity, budget issues, and response times for providing necessary documentation to release funds are sometimes delayed, which then has repercussions on getting budgets in place. Other challenges mentioned by the staff in Jordan are not specific to the MADAD programme, but are broader capacity challenges within the host national society**. One of the key challenges** mentioned is that while it is relatively 'easy' to get funding from donors for thematic training for staff that is relevant to a project, **donors are reluctant to pay for 'cross-cutting' trainings** which can impact upon, and undermine, the success of all projects. Examples provided by staff include project management, the financial management of projects, communications, M&E, partnership working, human resources, risk, procurement and corruption. For skills such as these there is the expectation that staff **'learn by doing'**, but those interviewed highlighted that some training is still needed, and that if it is not supported by project funding, then there are no institutional resources to invest in these areas.

Another important challenge that was noted in the interviews in Jordan was **retention of volunteers;** JRCS have to **continually train new volunteers**.

Regarding gaps in training, the Jordan staff mention that there were times when **beneficiaries asked for specific information** that staff and volunteers may not possess. There may be a need then to **update the training curriculum for volunteers** to make it (and keep it) relevant to the context and to the work of staff and volunteers in the field, and in relation to MADAD; and to ensure that if volunteers and staff do not know an answer, they know where the beneficiary could find one. It was also noted though that there is currently no referral system in place for cases and if volunteers or staff identify, for example, specific protection concerns, they are limited in terms of how they can support a beneficiary to get the help they require.

*How the MADAD programme identifies activities and the most vulnerable groups*

- The respondents within the FGD with staff and KIIs in **Turkey** indicated that there are both **formal and informal processes** to identify both the vulnerable beneficiaries and identify appropriate activities for this population. The formal processes include conducting **situational analysis** and **focus group discussions** to understand problems and raise possible solutions. TRCS also relies on **state data and reports on other TRCS projects and activities**, where there is reference to vulnerable individuals and potential beneficiary groups. Informal processes appear to include **observation through field workers' everyday work**. Respondents from the staff FGD and KIIs reported confidence in these methods to identify vulnerable groups of beneficiaries.

  In Turkey, one challenge in reaching the most vulnerable communities is the community centre model. Community centres are open to both host Turkish communities and Syrian communities. However, the **Turkish host community thinks that TRCS are just supporting Syrian refugees**. Another challenge includes the **changing needs of beneficiaries over time**, for instance the need for psychosocial support and emergency assistance during an acute crisis, to an increasing need for livelihoods support as the crisis becomes protracted.

- The FGD in **Lebanon** mentioned that **specific criteria** are applied to the **needs assessments** of communities for identifying vulnerable groups and individuals. The criteria include for example: number of persons in a household, number of children and elderly, employment, access to medical services, members of the household with chronic diseases and/ or acute diseases, disability, GBV and child protection, psychosocial needs, and infrastructure.

  One challenge noted in Lebanon for reaching vulnerable beneficiaries is external to the project and relates to the **political situation, which can create tensions that affect the ability of LRC to work with communities and the way vulnerable persons are targeted.** The conflict in Syria has polarised Lebanese society and political relations, and political crises oftentimes reflect on communities not wanting to interact with one another; or an LRC intervention risking compromising the relationship that has been forged with communities they engage with.

- In **Iraq** the staff reported that the **main criteria** for identifying vulnerable groups and individuals are similar to what is reported for Lebanon. **Criteria also include indicators of how vulnerable a family is,** for example in terms of renting or owning property, or having access to air conditioning. **IRCS also has eliminating criteria** like availability, permission and willingness to take part in training, and an assessment of whether the person is motivated to take part in a programme. **Another way to identify vulnerable groups** is for social workers/ coordinators on the ground to collect information on needs like pregnancy and maternity, children's health and need of help for elderly people.

  For **Iraq** the **main challenges are time needed to access to different areas**, since infrastructure has been destroyed, there are no roads, and **security coordination** takes

time. Other challenges affecting their operations include delay in getting to camps due to lack of transport facilities, and delays in payment of salaries.

- As for Iraq and Lebanon, in **Jordan** information is collected from households and communities to identify vulnerabilities. However, there are **specific challenges** to the Jordan context in being able to assist the most vulnerable groups related to **medical services not being free**, except for children under five; and the **inability to make referrals to psychosocial services as it lies outside their remit**.

# Conclusions and recommendations

*Overall Objective: Contribute to improved wellbeing, resilience and peaceful co-existence among vulnerable refugee and host communities in countries affected by the Syria crisis, contributing to overall stability in the region.*

The MADAD programme aims to contribute to social cohesion in societies that have been affected by the Syria crisis. Even though it is not possible to baseline social cohesion, this study aimed to examine the perceptions of respondents of the communities they live in. Our findings suggest that there are **recognisable tensions between host communities and refugees,** with the most noticeable case being Lebanon. Host communities are concerned with the presence of refugees and the impact it has on the use of shared resources, the environment, and access to jobs and rental housing. There is also a felt resentment towards refugees in contexts where there is no access to free healthcare – in Jordan and Iraq, mainly – where UNHCR and other organisations are seen to favour refugees over the host community.

**The MADAD programme has potential to contribute to creating spaces for interaction between host communities and refugees,** and it ought to optimise the opportunities provided by their activities to do so. **However, it is equally important that the MADAD programme is effective in conveying the message that it aims to target both communities.**

We also note that **sexual harassment is highlighted as an issue that affects women in all countries, and that at times justifies their limited presence in public spaces or in the workplace.** In qualitative responses, this issue is linked with social cohesion in as far as it is attributed to refugee inflows, although this does not necessarily have to be the case. However, there is an indication that participants in the survey study are resorting to domestic violence and violence against children as a way of defusing the tension and frustration felt at the situation they live in. These findings indicate a strong need for addressing these issues under the MADAD intervention, **for example through referral to other stakeholders specialising in, or with capacity to respond to these issues**.

We recognise that some of the issues that are causing tensions are beyond the scope of the MADAD programme. Many of the challenges faced by the surveyed communities are due to the systems in which they find themselves: legislation on refugee employment, employment regulations or lack thereof, weaknesses in the regulation of the housing market, non-recognition of qualifications, reliance on personal connections to access jobs, absence of free health services, and so forth. It would be inappropriate, therefore, to measure MADAD's success on fostering social cohesion without contextualising the intervention. We therefore suggest that at midline and endline **beneficiaries' perceptions of social cohesion are explored qualitatively, and that they are directly linked with whether these perceptions have been in any way influenced by the intervention.**

The definition of social cohesion that was agreed at inception corresponds to the American Red Cross' definition: *Willingness to cooperate to survive and prosper*. **If there is a requirement to measure social cohesion quantitatively, we recommend that there the three elements identified during the inception in relation to this definition: health, livelihoods and community development. These three areas would need to be appropriately operationalised in survey questions and weighed to provide a value that captures the complexity of social cohesion.**

*Outcome 1: Refugees from Syria and host communities are more self-reliant and resilient to prevalent risks and local conflicts*

- **Livelihoods is the most prominent concern of participants in the baseline study.** The study's findings suggest that unemployment is a big concern for most households, and

participants note significant barriers to finding employment: exploitation of refugees by employers by paying them lower salaries, the predominance of connections for securing employment, lack of recognition of Syrian qualifications in Turkey, difficulties in security work permits for refugees in Jordan, and Palestinians being forbidden from many job sectors in Lebanon. **The MADAD livelihoods intervention is the most significant element of the programme, although smaller in comparison with the health intervention.**

**Recommendation:** The baseline study puts forward a strong argument for ensuring that the livelihoods component is made as relevant as possible given the constraints that MADAD is operating in in each country. We strongly recommend that the MADAD team assesses the particularities of each context and implements livelihoods activities that can lead to an improvement in the financial situation of beneficiaries, for instance by ensuring that training received is in topics for which beneficiaries are likely to be able to secure employment, or in areas where work permits or start-up licences are granted.

- **Unemployment levels for refugees and for women are for the most part higher than for other groups in the surveyed countries.**

  **Recommendation:** MADAD interventions ought to take into account the constraints faced by the most vulnerable groups to access the job market within the scope of the programme. For example, trainings need to be made relevant to the job market and to the realities of obtaining permits, for instance for start-up activities. Given that women have higher levels of unemployment, livelihoods activities targeted at women need to consider social and cultural constraints faced by this demographic.

- **The baseline suggests that there is limited use by the survey respondents of community centres in Turkey, and limited involvement in social initiatives and projects.** This is a key element of the MADAD intervention, and it is strongly linked with the spaces that are being made available to foster interaction between beneficiary communities.

  **Recommendation:** The MADAD team ought to ensure that appropriate outreach activities are organised, and that knowledge of the programme is disseminated widely. This dissemination message should focus on the availability of activities, but should also be tailored to the groups that are less likely to use them such as men, host communities.

*Outcome 2: Refugees from Syria and host communities have improved health and psychosocial well-being*

- **Knowledge of health services does not emerge as a significant barrier to access.** Participants in the baseline study overall exhibit reasonable levels of knowledge of health services. There is an emphasis on issues that are prominent in each context – blood pressure and diabetes are the two most mentioned ones. There is also interest in chronic diseases, respiratory tract infections, skin conditions, and for women an interest in learning more about prevention of conditions that may affect them.

  **Recommendation:** The survey suggests that there are specific health topics that are of interest to beneficiaries, and the MADAD programme is well placed to provide additional health education information through planned activities and interventions. It will be important to contextualise MADAD contributions to knowledge of health services, not only in terms of the location, but also in relation to specific demographics such as women or host communities/ refugees.

- **The most significant barrier to accessing health services is cost; other important barriers include quality and availability of services in the locations surveyed.** This finding reinforces the importance of the first point on livelihoods. The only country where cost is not a barrier to the same extent as others is in Turkey, where the main problem encountered is cultural and communication barriers.

**Recommendation:** Even though we note that the MADAD intervention is focused on the provision of knowledge on health services, the study highlights that it is important to consider other barriers that beneficiaries face, such as the shortage or high cost of medicines, inability to pay for transport to clinics and hospitals, and in the case of Turkey, cultural and communication barriers. For MADAD interventions where there are mobile health services being provided, the frequency of these services is key and can directly contribute to enhancing access to health services.

- **Even though there is a recognised stigma on mental health, PSS is an area of interest even in countries where no PSS MADAD component is being implemented.** There are strong indications that beneficiaries feel a need to access psychosocial support and to be able to access specialists. This is a limitation for MADAD countries where there is no PSS component, where there is a recognised constraint in not being able to pay for health services, or where there is no possibility of making PSS referrals.

  **Recommendation:** In countries where MADAD does not have a PSS component, there should be consideration of how to avail beneficiaries with referral services as this is a prominent area of concern for participants in the baseline study.

- **Hygiene promotion has an important place in the MADAD intervention, and it emerges as an area of interest to participants in the baseline study.** The most pressing concerns relate to sewerage systems, rubbish collection and general community cleanliness. However, some of the concerns expressed by beneficiaries stem from the lack (or limited frequency) of public services in the countries and contexts they live in; or the inability to afford hygiene items.

  **Recommendation:** Hygiene promotion activities ought to be tailored to the interests of beneficiaries, and there needs to be an assessment of whether it would be helpful to strengthen the distribution of hygiene items given the constraints expressed in being able to afford them.

*Outcome 3: RCRC Host National Societies in the region have strengthened their capacity and enhanced their ability to reach out to most vulnerable groups within the refugees and host communities*

- **HNS involved in the MADAD implementation overall exhibit adequate training capacity, which is either possessed in-house or easily outsourced.** This is particularly the case for the core MADAD interventions, and areas where RCRC has extensive experience, for instance CBHFA. However, given the prominence of psychosocial support needs, as well as instances of GBV, violence against children and conflict, it may be necessary to strengthen training on these areas.

  **Recommendation:** It would be beneficial for the MADAD team to consider specialised training as a core element of staff and volunteer training, given their centrality to the beneficiary population targeted through the programme and the explicit focus of this outcome on the ability to identify and reach vulnerable beneficiaries.

- **HNS also recognised skills related to monitoring and evaluation and project management as a gap.** It is important to strengthen skills on these fronts, particularly to ensure that reliable data is collected on MADAD that can feed into quarterly reporting, and to midline and endline evaluations.

  **Recommendation:** Being able to measure and monitor progress on the programme will depend on having in place a robust M&E system. We would strongly encourage that M&E and project management training needs are addressed under the MADAD programme for relevant staff from HNS.

- **The programme aims to support the improvement of the confidence of staff and volunteers in employing the skills gained under MADAD.**

**Recommendation:** All MADAD country teams ought to ensure that there are appropriate appraisal mechanisms to assess staff and volunteer performance and monitor their confidence in putting the skills they garner through training into practice in identifying vulnerable individuals. This will be key to reporting on the relevant indicator at midline and endline.

- **There is a strong message emanating from FGDs on the fluidity of humanitarian assistance and the impact it has on the wellbeing of beneficiaries.** Gaps in healthcare assistance, access to education and child protection services, as well as cash assistance, is sometimes attributed to short-lived interventions by organisations that have ceased operations in some of the locations where MADAD is being implemented. This is an important point for reflection, particularly in what pertains to the sustainability of interventions.

  **Recommendation:** Given that Outcome 3 focuses on HNS capacity and skills to identify and reach vulnerable populations, it is important to continue to reflect on the sustainability of the intervention beyond the lifetime of the programme and to invest in ensuring that these communities can continue to be supported once the intervention ends.

# Annex 1: Terms of Reference

## Regional baseline: Tool synchronisation and indicator benchmarking

*For the Action "Addressing Vulnerabilities of Refugees and Host Communities in Five Countries Affected by the Syria Crisis" funded by the MADAD Trust Fund"*

**Coordinator:** Danish Red Cross (DCR)

**Partners:** / Egypt Red Crescent Society / French Red Cross/German Red Cross / Iraq Red Crescent Society / Jordanian Red Crescent Society / Lebanese Red Cross / Netherlands Red Cross / Norwegian Red Cross / Palestine Red Crescent / Spanish Red Cross / Swedish Red Cross / Swiss Red Cross / Turkish Red Crescent Society and International Federation of Red Cross and Red Crescent Societies

**Location of the Action:** Lebanon (country wide), Jordan (Governorates of Amman, Mafraq, Ajloun and Irbid), Iraq (Domiz camp, Dohuk and Erbil Governorates in the Kurdistan region), Turkey (Ankara, Istanbul, Konya, and Sanliurfa and six major Turkish cities in Turkey), Egypt (Alexandria, Damietta and Greater Cairo)

**Background**

In December 2014 the European Commission launched the MADAD Trust Fund as a European joint response to the Syrian crisis. The overall objective of the MADAD Trust Fund is to provide a coherent and reinforced aid response to the Syrian crisis on a regional scale, responding primarily in the first instance to the needs of refugees from Syria in neighbouring countries, as well as of the communities hosting the refugees and their administrations, in particular as regards resilience and early recovery.

Funded under MADAD, the Action "*Addressing vulnerabilities of refugees and host communities in five countries affected by the Syria Crisis*" provides a coherent, regional and coordinated response to the crisis following the Syria conflict with activities in Lebanon, Jordan, Egypt, Iraq and Turkey. The total budget of the programme is **53.000.000 EUR**. The budget distribution per country is planned as follows:

**Table 1: Overview of the Action**

| Country | Country Lead | Amount (excl. indirect cost) |
|---|---|---|
| Regional | DRC (overall lead) | 1.226.383 EUR |
| Turkey | IFRC Europe | 32.558.895 EUR |
| Lebanon | Netherlands Red Cross | 7.837.215 EUR |
| Iraq | Norwegian Red Cross | 3.951.670 EUR |
| Jordan | IFRC MENA | 2.886.889 EUR |
| Egypt | German Red Cross | 1.071.659 EUR |

The Action will be implemented over a **36 month period**, across multiple contexts with various institutional challenges and varying needs of vulnerable persons from Syria, as well as in the host communities, as is also evident in the Response Plans of Lebanon and Jordan and the 3RP country chapters of Turkey, Egypt and Iraq.

DRC will be responsible for overall program coordination and oversight, while country level project management will be overseen by a Country Lead (EU National Societies or IFRC) in close partnership with the National Societies who are implementing the Action.

The Overall Objective of the Action is to "*Contribute to improved wellbeing, resilience and peaceful co-existence among vulnerable refugee and host communities in countries affected by the Syria crisis, contributing to overall stability in the region"* through the achievement of three specific objectives described below. The estimated number of direct beneficiaries is one million. Operationally the Action is structured around three specific objectives:

Specific Objective 1: "*Refugees from Syria and host communities are more self-reliant and resilient to prevalent risks and local conflicts (all countries)"*

The Action will provide economic opportunities to refugees and host community members in Egypt, Iraq, Jordan and Turkey. The expected outcomes are that the communities are provided with a diverse range of employment and income opportunities through livelihood programming, support to public vocational trainings initiatives, job centres, vocational and business skills training and income generating activities. Communities will also have improved knowledge and be enabled to manage the risks facing them through holistic assessment of needs, risks, vulnerabilities and capacities through participatory Vulnerability and

Capacity Assessment (VCA) and baselines; contingency plans, public awareness and public education in risk reduction, evacuation plans; training in in risk reduction, first aid, safe shelter awareness.

Specific Objective 2: "*Refugees from Syria and host communities have improved health and psychosocial well-being (all countries)"*

The Action will provide better community access to health care in all five countries. The Action will work with the formal health systems through referrals, providing ambulance services, ensuring adequate blood supply; promotion of healthy lifestyle, screening for chronic diseases and psychosocial support. Communities will have improved knowledge and health as they are able to manage the health risks facing them and have access to a sustainable sanitation system.

Specific Objective 3: *"RCRC Host National Societies in the region have strengthened their capacity and enhanced their ability to reach out to most vulnerable groups within the refugees and host communities (Iraq, Jordan, Lebanon, Turkey)".*

Considering the protracted nature of the crises, there is a need to support long term community based organizations with a strong presence in the targeted areas as these will stay beyond the timeframe of the Action. RC/RC aims to strengthen and complement current national efforts in all five countries and existing community initiatives through support to development of individual, organizational and institutional skills to address their own needs and challenges, as well as to support others. The interventions at community level are developed and delivered as extension of and in accordance with national policies, programmes and standards to achieve higher coverage among out of reach populations and to improve cooperation and dialogue between the communities and the authorities. The involved RC Host National Societies will include resilience related objectives as specific targets and indicators in their strategic planning, training objectives and monitoring and evaluation activities.

**Objectives of the Regional baseline: Tool synchronisation & indicator benchmarking**

The main objective of the regional baseline is to kick-start the operationalisation of the Action's M&E system. Specifically, the regional baseline will:

1. Establish accurate benchmarking of indicators for all Specific Objectives (see Table 2 below), from which the Action's progress can be monitored and measured over the course of implementation. This will entail the development of tools for data collection, and the subsequent collation of data from five country-level baseline exercises (managed locally by the partners), through a consistent and harmonized approach.
2. Set or confirm targets for the Action, in light of baseline information gathered, and in consultation with partners.
3. Contribute to outline the definition of the selected indicator to the Action's overall objective according to geographical context and develop suggested tools and methodology to measure it during implementation and at the end of program evaluation.

**Table 2: Indicators for Specific Objectives**

| Specific objective | Indicators | Countries concerned |
|---|---|---|
| | IN 1.1: % of the targeted refugee and host<br><br>community families having increased their income during the project. | Turkey, Egypt, Iraq Jordan |

| | | |
|---|---|---|
| 1 | IN 1.2: % of targeted beneficiaries reporting improved skills and capacities to promote personal and community-driven development. | Turkey, Iraq, Jordan Lebanon |
| 2 | IN 2.1: % of targeted populations (women, men, girls and boys) report improved personal and interpersonal well-being by the end of the project | Turkey, Jordan Lebanon |
| | IN 2.2: % of targeted vulnerable refugees and host community members with improved access to health services by the end of the project | Turkey, Egypt, Iraq, Jordan, Lebanon |
| | IN 2.3: % of targeted vulnerable refugees and host community members with improved health knowledge and hygiene practices by the end of the project | Turkey, Egypt, Iraq, Jordan Lebanon |
| 3 | IN 3.1:Increase in number of beneficiaries reached by Host National Societies' interventions by the end of the project | Turkey, Iraq, Jordan Lebanon |

**Methodology**

The consultancy is to be undertaken in complementarity with assessments and baseline efforts at country level, where baseline data for result (output) level indicators will be collected. The consultancy will work to design the methodology, guidance and tools for overall objective and specific objective level indicators, and will disseminate these to country-level teams, who will then be responsible for data collection and collation as part of country-level baseline processes. The consultancy will then focus on validating, and aggregating country-level data to create a regional overview, ensuring consistency and commonality in approach. The consultant will then be responsible for analysing the information gathered from the five countries, to assist in setting targets for the Action. The consultancy assignment will include five phases:

*Phase I: Preparation – Baseline methodology and tools*

The consultant will conduct an initial desk review of existing relevant documentation, including the Document of Action, regional and country logframes, program M&E framework, and indicator tracking tools (ITTs). She/he will base her/his strategy, methodology and tools for the regional baseline on the information presented in these documents, particularly considering the necessity to adopt common tools for all countries and to extract comparable data for aggregation into regional figures.

*Phase II: Establishment of relationship between national and regional processes.*

The regional baseline process will need to align with and leverage country level assessment and baseline processes, in order to avoid duplication of data collection efforts. The planned country level assessments that the regional baseline will need to coordinate with are outlined in the table below:

**Table 3: Planned country level assessments[1]**

| Country | Partner | Inception phase assessments & studies | Relevant Objectives |
|---|---|---|---|
| Regional | DRC | 5.4.1 Regional Baseline Study | All 3 |
| Egypt | GRC and SRC | 6.0.1 ERCS Baseline Study | 1 and 2 |
| Iraq | NorCross | 6.0.2 IRCS Baseline Study | All 3 |
| | FRC | 6.1.1 Initiate labour market analysis and consultations with stakeholders to determine vocational and business skill training directions for targeted beneficiaries | 1 |
| Lebanon | SRC | 6.0.4 PCRS Baseline study | 1 and 2 |
| | GRC | 6.4.1 Conduct Vulnerability and Capacity Assessments in targeted communities (act. 1.2.1, Lebanon) | 1 |
| Turkey | IFRC Europe | 6.0.5 TRCS Baseline Survey | All 3 |
| | IFRC Europe | 6.1.3 TRCS Community Center baseline (6 CCs) | 1 and 2 |
| | IFRC Europe | 6.1.4 TRCS 1-year Community Center needs assessment (10 CCs) | 1 and 2 |
| Jordan | IFRC MENA | 6.0.6 JRCS Baseline Survey | All 3 |
| | IFRC MENA | 6.1.2 Initiate labour market analysis and consultations with stakeholders to determine vocational and business skill training directions for targeted beneficiaries (act. 1.1.1) | 1 |

1. Assessments related to year 1

*Phase III: Data collection*

In collaboration with DRC and partners, the consultant will conduct a jointly designed, planned and coordinated data collection system. Across the different partners, the consultant will ensure consistency of approach, methodology, tools and techniques for data collection at field level. The consultant will collaborate and communicate with Country Leads (refer to Table 1) to coordinate the enumerator recruitment and training, data collection, and data entry. The study shall be conducted in forms of survey, key informant interview and focus group discussions as needed, with appropriate sampling methodologies employed. The information will be collected in collaboration with the partner staff and volunteers.

*Phase IV: Data analysis*

The consultant will analyze the collected data at country and regional level across the Specific Objectives level, with a view to establish baseline values for associated indicators. The consultant will also analyse data to inform recommendations on the setting or confirmation of the Action's targets, and to make recommendations on the methodology and tools for measuring selected Overall Objective indicators.

*Phase V: Development of end products*

The consultant will liaise with DRC and relevant partners in the process of developing end products. For the aid memoir, a first draft will be shared with partners for consultation and previous approval before it is finalized. The aid memoir will follow an agreed format (see below) and will report qualitatively and quantitatively on the status of the population sampled, with respect to key indicators measured.

Briefing and debriefing meetings will take place in Beirut and/or Copenhagen with virtual participation made possible. A briefing on findings will be presented to the M&E working group.

**Duration and Timeline**

The baseline study shall be expected to complete within 3 months (90 days) beginning as soon as possible. The budget of the study will be offered as a package. The contract will be undertaken in accordance with the following timetable:

**Table 4: Timetable**

| Phase | Activities | Timing | | |
|---|---|---|---|---|
| | | Month 1 | Month 2 | Month 3 |
| Phase 1 (4 to 6 working days) | Desk review of documentation | x | | |
| | Design of methodology, tools and guidance for data collection | x | | |
| | Discussion of tools and guidance with partners | x | | |
| | Revision and refinement of tools and guidance | x | | |
| Phase 2 (5 to 7 working days) | Development and agreement of coordinated data collection strategy at country levels | x | | |
| Phase 3 (5 to 7 working days) | Coordination and oversight with partners on enumerator recruitment and training, possible pre-testing of tools, data collection, and data entry. | | x | |
| | Data collection, cleaning, entry and collation (country teams). | | x | |
| Phase 4 (10 to 12 working days) | Data analysis | | x | x |
| | Recommending and agreeing targets with partners | | | x |
| | Development of final products | | | x |

| | | | | |
|---|---|---|---|---|
| | Dissemination of final products | | | x |

**Summary of Deliverables:**

- All materials and templates used for data collection and management e.g. questionnaires, data entry tools, guides etc.
- Development of time plan and strategy for implementation
- A complete dataset
- A completed regional ITT with baseline data and targets and linked to country and overall program levels.
- Documented methodology and tools for the collection of data for selected indicators at Overall Objective level.
- Aid memoir (max 10 pages + annexes) +. The aid memoir should include the following points:
    - *Introduction*
    - *Methodology*
    - *Limitations*
    - *Findings*
    - *Conclusion and recommendations*
    - *Annexes (ToR, teams' itinerary, list of persons met, village maps, list of documents used, etc.).*
- Presentation (between 15-20 slides) that follows the structure of the aid memoir, to be used for debriefing of DRC and partners.

The first draft of aide memoir shall be submitted not later than 15 days after the completion of the field missions. Final draft shall be ready not later than one week after receiving comments.

**Qualification of the consultant**

- A degree holder with a MA in a relevant field related to at least one of the programme's objectives
- Prior experience in undertaking regional and/or cross country studies (quantitative and qualitative) in the MENA region and/or Turkey
- Experience working in humanitarian or international development programming
- Long-standing and proven experience with M&E, Results Based Management, Logframes and associated tools
- Solid methodological and research skills
- Demonstrated experience coordinating and working with partners
- Fluency in spoken and written English; Arab and Turkish are an asset

**Communications**

The schedule and arrangement of field visits in the five countries, as well as the accommodation and transportation of the consultant will be coordinated with the DRC Trust Fund Advisor and DRC Regional Grant Coordinator.

**Contract and Financial Provisions**

The contract (subject to final approval of funding from donor) is expected to be about 24-32 working days over a 3 month period. Payments are made to the Individual Consultant/Contractor based on the number of days worked. DRC shall pay the Consultant an amount not to exceed a ceiling of 19.000 EUR. This amount has been established based on the understanding that it includes all of the Consultant's costs (including transport, accommodation, insurance, per diem, telephone etc.) and profits as well as any tax obligation that may be imposed on the Consultant.

**How to apply**

Interested consultancy firms or independent consultant(s) can apply. The application should be accompanied by:

- Technical proposal not exceeding 5 pages typed in New Times Roman size 11, single spaced
- Summarized firm profile, CVs of the lead and (possibly) associate consultants.
- Financial proposal (detailed budget specifying daily fee and estimated number of days, travel expenses and other additional costs quoted in separate line items)

For additional information on the consultancy please contact the Danish Red Cross MADAD Regional Grant Coordinator on email ilrav@rodekors.dk

Deadline for applying is 9th of April 2017. Interviews are expected to take place in April.

Technical and financial proposal, summarized firm profile and CVs should be uploaded at Danish Red Cross web page www.rodekors.dk/job

# Annex 2: Documents and resources

| Title | Document type | Country |
|---|---|---|
| Chaaban, J., Salti, N., Ghattas, H., Irani, A., Ismail, T., Batlouni, L. (2016), "Survey on the Socioeconomic Status of Palestine Refugees in Lebanon 2015", AUB and UNRWA | Reference document | Lebanon |
| CIA, *The World Factbook; Lebanon, https://www.cia.gov/library/publications/the-world-factbook/geos/le.html* | Reference document | Lebanon |
| CIA, *The World Factbook; Egypt,* https://www.cia.gov/library/publications/the-world-factbook/geos/eg.html | Reference document | Egypt |
| CIA, *The World Factbook; Jordan,* https://www.cia.gov/library/publications/the-world-factbook/geos/jo.html | Reference document | Jordan |
| CIA, *The World Factbook; Iraq,* https://www.cia.gov/library/publications/the-world-factbook/geos/iz.html | Reference document | Iraq |
| CIA, *The World Factbook; Turkey*, https://www.cia.gov/library/publications/the-world-factbook/geos/tu.html | Reference document | Turkey |
| EU Regional Trust Fund in Response to the Syrian Crisis: Factsheet | Project info | Regional |
| European Commission, Currency Converter, http://ec.europa.eu/budget/contracts_grants/info_contracts/inforeuro/index_en.cfm | Tool | Global |
| IFRC Technical Note: Counting People Reached | Reference document | Global |
| MADAD Fund Constitutive Agreement | Project document | Regional |
| MADAD Fund Operational Criteria | Project document | Regional |
| MADAD Fund Results Framework 2015-2017 | M&E | Regional |
| MADAD Monitoring and Evaluation Plan 21.07.2017 | M&E | Regional |
| MADAD Trust Fund: Annex A (Grant Application Form) | Project document | Regional |
| MADAD Trust Fund: Annex B (Budget) | Financial | Regional |

| | | |
|---|---|---|
| MADAD Trust Fund: Annex C (Logframe) 16.10.2017 | M&E | Regional |
| MADAD Intervention Logic | Logic framework | Regional |
| Mapping of regional activities and beneficiaries | Background | Regional |
| Presentation: MADAD Programme (Overview) | Background | Regional |
| Strategy 2020: Saving Lives, Changing Minds | Reference document | Global |
| UNHCR, Syria Refugee Regional Response data, Jordan, http://data.unhcr.org/syrianrefugees/country.php?id=107 | Reference document | Jordan |
| UNHCR, Syria Refugee Regional Response data, Iraq, http://data.unhcr.org/syrianrefugees/country.php?id=103 | Reference document | Iraq |
| UNHCR, Syria Refugee Regional Response data, Turkey, http://data.unhcr.org/syrianrefugees/country.php?id=224 | Reference document | Turkey |
| UNHCR, Syria Refugee Regional Response data, Lebanon, http://data.unhcr.org/syrianrefugees/country.php?id=122 | Reference document | Lebanon |
| UNHCR, Syria Refugee Regional Response data, Egypt http://data.unhcr.org/syrianrefugees/country.php?id=8 | Reference document | Egypt |
| UNRWA, Palestinian refugees affected by the Syria regional crisis, https://www.unrwa.org/prs-lebanon | Reference document | Lebanon |
| UNRWA, *Where we work; Lebanon*, https://www.unrwa.org/where-we-work/lebanon | Reference document | Lebanon |
| World Development Index, Google, Public Data: GDP per capita (current US$). Available here. Accessed on 30 November 2017. | Reference document | Regional |

# Annex 3: People interviewed

| Name | RCRC society | Country |
|---|---|---|
| Nawar Abdulqader | IRCS | Iraq |
| Achim Apweiler | NLRC | Lebanon |
| Berna Beyrouthy | LRC | Lebanon |
| Kamil Erdem Guler | TRCS | Turkey |
| Rad Hadid | JRCS | Jordan |
| Kozue Hirata | IFRC | Jordan |
| Hilary Motsiri | IFRC | Jordan |
| Shafiquzzam Rabbani | IFRC | Turkey |
| Laila Touqan | JRCS | Jordan |
| Alice Victor | FRC | Iraq |

# Annex 4: Team itineraries

| Team member | Destination | Dates |
|---|---|---|
| Nur Abdelkhaliq | Beirut, Lebanon | 3-6 July 2017 |
| Naomi Blight | Amman, Jordan | 13 July 2017 |
| Naomi Blight | Erbil, Iraq | 16 July 2017 |

# Annex 5: Inquiry Matrix

| AREAS OF ENQUIRY | Definition and/ or focus areas | Relevant outcome indicators | Applicable country | Quantitative questions focus | Qualitative questions focus | Method |
|---|---|---|---|---|---|---|
| **GOAL: Contribute to improved wellbeing, resilience and peaceful co-existence among vulnerable refugee and host communities in countries affected by the Syria crisis, contributing to overall stability in the region** | | | | | | |
| **Feeling of better integration** | Willingness to cooperate to survive and prosper.<br>Focus areas to assess are to be linked to MADAD intervention in the following areas: health, livelihoods, and community development.<br><br>The definition for community development will draw on IFRC's elements: intervention, partnership, communication, programmes, public information, and projects. | All outcome indicators | All countries (except Lebanon on livelihoods) | Health<br>- Registration with healthcare provider/ private insurance access<br>- Ability to pay for health services as needed<br><br>Economic opportunities<br>- Self-reported employment and unemployment status for refugees and host communities<br><br>Community development/ resilience:<br>- Self-reported actively interacting with people from different backgrounds (host/ refugee/ IDP) in everyday situations. | Health<br>- Equal opportunities in relation to health<br>- Feeling of discrimination based on status, as a refugee/IDP/ national<br><br>Economic opportunities in relation to livelihoods<br>- Satisfaction with access to work and type of work accessed<br>- Discrimination felt based on status as refugee/ IDP/ national<br><br>Community development/ resilience:<br>- Contribution to community<br>- Mixing of community<br>- Leadership of initiatives/services<br>- Attitudes to different members of communities<br>- Perception of possibility for interaction between people from various backgrounds in community | Baseline survey<br>FGDs |

| AREAS OF ENQUIRY | Definition and/ or focus areas | Relevant outcome indicators | Applicable country | Quantitative questions focus | Qualitative questions focus | Method |
|---|---|---|---|---|---|---|
| **Improved access to health services and economic opportunities** | Economic opportunities are addressed under outcome 1. | Indicator 1.1<br>Indicator 2.1b (only applicable to Lebanon and Egypt, so context of access to health gauged here) | For access to health services: All countries<br><br>For economic opportunities: See Outcome 1, indicator 1.1 below. | Barriers for accessing health services: quality, capacity, knowledge, availability of equipment, availability of information on health service, transportation, financial, cultural/ communication, access to childcare, inability to go during times of service availability, not permitted, status as refugee/ IDP. | Detail on barriers to access health services.<br>Perceived differences in access depending on medical service area (e.g. chronic health conditions, common physical conditions, reproductive health, GBV, psychological/ mental) | Baseline survey<br>FGDs |
| **Outcome 1: Refugees from Syria and host communities are more self-reliant and resilient to prevalent risks and local conflicts** | | | | | | |
| **Increase in income** | Self-sufficiency as ability to pay/ survive without external support and without opting for negative coping mechanisms.<br><br>Note: Respondents may be unwilling to divulge income due to fear of decreased social support. | Indicator 1.1 | Iraq<br>Jordan<br>Turkey | | Opportunities and constraints for starting up businesses<br>Opportunities and constraints for scaling-up income generating activities | Baseline survey<br>FGDs |
| | | | Egypt<br>Iraq<br>Jordan<br>Turkey | Monthly household financial income and detail of sources (e.g. salary, cash transfers, savings)<br><br>Ability to spend on vital services | | |

| AREAS OF ENQUIRY | Definition and/ or focus areas | Relevant outcome indicators | Applicable country | Quantitative questions focus | Qualitative questions focus | Method |
|---|---|---|---|---|---|---|
| **Improved skills and capacities that promote personal and community-driven development** | Community development projects have the potential for benefitting large numbers of people. We suggest focusing on improved skills and capacities to more meaningfully measure and baseline this outcome – therefore to count only people directly involved in gaining skills and capacities. | Indicator 1.2/1.3 | Lebanon<br>Iraq | Completion of training on hazards and threats<br><br>Self-reported ability to respond to hazards and threats<br><br>Self-reported ability to identify resources and opportunities to reduce impact of hazards and threats on the community.<br><br>Self-reported ability to apply mitigation measure to reduce risks and hazards. | Perceptions of community tensions and divisions<br><br>Capacity to reduce divisions and tensions within the community<br><br>Capacity at community level to respond to their own needs | Baseline survey<br>FGDs (for context) |
| | | | Jordan<br>Lebanon | Number of refugees/ IDPs/ host community members involved in the identification, planning and implementation of community development projects<br><br>Self-reported capacity to contribute to community development | Perception of community projects that would be of relevance to local needs<br><br>Capacity at community level to respond to their own needs | Baseline survey<br>FGDs |
| | | | Turkey | Community services offered by community centres respond to needs of users<br>Type of service received | | Baseline survey<br>Data on use of community centre services |
| **Outcome 2: Refugees from Syria and host communities have improved health and psycho-social well-being** | | | | | | |

| AREAS OF ENQUIRY | Definition and/ or focus areas | Relevant outcome indicators | Applicable country | Quantitative questions focus | Qualitative questions focus | Method |
|---|---|---|---|---|---|---|
| **Improved health knowledge** | Health knowledge in relation to: information on the major health problems and risks; knowledge on the availability and location of health services; provision of knowledge about signs and symptoms of disease | Indicator 2.1a | Iraq Jordan Lebanon | Awareness of where specific health services can be accessed (e.g. reproductive health services, paediatric health services, maternity services, emergency medical care, gastro-intestinal/ food poisoning, etc. | Details of the major health problems and risks in community | Baseline survey (for context) FGDs |
| | | | All countries | Interest in participating in health education activities | Gaps in health knowledge | Expected to be zero at baseline. Baseline survey and FGDs (for context) |
| **Improved access to health services** | Access to health services related to emergency and blood transfusion services in Lebanon (LRC), provision of medicines and surgeries (PRCS), and patients served by mobile clinics (Egypt). | Indicator 2.1b | Lebanon Egypt | | | Annual report and/ or monitoring data on number of access to health services: EMS and BTS (LRC), medicines and surgeries (PRCS), and mobile clinics (Egypt). |
| **Improved hygiene practices** | (Note: Use and maintenance of sanitation facilities | Indicator 2.2 | Iraq Lebanon Turkey | Interest in participating in hygiene promotion activities. | Interest in/ need for receiving hygiene promotion activities. | Expected to be zero at baseline. FGDs for context. |

| AREAS OF ENQUIRY | Definition and/ or focus areas | Relevant outcome indicators | Applicable country | Quantitative questions focus | Qualitative questions focus | Method |
|---|---|---|---|---|---|---|
| | included in KAP survey) | | Turkey | | Interest in/ need for receiving hygiene packages for expecting mothers. | Expected to be zero at baseline. FGD question included in FGD for context. |
| **Improved personal and interpersonal well-being** | Personal well-being: how beneficiary feels about him/ herself. Inter-personal in relation to others in community. | Indicator 2.3 | Turkey Lebanon | Self-reported well-being and coping mechanisms Needed support mechanisms | | Baseline survey |
| **Outcome 3: RCRC Host National Societies in the region have strengthened their capacity and enhanced their ability to reach out to most vulnerable groups within the refugees and host communities** | | | | | | |
| **Number of beneficiaries Host National Societies' interventions reach** | | Indicator 3.1 | Iraq Jordan Lebanon Turkey | | | Annual reports and project documents (total number of people reached in 2016, if/ where possible disaggregated by project. |

| AREAS OF ENQUIRY | Definition and/ or focus areas | Relevant outcome indicators | Applicable country | Quantitative questions focus | Qualitative questions focus | Method |
|---|---|---|---|---|---|---|
| **Competence and confidence of RCRC Host National Societies staff and volunteers to reach out to most vulnerable groups** | Competence and confidence need to be divided here.<br>Furthermore, activities related to training may need to introduce appraisals to gauge confidence and use of skills. | Indicator 3.2 | Iraq<br>Jordan<br>Lebanon<br>Turkey | Self-reported improved competence and confidence in reaching out to the most vulnerable groups by the end of the project<br>Improved ability (self-reported)<br>Completion of training specific to vulnerabilities (e.g. on vulnerabilities, training, PTSD | Knowledge of needs of most vulnerable groups<br>Understanding of vulnerabilities<br>Use of skills gained in training | FGDs with staff and volunteers<br>KIIs |

# Annex 6: Data collection tools and sampling strategy

## Data collection tools

*Regional baseline survey – Beneficiaries*

| Demographic Questions: All countries |
|---|
| 1: Sex:<br>□ Female □ Male □ Prefer not to say |
| 2. Age:<br>□ 18-30 □ 31 – 59 □ 60 and over |
| 3. Marital Status:<br>□ Single □ Married □ Divorced □ Widowed |
| 4. What country are you based in?<br>□ Lebanon □ Turkey □ Jordan □ Iraq □ Egypt<br><br>What city, town or refugee camp do you live in?<br>5. Options for Turkey<br>6. Options for Jordan<br>7. Options for Lebanon (LRC + PRCS locations)<br>8. Options for Egypt<br>9. Options for Iraq<br>10. Option for Iraq surveying organization (FRC or NorCross) |
| 11. Nationality:<br><br>□ Egyptian □ Iraqi □ Jordanian □ Lebanese □ Palestinian (from Lebanon) □ Palestinian (from Syria) □ Syrian □ Other |
| 12. Status:<br><br>□ Internally displaced □ Refugee □ Habitually resident in the country □ Does not wish to answer<br>13. **If refugee/ IDP:** Are you registered? Yes/ No/ Do not wish to answer<br>14. Are other members of your household registered? If yes, how many? |
| 15. Education level<br><br>□ *Primary* □ *Secondary* □ *Vocational/ technical training* □ *University* □ *Post graduate* □ *Did not attend school or left school before completing primary education* |

16. Number of Family Members:

| Category | Number | Category | Number |
|---|---|---|---|
| Number of women 60 years and over | | Number of men 60 years and over | |
| Number of women aged 31-59 years | | Number of men aged 31-59 years | |
| Number of women aged 18-30 years | | Number of men aged 18-30 years | |
| Number of girls aged 12-17 years | | Number of boys aged 12-17 years | |
| Number of girls aged 5-11 years | | Number of boys aged 5-11 years | |
| Number of girls aged 0-4 years | | Number of boys aged 0-4 years | |
| Total in household: | | | |

17. Where are you and your family currently living?

Refugee camp, urban area, rural area

18. What type of accommodation do you and your family live in?

Owned property, rented property (single household), rented property (with others), Tent, Other ____

| Focus area | Question | Countries | | | | | |
|---|---|---|---|---|---|---|---|
| | | L/P | L/L | T | J | I | E |
| Community development | 19. Do the following hazards/ risks affect your community? (List: fire, medical emergency, accidents, natural disasters, health conditions, conflict) | ■ | ■ | | | ■ | |
| | 20. Do you feel you have sufficient knowledge of how to respond to threats and hazards? (Scale for each threat/ hazard: yes, I have sufficient knowledge; yes, I have some knowledge, I have limited knowledge, I have no knowledge at all) | ■ | ■ | | | ■ | |
| | 21. Have you received information on how to respond to the following threats and hazards? List: fire, medical emergency, accidents, natural disasters, health conditions, conflict | ■ | ■ | | | ■ | |
| | 22. Are you or have you been involved in social projects or initiatives in your community?<br>Yes, I am actively involved. Yes, I am somewhat involved. No, I am not involved. I am not aware of any projects in my community. I am not interested in being involved. | | ■ | | ■ | | |
| | 23. If yes, what part of these projects have you been involved in? Please tick all that apply: identification/ planning/ implementation. | | ■ | | ■ | | |
| | 24. Do you interact with community members who are from the host community/ refugees/ IDPs (as applicable to respondent)? Please tick all that apply: | ■ | ■ | ■ | ■ | ■ | ■ |

<table>
<tr><th rowspan="2">Focus area</th><th rowspan="2">Question</th><th colspan="6">Countries</th></tr>
<tr><th>L/P</th><th>L/L</th><th>T</th><th>J</th><th>I</th><th>E</th></tr>
<tr><td></td><td>In social settings/ at work/ in community projects/ I speak to them when running errands (shops, health centre)/ I do not interact with people from other backgrounds</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td>25. Rate the relationship between the refugee and host communities in this location, in general?<br>Good/ Fair/ Neutral/ Poor/ Hostile</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td>26. Do you use community centres? Yes, regularly/ Yes, sometimes/ Not very often/ No, I do not use the community centres at all.</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td>27. If yes, what services do you access there?<br>Protection activities<br>Child, Youth and Volunteer activities<br>Livelihood support activities<br>Social, cultural and harmonisation activities<br>PSS and health activities</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td>28. Do these services offered by community centres respond to your needs? Yes, the services offered meet all my needs/ Yes, the services offered meet most of my needs/ Yes, the services offered meet some of my needs/ No, the services offered do not meet my needs.</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Livelihoods</td><td>29. Please describe your current employment status: I am in formal employment (15-30 days a month); Informal employment; Temporary/casual employment; Unemployed; Self-employed; retired</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td>30. How many people in your household are working?
<table>
<tr><th>Category</th><th>Number</th><th>Category</th><th>Number</th></tr>
<tr><td>Number of women 60 years and over</td><td></td><td>Number of men 60 years and over</td><td></td></tr>
<tr><td>Number of women aged 31-59 years</td><td></td><td>Number of men aged 31-59 years</td><td></td></tr>
<tr><td>Number of women aged 18-30 years</td><td></td><td>Number of men aged 18-30 years</td><td></td></tr>
<tr><td>Number of girls aged 12-17 years</td><td></td><td>Number of boys aged 12-17 years</td><td></td></tr>
<tr><td>Number of girls aged 5-11 years</td><td></td><td>Number of boys aged 5-11 years</td><td></td></tr>
</table></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
</table>

| Focus area | Question | Countries | | | | | |
|---|---|---|---|---|---|---|---|
| | | L/P | L/L | T | J | I | E |
| | Number of girls aged 0-4 years: ____ Number of boys aged 0-4 years: ____ Total in household: ____ | | | | | | |
| | 31. Does any member of your household have a bank account/ cooperative/ or other savings account? Yes. No. Do not wish to respond | | | | | | |
| | 32. In the past 30 days, what was the total income of all HH members (in local currency)? | | | | | | |
| | 33. What is your main source of income?<br>• Salary from employment<br>• Self-employed<br>• Aid from international organisations/ NGOs<br>• Cash transfers<br>• Friend and family support (in-country)<br>• Remittances from friends and family abroad<br>• Personal savings<br>• Selling assets<br>• Rent allowance<br>• Agriculture/farming/livestock<br>• Begging<br>• Food voucher/ e-card<br>• Credit/ debts (informal, in shops)<br>• Credit/ debts (formal, from a bank)<br>• Sale of food aid<br>• Sale of non-food assistance<br>• Other – please specify<br>• I do not have a main source of income<br>• I do not wish to respond | | | | | | |
| | 34. What are your secondary sources of income? Please tick all that apply.<br>• Salary from employment | | | | | | |

| Focus area | Question | Countries | | | | | |
|---|---|---|---|---|---|---|---|
| | | L/P | L/L | T | J | I | E |
| | • Self employed<br>• Aid from international organisations/ NGOs<br>• Cash transfers<br>• Friend and family support (in-country)<br>• Remittances from friends and family abroad<br>• Personal savings<br>• Selling assets<br>• Rent allowance<br>• Agriculture/farming/livestock<br>• Begging<br>• Food voucher/ e-card<br>• Credit/ debts (informal, in shops)<br>• Credit/ debts (formal, from a bank)<br>• Sale of food aid<br>• Sale of non-food assistance<br>• Other – please specify<br>• I do not have a main source of income<br>• I do not wish to respond | | | | | | |
| | 35. Are you able to meet household expenditure in the following areas? Please tick all that apply. Education/ Health (not including medicine)/ Accommodation/ Clothing/ Hygiene items/ Household items (cooking pots, utensils, furniture)/ Food/ Transportation/ Entertainment/ Taxes/ Utilities (water, electricity, gas, fuel for heating)/ Communications (telephone/ internet)/ Shelter materials/ Cost of registration/ legalising stay in the country/ Other – please specify | | | | | | |
| Health | 36. What are you and your families' current arrangements for accessing primary health care?<br>• Able to access free health care<br>• Discounted/subsidized/financial contribution/ cost sharing for primary health care<br>• Private insurance access<br>• Pay as needed<br>• Cannot afford to access health care | | | | | | |

| Focus area | Question | Countries | | | | | |
|---|---|---|---|---|---|---|---|
| | | L/P | L/L | T | J | I | E |
| | • Primary health care assistance never required<br>• Other – please specify | | | | | | |
| | 37. Do you receive secondary/ specialized or hospitalization health assistance?<br>• Able to access free hospital care<br>• Discounted/ subsidized/ financial contribution/ cost sharing for hospital care<br>• Private insurance for hospital care<br>• Need to pay in full for hospital care<br>• Hospital care not required<br>• Other – please specify | | | | | | |
| | 38. Do you face barriers in accessing health services? Many barriers/ Some barriers/ No barriers/ Do not know | | | | | | |
| | 39. If you do face barriers, which of these have you experienced? (Please tick all that apply)<br>• Inadequate or poor quality of health services<br>• Service not available<br>• Capacity of health service providers (e.g. lack of staff or equipment)<br>• Knowledge of where and how to access health services (location, opening hours, costs)<br>• Availability of medical equipment<br>• Availability of information on health services<br>• Transportation barriers (e.g. distance, travel restrictions, checkpoints, not allowed to leave refugee camp)<br>• Inability to pay for health services<br>• Unable to afford transport to reach health services<br>• Financial constraints<br>• Cultural or communication barriers (e.g. Not permitted by another household member, do not speak the language)<br>• Status (refugee/ IDP) | | | | | | |
| | 40. If anyone in the HH needs medical attention, do you know how to access medical services/assistance? Yes, I know how to access medical services/ Yes, I know how to access some | | | | | | |

| Focus area | Question | Countries | | | | | |
|---|---|---|---|---|---|---|---|
| | | L/P | L/L | T | J | I | E |
| | medical services/ I am unsure how to access medical services/ No, I don't know | | | | | | |
| | 41. Are you aware of where you can access the following services?<br>Maternal and child health/ Immunisations/ acute infections/ emergencies/ chronic conditions/ skin and nutrition/blood transfusion. | | | | | | |
| | 42. What are the main sources of stress in your life? Tick all that apply.<br>☐ Family ☐ Money ☐ Health ☐ Study or work ☐ Political situation ☐ Community Relations ☐ Domestic Violence ☐ Security ☐ Living conditions ☐ Others: ..... ☐ No sources of stress | | | | | | |
| | 43. How do you deal with stress? Please tick all that apply: Talking to relatives and friends; speaking to a specialist; speaking to Red Cross/ Red Crescent volunteers; speaking to staff or volunteers from NGOs; taking medication; exercise; leisure activities; smoking; I do not have support mechanisms; others, please specify. | | | | | | |
| | 44. What support mechanisms would you want to have to deal with stress? Talking to relatives and friends; speaking to a specialist; speaking to Red Cross/ Red Crescent volunteers; speaking to staff or volunteers from NGOs; taking medication; exercise; leisure activities; smoking; I do not have support mechanisms; others, please specify. | | | | | | |
| | 45. Would you be interested in learning about the following hygiene promotion activities? Scale for each: Very interested, somewhat interested, not at all interested.<br>Activities: positive behaviours to promote and protect good health; measures to prevent the deterioration of hygienic conditions; use and maintenance of sanitation facilities; learning about harmful behaviours in relation to hygiene; water treatment; solid waste disposal. | | | | | | |

*FGD tool – Beneficiaries*

| Focus area | Question | Countries | | | | | |
|---|---|---|---|---|---|---|---|
| | | L/P | L/L | T | J | I | E |
| Context | What are the main problems, challenges and stresses faced by your community/the community you are living in at the moment? | | | | | | |
| | Who is most affected by these problems? | | | | | | |
| | What are the consequences of these problems? | | | | | | |
| | Are there support structures/ networks/ organisations to provide services for people living in this community? What are they? What services are they providing? | | | | | | |
| Community development | Are you contributing to the community (in terms of active involvement in activities, clubs, etc.)? If yes, can you give examples? | | | | | | |
| | How do you interact with the host community/IDPs/Refugees? (Delete as applicable to focus group attendance) | | | | | | |
| | Do you feel there are opportunities for shared leadership of community initiatives between host community and refugees/ IDPs? | | | | | | |
| | Are there examples of divisions/ tensions that your community faces? | | | | | | |
| | Are you able to contribute to reducing those tensions/ divisions? If so, how? | | | | | | |
| | What are examples of community projects that may benefit your community? | | | | | | |
| Livelihoods | Do you face constraints in the community to access economic opportunities? If yes, can you give examples? | | | | | | |
| | How do members of the community cope with these constraints? | | | | | | |
| | What kind of jobs are members of your community engaged in? (e.g. construction, agriculture, health, education) | | | | | | |
| | Do you know of instances of discrimination in your community in accessing economic opportunities? If yes, can you give examples? | | | | | | |
| | Are you able to use your skills and experience to find employment/ economic opportunities? | | | | | | |
| | Would you be interested in starting up your own business or scaling up your current income-generating activities? | | | | | | |
| Health | What for you are the key health issues facing your community? | | | | | | |
| | What are the health issues (in terms of medical issues) that you would want to have more information on? If so, can you give some | | | | | | |

| Focus area | Question | Countries | | | | | |
|---|---|---|---|---|---|---|---|
| | | L/P | L/L | T | J | I | E |
| | examples/ say why you want more information? | | | | | | |
| | What do you think are barriers for people accessing health services? | | | | | | |
| | Are you aware of the free health services available in your community (including free medication)? If yes, do you know how to access these services? | | | | | | |
| | Have you heard of any instances of discrimination in your community in accessing health? What happened? | | | | | | |
| | Are there any cleanliness/ hygiene problems in your area? | | | | | | |

*RCRC FGD Tool – Staff and volunteers*

| Focus area | Question |
|---|---|
| Context | What are the main problems faced by the community you are working in at the moment? Are these different for refugees/Host communities/IDPs? |
| | Who is most affected by these problems, and what are the consequences of these problems? Is this different for refugees/Host communities/IDPs? |
| | Do you have any criteria for identifying vulnerable groups and individuals? |
| | Who are the most vulnerable groups in the communities you are working in? Are these different for refugees/Host communities/IDPs? |
| | Which are the support structures/ networks/ organisations to provide services for people living in this community? And what are the activities they conduct? |
| | What are the biggest challenges in working to successfully address the needs of vulnerable groups? |
| Training and practice | Before the start of MADAD, what training had you had on: gender, social inclusion, psychosocial support (such as how to deal with stress and trauma), disability, livelihoods, vulnerable groups, conflict resolution or mediation, managing and caring for volunteers? |
| | Since the start of MADAD, have you had any additional training in these areas? List areas: gender, social inclusion, disability, livelihoods, vulnerable groups, conflict resolution or mediation, managing and caring for volunteers. |
| | How have your training needs in working with vulnerable groups been identified? (i.e. I requested training, identified through appraisal…) |
| | Do you feel this training has been helpful or improved your confidence or competence in working with these groups? |
| | Has this training changed your approach or way of working with vulnerable groups? If so, how? If not, why not? |
| | Do you feel that you had any training needs that were not addressed? |
| | Have you undertaken needs assessments/vulnerability assessments? Do you feel that you have adequate skills/knowledge/understanding to be able to undertake these successfully? |
| | What kind of knowledge/skills/understanding would support you in working with vulnerable groups more successfully? |
| | Are you aware of specific challenges or issues around collecting monitoring data for vulnerable groups (please describe)? |
| | Have you had training in any of the following areas since the beginning of the MADAD project? Vocational and livelihood skills training; mentoring and coaching; Labour Market assessment; Psychosocial support; FA; Self-Care; Peer Support; PSS training; Refresher trainings; Volunteer Management; Health Topics; Needs Assessment Tools. |
| | Did these trainings address the needs of vulnerable groups within these intervention areas? If so, how? (Please describe) |
| | Do you feel you understand the specific needs of vulnerable groups in (for example) a livelihoods intervention? Please provide examples of the kinds of considerations you'd need to make… |

*RCRC KII Tool – Country Lead and HNS partner*

| Focus area | Question |
|---|---|
| Context | What are the main problems faced by the communities that staff and volunteers are working in at the moment? Are these different for refugees/Host communities/IDPs? |
| | What is the criteria for identifying vulnerable groups and individuals? |
| | What are the biggest challenges that staff and volunteers face in working to successfully address the needs of vulnerable groups? |
| Training and practice | **FOR HNS only:** Before the start of MADAD, what training have staff and volunteers had on: gender, social inclusion, disability, livelihoods, vulnerable groups, conflict resolution or mediation, managing and caring for volunteers? |
| | Since the start of MADAD, have staff and volunteers had any additional training in these areas? List areas: gender, social inclusion, psychosocial support (such as how to deal with stress and trauma), disability, livelihoods, vulnerable groups, conflict resolution or mediation, managing and caring for volunteers. |
| | How have the training needs in working with vulnerable groups been identified? (i.e. requests training, appraisal…) |
| | Do you feel the training provided has been helpful or can improve the confidence or competence of staff and volunteers in working with these groups? |
| | Do you feel there are any gaps in addressing the training needs of staff and volunteers? |
| | Do you think there are specific challenges or issues that staff and volunteers face around collecting monitoring data for vulnerable groups (please describe)? |
| | Has training in any of the following areas been provided to staff and volunteers since the beginning of the MADAD project? Vocational and livelihood skills training; mentoring and coaching; Labour Market assessment; Psychosocial support; FA; Self-Care; Peer Support; PSS training; Refresher trainings; Volunteer Management; Health Topics; Needs Assessment Tools. |
| | Do you think these trainings are helping staff and volunteers address the needs of vulnerable groups within these intervention areas? If so, how? (Please describe) |

## Sampling strategy

The table below offers the sample size suggested to each country for the baseline study survey for a 90% confidence level, based on the number of beneficiaries targeted as detailed in the country indicator tracking tables.

We suggest a stratified sampling approach based on the proportions of each community (refugee/ IDP and host community) group, gender and age composition of the various groups in the locations that will be sampled. The data that will emerge from employing this sampling strategy will be statistically significant at a 90% confidence interval for the sample population in relation to the overall target population. Disaggregated data by community group, gender and age will be provided as sample statistics. However, these will not be statistically significant.[9]

Data collection is expected to take place between August and October 2017. Our estimate is that each survey should take 1.5hrs to administer (including getting to and from the survey location and including data entry where paper surveys are being administered), and we calculate that five to six surveys can be administered per day per enumerator, but these estimations may be reviewed when training and trialling takes place. All data collection is envisaged to take place over a period of two weeks unless otherwise agreed with the country team.

We suggest focus group discussions to be conducted with community groups separately, as well as broken down by gender and age group, and to be limited to a maximum of eight people per focus group. FGDs will only target age groups 18-30 and 31-above; engaging with younger respondents would entail ethical considerations and more stringent requirements on the training of enumerators.

**Lebanon/ LRC**

We agreed a sample size of 400 for Lebanon for the baseline survey at the country meetings held in Beirut on 4-5 July 2017, which has now been increased to 420. Data collection will take place in the first four communities where VCAs will be undertaken, with 105 surveys being administered per community in Ghazieh (South near Saida), Kfar Chelane (El Donnieh Tripoli), Aamar Al Baykat (Akar), and Hawouch El Rafika (Baalbak). In these communities both medico-social and DRR components will be implemented with targets of 700 and 2,160 people per community, respectively. Data for the baseline survey will be collected in September.

In terms of focus group discussions, we suggest a total of eight FGDs with beneficiaries broken down by age group, gender and community group: one with Syrian women 18-30, one with Syrian women 31-above, one with Syrian men 18-30, one with Syrian men 31-above, and the same for Lebanese host communities. These FGDs can mix people from different MADAD locations within each group if feasible.

**Lebanon/ PRCS**

We propose a sample size of 420 for the baseline survey. From the meetings held with PRCS in Lebanon on 6 July 2017, we understand that some camps have a greater number of volunteers that will be relied on as day workers for data collection. As such, we suggest that 80 surveys are administered in each of Ain El-Helweh, Burj El-Chemali, Nahr El Bared and Shatila; and 25 surveys in each of Baalbak, Burj El Barajneh, Rashidiyyeh and Qasmieh.

Data collection is expected to take place in August 2017. We recognise that the estimated number of surveys to be administered per day may need to be adapted to the time constraints discussed at the

[9] In order to achieve statistical significance for each category, we would have to apply the same sample size to each, i.e. 420. This would mean, for example, having 420 Syrian refugee women of the 18-30 category, 420 Lebanese women of the 18-30 category, and so on. This approach is not feasible for this baseline study.

country meeting (availability of respondents, for example if home-based or in employment, or by age group), as well as the need to administer paper surveys and factor in data entry separately.

In terms of focus group discussions, we have agreed with PRCS that six FGDs will be conducted as follows, acknowledging time and movement restrictions:

| PRCS FGDs | No. of Participants | Area |
|---|---|---|
| One with PRS women 20-50 | 8 | South |
| One with PRS men 20-50 | 8 | Beirut |
| Syrian refugees women 20-50 | 8 | South |
| Syrian refugees men 20-50 | 8 | Beirut |
| PRL as the host community women 20-50 | 8 | South |
| PRL as the host community men 20-50 | 8 | Beirut |
| **Total participants** | 48 | |

**Turkey**

Our suggested sample size for Turkey is of 420. We would look for the survey to be administered in six of the ten locations where community centres are/ will be located: three new community centre locations (Mardin, Kayseri and Kahramanmaraş) and three existing locations (Şanlıufra, Konya and Ankara).

Data collection for the regional baseline in Turkey will take place at the same time as the country baseline in September 2017.

In terms of focus group discussions, we suggest a total of eight FGDs with beneficiaries broken down by age group, gender and community group: one with Syrian women 18-30, one with Syrian women 31-above, one with Syrian men 18-30, one with Syrian men 31-above, and the same for Turkish host communities. These FGDs can mix people from different MADAD locations within each group if feasible.

**Jordan**

The ideal sample size for Jordan to achieve a 90% confidence level would be 417. The survey should be administered in areas where livelihoods, community development and health components are likely to be implemented together. We would strongly discourage separating the surveys per component given that Jordan has a limited budget to cover the administration of the survey.

Data collection for the regional baseline in Jordan is envisaged to take place in September, at the same time as data for the country baseline.

In terms of focus group discussions, we suggest a total of eight FGDs with beneficiaries broken down by age group, gender and community group: one with Syrian women 18-30, one with Syrian women 31-above, one with Syrian men 18-30, one with Syrian men 31-above, and the same for Jordanian host communities. These FGDs can mix people from different MADAD locations within each group if feasible.

**Iraq**

Our proposed sample size for Iraq is 416 for the baseline survey. The survey would be administered in two locations: Erbil and Dohuk. Data collection in Iraq is envisaged to take place in August-September 2017. The baseline survey should be administered in locations where all MADAD components will be implemented. If this is not possible, please note that the sample size will increase to ensure statistical significance: 206 for livelihoods and 407 for health, making the total sample for Iraq 613.

In terms of focus group discussions, due to capacity and time considerations, nine FGDs will be conducted: three by French Red Cross focusing on the livelihoods component (one with Syrian refugees, one with Iraqi IDPs, and one with Iraqi host communities, of mixed gender and ages); and between six by the Norwegian Red Cross focusing on health: one with Syrian refugee women, one with Syrian refugee men, one with Iraqi IDP women, one with Iraqi IDP men, one with Iraqi host community women, and one with Iraqi host community men, mixing ages.

**Egypt**

The sample size in Egypt is proposed to be 832 in total, with 415 to be rolled out in Alexandria, which will exclude the livelihoods component, and 419 in Greater Cairo, where the full survey will be implemented. This sample was calculated based on the percentage populations in each of these locations as exact targets for each were not available.

In terms of focus group discussions, we suggest a total of eight FGDs with beneficiaries broken down by age group, gender and community group: one with Syrian women 18-30, one with Syrian women 31-above, one with Syrian men 18-30, one with Syrian men 31-above, and the same for Egyptian host communities. These FGDs can mix people from different MADAD locations within each group if feasible.

*Sampling detail per country*

| | Lebanon (LRC) | Lebanon (PRCS) | Turkey | Jordan | Iraq | Egypt |
|---|---|---|---|---|---|---|
| Beneficiaries (total) | 248,987 | 230,236 | 210,000 | 51,550 | 12,400 | 129,240 |
| Sample size for baseline survey | 420 | 420 | 420 | 417 | 613 (206 for livelihoods and 407 for health) | 832 (419 in Greater Cairo and 415 in Alexandria) |
| Locations | Ghazieh (South near Saida), Kfarchelane (El Donnieh Tripoli), Aamar Al Baykat (Akar), and Hawouch El Rafika (Baalbak) | 80 surveys in each of Ain El-Helweh, Burj El-Chemali, Nahr el Bared and Shatila. 25 surveys in each of Rashidiyyeh, Naher El-Bared, Burj El Barajneh and Qasmieh. | Six community centre locations, three new (Mardin, Kayseri and Kahramanmaraş) and three old (Şanlıufra, Konya and Ankara); 70 per location | Amman and Ajloun | Erbil and Dohuk | Alexandria and Greater Cairo |

# Annex 7: Outcome indicator 3.1 country figures

| HNS | Locations and beneficiaries (per sector/department) | Total number direct beneficiaries reached in 2016 |
|---|---|---|
| JRC | Amman and Ajloun – Livelihood and CBHFA<br>Mafraq, Madaba, Jerash and Balqa – only CBHFA | Livelihoods:<br>75 (60 beneficiaries Amman and 15 Ajloun)<br><br>CBHFA:<br>East Amman: 1,871<br>Amman, Ajloun, Jarash and Mafraq: 20,964<br>Madaba and Balqa: 4,131<br><br>**TOTAL: 27,041** |
| TRCS | Şanlıurfa<br>Istanbul<br>Konya<br>Ankara<br>Kilis<br>Gaziantep<br>Mardin<br>Kahramanmaraş<br>Kayseri<br>Hatay | Beneficiaries reached in 2016 through five community centres in Şanlıurfa, Istanbul Bagcilar, Konya, Ankara and Kilis: 39,796<br><br>Beneficiaries reached through contingency stock of food and non-food items: 6,500<br><br>**TOTAL: 46,296** |
| LRC | All country – all departments except Youth | BTS patients benefitting from blood products: 23,006<br>EMS patients served: 58,018<br>First Aid: 17,363<br>Medico-Social: 455,515<br>DRR: 204,131<br><br>**TOTAL: 758,033** |
| IRCS | Erbil and Douhuk – Health, WASH and Livelihood, DRR | *Erbil and Dohuk,* Health: 32,540<br>*Erbil,* WASH and DRR*:*<br>Water provision: 5,500<br>Hygiene promotion: 5,451<br>DRR: 400,580<br>*Dohuk,* WASH and DRR*:*<br>Latrines: 13,000<br>Hygiene kits: 15,000<br>Hygiene promotion: 18,000<br>DRR: 2,996<br><br>**TOTAL: 493,067** |

# Annex 8: Notes on baseline value calculations

- The table below outlines the survey questions that were used as the basis for calculating baseline values.

| Outcome | Indicators | Survey questions used to calculate the baseline figures | Actual regional targets |
|---|---|---|---|
| OC 1: Refugees from Syria and host communities are more self-reliant and resilient to prevalent risks and local conflicts (all countries) | IN 1.1: % of the targeted refugee and host community families having increased their income during the project. | Please describe your current employment status. Answers considered for calculating baseline value: Respondents in formal employment or self-employment. | 15% (2019) |
| | IN 1.2/1.3: % of targeted beneficiaries reporting improved skills and capacities to promote personal and community-driven development. | For indicator 1.2: Have you received information on how to respond to the following threats and hazards? (Lebanon PRCS and Iraq)<br>For indicator 1.3: Have you been involved in social projects or initiatives in your community? (Lebanon LRC and Jordan) and Do you use community centres? (Turkey)<br>Answers considered for calculating baseline value: 100 percent minus answers reporting that they had not received any information for indicator 1.2. 100 percent minus answers reporting that they have not been involved in social initiatives or projects/ community centres for indicator 1.3. | Will be defined with baseline process |
| OC 2: Refugees from Syria and host communities have improved health and psychosocial well-being (all countries) | IN 2.1a: % of targeted vulnerable refugees and host community members with improved health knowledge and hygiene practices by the end of the project | If anyone in the HH needs medical attention, do you know how to access medical services/assistance? Answer considered for calculating baseline: Respondents who reported that they have knowledge of how to access all health services | 70% (2019) |

| | | | |
|---|---|---|---|
| | IN 2.1b: % of targeted vulnerable refugees and host community members with improved access to health services by the end of the project | Do you face barriers in accessing health services? Answer considered for calculating baseline: Respondents who reported no barriers in accessing health services | 70% (2019) |
| | IN 2.2: % of targeted vulnerable refugees and host community members with improved hygiene practices by the end of the project | Baseline unknown; we only measured interest in hygiene promotion as baseline would not have been able to measure hygiene practices knowledge levels. | 70% (2019) |
| | IN 2.3: % of targeted populations (women, men, girls and boys) report improved personal and interpersonal well-being by the end of the project. | How do you deal with stress? Answer considered for calculating baseline: Respondents who reported having two or more support mechanisms that are being covered under MADAD (talking to friends and relatives, speaking to specialist, speaking to RCRC, speaking to NGO staff and volunteers, exercise and leisure activities). | 70% (2019) |
| OC 3: RCRC Host National Societies in the region have strengthened their capacity and enhanced their ability to reach out to most vulnerable groups within the refugees and host communities (Iraq, Jordan, Lebanon and Turkey) | IN 3.1:Increase in number of beneficiaries reached by Host National Societies' interventions by the end of the project | Number of people reached by HNS in 2016. | To be defined with baseline (2019) |
| | IN 3.2: % of RCRC Host National Societies staff and volunteers who reported improved competence and confidence in reaching out to most vulnerable groups by the end of the project | Baseline unknown. This indicator measures improved confidence and competence in reaching out to vulnerable groups. This indicator needs to be monitored through pre- and post-tests consistent at regional level. | 80% (2019) |

- As a first step in the calculations, we weighed target beneficiaries disaggregated by community, age and gender against the MADAD intervention's overall targets per country, based on revised figures provided to IOD PARC in December 2017. The basis for this calculation were the values that were outlined in the baseline study's sampling strategy.

| | Lebanon (LRC) | Lebanon (PRCS)[10] | Turkey | Jordan | Iraq | Egypt |
|---|---|---|---|---|---|---|
| Beneficiaries (total) | 267,532 | 43,384 | 258,200 | 60,228 | 24,555 (400 livelihoods and 24,155 health) | 129,240 (of which 3,240 are livelihoods and health combined) |
| Target group composition for MADAD | 50% Syrian and 50% Lebanese host community | 8% PRS, 5% Syrians in Palestinian refugee camps, 87% PRL host community | 95% Syrian and 5% Turkish host community | 70% Syrian and 30% Jordanian host community | 75% Syrian, 15% IDPs, 10% Iraqi host community | 75% Syrian and 25% Egyptian host community |
| Gender distribution for MADAD | 50% women and 50% men | 53% women and 47% men | 80% women and 20% men | 50% women and 50% men | 60% women and 40% men | 60% women and 40% men |
| Age distribution for MADAD | 50% youth (18-30) and 50% adults (31 and above) | 50% youth (18-30) and 50% adults (31 and above) | 50% youth (18-30) and 50% adults (31 and above) | 50% youth (18-30) and 50% adults (31 and above) | 50% youth (18-30) and 50% adults (31 and above) | 50% youth (18-30) and 50% adults (31 and above) |

- The values for each disaggregation of the overall target were multiplied by the percentage for that disaggregation from the survey. For example:

- The Turkish target female population of 18 to 30-year-olds in Turkey is 5,164.

[10] We only calculated responses for Palestinian refugees from Lebanon. Figures for Syrians in Palestinian communities in Lebanon and Palestinians from Syria were not calculated as we only received 15 and 29 responses from these two groups in the survey.

- The percentage of responses for Turkish females in the 18-30 age bracket with knowledge of how to access health/ medical services (indicator 2.1a) is 75 percent.
- The value for Turkey for this disaggregated group able to access healthcare with no barriers is 4,200*0.75/100 = 3,873 individuals.

- The value for each disaggregated category per indicator is added up to give a weighed value for each indicator.
- The number of individuals calculated per indicator is divided by the total target of beneficiaries in the country and multiplied by 100 to get a percentage for that indicator at country level. Where the intervention is divided into specific components, percentages were calculated in relation to the target for that discrete component of the intervention. For example, in Turkey the division was done by 258,200; but in Egypt, livelihoods components were divided by the target for that specific intervention (3,240) and multiplied by 100 to get a percentage. In Iraq, separate calculations were also done for health and livelihoods as these are implemented in different locations.
- For the regional logframe, figures of beneficiaries per indicator are added together. For example, the total number of weighed beneficiaries for health knowledge are added for Lebanon, Egypt, Jordan, Iraq and Turkey. This total number of beneficiaries is then divided by the total number of target beneficiaries for the project overall (783,139), and multiplied by 100 to get the regional percentages for each indicator.