Final Evaluation, Endline and Learning for Danish Red Cross' MADAD Programme

Final Synthesis Report

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Acronyms and Abbreviations

ACF	Action Against Hunger
CBHFA	Community-Based Health and First Aid
CDP	Community Development Project
CEA	Community Engagement and Accountability
CERT	Community Emergency First Response Teams
DRC	Danish Red Cross
DRR	Disaster Risk Reduction
ERCS	Egyptian Red Crescent Society
EUTF MADAD	EU Regional Trust Fund in Response to the Syrian Crisis
FEEL	Final Evaluation, Endline and Learning
FGD	Focus Group Discussion
FRC	French Red Cross
GRC	German Red Cross
HNS	Host National Society
HQ	Headquarters
IDP	Internally Displaced Person
IFRC	International Federation of the Red Cross and Red Crescent Societies
IRCS	Iraqi Red Crescent Society
ITS	Informal Tent Settlement
I/NGO	International Non-Governmental Organisation
JRCS	Jordanian Red Crescent Society
KII	Key Informant Interview
LRC	Lebanese Red Cross
M&E	Monitoring and Evaluation
MEAL	Monitoring, Evaluation, Accountability and Learning
MENA	Middle East and North Africa
MTR	Mid-Term Review
MOU	Memorandum of Understanding
NCD	Non-Communicable Disease
NCE	No-Cost Extension
NGO	Non-Governmental Organisation
NLRC	Netherlands Red Cross
NorCross	Norwegian Red Cross
OECD DAC	Organisation for Economic Co-operation and Development, Development Assistance Committee
PRCS	Palestinian Red Crescent Society
PRL	Palestinian Refugees from Lebanon
PRS	Palestinian Refugees from Syria
PSS	Psychosocial Support
RC/RC	Red Cross and Red Crescent
ROM	Results-Oriented Monitoring
SGBV	Sexual and Gender-based Violence
SRC	Swedish Red Cross
SpRC	Spanish Red Cross
SwissRC	Swiss Red Cross
TOR	Terms of Reference
TRCS	Turkish Red Crescent Society
VCA	Vulnerability and Capacity Assessment
WASH	Water, Sanitation and Hygiene

Executive Summary

The Danish Red Cross (DRC) commissioned IOD PARC, in partnership with Q Perspective, to conduct the Final Evaluation, Endline and Learning (FEEL) of the programme *'Addressing vulnerabilities of refugees and host communities in five countries affected by the Syria Crisis*[1]' - hereafter referred to as the MADAD Programme. The EUR 53 million programme has been funded by the EU Regional Trust Fund in Response to the Syrian Crisis (EUTF MADAD) and was implemented in Turkey, Lebanon, Iraq, Jordan and Egypt by a consortium led at the regional level by DRC.

The FEEL process was launched in March 2020 and was completed in December 2020. The purpose of the FEEL was to:

i) Evaluate the programme's contribution towards its higher-level objective of improved well-being, resilience and peaceful co-existence among (vulnerable) refugee and host communities in the five countries, as well as overall regional stability;
ii) Evaluate the effectiveness in (a) strengthening self-reliance and resilience among refugees from Syria and host communities in all five countries; (b) improving the health and psychosocial well-being of refugees from Syria and host communities in all five countries; and (c) strengthening the capacity of HNS Iraq, Jordan, Lebanon and Turkey
iii) Investigate whether, how and why changes have (or have not) occurred, and what DRC can learn from these changes going forward.

As part of this process, 103 documents were reviewed; 59 Key Informant Interviews were conducted at the global, regional and country level; 40 Focus Group Discussions and 22 telephone interviews were held with beneficiaries and 10 Focus Group Discussions were conducted with RC/RC staff and volunteers. A household survey was also conducted with 2,950 participants. Although field work and in-person data collection was planned, Covid-19 meant that most interactions and data collection were conducted remotely.

Findings

The findings are broadly positive and demonstrate positive progress against programme objectives. One cross-cutting limitation to note relates to the regional programme logframe, developed at programme design stage and agreed with EUTF during the phase of negotiation about the contract. There were several issues that affected the extent to which outcomes and impact could be measured and demonstrated, including the fact that indicators were mostly quantitative; there were weak linkages between output objectives and indicators in some areas; and the challenge of measuring social cohesion, or "peaceful coexistence," at a societal level. Monitoring mechanisms were also not always designed to capture data to report against indicators. The evaluation sought to address these limitations through the design of FEEL process. It should be noted that the limitations of the logframe do not detract from the overall positive results of the MADAD programme; despite gaps, the programme was implemented efficiently and effectively and was relevant to the needs of the target groups.

Relevance

Overall, the programme has been largely relevant to the needs of the target groups, including vulnerable beneficiaries among refugee and host populations as well as other groups

[1] In Iraq, the programme also targets Internally Displaced Persons (IDPs).

supported. The programme has been successful in identifying target beneficiaries across all five country contexts. This resulted from HNS's valuable insight and strong coordination with local stakeholders and leaders, as well as vulnerability assessments. The programme was successful in identifying beneficiary needs, through good baseline assessments and responsiveness to new needs that emerged over the course of the programme. In some instances, needs assessments could have been conducted earlier to allow a more tailored approach from the outset. Crucially, the programme has shown adaptability in responding to emergent needs over time and in course-correcting, for example, when it did not engage a balance of beneficiaries between the Syrian refugee and host communities. In 2020, the programme adapted well to COVID-19. Each HNS has pivoted activities to mitigate the impact of COVID-19 on their beneficiaries, using the established MADAD channels.

Effectiveness

Feedback from stakeholders indicates the MADAD programme was effective overall, with particular success in relation to the health component. This is likely due to partners' long-standing experience and expertise in providing healthcare services and activities. The livelihoods component had a slow start and its initial effectiveness was hampered due to a lack of robust, tailored labour market assessments and weak linkages between assessments and design of livelihoods activities. This was addressed over the course of the programme and the livelihoods component became more effective, particularly following the recommendations of the MTR. Feedback also indicates that the programme was largely successful in meeting the needs of vulnerable groups, though more could have been done to include people with disabilities.

There were also some positive unintended changes facilitated by the programme. The MADAD programme was a new approach for the RC/RC partners and the evidence shows that relationships between them have been strengthened as a result of working together. The capacity of HNS has also been strengthened as a result of participating in the programme, which has led to greater effectiveness in their approaches to programme management and reporting. This has also had a positive effect on sustainability.

Efficiency

Overall, feedback from stakeholders pointed to a positive and efficient management process of the MADAD programme, with good consortium coordination and communication. The relationships were well managed by DRC HQ, from EUTF level through to the country level. Regular engagement included annual face-to-face meetings with all partners, bi-annual meetings with country programme leads and DRC; monthly group virtual meetings across all countries; meetings in line with major MEAL milestones, as well as ad hoc meetings as and when required ensured consistent support and communication with the programme teams. Feedback indicates that this structure worked well and improved over time, particularly as key consortium members remained the same over the last eighteen months. Delays at the beginning of the programme hampered efficient starts across all countries; however, through efficient and effective programme management, countries still largely succeeded in meeting, and sometimes exceeding, targets.

Impact

Overall, the MADAD programme has had a positive impact on the lives of beneficiaries across all programme components. The endline survey included a question on whether the RC/RC programme made a difference to beneficiaries' lives as a way of gauging attribution to MADAD. The majority of endline survey participants (76%) indicated that RC/RC services in their area had impacted their lives, and that of their households. The health component was the strongest performing element of the MADAD programme, reaching and often exceeding its targets despite COVID-19 and country-specific challenges. The livelihoods component was developed in a gender-sensitive manner, taking the different needs of men and women

into account and designing livelihoods activities that were appropriate and relevant. There were mixed results on impact in relation to social cohesion and integration across the programme. At baseline, 56.3% of respondents across the region reported 'good' relationships between refugees/IDPs and host communities, and this declined slightly to 55.3% at the endline. Social cohesion was likely affected by external factors in all five countries over the course of the programme, so it is difficult to determine the extent to which the programme contributed to social cohesion at a systemic level.

Coherence

Overall, the complexity of the MADAD programme and the size of the consortium limited the internal coherence that was achieved at a regional level. Regular meetings between country leads and annual meeting between all MADAD partners did allow some space for sharing lessons and building relations, but joint learning and cooperation was otherwise limited by time and funding constraints. This limited stakeholders' awareness of different approaches to activities being taken in different contexts, which hindered opportunities to strengthen internal coherence. In addition, the widely differing operating contexts in each country and the decision not to assign a single implementing partner to all health or livelihoods activities across the region limited the opportunity to achieve a more coherent approach. However, external coherence was strong. The MADAD partners engaged with other national stakeholders including government partners, UN agencies, I/NGOs and local NGOs through a range of coordination mechanisms to develop coherent approaches that avoided overlap and duplication in programming.

Sustainability

The sustainability of programme benefits appears to be a concern. The five MADAD countries have been developing transition plans to ensure sustainability but in the context of the ongoing COVID-19 pandemic, the sustainability of benefits produced by the programme are under threat. There is a certain level of sustainability guaranteed due to the infrastructure and skills that were developed in the host countries, as well as the equipment and tools provided that will continue to serve the countries and the HNS. However, key informants reported that beneficiaries have developed a certain level of reliance on the services provided under MADAD. With little in place following the close of the programme, the needs of the beneficiaries are unlikely to be met. This is likely to be exacerbated by the growing numbers of beneficiaries in the service areas due to the ongoing and often worsening social, political and health issues in the region.

Learning and recommendations

The large-scale regional MADAD programme, bringing together multiple national partners, host national societies and IFRC, was a new approach for RC/RC and represented a significant learning curve for the movement. There are obvious successes of this approach, including the effects the programme has had on the RC/RC movement's coherence and willingness to cooperate across national boundaries. It was also a success for DRC, particularly given that it was the first time the organisation managed such a complex, large-scale, multi-partner and high value programme. Given the novel approach, this programme offers key lessons and highlights possible improvements for the RC/RC movement in designing, managing, and implementing such complex programmes. The key learning points and associated recommendations are presented in detail in the final report, and cover the designing, managing, and implementing large-scale programmes; incorporating learning; and promoting sustainability. Eighteen recommendations based on the evaluation findings are provided and are intended to be as operational as possible.

Introduction

The Danish Red Cross (DRC) commissioned IOD PARC, in partnership with Q Perspective, to conduct the Final Evaluation, Endline and Learning (FEEL) of the programme *Addressing vulnerabilities of refugees and host communities in five countries affected by the Syria Crisis*[2] - hereafter referred to as the MADAD Programme. The EUR 53 million programme has been funded by the EU Regional Trust Fund in Response to the Syrian Crisis (EUTF MADAD) and was implemented in Turkey, Lebanon, Iraq, Jordan and Egypt by a consortium led at the regional level by DRC. As the regional consortium lead, DRC had a dedicated budget of EUR 1,226,383.[3]

In each country, the programme was led by the International Federation of Red Cross and Red Crescent Societies (IFRC) or a European Red Cross partner working in conjunction with Host National Societies (HNS) and, in some cases, with support from other Red Cross and Red Crescent (RC/RC) partners. Table 1 summarises which RC/RC societies lead and work in each country, and the respective country programme budgets.

Table 1: DRC MADAD Programme partners and budgets, per country

	Turkey	Lebanon	Jordan	Iraq	Egypt
Lead	IFRC Europe	NLRC	IFRC MENA	NorCross	GRC
HNS	TRCS	LRC and PRCS Lebanon Branch	JRCS	IRCS	ERCS
European partners		DRC, SpRC Swiss RC, GRC and SRC		FRC, SRC and DRC	Swiss RC
Budget (EUR)	32,558,895	7,837,215	3,088,971	2,886,889	1,071,659

The DRC initially planned to implement the MADAD Programme over a period of 36 months, between December 2016 and December 2019. The project was approved by EU on 30 March 2017 retroactively from 16 December 2016. It had a delayed start in 2017 and was granted a one-year No-Cost Extension (NCE) until 31 December 2020.

RC/RC's MADAD programme focused three specific objectives (referred to in the programme logical framework as outcomes):

- 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 - RC/RC 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

The MADAD programme was implemented with some variations in each of the five countries, with activities designed and adapted to fit the context and the RC/RC partner configuration already present in each country.

[2] In Iraq, the programme also targets Internally Displaced Persons (IDPs).
[3] All budget figures exclude indirect costs.

Purpose and scope

The FEEL process was launched in March 2020 and was completed in December 2020. It was undertaken with the dual purpose of accountability and learning in mind. The FEEL builds on the baseline conducted in 2017, as well as the Result Oriented Monitoring (ROM) in 2018 and an internal Midterm Review (MTR), also conducted on 2018, and assesses the extent to which the MADAD programme achieved or contributed towards its intended objectives.

While individual evaluations of each country component are out of scope, the FEEL examined changes at objective level and mapped how these have occurred in the five countries. These country reports formed the basis for the synthesis report. Short reports on each country programme are provided in Annex 1.

The purpose of the FEEL was to:

- Evaluate the programme's contribution towards its higher-level objective of improved well-being, resilience and peaceful co-existence among (vulnerable) refugee and host communities in the five countries, as well as overall regional stability.
- Evaluate effectiveness in (a) strengthening self-reliance and resilience to risks and local conflicts among refugees from Syria and host communities in all five countries; (b) improving the health and psychosocial well-being of refugees from Syria and host communities in all five countries; and (c) strengthening the capacity of HNS in Iraq, Jordan, Lebanon and Turkey and enhancing their ability to reach out to most vulnerable groups within refugee and host communities, as well as harmonising and aligning the measurement of indicator 3.2[4] across all countries.
- Investigate whether, how and why changes have (or have not) occurred, and what DRC can learn from these changes going forward with learning focused on both programme design and governance, as well as implementation.

Report structure

In the following section, we outline the FEEL methodology, its limitations and mitigation measures to overcome these. We then provide an overview of how data were collected, followed by an overview of key findings, per evaluation criteria. The concluding section presents the key learnings from the FEEL exercise and provides recommendations stemming from that learning. The annexes include summary reports for each of the five countries, as well as a selection of regional-level data visualisations, the Evaluation Matrix, the list of documents reviewed, interviews conducted, and the TOR that guided the FEEL.

Methodology

The FEEL process was conducted between March and December 2020 and coincided with DRC's internal Communications and Visibility sub-project evaluation. The FEEL has three distinct but inter-related components:

- A **final evaluation** that is guided by 15 evaluation questions, and which frames other elements of the FEEL process. The evaluation questions, which are outlined in the Evaluation Matrix (see Annex 3), are aligned with the 2019 revised OECD DAC evaluation criteria of relevance, coherence, effectiveness, efficiency, impact and

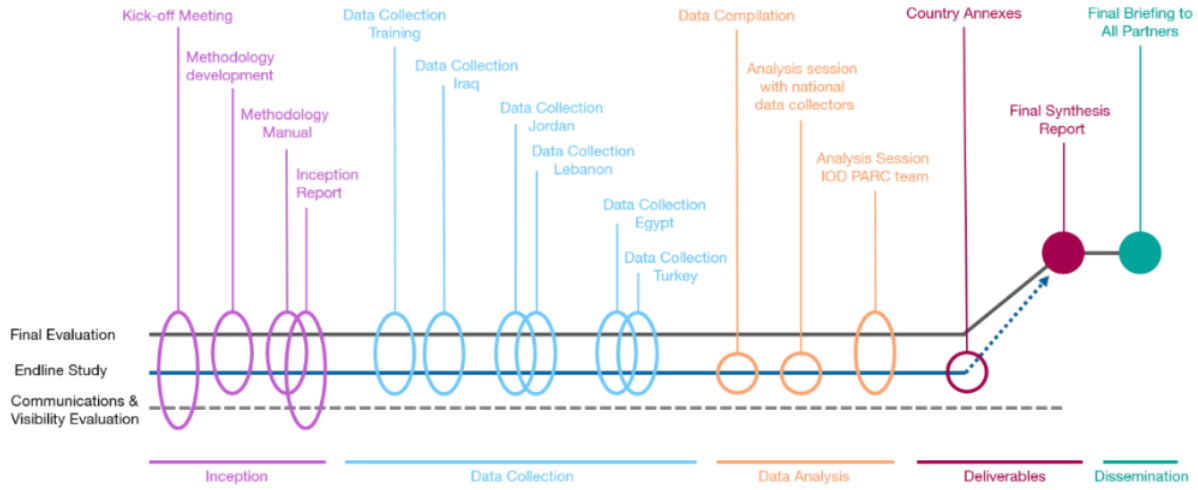
[4] RC/RC Host National Societies staff and volunteers who reported improved competence and confidence in reaching out to most vulnerable groups

sustainability. The evaluation component is dealt with in this synthesis report and focuses on the programme as a whole.

- An **Endline study** that measures progress against outcome indicators to provide a sense of trajectory and change as a result of the programme's activities. The Endline focuses on both regional and country levels to provide insights into the impact of the programme on target beneficiary groups, what change can be attributed to it, and contextual considerations that may have contributed or hindered change. The Endline study is outlined in the country annexes (see Annex 1), where the particularities of each country are elaborated. Evidence from the Endline study has been incorporated into this synthesis report.
- A **learning** component, which addresses questions related to the design, management and implementation of the programme, sustainability of interventions, as well as lessons and recommendations that can be taken forward. This component builds on findings from the final evaluation and Endline study and is presented at the end of the synthesis report.

Figure 1 illustrates how the three FEEL elements were coordinated and managed.

Figure 1: Delineation of the FEEL process and its components



A mixed methods approach was used, drawing on qualitative and quantitative data from primary and secondary sources to address the evaluation questions and conduct the analysis for the Endline study. Even though the FEEL was originally designed as a process that would combine desk- and field-based data collection, our methodology and approach had to be adapted as a result of COVID-19. Most data collection thus took place remotely.

Data collection took place between August and October 2020. The data collection methods employed for the FEEL included the following:

- **Review of existing documentation and data** held by DRC and programme partners, including programme documents, monitoring data, baseline assessment, mid-term review, ROM reports and other relevant literature. See Annex 4 for a list of documents consulted.
- **KIIs** conducted with informants representing DRC and RC/RC programme partners, including HNS, as well as national counterparts and the EUTF as funder at EU Delegation and HQ levels. KIIs were also conducted with RC/RC management staff who oversaw and/or coordinated capacity building in relation to the programme's Outcome 3 (capacity strengthening of RC/RC Host National Societies in Iraq, Jordan, Lebanon and Turkey). A list of people interviewed can be found in Annex 5. KIIs were

conducted via Zoom, Teams or Skype in English, Arabic and Kurdish, and in some cases with interpretation in Arabic and Turkish.

- **Focus Group Discussions (FGDs) and telephone interviews** were conducted with programme beneficiaries in all five countries. FGDs were disaggregated by sex, age, nationality and location, and in Jordan and Egypt also by sector. FGDs were conducted via Zoom or, in the case of Jordan and Egypt, in person. FGDs and telephone interviews were carried out in Arabic, Turkish and Kurdish.
- **FGDs** were also conducted with a sample of staff who have completed training under Outcome 3, except for Egypt where this outcome is not applicable. These FGDs were held on Zoom in Arabic, or with Arabic and Turkish interpretation.
- Using SurveyGizmo, an electronic **survey** was conducted among selected beneficiary households in areas of programme implementation in all five countries. The Endline survey was largely consistent with the baseline survey, using the same electronic platform and the same methodology. The cohort of respondents for the Endline were not the same as those surveyed for the baseline. Therefore, the analysis gives a snapshot of the people surveyed then and now, and not a change for the same cohort. The Endline survey included all the questions included in the baseline to capture changes, as well as several new questions not included in the baseline to capture specific information. It was tailored to each country and to the sectors of focus where these differed between and within countries. Additional questions gauged progress over time and attribution to the programme, where possible. The survey was available in English, Arabic, Turkish and Kurdish.

All data collection tools were documented in a Methodology Manual, which additionally contained ethics and consent guidance and directions for using SurveyGizmo. The Methodology Manual was translated into Arabic, Turkish and Kurdish for ease of use by in-country consultants and for RC/RC staff who assisted with Endline survey data collection. It was also the basis for in-team training on the use of data collection tools to ensure common understanding and consistency in the data collection process.

The various data collection methods provided the evaluation team with several streams of evidence that could be triangulated and consolidated during analysis. Qualitative data was coded and analysed using MAXQDA; codes included the sector focus of the programme and its activities, as well as the overarching evaluation questions and cross-cutting themes such as gender. For additional triangulation and brainstorming prior to drafting the report, country-focused analysis sessions were also held, involving members of the team that covered a particular country. Excel and Tableau were used for quantitative data analysis and visualisation.

Note on survey figures presented in the report

The report contains figures presenting the analysis of the Endline survey, as well as visualisations s to compare baseline and Endline responses to the same questions. A selection of regional-level data, disaggregated by nationality and gender, is included in Annex 2.

The graphs illustrate percentages of total respondents per question to neutralise the effect of various population sizes across the surveys, and to show differences over time. A caveat is that the respondent groups for baseline and Endline surveys were not the same, so the actual respondents are likely to be different people. However, the two groups are closely matched on several key criteria (see Figures 2 to 8), and the data generated are used descriptively rather than inferentially. There may also be other effects on responses, for example COVID-19 and the impact it may have had on access to health services and livelihoods. Despite these challenges, the findings remain credible and useful to stakeholders.

The survey uses several different question structures, including branching logic, single choice (nominal) questions (tick one), multiple choice questions (tick all that apply), Likert scale questions and open-ended entry fields. The results of these different types of questions are represented as follows:

- **Single choice question:** These will have been responded to by the full respondent group. Percentages within a table or chart will add up to 100%.
- **Multiple choice questions:** The percentages shown are based on the total number of responses, and totals could exceed 100%. It will be noted in the report where this is the case.
- **Follow-up questions:** These follow nominal questions, where respondents are asked to explain their response in a follow-up question. Percentages for follow-up questions will add up to 100% of the respondents who qualified to answer the follow-up question based on their response to the initial question.
- **Likert scale questions** contain and ascending or descending scale of five to seven response options. Where they were responded to by the full respondent group, the percentages of respondents in each of the response options will add up to 100%.

Where percentages do not apply to the total respondent group, this will be noted in the report.

- The survey also included **open-ended questions (Free entry fields):** Percentages were not calculated for responses to these questions, as they represent the unique perspectives of only those respondents who supplied answers, in their own words. Where relevant, similar types of open-ended responses have been grouped together and categorised, and the total number of respondents in each category was calculated. However, it would not be meaningful to calculate percentages for these.

The limitations that were experienced during the FEEL process, and the mitigation measures that were put in place to address them, are outlined below.

- The FEEL process had to be adapted to the restrictions and limitations imposed by COVID-19. The FEEL was originally envisaged as a combination of in-person, face-to-face exchanges, field visits for data collection, and desk-based work. At the inception stage, the evolving nature of the COVID-19 pandemic and government responses made it clear that planning and adaptation needed to be fluid throughout the assignment, and decisions were taken as close as possible to the time when tasks would be implemented. Still, a longer timeframe was needed to complete the work.
- It was possible to capitalise on some elements of in-person engagement and data collection, but most interactions and data collection were eventually conducted remotely as a result of COVID-19. These included:
    - Conducting the methodology workshop, which was meant to bring together all programme partners in person, via Zoom. Despite being conducted remotely, the workshop served its intended purpose of validating and further tailoring of the methodology prior to the finalisation of the inception report and the data collection tools, thereby enhancing ownership and participation of all relevant stakeholders.
    - Training of RC/RC data collectors, who were responsible for implementing the Endline survey, was organised remotely via Zoom. In the case of Jordan, Egypt, Turkey PRCS in Lebanon, training took place in RC/RC premises with the trainer joining remotely. For LRC and Iraq, enumerators joined

individually. Despite occasional technology challenges, the training process was successful.

  - KIIs, which were meant to be conducted in person, in-country in Turkey, Lebanon, Jordan, Iraq and Egypt, took place remotely via Zoom and Microsoft Teams. A total of 72 informants were interviewed in 59 KIIs, which is in line with original plans. The additional time needed to interpret remote KIIs did reduce the time available for interviews, but this did not affect the quality of data collected through KIIs.
  - FGDs with staff were conducted remotely via Zoom. In some cases, technology challenges affected the smooth flow of interactions and conversations.
  - Interaction with beneficiaries took place through FGDs and telephone interviews. For remote FGDs, participants were brought together at a particular venue, and the facilitator joined remotely (PRCS, Turkey), or FGDs were conducted in person in RC/RC premises (Jordan, Egypt). Telephone interviews were conducted with LRC and IRCS beneficiaries in Lebanon and Iraq, respectively, as remote FGDs were not considered feasible. As a result, the number of participants and informants varied between countries. It was generally possible to include more participants in FGDs, compared to key informants in interviews (see visualisation of data streams below). However, the number of participants in FGDs had to be reduced to comply with RC/RC and WHO COVID-19 guidance on gatherings.
  - Except for Jordan, Endline surveys were conducted via telephone. In Jordan, it was conducted face-to-face. To ensure data quality and safeguard respondents and data collectors against COVID-19, the survey questionnaire was shortened, and in some countries the sample size was reduced compared to the baseline.

- In Jordan, FGDs with beneficiaries were not organised in accordance with the disaggregation criteria applied in other countries. FGDs were divided by location and sector but they were not gender- or nationality-disaggregated. This meant that issues could not be explored in a gender-sensitive manner, and that issues of social cohesion were not freely discussed in sessions. This limitation was mitigated through in-team and cross-method triangulation, but gaps remain in the data in these regards compared with other countries.

Overview of data collection

59 Key Informant Interviews – 72 people interviewed

10 Focus Group Discussions with RC/RC Staff and Volunteers

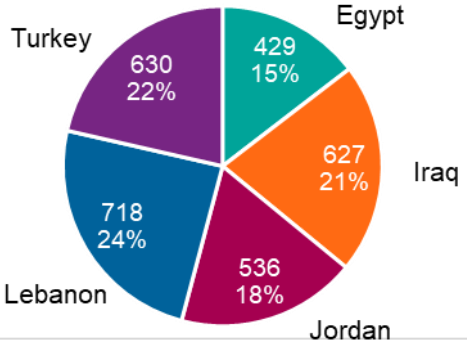
40 Focus Group Discussions & 22 Telephone Interviews with Beneficiaries

103 Documents Reviewed

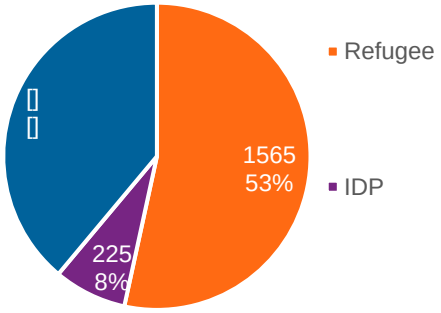
2940 Endline Household Survey Responses

Composition by gender

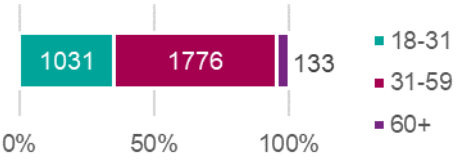
Composition by country



Composition by status



Composition by age



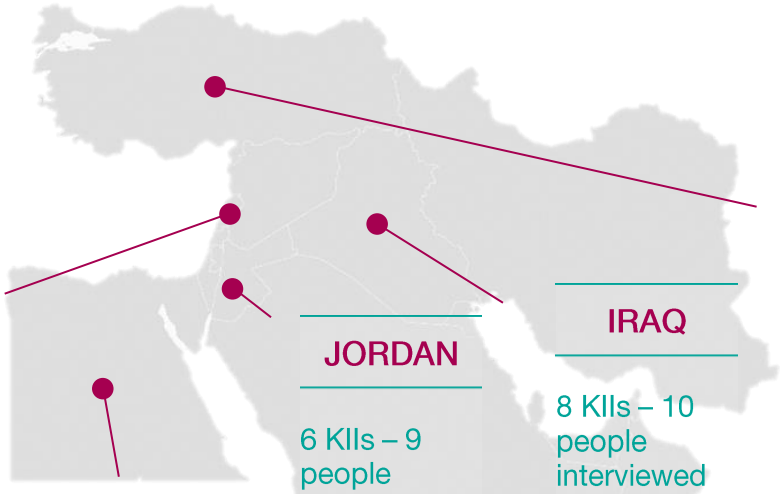
LEBANON

11 KIIs (8 LRC, 3 PRCS) – 16 people interviewed

8 Remote FGDs with beneficiaries (PRCS)

10 Telephone interviews with beneficiaries (LRC)

4 Remote FGDs with staff (2 LRC, 2 PRCS)



EGYPT

8 KIIs

8 In-person FGDs with beneficiaries

JORDAN

6 KIIs – 9 people interviewed

8 In-person FGDs with beneficiaries

2 Remote FGDs with staff

IRAQ

8 KIIs – 10 people interviewed

12 Telephone interviews with beneficiaries

2 Remote FGDs with staff

TURKEY

18 KIIs – 20 people interviewed

16 Remote FGDs with beneficiaries

2 Remote FGDs with staff

REGIONAL

8 KIIs (DRC HQ and regional, EUTF, EUD) – 9 people interviewed

Baseline-Endline comparisons of respondent demographic profiles are illustrated below.

Figure 2: Baseline and Endline respondents by sex

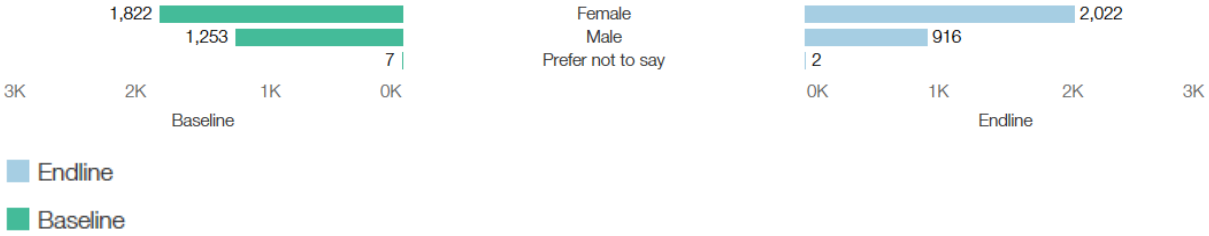


Figure 3: Baseline and Endline respondents by age

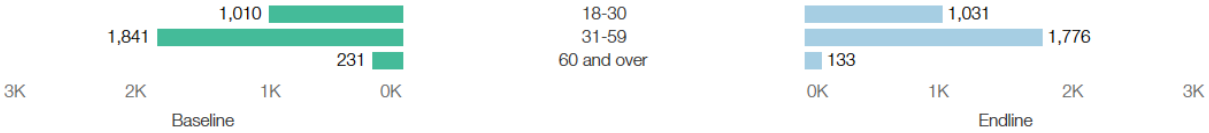


Figure 4: Baseline and Endline respondents by marital status

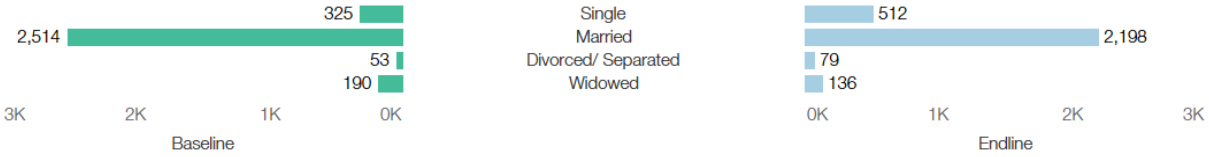


Figure 5: Baseline and Endline respondents by country

Figure 6: Baseline and Endline respondents by nationality

Figure 7: Baseline and Endline respondents by status

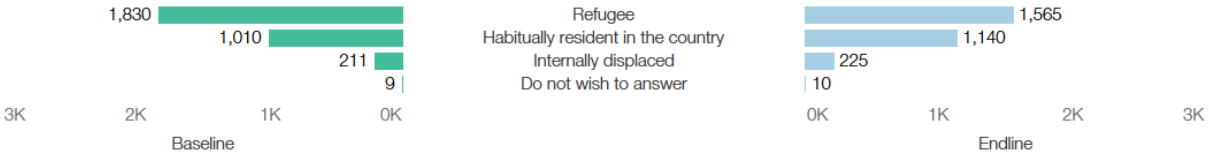
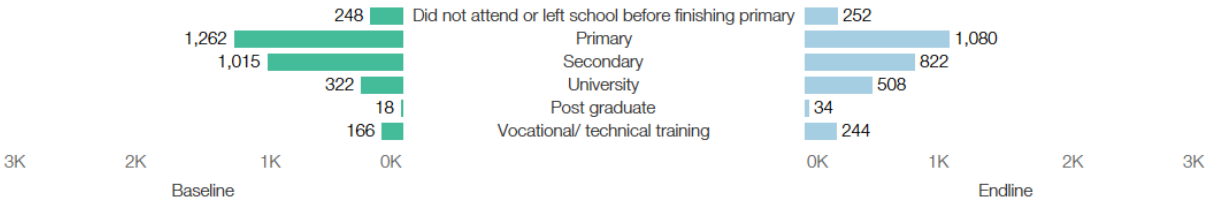


Figure 8: Baseline and Endline respondents by education level



Findings

This section presents the evaluation's key findings against each of the specific OECD-DAC evaluation criteria, namely Relevance, Effectiveness, Efficiency, Impact, Coherence and Sustainability. The sections below synthesise key findings from the overall regional programme and each of the five country components, with examples drawn from document review, KIIs, FGDs and survey results to illustrate the findings.

Note on the regional programme logframe

The findings are broadly positive and demonstrate positive progress and achievement of the outputs and therefore by extension the positive contribution to the achievement of specific and over all objectives over the course of the MADAD programme.

One cross-cutting limitation to note relates to the regional programme logframe, developed at programme design stage and agreed with EUTF during the phase of negotiation about the contract. The programme is contractually accountable with one common logframe at the regional which is then dissolved into five country level logframe against which the country programmes report. There were several issues that affected the extent to which outcomes and impact could be measured and demonstrated which were discussed at the time of the baseline and again during the Mid-Term Review and ROM process.

In terms of the overall impact objective, it is challenging to measure social cohesion, or "peaceful coexistence," at a societal level and the indicator against this, i.e., "% of the targeted refugees and host communities people (women, men, girls and boys) feeling better integrated" does not quite capture the depth or detail of the extent to which social cohesion has improved. This is a limitation in the original design, which the partnership chose not to change at the time of completing the contract with EUTF. Perhaps a case could be made that things would have been worse, had the programme not been implemented, but this is speculation and cannot be documented by evidence.

This relates to a further issue, namely the fact that indicators are mostly quantitative. In addition, there are weak linkages between output objectives and indicators in some areas. For example, output indicator 2.1 focuses on "increased access to inclusive and high-quality health services for vulnerable refugees from Syria and host communities," but none of the corresponding indicators focus on measuring or demonstrating quality. "Access" is also not well captured in the corresponding indicators.

Monitoring mechanisms were also not always designed to capture data to report against indicators; for example, output indicator 1.1 focuses on "increased economic self-reliance and increased access to basic livelihood opportunities for vulnerable refugees and host community members" but monitoring processes at the country level were not originally set up to capture whether participants of vocational trainings were subsequently able to secure employment or increase their income, and if they did whether this was helped by the training they undertook.

Efforts were made to correct this in some instances but were inconsistently applied. Although these issues were highlighted at the time the baseline was conducted, it was recognised that this was contractually binding with the EUTF and negotiations could not be reopened to allow for a redesign of the logframe which would have delayed the start up further.

The evaluation sought to address these limitations through the design of the survey and through the semi-structured interviews and focus group discussions to ensure qualitative data was collected to inform and support overall findings.

It should also be noted that the limitations of the logframe do not in any way detract from the overall positive results of the MADAD programme; despite gaps, the programme was implemented efficiently and effectively and was relevant to the needs of the target groups.

Relevance

Overall, the programme has been largely relevant to the needs of the target groups, including vulnerable beneficiaries among refugee and host populations as well as other groups supported. Throughout there has been active identification of needs and of target beneficiaries. Crucially, the programme has shown adaptability in responding to emergent needs over time and in course-correcting when it did not engage a balance of beneficiaries between the Syrian refugee and host communities. Some challenges did stem from the timing and regularity of needs assessments and limited ability to respond in some instances. For example, in Lebanon livelihoods were not included in programming dur to Lebanon's legal framework prohibiting LRC to provide such services.

Needs identification and assessment

The programme was largely successful in identifying target beneficiaries and establishing their needs, through good baseline assessments and responsiveness to new needs that emerged over the course of the programme. In some instances, needs assessments could have been conducted earlier to allow a more tailored approach from the outset.

The MADAD programme focused on three intervention areas, namely community development, livelihoods and health. Programme beneficiaries were drawn from groups targeted by the EUTF, that is both Syrian refugees and host communities in countries affected by the Syrian crisis. Other refugee nationalities were also included, as well as IDPs in Iraq. At the time of programme design, programme beneficiaries were identified by drawing on secondary data from stakeholders such as UN agencies and I/NGOs, as well as the experience and know-how of RC/RC partners.

The baseline study conducted for the programme is regarded as a starting point for programme planning at country level. Partners had different methods for monitoring and assessing beneficiary needs. For example, in Egypt surveys were conducted in programme locations, and feedback on activities was collected to assess alignment of the programme to beneficiary needs, and in Iraq, NorCross carried out needs assessments in programme locations in conjunction with the Directorate of Health and the Joint Crisis Coordination Centre once the intervention kicked off. This meant that programme interventions were tailored to the needs of beneficiaries in different areas. For example, emergency services were introduced in Iraq; in Lebanon PRCS organised health awareness sessions around the illnesses most prominent in certain camps and LRC conducted needs assessments of communities to ensure available health services were advertised, and that Disaster Risk Reduction (DRR) activities are in line with community needs; in Turkey, community centre activities were planned in consultation with communities attending them and rapid needs assessments are also conducted in each of the community centres.

Some stakeholders believed that the needs assessments were conducted too late, and that it should have been conducted before programme implementation started. In most countries, the baseline study, as well as risk assessments and various country-based needs assessments were conducted after implementation had started. There was also sometimes a mismatch between beneficiaries' expressed needs and interests, and what was possible in a particular country context. For example, in Jordan, labour market assessments were undertaken to assess market demand, but the programme also had to adapt to Jordanian regulations on sectors and modalities of work open to Syrian refugees. Both PRCS and LRC beneficiaries indicated that awareness raising did not add to what they already knew, and

did not always align with their interests. In Lebanon, socio-economic issues were strongly emphasised by beneficiaries, but there was no livelihood component implemented by MADAD in the country, though this was an external limitation and not a programme design issue.

The programme made positive steps to strengthen the integration of gender considerations in some country contexts. Gender and diversity training reportedly led to the needs of different groups being taken into consideration. For example, in Iraq, Turkey, Egypt and Jordan, gender-sensitive monitoring data indicated that women far outnumbered men when it came to participating in programme activities, so activities were adapted to enable more men to participate. The times and days when activities were offered changed so that men could coordinate it with their work schedules. In Jordan, cultural barriers made it difficult for Syrian women to engage in livelihoods activities, so women-only training sessions were introduced to enable more women to attend.

An unexpected result of the PRCS programme was the development of a referral system for women affected by domestic violence. Through health activities, PRCS staff and volunteers became aware of the need for a professionalised and confidential referral system. They were able to establish this and advertise the service safely to women through Community-Based Health and First Aid (CBHFA) activities. Nonetheless, not all partners were able to address gender issues appropriately. In Jordan, GBV was flagged as an ongoing problem by RC/RC volunteers, but JRCS did not have the capacity under the programme to set up appropriate referral systems.

Disability was not explicitly addressed in the programme, but during data collection stakeholders identified it as an issue that would have been relevant to programme interventions. There were some considerations incorporated in the provision of services, for example, ensuring that mobile health clinics were accessible in Egypt and that risk assessments for protection activities include people with disabilities in Turkey, but programme partners noted that there was no formal system for specifically identifying people with disabilities to participate in the programme, or for referring people with disabilities for appropriate services elsewhere. There was thus a potential missed opportunity to mainstream disability across all programme activities.

Identification of target beneficiaries

The programme has been successful in identifying target beneficiaries across all five country contexts. This resulted from HNS's valuable insight and strong coordination with local stakeholders and leaders, as well as vulnerability assessments.

Engagement by HNS has offered valuable access to the communities targeted by the programme, which contributed positively to its relevance. HNS have established relationships with local stakeholders, for example municipalities in Lebanon, Jordan and Turkey, and community leaders in Egypt. In Iraq, community engagement was instrumental for gauging beneficiary interest in training and the type of training they wished to receive; and in Jordan volunteers, mosques and other local actors were very helpful in identifying vulnerable groups. TRCS community centres are already located where the most vulnerable communities are, and they are known to communities. In addition, home visits are conducted to assess additional needs and identify vulnerable beneficiaries, and if required, beneficiaries were referred to other service providers and institutions to cater to their needs. These relationships are a source of information and feedback on activities being implemented, as well as providing insights into additional needs that may not be covered by the programme.

There was good coordination with local and national government in some contexts, which contributed to the overall relevance of the programme. For example, in Turkey, there are strong relationships between TRCS and the respective Ministries for Education, Labour and Social Services, which allowed for good synergies in terms of identifying needs and providing

services; this included language courses and some vocational trainings being conducted by Ministry of Education-certified trainers. In Iraq, the FRC coordinated with the Iraq government to oversee and certify the vocational training courses, ensuring that the qualifications gained are officially recognised. Strong relationships with academic institutions were also useful, including the joint efforts of TRCS and the University of Ankara in developing Turkish language modules for Syrian beneficiaries.

Some activities were specifically aimed at beneficiaries identified through vulnerability assessments, for example the provision of hygiene kits, and maternal and newborn health kits in Turkey. However, not all activities undertaken by the programme had a specific target group. For example, in Iraq entire camps were reached with awareness raising activities, and outside camps medical services were provided to those in need and not only to those that meet specific criteria. Similarly, in Lebanon, services provided by LRC, such as dispatch or blood transfusion services, are open to those who need them. In this sense, there was no specific targeting of beneficiaries, as such, but enhanced provision of information and services to those who needed it.

It was sometimes challenging to maintain an appropriate balance between beneficiary groups. For example, in Jordan the programme initially reached out predominantly to Syrian refugees and vulnerable host community members were not reached, so they had to be targeted later in the programme. In Egypt, beneficiaries from the Egyptian community outnumbered those from the Syrian community. Similarly, in Lebanon members of the host community have been the primary target of some activities, in particular DRR. There are some examples of efforts made to course-correct once these imbalances were highlighted but overall, it meant that in some instances, there were missed opportunities to reach the most vulnerable and to include relevant beneficiaries in key processes and activities.

COVID-19 response

In 2020, the programme adapted well to COVID-19. Each HNS has pivoted activities to mitigate the impact of COVID-19 on their beneficiaries, using the established MADAD channels.

PRCS, LRC, TRCS, IRCS, JRCS and ERCS provided awareness on medical information and COVID-specific hygiene practices, shared information through social media platforms, and distributed hygiene kits and masks. In Lebanon, the LRC ambulance service assumed responsibility for transporting COVID-19 patients, and in Turkey TRCS has been active in responding to needs related to COVID-19 through risk communications and community engagement (RCCE) including disseminating information among Turkish and refugee communities about the disease, also the TRCS community centres, distributed hygiene and PPE items among the vulnerable population as well as the refugees and staff since the start of the pandemic start producing face mask. So far 2.4 million masks have been produced which are being distributed among the people and institutions

TRCS with the support of IFRC have conducted a survey to understand communities' knowledge, attitudes and practices (KAP), along with their information needs on COVID-19. Assessment findings show that generally there is good awareness of COVID-19 (96.5%), but there are some differences in how refugees and people from host communities access information. Based on the assessment findings, TRCS is working on information materials and reviewing existing tools for collecting and responding to feedback to improve services. This issue will be be followed up in the coming period.

To address challenges in accessing primary health care services, the medical convoy in Egypt was dispatched to Alexandria to support beneficiaries who were previously reliant on the two fixed ERCS clinics in the city. In Turkey, staff tried to conduct PSS activities online and over the phone but reported that virtual engagement impacted the quality and reach of activities, and in some cases PSS activities were not running at all, which left many adults and children

vulnerable. It is therefore not surprising that the restrictions and precautionary measures introduced as a result of COVID-19 in 2020 saw a decrease in the number of beneficiaries reached across all countries.

The was also a significant impact on the livelihood component across the region, and the outcomes of livelihood activities are severely threatened by the economic slowdown associated with the pandemic in the entire region. Many beneficiaries from both host and refugee communities lost their jobs and/or businesses, which had an impact on livelihoods and income. In Iraq, the Endline survey results and COVID-19 Business Impact Survey highlighted that over two thirds of respondents have seen a decrease in their household income since the beginning of the pandemic.[5]

Most vocational training was forced to stop, although some activities were adapted to take place online. Monitoring processes were not adapted to capture the number of activities and participants in online activities, and focus group discussions with beneficiaries indicated that not everyone was aware that activities were being conducted online. COVID-19 has also delayed the implementation of some planned projects. For example, there has only been one job fair to date in Egypt, in part because of COVID-19 restricting large public events.

Effectiveness

Feedback from stakeholders indicates the MADAD programme was effective overall, with particular success in relation to the health component. This is likely due to partners' long-standing experience and expertise in providing healthcare services and activities. The livelihoods component had a slow start and its initial effectiveness was hampered due to a lack of robust, tailored labour market assessments and weak linkages between assessments and design of livelihoods activities. This was addressed over the course of the programme and the livelihoods component became more effective, particularly following the recommendations of the MTR. Feedback also indicates that the programme was largely successful in meeting the needs of vulnerable groups, though more could have been done to include people with disabilities.

There were also some positive unintended changes facilitated by the programme. The MADAD programme was a new approach for the RC/RC partners and the evidence shows that relationships between them have been strengthened as a result of working together. The capacity of HNS has also been strengthened as a result of participating in the programme, which has led to greater effectiveness in their approaches to programme management and reporting. This has also had a positive effect on sustainability.

Effectiveness of the MADAD health component

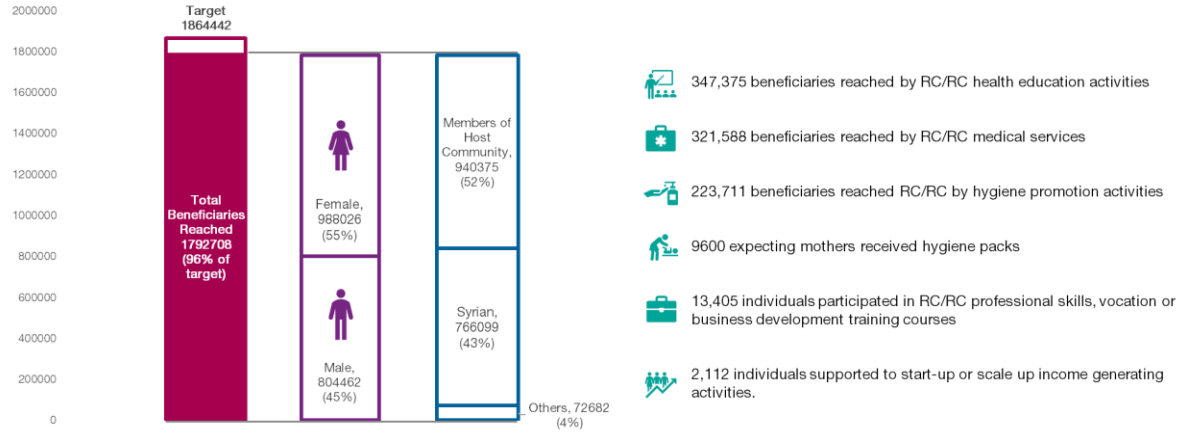
Overall, the MADAD health programme corresponded with beneficiary needs, including the needs of vulnerable groups as defined by the programme, and activities and services were effective.

As a multi-sectorial programme, MADAD has provided health services and health education (or referrals to health services), information on these services and hygiene promotion activities, as well as livelihoods training and support in various forms. According to MADAD data, the programme reached 1,792,708 beneficiaries out of a target of 1,864,442 (96% of target achieved); of which 804,462 (45%) males and 988,026 (55%) females; 766,099 (43%) Syrians, 940,375 members of host communities (52%) and 72,682 (4%) "others".[6] In total,

[5] Covid Business Impact Survey Results (April 2020). Survey administered by the FRC/IRCS MADAD livelihoods team in May 2020 for 121 functioning small businesses out of a planned 138 businesses known to be functioning in Dec-Jan 2020.
[6] MADAD Dashboard (29 October 2020). Figures not verifiable.

347,375 beneficiaries were reached by health education activities, 321,588 by medical services, 223,711 by hygiene promotion activities and 9600 expecting mothers received hygiene packs.[7] 13,405 individuals participated in professional skills, vocation or business development training courses whilst a further 2,112 individuals were supported to start-up or scale up income generating activities.

Figure 9: MADAD Beneficiaries Reached Summary



Beneficiaries indicated that the services provided by RC/RC were aligned with their needs, and that services remained relevant over the course of the programme. Nonetheless, beneficiaries continue to experience barriers in accessing the level of healthcare support they need. It is encouraging that, compared to the baseline, proportionally more respondents in the Endline survey indicated that they experienced no barriers in accessing health services (see Figure 10).

Figure 10: Baseline-Endline comparison of the extent to which beneficiaries experience barriers in accessing health services

Those who reportedly experienced 'some' or 'many' barriers, identified these as the inability to pay for health services and inadequate/poor quality of health services, followed by lack of knowledge of how to access services and inability to afford transport. These are consistent with the barriers that were reported at baseline. A larger proportion of women than men reportedly experienced these four types of barriers (see Annex 2 for detailed figures) according to the results of the Endline.

Survey results about barriers to accessing health services were substantiated by qualitative data from FGDs and KIIs. For example, transportation costs to reach health services was noted as a barrier in several country contexts. In some cases, barriers to healthcare access appear to be due to lack of information; for example, beneficiaries reported in FGDs that they did not always know which services were available in which clinics, or when these were available.

Availability of health services due to high demand also appears to be an issue. For example, in Egypt, beneficiaries experienced prohibitively long waiting times and are sometimes not seen by a health professional due to large numbers of people seeking health services. Also,

[7] MADAD Dashboard (29 October 2020). Figures not verifiable.

beneficiaries were less likely to attend the two clinics in Alexandria due to their location - one is in a busy marketplace and the other on the outskirts of town, both far from target communities. The medical convoy that started visiting Alexandria since the COVID-19 outbreak gave them greater access to health services, as the mobile clinic is set up in their communities.

In Turkey and Lebanon, the health component included PSS. In total, 180,472 individuals attended psychosocial sensitisation or group sessions.[8] The community centre model in Turkey was conducive to PSS activities. The community centres were intentionally set up to provide a safe, private space for PSS activities, and they were provided free of charge. Furthermore, PSS was a niche area for TRCS which contributed to its effectiveness from the outset of the programme. In Lebanon, PSS was the smallest part of the health component and was perceived as somewhat of a missed opportunity. Although MADAD expanded PSS provision to nine new areas of the country, it replicated existing PSS activities implemented elsewhere rather than tailoring them to local needs. The original programme design also contained a PSS component for Jordan. However, this was removed with the withdrawal of the FRC and DRC at the beginning of the programme. It was not replaced due to lack of technical expertise in the Jordan consortium.

Effectiveness of the MADAD livelihoods component

Overall, the livelihoods component could have been more effective from the beginning if it had been informed by robust analyses of local labour market needs. However, labour market assessments were adapted over time to become more effective at identifying market needs and linking them with vocational training design. Thus, the approach to livelihoods activities has become more tailored and effective over the course of the programme.

In the livelihoods component, labour market assessments were conducted at the beginning of the programme to inform vocational training design and development. However, these assessments were not always sufficiently robust. This was addressed in several countries following midterm reviews and ROM recommendations to strengthen linkages between labour needs and vocational training. For example, in Jordan, the programme now offers a wider range of courses that align with market demands in areas such as technology, design, and in professions that allow beneficiaries to work from home or as freelancers. In Egypt, a household economy approach was used to screen applicants in advance to ensure they were a good match for the training the applied for. The intensity of training was also improved to allow topics to be covered in greater depth and detail.

TRCS has placed greater focus on livelihood activities of late, with considerable catch-up from prior delays. Building on the recommendations of the MTR and the ROM, the livelihood sector has expanded with the focusing on employability, training in the agricultural sector, skills assessment, job counselling, and building rapport with potential employers to facilitate referrals for qualified trained employees.

Beneficiaries indicated that the services provided by RC/RC were aligned with their needs, and that services remained relevant over the course of the programme. For example, in Turkey the community centres' focus on language tuition was viewed as pertinent in relation to the constraints faced by refugees there. Turkish language courses were provided from the beginning of the programme to reduce barriers to accessing healthcare and employment opportunities, as well as to facilitate social interaction and engagement. This was appreciated by beneficiaries; however, they also indicated that more advanced levels of tuition were required, as well as livelihoods-specific Turkish language classes. TRCS took this feedback on board and worked with partners to provide a wider range of Turkish language courses.

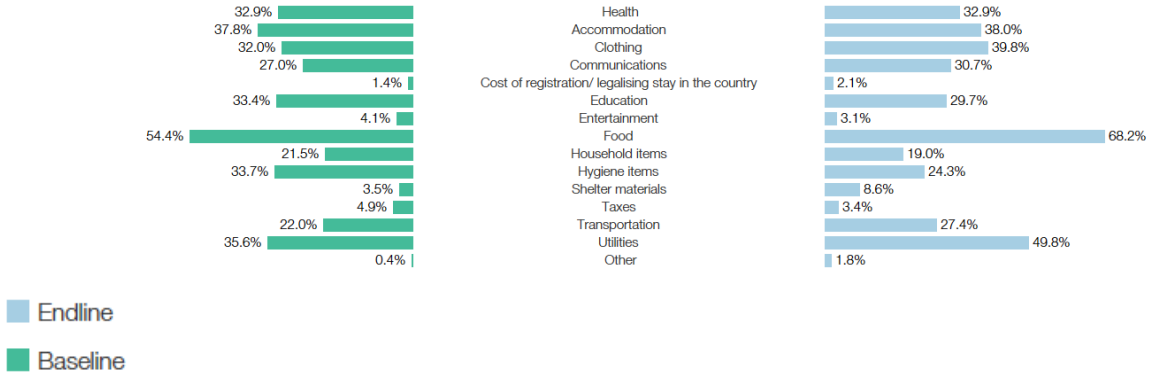
[8] MADAD Dashboard (29 October 2020). Figures not verifiable.

MADAD livelihoods interventions were considered very helpful where beneficiaries could set up their own businesses or initiatives, but less so for securing employment or work opportunities, or teaching new skills. In total, 13,405 individuals participated in professional, vocational or business skills development training courses provided under MADAD, and 2,112 were supported to start or scale up income generating activities.[9] However, financial issues continue to be a significant challenge for beneficiaries. While services provided by RC/RC are regarded as helped, they are not considered to be sufficient. At times, financial support would have been helpful to set up a business in order to capitalise on training received, but the programme could not provide this in all five countries; it was however, provided in Iraq.

Figure 11 suggests that, despite programme investments to improve livelihoods and economic opportunities for beneficiaries, they continue to face difficulties in meeting many household expenditures.

Figure 11: Baseline-Endline comparison of households able to meet different kinds of household expenditure

Proportion of respondents who answered "yes" to the question: Are you able to meet household expenditure in the following areas?



There were suggestions that, in terms of programme design, it may have been advisable to decrease the number of target beneficiaries to enhance the quality of livelihoods services. This would have allowed the budget allocation per beneficiary to be higher, and to expand the range of services for individual beneficiaries. For example, in Egypt, this could have helped beneficiaries who successfully completed training courses to set up their own businesses.

During the lifetime of the programme, the context of implementation changed in some of the countries. As a result of the economic crisis In Iraq and ISIS operations, the needs of Iraqi people – host and IDP population - became more dire compared to those of refugees, and authorities did not understand why the programme continued to focus predominantly on refugee populations. The MADAD dashboard shows that the programme reached 48,759 Syrians, 5,039 host community members and 31,476 IDPs in Iraq which highlights that activities were adapted to meet the shifting needs in the country.[10] Similarly, in Jordan, unemployment increased and the economic situation of host community beneficiaries who participated in the Endline survey appears to have deteriorated. Therefore, the initial focus on Syrian refugees had to be revised to adapt to the changing needs of host communities. The subsidy on refugee healthcare was also removed in Jordan, which meant that access to healthcare was further limited for refugees, an evolution the programme was not able to respond to given its focus on health awareness rather than service provision in Jordan.

Livelihoods programming was found to respond to the needs of men and women. In all countries, more women than men took part in vocational training. For example, in Jordan 81% of female livelihoods beneficiaries took part in vocational training compared to 54% of

[9] MADAD Dashboard (29 October 2020). Figures not verifiable.
[10] MADAD Dashboard (29 October 2020). Figures not verifiable.

male livelihoods beneficiaries. Vocational training was found to be gender sensitive and tailored to needs identified in the baseline around barriers in women's access to the labour market. For example, in Turkey, Jordan and Egypt, women from both the host and refugee communities prefer to work from home for cultural reasons, so vocational training focused on providing them with the skills to be able to do this, including hairdressing, sewing and tailoring, which has provided them with an option for home-based self-employment who may not have had access to gainful employment before. While a smaller proportion of men participated, they generally gained more from the activities than women. For example, in Jordan more men were able to turn their training into income generating activities than women.

The programme was instrumental to help overcome administrative constraints imposed in each of the countries in relation to refugees' access to employment. For example, in Turkey, Syrians can only work in the formal sector if they have an official work permit. TRCS support Syrian beneficiaries both logistically and financially to obtain work permits to overcome this barrier, contributing to the effectiveness of the livelihoods component. Syrians in Egypt can also only work in the informal sector, which was also taken into consideration by the programme design which sought to equip Egyptian beneficiaries with skillsets necessary in the informal sector. In Lebanon, Palestinian refugees in Lebanon and refugees from Syria face barriers related to their status and access to the labour market, with the Ministry of Labour requiring Palestinian workers to obtain a work permit in order to gain employment, thus restricting their access to certain professions. For these reasons, it has never been the programme's intention to support this, despite the acknowledged need.

Efficiency

Overall, feedback from stakeholders pointed to a positive and efficient management process of the MADAD programme, with good consortium coordination and communication. The relationships were well managed by DRC HQ, from EUTF level through to the country level. Regular engagement included annual face-to-face meetings with all partners, bi-annual meetings with country programme leads and DRC; monthly group virtual meetings across all countries; meetings in line with major MEAL milestones, as well as ad hoc meetings as and when required ensured consistent support and communication with the programme teams. Feedback indicates that this structure worked well and improved over time, particularly as key consortium members remained the same over the last eighteen months. Delays at the beginning of the programme hampered efficient starts across all countries; however, through efficient and effective programme management, countries still largely succeeded in meeting, and sometimes exceeding, targets.

Programme governance, set-up and management

The MADAD programme was designed to cover five countries, engaging with six national host societies (two in Lebanon). Even though it aimed to be a regional programme, it can better be conceptualised as a multi-country programme. There was little interaction between the country teams as part of MADAD, which was partly due to the lack of a formal mechanism to support this, as well as teams being focused on their own areas of intervention. Under-resourcing of some areas of the country programmes, particularly in the beginning, and time constraints were also a barrier to regional interaction. In addition, whilst there were common components across country programmes, i.e. livelihoods and health, these were tailored to country contexts at the activity level based on local needs assessments; the programme was designed based on existing presence of the partners before MADAD and the response designed to build on this. Key informants noted that this left little scope for cross-learning. However, there was also little evidence of attempts at collaboration in the programme design which could have supported a regional approach. For example, FRC and GRC were both

implementing livelihoods components in Egypt and Iraq and used their own strategies for design and development of livelihoods activities, rather than a unified approach under the regional programme. Regional coherence of the programme is discussed in greater detail below.

The programme experienced a slow start, due largely to lengthy negotiations with the funder, EUTF MADAD. The initial contracting process with the EUTF MADAD was described as slow and complex. It took nine months to sign the contract, and then required a further ten months of renegotiation due to the situation in Jordan (outlined in greater detail below). The implementation of activities in all countries was significantly delayed, and some of the needs identified at the design stage had changed by the time implementation started.

The long-standing presence of the HNS in each countries offered an extremely valuable entry point for the MADAD programme. The trust and positive reputation built up by the RC/RC movement over time ensured that target communities were already familiar with the work carried out by RC/RC organisations. Existing HNS relationships with local government, schools and employers were beneficial to the programme across the board, as these reduced the need for long waiting times for government approvals, including for example, setting up activities in schools and camps.

Diverse management and implementation arrangements across a large consortium

The number of partners involved in the consortium, each with their own internal structures, processes, approaches and budgets, caused delays. Key informants suggested that fewer partners could have enhanced programme efficiency and made for more efficient management processes overall. The consortium agreement was essential for the efficient management of such a large programme, with rigorous reporting requirements to a newly established Trust Fund. It was deemed effective in setting out partner roles and responsibilities, but was initially viewed by some partners as overly rigid. Key informants suggested that the complementarity between programmes and partners was not always adequate, leading to inefficiencies which are outlined in greater detail below.

Management and implementation arrangements – some planned and some unforeseen – caused challenges and delays in all countries, although less so in Lebanon.

- In Jordan, the programme experienced implementation delays when DRC and FRC left the country as bilateral and implementing partners before the programme started. Consequently, the Jordan country programme was the only to be supported by IFRC rather than a national RC/RC partner. As an INGO, IFRC has different structures and processes, including around financial management and reporting compared to other national RC/RC partners. These different ways of working created a different dynamic for the Jordan country programme compared to other country programmes. As an International Organization, IFRC also had different expectations regarding direct engagement with the EU, and the extent of headquarters versus decentralised decision-making. This required negotiation with DRC in order to align with the wider programme framework. Also, the withdrawal of the initial two bilateral partners required a redesign of programme activities. The PSS component was dropped, which was considered a gap in the programme as there was a clear need for PSS activities in Jordan. Delays at inception necessitated a No Cost Extension for the Jordan programme. In addition, it emerged that the community projects required technical consultants and engineers to draft requirements for the construction and renovation of the community projects. There was not budget initially allocated for this which cause delays in procurement.
- The programme in Egypt experienced significant delays in getting started and encountered several challenges relating to procurement and recruitment. For example, the MADAD project manager was only hired in 2018 and the full-time livelihoods programme officer was only recruited into the role in 2019. Differences in

compliance and procurement regulations between ERCS, GRC and SRC contributed to significant delays in procurement processes and led to a delay in the procurement of key equipment for the programme. This included the vehicle for the mobile health clinic, which was only procured and operationalised 18 months after the official programme start. Egypt did not report on beneficiaries in the first year. Targets were still achieved in Egypt, though stakeholders pointed to the fact that more people could have been reached had the programme been up and running efficiently on time.

- In Turkey, slow internal processes around procurement and recruitment were also cited as hampering the programme, particularly in the beginning. For example, it took three years to have all programme staff recruited into their roles. Despite these delays, however, Turkey has largely achieved its targets which have been adjusted (increased several times).
- In Iraq, funding delays from the EU MADAD fund severely impacted implementation. It resulted in lengthy delays at the beginning the programme, which had a knock-on effect throughout. The delays also created difficulties in motivating and retaining volunteers. The complicated and lengthy approval procedures for programme allocations created further delays in implementation, with staff reporting that this limited programme effectiveness and impact. There was also an initial delay in the delivery of the labour market assessment and the selection and refurbishment of the vocational training centres, causing the livelihoods activities in Iraq to start 16 months behind schedule. Despite these delays, the RC/RC activities in Iraq still achieved the majority of the set targets.
- In Lebanon, the programme experienced payment delays between RC/RC partners and LRC throughout, with a particularly long delay at the end of the first year. However, these delays did not have a major impact on programming. There were some delays in procuring programme equipment due to the successive crises in Lebanon and the ongoing economic crisis making timely procurement very challenging. Despite these payment and procurement delays, the programme still managed to meet most targets.

There was a lack of flexibility where specific elements of the programme had not been allocated any budget lines at the beginning of the programme. For example, the MTR identified the need for the inclusion of first aid training and resources to support business start ups in Egypt but this could not be incorporated in the programme and the budget had already been allocated and could not be moved around. This led to inefficiencies and a lack of effectiveness around vocational training, where beneficiaries participated in courses but then could not implement the skills learned due to a lack of seed funding or equipment, e.g. hairdressing. This also led to a lack of sustainability of the training due to a lack of funding which could have contributed to longer-term changes, including increased opportunities for income generation and economic resilience.

There has been a high turnover of delegates over the course of the programme, which has made it difficult to institutionalise MADAD and ensure continuity of programme knowledge. However, this has been managed well by the DRC HQ team, providing support to new delegates and seeking to ensure smooth transition processes. Coordination at the country level was more nuanced but was found to be efficient, overall. For example, partnership management in Iraq was seen by stakeholders as highly effective, with regular communications and cohesive implementation of activities between the partners. The four partners all contributed to a steering committee as well as working groups, and regular meetings with both internal and external partners ensured strong communication between the societies and other organisations working in the country. The relationship between the Swiss RC, German RC and ERCS in Egypt also improved and strengthened over time, with positive engagement and support noted from all key stakeholders there.

The exception is Lebanon where a large number of partners created a complex operating context. Aligning multiple partner's approaches and regulations to the EU standards was a challenge and there was a lack of shared understanding of project requirements initially. This has been complicated by high turnover of programme staff at RC/RC partners and at NLRC as country lead. Each national partner was responsible for an activity area and maintained a direct point of contact at LRC which has worked smoothly. Partnership between the Swedish Red Cross and PRCS was particularly well-coordinated. However, at a country and consortium level there is not a clear understanding of what other RC/RC partners are implementing via MADAD and there have been few coordination meetings involving the whole Lebanese consortium. The programme has been implemented as five separate projects rather than as a cohesive programme.

Reporting structures worked well, with HNS reporting to the RC/RC partners, who in turn submitted to DRC for final submission to the EU. Feedback from interviews indicated that the quarterly reporting system also worked well, and also included a financial update. The main challenge was Turkey, as there are two reporting processes and the FRIT reporting was changed three times due to EU requests related to the fact that in Turkey the programme is funded primarily by the Facility for Refugees in Turkey offering different accountability requirements and result frameworks and also due to RC/RC internal management structures, as Turkey lies in the Europe region while the other countries fall under the MENA jurisdiction.

Financial management and cash flow generally worked well; financial updates included in quarterly reports provided detail on programme expenditure in relation to implementation and funds flowed relatively smoothly from the EU to DRC, and then on to RC/RC partners and HNS. Where delays in payment occurred at the central level, this did not adversely affect programme implementation as partners were able to pre-finance activities. DRC transfers funds within 24 hours of receipt from the EU, though different models in each of the countries led to delays in some instances. For example, there were some delays in Turkey due to IFRC's internal processes. The cash transfer model could potentially have been more streamlined, with a centralised budget managed by DRC; however, RC/RC partners preferred funds transferred through their own systems and on to HNS in the relevant countries.

Use of monitoring information and reporting

Regional level

Programme monitoring, evaluation and learning framework had several shortcomings which affected programme management and evaluability. The overall (regional) programme logframe did not lend itself to support data collection at the impact level and the programme-level indicators were found to be quite rigid, which made it difficult to adapt or tailor them to local country contexts. Data collection and reporting generally focused on the output rather than outcome level, which limited the appraisal of contribution at an outcome level and made it difficult to demonstrate higher level changes.

There was a further specific challenge in the livelihoods component, namely collecting data to monitor and report on output indicator 1 (vulnerable refugees and host community members would demonstrate "increased economic self-reliance"). The monitoring process was not originally set up to trace whether participants in vocational trainings were subsequently able to secure employment or increase their income and, if so, whether the training they undertook contributed to it. Subsequent attempts to adapt the monitoring process to try and capture this information were limited by consistency of application. Therefore, it was difficult from the outset to demonstrate whether, or to what extent, the MADAD livelihoods intervention was contributing to increases in beneficiaries' income.

Monitoring and assessment data have been used to introduce course corrections and adaptations in the programme. However, the adaptation of budget allocations across programme components and countries was not always consistent to allow for course

corrections. At a programme management level with DRC HQ, a formal information management database was only established in September 2019. This has allowed programme management staff at DRC HQ to identify necessary course corrections to address emerging issues such as the under-representation of Syrian refugees in Lebanon, such as in the DRR activities. lack of inclusion of Syrian refugees in the Lebanon programme. More effectiveness and efficiency gains could arguably have been made had it been established earlier in the programme.

At a country level, various monitoring tools were employed by programme partners to collect feedback on specific activities and, at times, to introduce changes. For example, in Egypt beneficiaries were consulted on the health services they needed, and data provided was analysed over time leading to changes in specialised medical services provided in mobile clinics and extension of mobile services to Alexandria when COVID-19 struck. Nonetheless, some constraints were noted in terms of the volume and detail of data collected, which proved challenging to process and which may delay adaptations.

Programme learning

Several programme partners credit the baseline study, which was conducted in 2017, as a point of reference which contributed substantially to the development of country-specific programme plans. The MTR and the ROM findings are also noted to have contributed to adjustments in implementation. This included, for example, referral systems incorporated by LRC, which the ROM flagged as not being formalised; and standardisation of CBHFA activities in Lebanon following the MTR. In Jordan, Turkey and Egypt, the ROM highlighted that male beneficiaries were being excluded from activities due to their timing, and weekend events were introduced as a result.

In Turkey, a key finding of the MTR was that vocational training was not sufficiently aligned to the specific needs of the labour market, and that it was also not adequately tailored to each regional and provincial context. The programme responded by undertaking a more robust labour market analysis in each province, by screening participants in advance to ensure they were suitable for the training, and by developing relationships with potential local employers to build a viable recruitment network. A budget modification was permitted to facilitate this more in-depth analysis. Conversely, a budget modification was not permitted in Egypt to address the MTR finding that financial resources were needed to support beneficiaries to start their own businesses, or to allow for more first aid training.

Capacity of RC/RC staff and volunteers

Capacity building activities under Specific Objective 3 - “RC/RC 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” - were carried out in Iraq, Jordan, Lebanon and Turkey. Overall, staff and volunteers provided positive feedback about the variety and quality of training provided, and found this to be both effective and efficient.

Capacity building activities were found to be relevant to support the MADAD programme and supported the development of new, transferrable skills that are useful for staff and volunteers in their current programme activities, as well as for potential future roles. Staff and volunteers also reported increased confidence in working with beneficiaries as a result of the training, with awareness and sensitisation trainings aimed at enabling volunteers and staff to reach and work with vulnerable groups considered especially successful.

Capacity building for RC/RC Host National Societies varied between countries and was relevant to the MADAD programme in each country context. For example, in Lebanon capacity building for LRC focused on Volunteer Management and Peer Support, which staff said substantially improved their capacity to support peers and volunteers in recruitment processes, their everyday work, as well as learning from feedback provided once staff and volunteers left LRC. However, these trainings did not have a specific angle on engagement

with vulnerable populations and refugees. This stands in contrast to Jordan, Iraq and Turkey where, according to staff and volunteers, the trainings improved their knowledge about refugees and how to identify and provide services to them, as well as their self-confidence to do so.

HNS capacity building activities contributed to social cohesion. For example, in Jordan the programme engaged community volunteers from both the Syrian refugee and Jordanian host communities, as well as volunteers taking part in comprehensive training such as CBHFA and Life Skills. Similarly, in Iraq, a mix of IRCS volunteers, staff and local community volunteers attended trainings, providing a space for them to mix and encouraging social cohesion. In Turkey, Community Engagement and Accountability (CEA) training for staff and volunteers helped with social cohesion and allowed this to be mainstreamed across other activities, including health and livelihoods. Training included cultural awareness and how to communicate and engage most effectively with different demographic groups within communities, as well as behaviour and social change communication strategies to encourage more positive attitudes and behaviour within the communities.

There is also evidence of **capacity building activities contributing to sustainability**, with a significant portion of MADAD funding invested in upskilling staff and volunteers in various technical and thematic areas, also providing transferrable skills that participants reported would improve their future performance and opportunities.

There are a few areas where capacity building could have been more tailored to context. In Turkey, additional training would have been desirable on peacebuilding, social cohesion, and impact analysis, amongst others, although staff and volunteers were careful to note that this would have been an addition to an already well-designed suite of training opportunities. In Jordan, volunteer management training was not included in capacity building for the Host National Society. As the recruitment and upskilling of community volunteers was pivotal to the programme, training for JRCS staff in this area would have been beneficial.

Volunteer incentivisation and retention also raise efficiency issues. For example, in Turkey, TRCS volunteer incentivisation does not compare favourably with other NGOs. TRCS policy is to only provide transport, breakfast and lunch allowances, and only on receipt of proof of expenditure. This leads to increased volunteer turnaround. The five days of training that volunteers receive to support the health and PSS officers is a substantial investment, and efficiency is jeopardised if they do not remain with the programme long-term.

An unintended consequence of the programme's capacity building for National Host Societies is their organisational strengthening beyond the Outcome 3 remit. In Jordan and Lebanon, the management capabilities of LRC, PRCS and JRCS showed substantial improvements, including in the areas of M&E, procurement and financial management. LRC's increased capability is substantiated by the fact they have secured direct grants with the EUTF for MADAD II. Additionally, MADAD enabled JRCS to expand their national profile, building strong relationships with local authorities through the community projects component. This has undoubtedly contributed to sustainability, as it has strengthened JRCS' reputation and position for future interventions and enhanced the level of trust amongst key stakeholders. In Jordan, updating of the livelihoods programme created an offering that JRCS can transfer to other areas of work, and strengthened their networks and procurement experience through their new partnerships with national training providers.

Impact

As of November 2020, the DRC MADAD programme has reached 1,792,708 beneficiaries across all five countries, including 988,026 women and 804,682 men. Across the five countries, the total number of host community members reached outnumbered the number of Syrians reached, by 940,375 to 766,099. However, there are variations between countries,

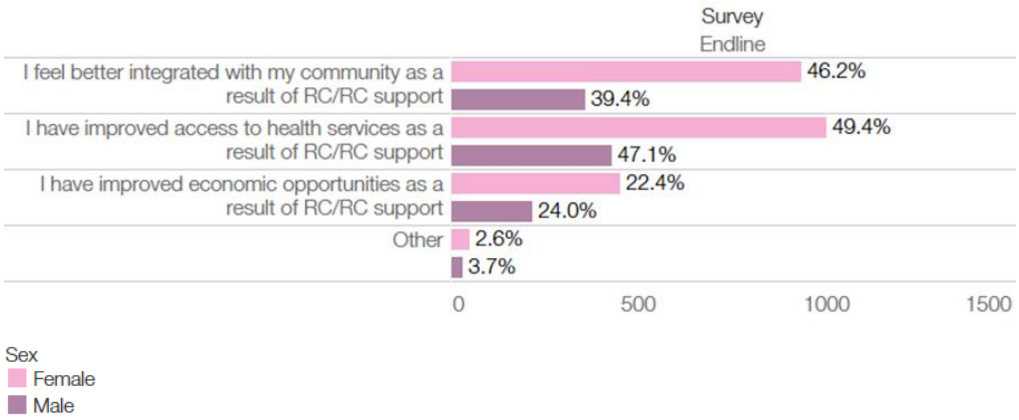
with both Turkey and Iraq having reached a larger number of Syrian refugees, compared to host community beneficiaries. The table below shows this breakdown by country.

Table 2: Syrian and host community beneficiaries reached, per country, over the programme lifetime

Country	Total reached	Syrian	Host	Others
Turkey	933,473	547,243	359,401	26,829
Lebanon	523,275	98,455	418,101	6,709
Jordan	179,712	55,019	106,853	4,298
Iraq	85,274	48,759	5,039	31,476
Egypt	70,974	16,623	50,981	3,370

Overall, the MADAD programme has had a positive impact on the lives of beneficiaries across all programme components. The Endline survey included a question on whether the RC/RC programme made a difference to beneficiaries' lives as a way of gauging attribution to MADAD. The majority of Endline survey participants (76%) indicated that RC/RC services in their area had impacted their lives, and that of their households. Figure 12 illustrates the areas in which men and women ascribe positive change to MADAD interventions. Overall, impact in terms of social integration and access to health services outweigh economic opportunities by almost 50%. However, women self-reported slightly higher changes in social integration and access to health services, while proportionally slightly more men than women reported improved economic opportunities.

Figure 12: Endline Survey – Proportion of women and men, respectively, self-reporting positive change in social integration, access to healthcare and economic opportunities as a result of the programme



Health service delivery, health knowledge and PSS

Based on beneficiaries reached and impact, the health component was the strongest performing element of the MADAD programme, reaching and often exceeding its targets despite COVID-19 **and country-specific challenges.** This is partly because RC/RC is well versed in health programming, while RC/RC partners and HNS had extensive experience in implementing health projects prior to MADAD. There is also a high level of existing trust towards HNS as health service providers in each of the five countries. MADAD health programming built on this experience and focused on health awareness and education; provision of health services and PSS activities. A total of 1,092,289 people benefitted from

the MADAD programme's health component across the five countries, exceeding the initial the target of 1,052,581.

Impact on access to healthcare

A comparison of baseline and Endline survey results show that, while most target beneficiaries still face barriers to accessing health services, the proportion of those facing barriers to access has decreased (see Figure 13). At baseline, 57% of beneficiaries reportedly experienced many or some barriers to accessing health services, compared to 48% at Endline, while the proportion of those reportedly facing no barriers in accessing health services increased from 27% at baseline to 39% at Endline. Although barriers still exist, including transport costs, inability to pay for services and lack of knowledge of where and how to access these services, these appear to be reducing across the board (see Figure 14).

Figure 13: Baseline-Endline comparison of the proportion of beneficiaries experiencing barriers in accessing health services

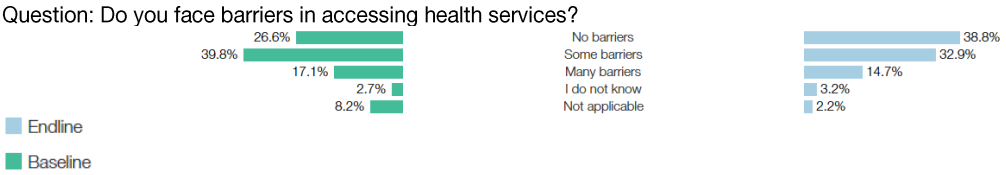
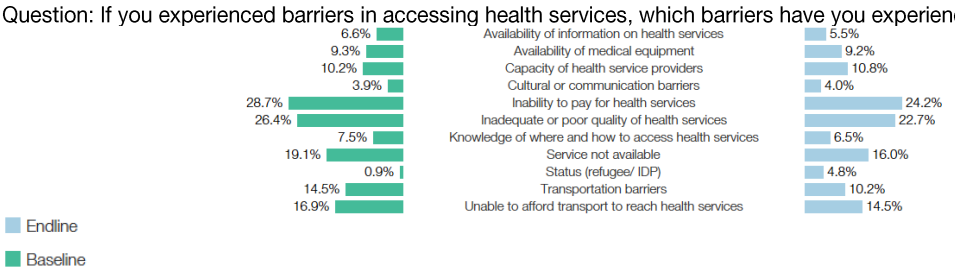


Figure 14: Baseline-Endline comparison of the type of barriers beneficiaries face in accessing health services



These **overall results conceal important variations.** For example,

- In Jordan barriers to accessing healthcare have reportedly increased over time, and there has also been a substantial increase in beneficiaries who cannot afford healthcare. There was a change in UNHCR funding of this component, which was outside of the programme's capacity to address. This is substantiated by the baseline and Endline survey results, while FGD participants explained that unemployment and economic challenges impact their ability to pay for healthcare.
- In Turkey, the proportion of beneficiaries who reportedly faced barriers in accessing health services increased from 60% at baseline to 76% at Endline, mainly due to the language barrier that exists there. Covid-19 may also have affected the endline figures as some hospitals were only accepting Covid-19 patients and beneficiaries may not have wanted to go to a hospital out of fear of contracting the virus.
- In all five countries, Syrian communities generally face more barriers, particularly barriers relating to culture and communications.

Increased health service provision is also one of the programme's successes. The programme enabled HNS to build on their existing health services, to scale up existing services and expand into new areas. For example:

- In Lebanon, PRCS has been able to provide new medical equipment and medicine, equip an ambulance and support the provision of menstruation kits as a result of MADAD.
- In Iraq, emergency medical services, ambulance services and first aid kits provided by the RC/RC were found to be well targeted and accessible by both beneficiaries and RC/RC staff, providing essential services to IDP (Internally Displaced Person), refugee and host communities where few services otherwise existed.
- In Egypt, the mobile health clinic, although severely delayed in operationalisation, received excellent feedback from beneficiaries from the very beginning and this further improved over time as the service responded to the evolving needs of the communities and added more specialities to the clinic rotation.

The COVID-19 pandemic has also made it difficult to assess the full impact of the programme on improved healthcare access, as clinics were forced to close in the first quarter of 2020, and beneficiaries could not freely access medical services. For example, 56.3% of Endline survey respondents in Jordan reported that COVID-19 has made it more difficult for them or their household to access healthcare.

Impact on health and hygiene knowledge

CBHFA activities have increased beneficiaries' health and hygiene knowledge, as well as access to services. All HNS had experience in CBHFA, and the programme enabled them to scale up these activities. Health awareness activities were generally tailored to the needs of each community and included topics relevant to their needs and areas of interest.

However, there was an unbalanced gender dynamic in relation to health and hygiene promotion activities. Because it is culturally associated with women's roles at a household level, more women than men engaged in CBHFA activities. Adjusting the timings of health education sessions to allow men to attend outside of their working hours did not result in a substantial increase in the participation of men in these activities.

Impact on psycho-social wellbeing

PSS was a smaller part of the health component which was delivered only in Turkey and Lebanon. Overall, it is challenging to assess the full impact of PSS on beneficiaries due to increasing levels of instability and stress, as well as the influence of COVID-19.

In Turkey, where private PSS services are expensive, the free PSS services provided by TRCS in community centres were successful. The community centres provided a safe space for men and women to receive PSS. PSS training for TRCS staff was well received and was found to be sufficiently tailored to the context to deal with Syrian refugees in Turkey.

Results were more mixed in Lebanon. Most key informants and FGD participants had not accessed PSS services, or were unsure what they were. This is likely because PSS was not a standalone component but was integrated into other activities CBHFA activities. Women, as well as beneficiaries in the 18-30 age group were more open to discussing their experience of PSS services, and generally spoke positively about it. There was also a sense in Lebanon that PSS represented a missed opportunity. It did not reach the proportion of Syrian beneficiaries it had aimed for, and although the programme allowed PSS provision to expand into nine new areas of the country, it replicated PSS activities implemented elsewhere rather than tailoring it to local needs.

In Jordan, PSS activities were replaced with a larger CBFHA component and the rescoping of the community development programme. The absence of PSS was considered a major gap in Jordan, given the need for such support among refugee populations.

Livelihoods

The baseline study conducted in 2017 found that livelihoods concerns among beneficiaries were common across Turkey, Jordan, Egypt and Iraq (the livelihoods component does not apply in Lebanon). Against this backdrop, the MADAD programme sought to provide economic and livelihoods opportunities to refugees, IDPs and host communities. The livelihoods component of the programme had a slow start in all the countries and was initially focused on the implementation of activities, rather than the kind of activities that should be offered to meet labour market demands. This was addressed over the course of the programme. Labour market analyses were updated in Turkey, Egypt and Jordan, and livelihoods activities were updated accordingly. This resulted in a more fit-for-purpose and multi-faceted approach to developing livelihoods activities in line with labour market needs in the various regional, provincial and local contexts. As a result, livelihoods activities (and their impact) improved substantially.

Gender-disaggregated participation and impact

The livelihoods component was developed in a gender-sensitive manner, taking the different needs of men and women into account and designing livelihoods activities that were appropriate and relevant. This includes, for example, the cultural sensitivities around women in Turkey and Egypt working outside the home. Vocational training was thus developed to provide women with income generating skills that would allow them to work from their homes, including hairdressing, tailoring and sewing. The livelihoods component also adapted to meet the evolving needs of male beneficiaries. In Turkey, for example, language courses were initially being offered during the day when men were most likely to be working. Additional classes were subsequently offered in the evenings to accommodate men's working hours and allow them to attend.

Overall, 36.8% of respondents to the Endline survey reported taking part in livelihoods activities or training courses provided by HNS and RC/RC partners. Proportionally more women (39%) than men (31%) took part in MADAD livelihoods activities.

The most popular livelihoods activities across the board were vocational training courses, and 24% of respondents reported participating in these. The most popular livelihood course taken by both men and women was vocational training, with 30% of women and 16% of men taking part in it, followed by adult language courses which were attended by 16% of men and 12.5% of women (see Figure 15 and Figure 16).

Figure 15: Participation in livelihoods activities by women and men

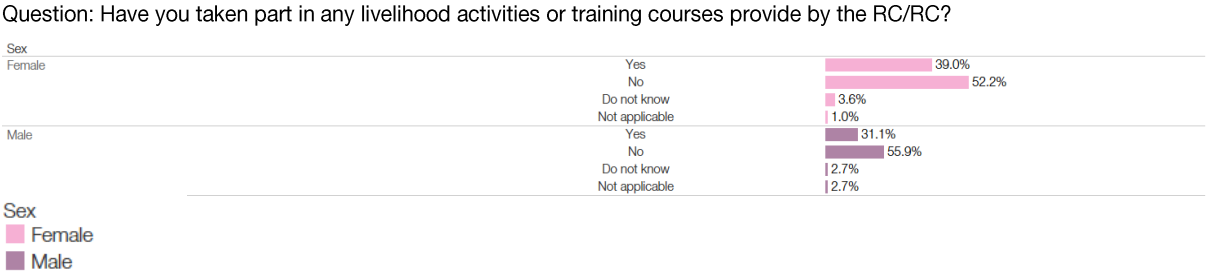


Figure 16: Participation in specific livelihoods courses by women and men

Question: Which of the livelihood courses did you participate in?

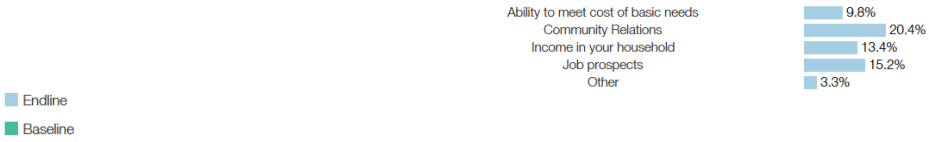
Although proportionally more women than men participated in livelihood activities, they did not always experience the same benefits as men. For example.

- **Men were more likely to experience an increase in job prospects compared to women**: 17.5% of men reported improved job prospects as a result of participation, compared with 14% of women (see Figure 17). Factors such as cultural barriers women face in securing employment outside the home could help to explain this.
- In Jordan, 81% of female livelihoods beneficiaries took part in vocational training compared to 54% of male livelihoods beneficiaries. However, 81.8% of men reported improvements in their ability to meet the cost of basic needs, while 63.6% reported an increase in household income, and 36.4% reported improved job prospects. This compares to 28.6%, 26.2% and 11.9% of women across the same categories, respectively.

Overall, 13.4% of respondents reported an increase in household income as a result of MADAD livelihoods activities, and 9.8% reported that that it improved their ability to meet the cost of basic needs (see Figure 17).

Figure 17: Reported overall impact of programme livelihood activities on beneficiaries

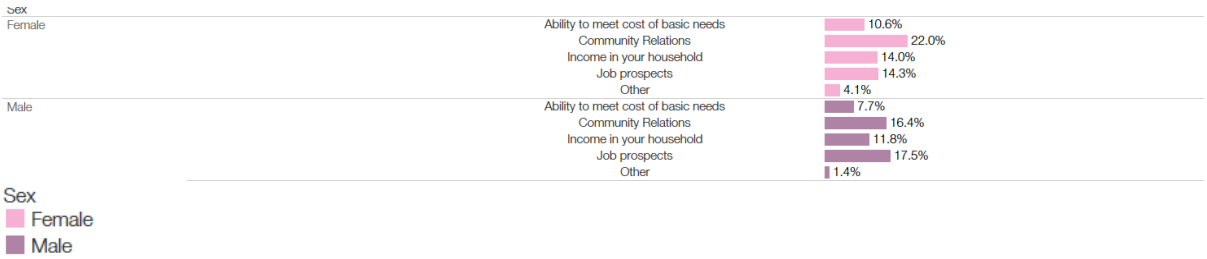
Question: Have livelihood activities or services provided by the RC/RC improved or increased any of the following?



In addition to economic and financial benefits, both men and women experienced an improvement in community relations as a result of their participation in livelihoods activities, with 22% of women and 16.4% of men reporting improved community relations (see Figure 18).

Figure 18: Reported impact of livelihoods activities, disaggregated by gender

Question: Have livelihood activities or services provided by the RC/RC improved or increased any of the following?



Comparison of participation and impact across nationalities

Overall, Syrian, Turkish and Iraqi beneficiaries appeared to be more likely to participate in livelihoods activities compared to Egyptian and Jordanian beneficiaries. According to Endline survey results, 54.5% of Turkish respondents participated in livelihoods activities, followed by 50.2% of Syrians and 50% of Iraqi respondents. By comparison, only 15.4% of Egyptian respondents and 8.7% of Jordanians reported participation (see Figure 19; the graph needs to be carefully read as some of the bars are unevenly displayed).

Figure 19: Participation in livelihoods activities disaggregated by nationality

Question: Have you taken part in any livelihood activities or training courses provided by the RC/RC?

As illustrated in Figure 20, the livelihood activity most respondents reportedly participated in was vocational training. There were notable variations across the other activities. For example, 20% of Syrian respondents reported participating in adult language courses, reflective mainly of Syrians in Turkey attending Turkish language classes, from beginner through to advanced levels. 0.9% of Egyptian respondents reported receiving business start-up cash grants or kits, reflective of the lack of budget allocation under MADAD for post-training support for livelihoods beneficiaries in Egypt. However, this figure was low for other nationalities too, with 4% of Iraqis reporting that they received business start-up cash grants or kits – this was the highest figure across all nationalities.

Figure 20: Participation in specific livelihood courses, disaggregated by nationality

Question: Which of the livelihood courses did you participate in?

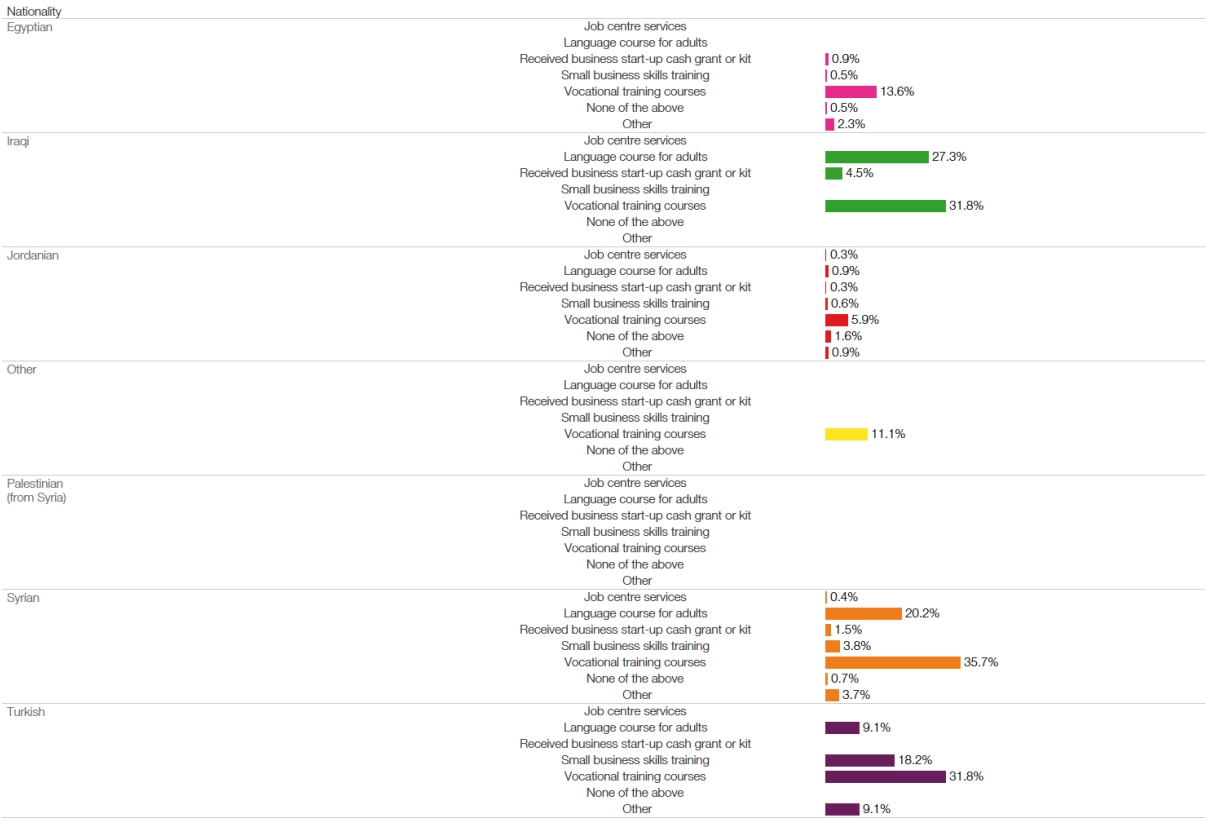
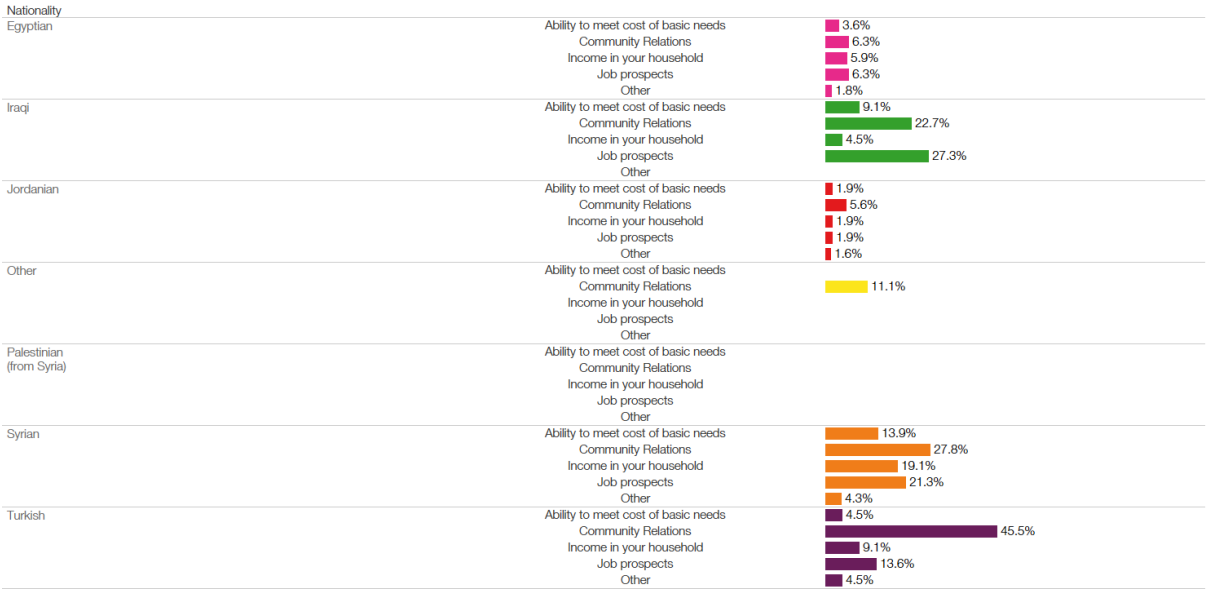


Figure 20 summarises the impact of livelihood activities on beneficiaries from different nationalities.

- **The biggest impact of livelihood activities on community relations was reported by Turkish respondents**: 45.5% reporting improved community relations as a result of participating in livelihoods activities, followed by Syrian respondents (27.8%) and Iraqi respondents (22.7%). Egyptian and Jordanian respondents reported less of an improvement in this area, at 6.3% and 5.6% respectively.
- **There were substantial variations across nationalities in increased job prospects as a result of participating in livelihoods participation**, ranging from 1.9% of Jordanian, to 21.3% of Syrians and 27.3% of Iraqi participants.
- **Syrian participants (13.9%) reported the biggest increase in the ability to meet the cost of basic needs** due to their participation in livelihoods activities, compares with 9.1% of Iraqis, 4.5% of Turkish, 3.6% of Egyptians, and 1.9% of Jordanians.

Figure 21: Impact of participation in livelihoods activities, disaggregated by nationality

Question: Have livelihood activities or services provided by the RC/RC improved or increased any of the following?



Country contexts influenced the impact of the livelihoods component of MADAD in terms of its approach and results, particularly the right of Syrians to work in the countries. In Egypt, for example, Syrians are mainly restricted to work in the informal sector. The livelihoods programme adapted to this and ensured availability of vocational training to provide skills needed for jobs in the informal labour market. In Turkey, TRCS provided work permit support as part of MADAD to allow Syrians to gain employment in both the formal and informal sector. In Jordan, more Jordanians who took part in livelihoods activities reported that participation had improved their job prospects – 21.4% of Jordanians compared with 11.9% of Syrians. This could suggest that while Syrians have benefitted from livelihoods activities, their employment opportunities within the Jordanian context remain limited.

Learning for livelihoods programming

A gap in livelihoods programming relates to the need for further support for beneficiaries after they have completed livelihood trainings. In Egypt, for example, there was no budget for post-training support. This meant there were no funds available to support entrepreneurs or beneficiaries after training, which was widely cited by both staff and beneficiaries as a major gap, as there was no seed capital available for small business start-ups, or for equipment needed for beneficiaries for income generation. For example, many female beneficiaries participated in hairdressing and sewing training, but there were no financial resources to provide them with hairdressing tools or a sewing machine and materials following the training. Both staff and beneficiaries reported that it would have been better to have fewer participants in livelihoods activities and training, but to increase spending per beneficiary to allow for seed capital/resources for post-training.

A further gap relates to output indicator 1, namely that vulnerable refugees and host community members would demonstrate "increased economic self-reliance" as a result of MADAD livelihoods activities. As outlined above, the monitoring process was not originally set up to capture whether participants of vocational trainings were subsequently able to secure employment or increase their income, and if they did, whether this was helped by the training they undertook. Attempts were made to address this but were limited by consistency and timing. As a result, it is difficult to demonstrate the extent to which livelihoods activities contributed to an increase in the ability of refugees and host community members to demonstrate increased economic self-reliance.

Social cohesion

There were mixed results on impact in relation to social cohesion and integration across the programme. In the beginning, there was no strategic approach to social cohesion and interaction between refugee, IDP and host communities, and there tended to be greater focus on the refugee communities. While improvements were noted by beneficiaries in relation to social cohesion and integration, these tended to be more at a superficial level, such as exchanging greetings or attending training sessions with different groups. Stakeholders are of the opinion that greater efforts could have been made to reach Syrians and to create joint activities to promote social cohesion.

Initially, social cohesion was a relatively new concept for many RC/RC partners and HNS staff and volunteers, but it is now much better understood and well embedded in programming, both as stand-alone components and as a cross-cutting element of other activities such as health and livelihoods. Over time, there was recognition that the whole community needed to be engaged if the programme was truly going to provide services of benefit to both refugee and host communities.

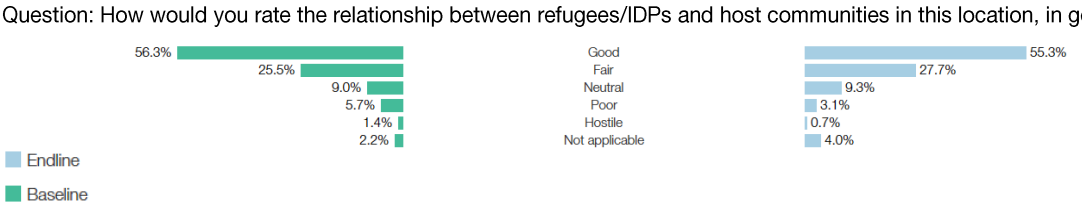
There were several positive examples of progress in relation to social cohesion, for example:

- Livelihoods training in Jordan promoted social cohesion by bringing together Jordanians and Syrians in the same trainings and increasing interaction between them
- In Jordan and Iraq, livelihoods activities provided a space for beneficiaries from different backgrounds to meet and get to know each other, and most participants reported an improvement in community relations resulting from participation in these activities.
- The restructuring of the Advisory Committees in community centres in Turkey led to improvements in both the approach to, and results of, social cohesion activities. The Committees were restructured to have 50% membership from each community, with women well represented, and advise and organise events to bring people together. By virtue of the make-up of the group, they work collaboratively together on key issues relevant for the local community as a whole.
- In Iraq, livelihoods activities were also reported by beneficiaries to have led to improved social relations between communities, particularly the refugee and host communities.

Social cohesion was likely affected by external factors in all five countries over the course of the programme, so it is difficult to determine the extent to which the programme contributed to social cohesion at a systemic level. Although there were variations between countries, baseline and Endline survey results indicate that relationship between refugees/IDPs and host communities remained largely positive, with most respondents describing it as 'good' or 'fair'. At baseline, 56.3% of respondents reported 'good' relationships between refugees/IDPs and host communities, and this declined slightly to 55.3% at the Endline. At the same time, the proportion of respondents who described the relationship as ''poor' decreased from 5.8% at the baseline, compared with 3% at Endline (see

Figure 22).

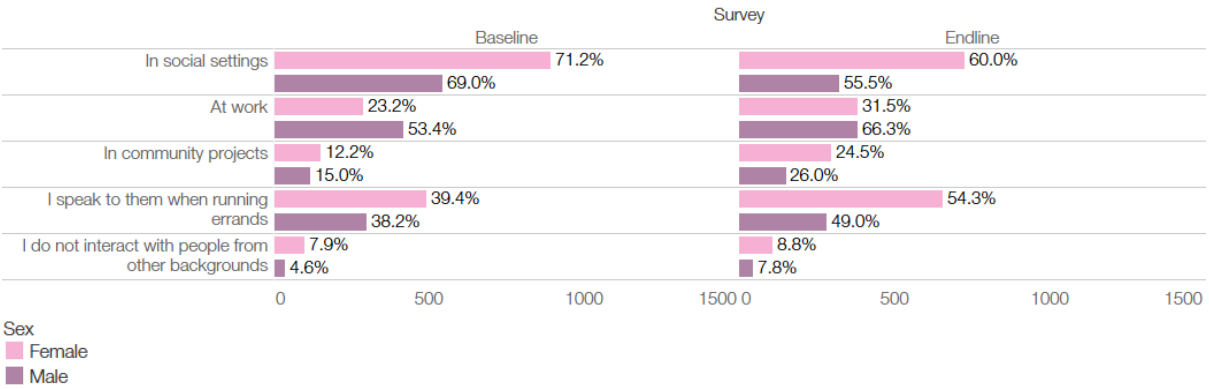
Figure 22: Baseline-Endline comparison of the relationship between refugees/IDPs and host communities



Women's and men's experience of social cohesion

The results of the Endline survey show that refugee and IDP men and women both had similar experiences in relation to social cohesion and integration (see Figure 23). Both men and women experienced an increase in engagement with members of host communities when running errands (for women, this increased from 39.4% at baseline to 54.3% at Endline; while for men it increased from 38.2% to 49%) and at work (for women, this increased from 23.2% at baseline to 31.5% at Endline; while for men it increased from 53.4% to 66.3%). At the same time, both women and men reported decreased interaction in social settings (for women, this decreased from 71.2% at baseline to 60% at Endline; while for men it decreased from 69% to 55.5%). There was also a marginal increase in the proportion of men and women who reported that they do not interact with people from other backgrounds (for women, this increased from 7.9% at the baseline to 8.8% at the Endline; while for men it increased from 4.6% and 7.8%).

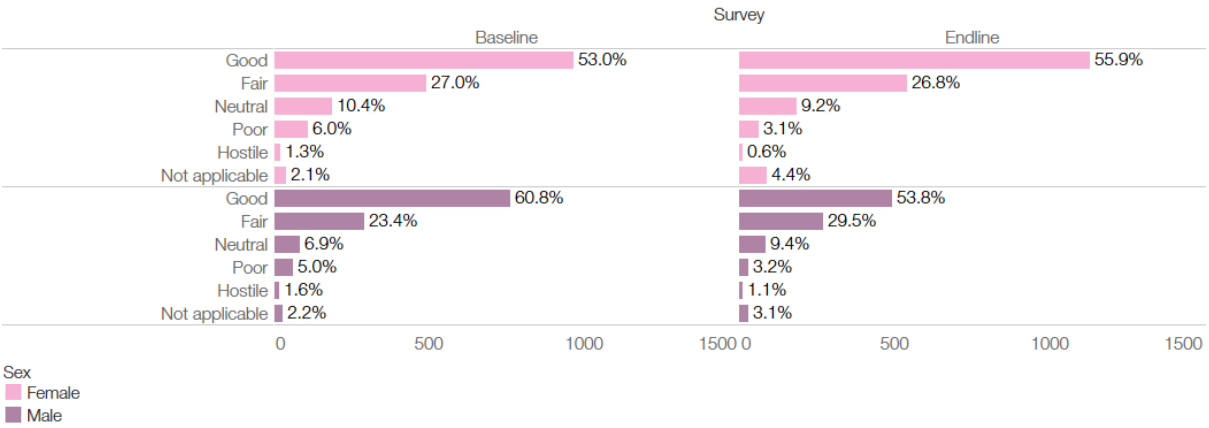
Figure 23: Baseline-*Endline* comparison of interaction between refugees/IDPs and host community members, disaggregated by sex



At both baseline and Endline, the majority of men and women described the relationship between refugees/IDPS and host communities as 'good' or 'fair'. However, men appear to believe these relationships deteriorated over time, while women appear to believe that they improved (see

Figure 24). At baseline, 60.8% of men reported 'good' relationships between the communities, and this decreased to 53.8% at Endline. At baseline 53% of women reported 'good' relationships, and this increased slightly to 55.9% at Endline. The proportion of both men and women who described the relationships as 'hostile' remained small, and decreased over time. At baseline, 1.3% of women and 1.6% of men described relationships as hostile, and this decreased to 0.6% and 1.1%, respectively, at Endline.

Figure 24: Baseline-Endline comparison of relationships between refugees/IDPs and host communities, disaggregated by sex



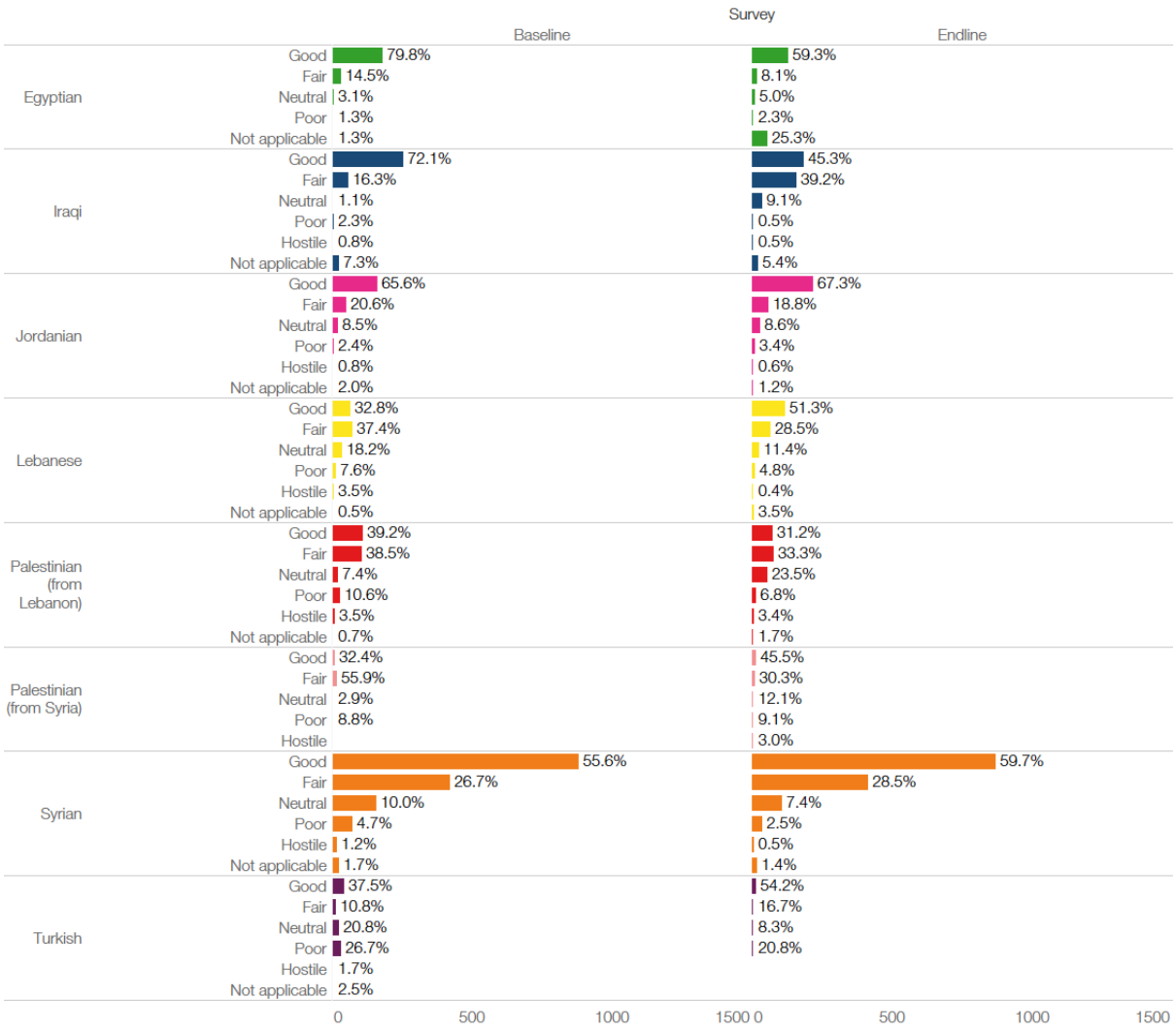
Impact on social cohesion according to nationality

At both baseline and Endline, the majority of respondents from all nationalities reported favourably on relationships between host communities and refugees, describing it as 'good' or 'fair'. However, the opinions on the programme's impact on social cohesion varied between people from different nationalities (see

Figure 25):

- The strongest improvements in relationships between host communities and refugees is amongst Turkish and Lebanese respondents. Turkish respondents reporting 'good' relationships between refugee and host communities increased from 37.5% at the baseline to 54.2% at the Endline, while for Lebanese respondents it increased from 32.8% at baseline to 51.3% at Endline.
- For the majority of Jordanians, relationships between refugee and host communities remained 'good' throughout. The proportion of Jordanians who described these relationships as 'good' also increased marginally from 65.6% at baseline, to 67.3% at Endline.
- Palestinians from Syria reported improved relationships, whereas Palestinians from Lebanon reported deteriorating relationships over time. At baseline, 32.4% of Palestinians from Syria and 39.2% Palestinians from Lebanon reported 'good' relationships, For the former, this increased to 45.5% at Endline, while for the latter it decreased to 31.2%.
- Egyptians and Iraqis reported a deterioration of relationships between host communities and refugees over the period of the programme. At baseline, 79.8% of Egyptians and 72.1% of Iraqis described these relationships as 'good', compared to 59.3% and 45.3%, respectively, at Endline.

Figure 25: Baseline-Endline comparison of relationships between refugees/IDPs and host communities, disaggregated by nationality



For countries where social cohesion was not an explicit programme component, there was little evidence of any unintended improvements. For example, in Egypt survey results showed that there was less interaction between Syrian refugees and members of the host community at the end of the programme compared to the beginning, with a decrease in interactions in social settings, at work, in community projects and when running errands.

Coherence

Overall, the complexity of the MADAD programme and the size of the consortium limited the internal coherence that was achieved at a regional level. Regular meetings between country leads and annual meeting between all MADAD partners did allow some space for sharing lessons and building relations, but joint learning and cooperation was otherwise limited by time and funding constraints. This limited stakeholders' awareness of different approaches to activities being taken in different contexts, which hindered opportunities to strengthen internal coherence. In addition, the widely differing operating contexts in each country and the decision not to assign a single implementing partner to all health or livelihoods activities across the region limited the opportunity to achieve a more coherent approach.

However, **external coherence was strong.** The MADAD partners engaged with other national stakeholders including government partners, UN agencies, I/NGOs and local NGOs through a range of coordination mechanisms to develop coherent approaches that avoided overlap and duplication in programming. There were opportunities where this could have been strengthened to achieve additional synergies, but overall external coherence was a strongpoint of the MADAD programme.

Strategic and operational internal coherence

Strategic internal coherence was ensured to an extent through strong regional leadership on the part of DRC, coordination meetings between country leads and annual meetings attended by all MADAD partners. The interviews highlighted that DRC provided clarity on the roles and responsibilities of the various partners in the consortium. In each country consortium, one of the RC/RC partners would take on the role of appointed country lead which would act as the regional focal point. The country leads attended regular regional coordination meetings during which DRC would give updates, pass on communications from donors and each country lead would update on implementation progress, budget spending and challenges faced in the country context. These coordination meetings represented an opportunity to discuss activities, share learning and generate more coherent approaches at a strategic level.

In addition, the **annual meetings between all MADAD partners acted as an opportunity to provide updates on challenges and lessons learned between the implementing partners in the five countries.** According to key informants, the communications and meetings allowed the implementing partners to build relations and networks across the region, and interview data substantiate that knowledge and lesson sharing between partners took place, particularly around technical implementation and challenges, for example NorCross invited ERCS staff to co-present training sessions on CBHFA in Iraq.

Interviews also highlighted that **the regional approach contributed to learning and capacity building in the RC/RC movement, particularly at the HNS level, allowing the organisations to develop more coherent approaches.** Key informants indicated that MADAD partners were now working towards more similar goals and were using similar tools and standards. For example, livelihoods tools developed in Iraq were shared with MADAD partners for use in other contexts. Other processes such as the collection of baseline data were also standardised across the countries.

However, there was also a sentiment that **the focus of cooperation and communications between consortium partners at the regional level was on reporting rather than on integrating programming.** Key informants noted that, at the regional level, linkages between RC/RC partners could have been more robust, and that there was a need for more learning opportunities between the countries to achieve greater levels of coherence. In particular, the KIIs highlighted that there was a missed opportunity to support beneficiaries in their movements between countries because service provision between the different MADAD countries was not coordinated.

Challenges of a regional approach

There were a number of challenges experienced by the MADAD partners related to the regional approach. This included **difficulties in adapting the programmes to specific country contexts and contextual changes, difficulties in establishing linkages between the country programmes, as well as complex negotiation and communication processes due to the size of the regional consortium.** In terms of the difficulties in adapting MADAD programming to specific country activities, the partners highlighted that the complexity of the programme structure, contracting restrictions and inflexibilities in the allocation of funding limited the adaptations that could be made according to shifting contexts. For example, implementing partners in Jordan noted that it was not possible to move funding allocations

between countries due to donor regulations, despite shifting circumstances. This supports the challenge highlighted by operational staff in Jordan that they did not have the budget flexibility to respond to emerging needs in the country.

In addition, it was **difficult for partners to produce comparable M&E data due to the different implementation contexts.** For example, key informants highlighted that PSS responses in each country were very different, making it difficult to draw the activities and results together at a regional level and subsequently watering down the value of the M&E data. This was also true of the regional baseline data collection exercise, which stakeholders believed had lost some of the nuances at country level and was not coordinated in a fully regional manner.

MADAD partners also highlighted that **it was difficult to build awareness of activities and coordination in programming at the regional level due to the time and resources required to do so.** The demands already placed on them by implementation limited the resources available for coordination, leading to a series of parallel programmes, both at regional and at country level. The links between country programmes were never fully established (e.g. the regional technical working groups did not come to fruition) and the activities implemented under the outcomes varied widely. This coordination process was further impeded by complex negotiation and communication processes caused by the large number of partners in the consortium with widely differing organisational cultures and overall goals for the programme.

The evidence also highlights that there was a **lack of clarity regarding communication and decision-making.** KIIs highlighted that there were some cases in which country partners felt it would have been beneficial to communicate directly with the EU regarding contracting issues and spending regulations. Although **the decision-making hierarchy was clearer towards the end of the programme with DRC taking a more central role**, during the programme the MADAD partners often lacked clarity on decision-making responsibilities. For example, it was not clear whether some decisions regarding programming in Turkey were to be taken by the MENA office or the HQ offices. Stakeholders also reported that **the programme duration was not sufficient to fully standardise approaches and processes across the region.**

External coherence

Engagement and coordination with national authorities in the five countries appeared robust and there was a good level of awareness of activities being carried out by other agencies. However, despite extensive use of existing coordination mechanisms, synergies were not sufficiently realised, while further efforts to establish coordination mechanisms where they were absent could have strengthened external coherence.

In terms of engagement and coordination with local authorities, the documented evidence and interviews highlight this as a strongpoint across the programme. There were evident efforts to understand and adapt to national policies to enable a coordinated and coherent approach with ongoing government activities. For example:

- For the livelihoods activities in Iraq, FRC and IRCS worked with the national vocational training centre and the Ministry of Labour and Social Affairs to provide official oversight and certification for the training participants.
- In Turkey, the TRCS worked closely with the Ministry of Family, Labour and Social Services
- The JRCS used its capital with the national government to allow for smooth implementation.
- In Lebanon, state authorities were involved in communications and CBHFA activities.

- In Egypt, the ERCS's strong relationship with the Egyptian authorities facilitated coordination with the Ministries of Social Solidarity, Internal Affairs and Health to secure approval for the mobile healthcare clinic as per the country's regulations.

Across the five countries, communication with other agencies including UN agencies, local NGOs and I/NGOs generated awareness of other ongoing activities and helped to avoid duplication and overlap. For example, in Iraq the implementing partners attended coordination meetings with UN and other camp partners, and contacted other local NGOs to provide specialised support; steering committees were set up as coordination mechanisms in Jordan and the TRCS tracked other agencies' activities in a central spreadsheet; and in Lebanon the MADAD partners made referrals to other agency programmes when appropriate.

However, stakeholders in Jordan, Turkey, Lebanon and at regional level believed that external coordination in-country could have been stronger. Use of existing coordination mechanisms was apparent, but where there were no pre-existing mechanisms there is no evidence that MADAD partners developed new mechanisms to fill the gaps in coordination. Documented evidence from Jordan and Lebanon also highlighted that synergies with other organisations were not realised, even where coordination mechanisms were in place to avoid duplication. The documents and interviews also highlight that there was little consideration of joint programming or activities with stakeholders outside of MADAD.

Sustainability

Overall, the sustainability of programme benefits appears to be a concern. The five MADAD countries have been developing transition plans to ensure sustainability but in the context of the ongoing COVID-19 pandemic, the sustainability of benefits produced by the programme are under threat. In both Iraq and Turkey, interview data highlighted concerns that exit strategies have not been put in place, despite the situation in the countries not markedly improving. In Jordan, at the time of interviewing, plans were being developed to continue activities but had not yet been implemented. In Lebanon, the LRC were indicated as having developed a sustainability plan. Therefore, despite some evidence that there was transition planning taking place, the data suggests that the planning for sustainability was severely hampered by the COVID-19 pandemic.

There is a certain level of sustainability guaranteed due to the infrastructure and skills that were developed in the host countries, as well as the equipment and tools provided that will continue to serve the countries and the HNS. MADAD addressed several immediate structural issues, including buying equipment, building capacity and securing accreditation for staff. However, concerns were expressed about the duration of the project arguing that IDPs and refugees in the camps needed longer-term support, including first aid, awareness, and capacity building, especially in the context of the COVID-19 pandemic. Key informants also reported that beneficiaries have developed a certain level of reliance on the services provided under MADAD. With little in place following the close of the programme, the needs of the beneficiaries are unlikely to be met. This is likely to be exacerbated by the growing numbers of beneficiaries in the service areas due to the ongoing and often worsening social, political and health issues in the region.

In terms of financial sustainability, MADAD partners are working to secure continued funding and resources in several countries. For example, in Egypt, the ERCS has secured further EU funds to continue medical service provision with the support of the Swiss RC. In Turkey, the TRCS are attempting to secure government buildings rather than rented buildings to continue services at a reduced cost and have been encouraged to seek additional non-EU funding. In

addition, the community centres in Turkey were planned as shared premises with UNICEF, GRC and WB, increasing the likelihood that the centres will continue to serve the communities. However, stakeholders expressed concerns that there is a general reliance on external funding and that neither the HNS' nor the host national governments have the funds to provide continued programme support. Therefore, there are uncertainties around the continuation of the programmes. In Turkey for example, the TRCS are contemplating scaling down the services due to reduced funding.

Health interventions

The sustainability of health outcomes will be ensured to some extent due to the investments in infrastructure and resources made available under the MADAD programme that will remain in country. For example, the ambulances procured in Iraq now belong to the Ministry of Health and other medical equipment such as incinerators remains at the disposal of the medical centres. In Lebanon, the evidence highlighted that the LRC has gained the capacity and resources to deliver emergency medical and blood transfusion services and are in dialogue with the Ministry of Health to expand funding for these components.[11]

In addition, **a strong focus of health activities implemented under MADAD was on working with and improving the capacity of communities so that capacity remains in place following the close of the programme.** For example, the Community Emergency First Response Teams (CERTs) trained under MADAD consisted of community volunteers to ensure that the skills would remain in the communities following the close of the programme. In Lebanon, a beneficiary commented that "*Ain Al Helwe camp is well-prepared to deal with risks and hazards as a big number of the camp's population participated in first aid and first response trainings*". However, the skills developed will need updating and although the skills may remain useful, many of the positions created under the programme will lose funding following the close of the programme. The evidence also highlighted the need for continued, regular trainings as well as the continued provision of medical equipment to ensure the sustainability of health activities in the region.

The evidence highlighted that MADAD health activities have had wide reach and have been successful in developing beneficiary awareness on a range of health-related issues. Figure 14 shows that proportionally fewer survey respondents at Endline viewed availability of information and knowledge of where and how to access health services as barriers to accessing healthcare, compared to the baseline. The improved dissemination of information on health-related topics included some innovative approaches such as the development of a website for blood donor management in Lebanon. This improved awareness and tools such as the website will remain of use in the communities whilst they remain relevant.

Securing continued funding was identified as a key element in the sustainability of health outcomes, and some partners have succeeded in securing funding to continue programme initiatives. Examples of funding being secured for health activities implemented under MADAD include plans to continue CBHFA activities with other funding streams in Jordan, and the PSS work in Lebanon being integrated into non-MADAD funding streams. Some efforts to continue activities through partnership with other agencies and governments are also underway. An area of best practice is in Lebanon where the emergency medical

[11] Please note that due to the economic and financial situation in Lebanon, funding from the Ministry of Health is no longer accessible. This development took place after the evaluation data collection phase.

services team have secured funding under MADAD II to continue the service and are working with the Ministry of Health to plug any remaining gaps in the budget.[12] In addition, the BTS have ensured a steady blood supply and a trained team following MADAD work with Lebanon Blood Transfusion Service, as well as the development of a blood donor database.

Unfortunately, COVID-19 is likely to impact the sustainability of the health benefits produced by the programme significantly. Stakeholders interviewed did remark that there is a possibility that the health crises will draw more funding for health-related activities, but many of the positive health outcomes produced in the region are under threat due to increasing difficulties in accessing health services. For example, in Jordan, the HNS are actively discussing how the COVID-19 response started under MADAD can be maintained in partnership with other organisations. However, the majority of beneficiaries and external stakeholders identified the continued and intensifying need for the provision of medical services in general, and especially awareness and hygiene services in relation to COVID.

Income generation

The sustainability of income-generation outcomes appears to be mixed. Improved knowledge, skills (technical and customer service skills amongst others) and self-confidence gained through trainings and RC/RC services will remain and serve beneficiaries seeking employment and income-generating activities in the long-term. In Jordan, key informants reported that the service providers of livelihoods training have also developed capacity which will continue to serve the communities. Entrepreneurial skills that participants have gained following trainings will allow for some level of long-term adaptability to shifting economic situations. However, the duration of the project limited ongoing support that could be provided to newly established businesses in a crucial period for their preservation. An area of best practice is in Iraq, where the HNS coordinated with the government to ensure that certificates received by beneficiaries following livelihoods training were officially certified and would be useful long-term when seeking employment opportunities.

However, the outcomes were limited in scale due to the limited reach of the livelihood activities. Stakeholders believe it would be possible to scale up the approaches, but additional funding will be required for this. The general lack of job opportunities and high rates of unemployment across the region, which have been exacerbated by the COVID-19 pandemic, also limits the sustainability of livelihood outcomes. Beneficiaries and RC/RC staff and volunteers interviewed indicated that businesses have closed, and employment has been lost as a result of the pandemic. Both staff and beneficiaries emphasised that continued financial support is needed to sustain income generating outcomes.

Social cohesion

The sustainability of the programme's social cohesion outcomes appears to be supported by several factors. Across the five countries, the MADAD activities brought together volunteers from different backgrounds helping to ease tensions and overcome misconceptions, improving social cohesion. Beneficiaries reported being more understanding and accepting of people from other communities. It is not certain that these benefits will endure, especially in uncertain and challenging economic times. However, increased awareness and knowledge of different customs and values between communities bode well for behaviour change.

[12] As above, please note that due to the economic and financial situation in Lebanon, funding from the Ministry of Health is no longer accessible. This development took place after the evaluation data collection phase.

In relation to the community development projects (CDPs) implemented in Lebanon and Jordan, interview and FGD data show that a certain level of community ownership and empowerment had been built. In addition, the communities had acquired lasting skills in risk identification and reduction. In Jordan, the HNS in charge of community projects has signed Memorandums of Understanding (MoUs) with the municipalities to confirm they will fund and maintain them after MADAD ends, and in Lebanon the LRC ensured that all elements of the DRR programme were absorbed into new grants. However, stakeholders indicated that more equipment, specialist knowledge and funding are needed to continue CDPs long-term.

HNS capacities

Sustainability was explicitly integrated into the MADAD programme through Outcome 3, aimed at improving the organisational and institutional capacity of the RC/RC Host National Societies of the five countries. The capacity building approach and sustainability planning intended to train and upskill community volunteers and the HNS, so that these capacities would remain in country following the close of the MADAD programme. According to the MADAD dashboard, 3,908 staff and volunteers had been trained in psychosocial interventions, livelihoods, conflict resolution, mediation skills and volunteer management, with 89% of trained staff and volunteers demonstrating adequate levels of knowledge and/or skills after the training.[13]

Both RC/RC staff and volunteers reported that community volunteers and HNS staff had become central to the success and sustainability of the programme due to the strong links they had built with the community, the investments they had made in building capacity, the thematic and technical skills they had gained, and their ability to identify community needs and communicate these back to the HNS. For example, in Iraq and Jordan, first responders have remained in the camps, where they will continue their work and have even been passing on their skills to other community members. Key informants from the LRC reported that knowledge has remained embedded in the community through initiatives such as the PSS support groups that can now operate without a facilitator or social worker present.

In terms of institutional sustainability, the HNS' were pushed to professionalise to comply with the MADAD regulations, producing lasting institutional changes. For example, the ERCS improved their HR structures, publishing official salary bands as well as separating their procurement and financial divisions, leading to better alignment with other RC/RC organisations. Stakeholders in the LRC stated that the culture of the organisation had shifted due to the MADAD programme, including better coordination between departments, improved volunteer management and improved training processes. The PRCS had also reportedly improved their procurement function due to the financial training received under MADAD. The long-term effects are already visible in some countries such as in Lebanon where the LRC have been able to secure a contract with the EU for MADAD II due in part to their increased capacity to manage and comply with EU standards.

The linkages, relationships and networks between the RC/RC partners developed through the regional communications and meetings may also last given the right conditions and continued joint work. Stakeholders in Jordan and Lebanon reported that the HNS' enjoyed increased visibility and trust in the communities in which they work, and that links have been built with both local organisations. Training materials developed under MADAD have been translated into Arabic and Kurdish and are now available to the HNS', where it can serve to improve organisational capacity long-term. However, there were some

[13] MADAD Dashboard (29 October 2020). Figures not verifiable.

concerns that there had not been enough follow up on capacity building activities given the time constraints of the project. More support was needed before HNS staff and volunteers felt confident enough in their skills to pass them on to others. There were also uncertainties expressed by stakeholders as to whether the HNS' had enough capacity to continue with the programmatic work following the withdrawal of MADAD funding and support.

Learning and recommendations

The MADAD programme represented a significant learning curve for RC/RC as a movement. The programme as a whole has had many successes, illustrated throughout this report and the country annexes. The regional programme worked with fifteen partners across five implementation contexts, each presenting their own unique challenges and specific beneficiary needs. As a result, the MADAD programme presents a rich learning opportunity for the RC/RC movement, especially in relation to future large-scale multi-country programmes.

The sections below present **key learnings and recommendations** for improvement across three key areas: **programming design, management, and implementation; incorporating learning;** and **promoting sustainability.**

In addition, the programme has had many successes with each HNS demonstrating strong initiative, responsiveness to beneficiaries and approaches to localisation. Consequently, **examples of best practice** across the programme are highlighted below, in relation to the learnings and recommendations provided.

Designing, Managing and Implementing Large-Scale Programmes

The large-scale regional programme, bringing together multiple national partners, host national societies and IFRC, was a new approach for RC/RC. There several key successes of this approach, discussed elsewhere in this report, including the effects the programme has had on the RC/RC movement's coherence and willingness to cooperate across national boundaries. It was also an achievement for DRC, particularly given that it was the first time the organisation had managed such a complex, large-scale, multi-partner, and high value programme. Given the novel approach, this programme offers key lessons and possible areas for improvement for the RC/RC movement in designing, managing, and implementing complex, multi-stakeholder programmes.

Conclusion 1

Stakeholders at all levels of the programme appreciated the value add of a regional programme in uniting the RC/RC movement and improving coherence. Although there could have been greater opportunities for joint learning and programming, there was clear value in how different RC/RC partners worked together to deliver a complex programme, bringing specific technical expertise from across the movement. However, this value did not necessarily translate into implementation and flexibility in responding to needs at a national level as the five country contexts covered by the programme were extremely diverse. The experience, and consequently the needs of beneficiaries, was also not uniform across all five countries. This stems from a range of factors including but not limited to: the extent refugees are integrated in their host societies; access to labour markets and healthcare; the number of refugees as the proportion of the country's population and the subsequent strain this places on infrastructure; and whether refugees are confined to camp settings or live amongst their host community. Thus, while the activity themes that the programme addressed in each country were similar the way support needed to be tailored differed.

The alignment of the programme at the regional level at times limited the ability of each national consortium to address challenges and trainings in their own context. Additionally, in-country stakeholders – in particular RC/RC national partner programme staff and HNS staff – were not well engaged at the regional level. Their experience was that of implementing five separate national programmes with the regional structure simultaneously constraining how adaptively they could work in their local context. There were some opportunities for joint learning at the regional level including the annual MADAD meetings but there was potential for improved knowledge exchange between the national partners such as the implementation of regional technical working groups.

Recommendation 1.1

Programming should be driven by national context and national programme components should have the flexibility to adapt their activities according to evolving country needs. To a large extent this was achieved by the programme but there is value in taking a multi-country rather than a regional approach as this allows for greater flexibility in tailoring activities to local needs.

Recommendation 1.2

There is added value in regional cooperation in regard to learning and the sharing of best practice, particularly where partners are addressing similar themes albeit with specific local needs. Opportunities for knowledge exchange at a regional level should be maintained, with opportunities for programme-level staff in national partners and HNS, as opposed to only management staff, to come together to learn and reflect. This would ensure that the benefits of regional coherence filter through to all partner levels.

Conclusion 2

The central management of budgets and strict adherence to EU standards, particularly on financial management and reporting, has been a success. This supported delivery of a complex programme across a range of contexts and allowed smoother coordination of fifteen partners. However, the contract and partnership structure was complex, undermining national components' flexibility to adapt their programmes according to changing contexts. Additionally, some programme components underwent significant change. For example, the change of programme partners in Jordan necessitated a change in activities. This was undermined by a lack of flexibility in the programme structure with budget lines and activity specifications largely locked-in at the design stage. There was limited scope to review and change these in line with evolving needs and partner expertise. This finding is strongly related to the programme's different experiences of delivery by RC/RC national partners and delivery by IFRC. These organisations differ in structure and a one size fits all model is difficult to apply. It is important to find a balance between managing the programme efficiently from the centre and ensuring that standards are consistently applied whilst also not impeding timely implementation and adaptation.

Recommendation 2.1

Centralised reporting and financial management are required to implement such a large project with numerous partners. However, in regard to programme activities and adaptations, structures should allow greater flexibility to enable programme responsiveness at a national level. Crucially changes to the programme at country level should be agreed bilaterally and not contingent on agreement of the regional consortium.

Recommendation 2.2

Working with a range of partners with different processes is challenging and the strict, consistent management has been a success. However, given the difficulties of incorporating IFRC into this framework it is important to plan for their inclusion and potential challenges related to this. This should be worked out ahead of implementation, or a contingency plan should be designed into the programme in case of a sudden pivot between RC/RC national partners and IFRC as was experienced in Jordan. This is essential to ensure that programme implementation is not impacted by challenges in design.

Conclusion 3

Regular needs assessments and the systematic review of data for course correction are essential to responsive activity design. The programme had a strong start, with beneficiary needs being identified through the baseline assessment, collaborative activity design with communities through use of Vulnerability and Capacity Assessment (VCA) tools, and the use of labour market assessments to inform livelihoods activities. This could be further strengthened through increasing the frequency of needs assessments throughout the programme and ensuring activities respond to emerging needs. This is particularly pertinent to livelihoods activities since labour market needs could change rapidly during the programme, as was the case in Jordan. In Turkey there was also the requirement for strong needs assessment to inform programme design whilst in Iraq, initial needs assessments were supplemented with regular monitoring and surveys tracking implementation, gaps and beneficiary satisfaction with the services provided. In several contexts and activities, particularly Lebanon and Jordan, there was unequal engagement of refugee and host communities. Timely establishment of the programme dashboard, which was implemented in 2019, would have enabled course correction earlier in the programme.

Recommendation 3.1

Ensure that needs assessments are conducted regularly using appropriate assessment tools, and that key findings are incorporated in the adjustment of programme activities.

Recommendation 3.2

Ensure that key findings are incorporated in the adjustment of programme activities. Identify the key learnings and put in place plans for how they can be included.

Recommendation 3.3

At a regional management level, data should be systematically reviewed to ensure that refugee and host community populations in each country remain appropriately engaged in line with the results framework. Establish a clear programme monitoring dashboard early in the programme to understand progress in each national context.

Best Practice Example: Adaptation of Livelihoods Activities in Iraq

Initially, livelihoods activities in Iraq were focused on trainings in a range of areas such as tailoring and baking, designed to provide beneficiaries with appropriate employment skills according to the demands of the labour market. However, the activities were adapted to provide continued support that enabled beneficiaries to establish their own businesses. The unspent budget for livelihoods trainings was reallocated to provide business start-up grants and kits to beneficiaries that had achieved strong results in the trainings and that had the greatest identified needs.

This support enabled beneficiaries to start a variety of small enterprises including bakeries, hair salons, tailors, and phone maintenance businesses. A survey, conducted by the FRC and IRCS in July 2020, to track the businesses that were set up following the livelihoods activities found that 86% of businesses were still functioning and on average were generating a monthly income of 180,950 Iraq Dinars.[14] Therefore, by narrowing the range of livelihoods activities provided through the programme and instead focusing on funding sustained and targeted livelihoods support, the

[14] Business Support Grants PDM (July 2020). 95 out of 110 of respondents.

MADAD partners in Iraq were able to support beneficiaries to start their own businesses and generate their own income rather than just improving skills.

Best Practice Example: PRCS's adaptation to COVID-19 Response in Lebanon

The changes made to the PRCS health activities in response to the COVID-19 pandemic is one of the major successes of the health component in Lebanon. PRCS showed agility and flexibility in pivoting their health activities to meet the emerging needs of beneficiaries in camps. They provided a cohesive and comprehensive response showing clever use of existing funds and approaches for reaching beneficiaries. Activities were tailored to meet the specific needs of different beneficiaries such as distributing equipment to whole camps, providing awareness raising sessions and providing specific support to vulnerable beneficiaries at home. PRCS beneficiaries had a clear understanding of COVID-19 related support on offer and reported high levels of trust in PRCS during this time.

Conclusion 4

Ensuring a fit-for-purpose results framework that reflects clear linkages between activities, outcomes and impact is essential. The aim of the programme at impact level was social cohesion. However, the activities related to social cohesion in each context were not fully aligned with this. Activities in several contexts, particularly micro projects and DRR in Jordan and Lebanon, have not engaged across communities. They have hosted consultations that are either for Syrian or host communities and have provided services for either Syrian refugees or the host communities. There has not been significant mixing of communities in these activities. Some HNS' did not recognise social cohesion as central to their programme. While it is acknowledged that this was a design decision and has promoted strong localisation, this has undermined the programme's ability to achieve impact as per the results framework.

Recommendation 4.1

It is important to ensure that the results framework is realistic and that outcomes, outputs and activities are aligned. If the overall ambition is to achieve social cohesion, there should be a clear understanding of how programme activities feed into outputs and outcomes to achieve this. It is also important to recognise that a goal such as social cohesion is difficult to achieve with relatively grassroots activities and over a relatively short period and is equally challenging to measure. However, if the programme continues to strive for outcomes such as social cohesion it is important that activities are clearly aligned with outcomes and impact. RC/RC should also ensure that all programme partners understand and are committed to the outcomes and impact towards which they are working, so that this is considered when designing and implementing activities. In this instance activities should always focus on bringing different communities together as opposed to running separate activities.

Conclusion 5

At both regional and national consortium levels, there is a need for early and clear identification of roles and responsibilities. Over the course of the programme, partners at management level have drawn lessons about how to structure and communicate roles and responsibilities across the consortium. This report highlighted examples of good practice in this regard.

At the regional management level, it was essential to clarify roles and responsibilities as the programme progressed, particularly regarding the decision-making hierarchy between HQ and the MENA regional office. There have been a few challenges at the national level in coordinating between national partners and the HNS. This was particularly the case in Lebanon, which had a complex programme set up with multiple RC/RC national partners and parallel programmes with two HNS'. In Lebanon there was a lack of national coordination meetings and a lack of awareness between partners of the work others are doing under MADAD, as well as differing expectations of roles in monitoring and reporting to DRC. This was further complicated by high turnover of programme staff which meant that understanding of programme operations and consortium dynamics at both the national and regional level were difficult to institutionalise. In contrast, in Iraq the four RC/RC partners were all represented in a steering committee, as well as in working groups and regular meetings with both internal and external partners, which led to strong communications between the societies and with other organisations working in the country.

Recommendation 5.1

At both the regional level and the national level, where the consortium structure is complex, establish clear role definitions early in the process, with clear responsibilities in contribution to both programme management and reporting. Ensure that decision-making responsibilities and chains of command are clearly understood by both programme partners and the donor. A clear and standardised handover process should be established for programme staff to maintain clarity on responsibilities and expectations across the consortium.

Conclusion 6

Most country programmes experienced significant delays at the start of the programme. It is recognised that some of these are due to circumstances beyond the control of the programme such as long negotiations with the EU and, in the case of Jordan, changes in programme partners which necessitated adaption of activities. However, the initial delays in funding significantly delayed implementation of programme activities, leading to a considerably shorter time period in which to achieve the results targets. In addition, in several instances such as in Egypt, Iraq, and Turkey, start-up efficiencies could have been improved by having staff in post, equipment procured, and needs assessments carried out before the programme began. For example, in Iraq the delay in the delivery of the labour market assessment and the selection and refurbishment of the vocational training centres caused the livelihoods activities to start 16 months behind schedule, limiting the time available to provide continued support to newly established businesses.

Recommendation 6.1

Ensure that staff are recruited and trained before the programme begins and there is a clear understanding of roles and responsibilities. Initial needs assessments should be carried out during the programme design phase. The design phase should also be utilised to identify where procurement is likely to be time consuming and plan accordingly, ensuring that these processes are underway before the programme is due to begin implementation.

Incorporating Learning

The programme has made adaptions in response to both internal and external reviews and monitoring exercises. This was essential to ensure that the programme remained relevant to the needs of beneficiaries over time and that there was a clear understanding across the consortium of the experience on the ground and willingness and capacity for course correction. There are key lessons to be drawn on systematising learning processes and incorporation of their findings.

Conclusion 7

The programme has been largely successful in adopting learning and recommendations from reviews and monitoring exercises, including the MTR and the ROM. Most country programmes showed willingness and ability to adapt and support course correction following reviews or were already showing understanding of programme changes that were required. For example, monitoring tools and data were used to inform adaptations to programme activities. Improvements could be implemented to ensure that learning is understood and can be systematically adopted by all partners, mainly relating to the capacity and resources required to respond to change and learning. For example, in Egypt there was a clear need for budget allocation for monitoring activities.

Recommendation 7.1

Ensure systematisation of monitoring to provide high-quality data and ensure there is capacity at all levels to analyse and reflect on data. This may require strategic investment. If there are capacity gaps ensure that staff are adequately upskilled in this area and resources are allocated for this purpose; as referenced above, this was particularly required in Egypt. There should be a shared understanding of the value of monitoring to allow for early course correction, and dedicated time for staff to commit to this.

Recommendation 7.2

Where monitoring exercises are internal, train staff and implement a consistent approach and set of tools for reviewing data across all programme components. With programme partners, establish a shared understanding of decision-making processes around how data is used. This should be strengthened to ensure the data collected is routinely assessed and discussed.

Recommendation 7.3

Ensure that budget is allocated for adaptions to enable the implementation of learnings. This, in turn, could support willingness of staff to dedicate time to collecting and reviewing high-quality data.

Best Practice Example: Use of Monitoring Tools and Regular Needs Assessments in Iraq

KOBO Toolbox was successfully used to monitor health activities in Iraq. The tool allowed for daily monitoring of health activities, with the data aggregated at the country level and used to inform implementation and adaptation of health activities. Reports generated using the software enabled the sharing of information amongst staff and partners, helping to inform decision making regarding programming. In addition, regular camp visits were implemented to continuously monitor beneficiary needs and programming gaps whilst post-service surveys were also administered to track beneficiary satisfaction with the health services provided.

Conclusion 8

Weight should be given to internal monitoring and review processes, as these add value and allow for reaction in real time rather than delayed reaction following external review processes. Feedback from beneficiaries should be incorporated on a regular basis to ensure that activities remain responsive to their needs. Overall, the programme has done this well with several HNS' demonstrating how they collect feedback from beneficiaries on activities and use this to make improvements and ensure relevance.

Recommendation 8.1

Continue to seek beneficiaries' real time feedback on services out with large or external review and learning processes. Ensure that budget is allocated for adaptions to enable the implementation of learnings. This, in turn, could support willingness of staff to dedicate time to collecting and reviewing high-quality data.

Best Practice Example: Adaption to beneficiaries' health needs in Egypt

The medical convoy originally placed in Greater Cairo was also dispatched to Alexandria to treat beneficiaries when services in the two clinics there were affected by COVID. Both staff and beneficiaries provided positive feedback on the impact this had. There were originally two fixed medical clinics for beneficiaries in Alexandria, but data showed that beneficiaries were not availing of the services. One of the reasons for this included the clinics' location. One was near a busy marketplace and the other on the outskirts of the city. Neither were easily accessible without transport, which was often expensive. The medical convoy helped to address this problem, setting up in the target communities and making health services more readily accessible. The programme thus adapted to rotate the medical convoy between Alexandria and Greater Cairo.

Promoting Sustainability

As highlighted in the report, sustainability of programme benefits remains a concern. It is recognised that the COVID-19 context hindered exit planning and continued implementation of activities. However, the lack of coherence in exit planning, both during the design phase and the final phases projects, is a major gap. Despite this, the focus on HNS capacity building and on the training of community volunteers will help ensure the sustainability of programme benefits to a certain extent.

Conclusion 9

The positive model of including HNS' in the programme promotes ongoing sustainability. HNS' have clearly developed their organisational capacities under the programme, both in terms of activity offering and institutional capabilities, including financial management, procurement, M&E, and planning. This bodes well for the potential of HNS' to implement similar programmes in the future. However, some HNS staff reported that their confidence levels in working on certain MADAD topics, and in recruiting and managing volunteers had not improved. High levels of HNS staff capacity and confidence are critical to ensure independent delivery of activities beyond the programme.

Recommendation 9.1

Continue to invest in the HNS capacity building and community volunteer model as it supports the sustainability of activities and outcomes once national RC/RC partners have withdrawn. Strengthen HNS autonomy and capacity through joint learning events for programme staff at a regional level on particular activity areas to understand challenges and opportunities in their own and other's implementation contexts. This would consolidate knowledge across the RC/RC movement and ensure it is filtered down to strengthen HNS capacity. Provide staff with refresher trainings and identify gaps in their knowledge and confidence levels where further, detailed training could be provided. For all HNS', ensure that training has earmarked funding.

Best Practice Example: Volunteer Management, Peer Support and Localisation by LRC in Lebanon

The progress made by LRC under Outcome 3 speaks to the importance and successes of localisation. LRC did not implement MADAD-specific Outcome 3 activities but used this funding stream as a catalyst for their ongoing organisational capacity development work, developing systems and approaches that can support their work in Lebanon beyond the remit of MADAD.

In particular, LRC has developed a strong volunteer management approach that provides a volunteer base and approach to volunteering to support activities across the organisation. The peer support system developed under MADAD is unique across the programme and most importantly tailored to meet LRC's very specific requirements demanded by Lebanon's high-pressure operating context. This has already proven its worth in responding to the COVID-19 pandemic and the August 2020 blast in Beirut.

Conclusion 10

The community volunteer approach embeds learning and skills in local communities. This has provided beneficiaries with skills and knowledge to independently implement activities and build community resilience beyond the end of MADAD. There is evidence of community volunteers using the skills developed in their communities as well as passing on their skills to other community members. This is one of the programme's key successes.

Recommendation 10.1

Continue the community volunteer approach to embed independent, sustainable change within communities. In addition to providing knowledge and transferable skills it is critical that communities are equipped with the tools to put their learning into practice. This is particularly the case with DRR and first aid training, where communities need to receive resources as well as upskilling if change is to last beyond the end of the programme. Budget should be allocated for these resources and plans should be developed with communities to understand how resources can be leveraged beyond the programme. Incentivisation could be built in to encourage volunteers to continue their volunteering work and leverage their training beyond the end of the programme.

Best Practice Example: Volunteer Management in Jordan

JRCS have made significant strategic investment in volunteer recruitment and management under the programme, making this area a key success. There are clear processes for recruiting and training volunteers who in turn report high levels of confidence in their work and improved knowledge and skills. JRCS has also been successful in recruiting volunteers from the communities in which they work, including Syrian refugee communities. This has built the capacity of both communities and individuals for whom more opportunities in the country are now available.

The investment in volunteer recruitment and management improved sustainability on two fronts. First, knowledge and skills are embedded in communities meaning they are likely to continue to be used beyond MADAD. Second, this has developed a sustainable volunteer recruitment practice as JRCS volunteers are highly likely to refer their peers and beneficiaries as volunteers. This means they are likely to maintain a high-quality volunteer base beyond MADAD.

Conclusion 11

A lack of clear exit planning undermined the sustainability of activities, results, and structures. There is inconsistency in the approach to exit planning across the programme. This is due to multiple factors including the fact that the programme is operating in a protracted crisis and beneficiary needs are still emerging and shifting. Additionally, during the programme, the EU discontinued regional programmes which has necessitated individual plans being drawn up for each country.

That said, the exit plan across different parts of the programme remains unclear. There were varying levels of management and material support for sustainability designed into each activity during implementation. There is also a lack of coherence between expectations of exit planning at HQ level and within national contexts. Although DRC have actively encouraged exit planning for each country programme, these plans are not sufficiently in place for all aspects of the country programmes. Within each national context there has also been a different approach to seeking future funding and handover of activities. Within consortiums, each RC/RC partner has developed separate approaches for exit concerning the activities they oversaw. This led to fragmentation in sustainability planning for programme activities and results, and loss of coherence in possible future implementation.

Recommendation 11.1

Conceptualise a clear exit and sustainability planning for activities at design stage. Over the course of the programme, ensure exit plans are embedded in new activities with a shared understanding across partners of how this will work. More support could be provided from the regional management level on developing exit plans for HNS and RC/RC partners, as well as regular monitoring of how exit arrangements are progressing. This support should be tailored to HNS capacity. For instance, some HNS' such as LRC have developed significantly over the course of the programme and have shown independence in attaining future funding. Other HNS' require more support from the RC/RC partners in developing plans. RC/RC partners should work closely with their HNS to assess early on the level of support needed, and design support for exit planning around this.

Conclusion 12

Some of the most promising examples of sustainability in programme activities occurred when there was clear planning and budget allocation for ongoing support that enabled pathways from programme activities to self-reliance. This was particularly clear in livelihoods components when in addition to training, material support for business start-ups was provided. This was observed across Iraq, Egypt, Jordan, and Lebanon, where beneficiaries were provided with hairdressing equipment, sewing machines, cash grants or mentoring following training. Conversely, in Lebanon there were examples of first response teams struggling to maintain adequate consumable material equipment to enable them to continue supporting their communities. Planning for and providing ongoing support helps to ensure that beneficiaries can put their training into practice and become more self-reliant over time.

Recommendation 12.1

Identify the ongoing support requirements that beneficiaries will need following training or other activities such as first response and first aid. Ensure there is budget allocated to provide these material resources and if these will require replenishment or maintenance over time (e.g. first aid equipment) work with beneficiaries to plan how they can access this in a more independent manner. Providing this level of support for many beneficiaries may be a challenge so the RC/RC could consider targeting smaller numbers of beneficiaries but focusing on providing high-quality, sustainable post-training support to ensure a high proportion of recipients can achieve self-reliance.

Best Practice Example: Evolution of the Livelihoods Programming in Turkey

The changes made by TRCS on the livelihoods represent one of the most responsive and agile adaptations in the programme across the region and reflects complex and well-considered strategic reorganisation and reinvestment from both IFRC and TRCS. Livelihoods activities were initially part of wider social cohesion efforts, including a focus on gender and language, but over time, and with considerable effort, became a separate and very successful component of the country programme. Activities have had a strong focus on preparing beneficiaries for the labour market with tailored, advanced language courses, a focus on soft skills including Turkish working cultural norms, and work permit support. This has helped promote sustainability by preparing beneficiaries to access the labour market.

Annex 1: Country annexes

Turkey

The country findings for Turkey are drawn from a robust document review, 18 semi-structured interviews with key informants, 18 focus groups with both host and refugee communities and an Endline survey of 630 programme beneficiaries. A further breakdown is provided in the table below. The diversity and number of sources contributes to the validity of findings.

Table 3: Turkey Data Collection

18 Key Informant Interviews	Included stakeholders from: • DRC • IFRC • TRCS • Turkish Ministry of Family, Labour and Social Services • Turkish Ministry of Education • EU Delegation in Turkey • EU Trust Fund staff in Brussels
18 Focus Group Discussions	Included discussions with: • TRCS staff • TRCS volunteers • Female representatives from host communities • Female representatives from refugee communities • Male representatives from host communities • Male representatives from refugee communities • Children from host communities • Children from refugee communities
Endline survey	• 630 respondents: 370 female, 260 male; 200 aged 18-30, 420 aged 31-59, 20 aged 60+; 590 Syrian and 20 Turkish. • 410 respondents to the baseline:290 female, 220 male; 210 aged 18-30, 180 aged 31-59, 20 aged 60+, 290 Syrian and 125 Turkish.

MADAD programme in Turkey

Context

When the DRC MADAD programme began in 2016, there were 2.6 million registered Syrian refugees in Turkey. That figure has since risen to 3,627,481[15], making Turkey the country that hosts the most Syrian refugees. It is also the world's largest refugee-hosting country, ahead of Pakistan and Uganda (1.4 million refugees each). Both the baseline and Endline surveys showed that the majority of Syrian refugees live in urban areas, though the Endline did show a slight increase in those now living in rural areas. The main barriers facing Syrian refugees

[15] UNHCR Syrian regional refugee response operational portal: https://data2.unhcr.org/en/situations/syria/location/113

in Turkey today have not changed significantly since the beginning of the MADAD programme and include language barriers, mobility and negative perceptions.[16]

Programme overview

Table 4: Turkey Programme Overview

Budget	Target Number of Beneficiaries	Beneficiaries reached (to October 2020)
EUR 32,558,895	1,150,000	933,473

With a budget of EUR 32,558,895, Turkey is the largest country programme under MADAD. MADAD programme implementation in Turkey was somewhat different from other countries in that it focused on a community centre model. The original target was to support ten community centres, which became operational at various points over the lifetime of the programme. However, the programme exceeded this target, with 15 community centres currently supported by MADAD in 14 provinces.

Since the start of the programme, a total of 933,473 beneficiaries have been reached against a target of 1,150,000. This includes 416,895 male and 516,578 female beneficiaries, and when disaggregated by community, includes 547,243 Syrians, 359,401 Turkish people and 26,829 who list themselves as 'other.' Through the TRCS community centres, 50,000 Syrian refugees arriving to the country and/or most vulnerable Syrian refugees living in urban areas were supported with emergency supplies; 58,911 refugees were provided with information on basic rights, services and protection activities; and 320,947 targeted refugees and host community members attended social, cultural or networking events arranged by the community centres.

Of those surveyed as part of the Endline, 72% reported that RC/RC services in their area had an impact on their and their household's lives, including better integration with the community and improved economic opportunities as a result.

Figure 26: Turkey - Endline Survey: Proportion of respondents reporting impact of RC/CR services in their or their household's lives

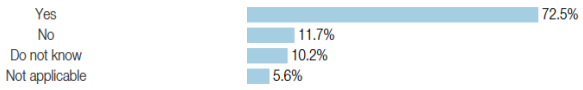
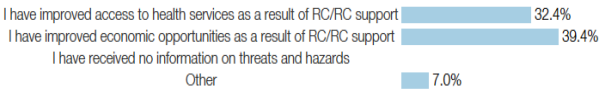


Figure 27: Turkey - Endline Survey: Reported impact of RC/RC services on the lives of refugees and their households



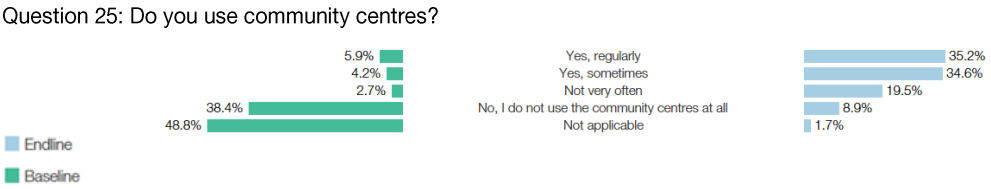
The development of the community centres was also designed to increase the capacity of TRCS to reach vulnerable Syrians in urban settings. The MADAD programme planned for the centres to provide vocational training, language courses, activities for youth and training and social services. TRCS, with support from IFRC, conducted a needs assessment and labour market analysis among Syrian refugees and members of the host communities in the areas where the community centres were located, with a particular focus on women and youth. This included an assessment of specific vulnerabilities; priority needs and challenges in integration. This led to psycho-social support, health education, health referrals and consultation services also being provided. There was also a focus on social cohesion activities, with events planned to strengthen cohesion and interaction between host and

[16] 3RP Regional Strategic Overview, 2020-2021

refugee communities. Strong complementarity between the different teams, including livelihoods, health and protection teams, was well noted by key informants in interviews.

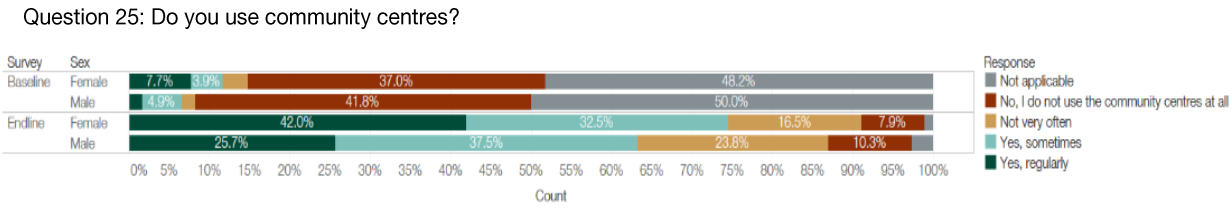
There has been a significant increase in people using the community centres. At baseline, 5.9% of respondents reported attending community centres 'regularly, and 4.2% reported 'sometimes'; this increased significantly at Endline, to 35% of respondents reporting they use community centres 'regularly' and 34% reporting they use them 'sometimes'. However, this increase could arguably be explained, at least in part, by the substantially larger number of Syrians participating in the Endline survey. A total of 590 respondents in the Endline survey was Syrian, compared to 290 who participated in the baseline survey. At the same time, 20 respondents in the Endline survey were Turkish, compared to 125 who participated in the baseline survey.

Figure 28: - Baseline-Endline comparison: Utilisation of Community Centres



Both the baseline and Endline showed that women were more likely to attend the community centres and avail of the services provided, though the Endline did show an increase in male engagement in some areas. When asked, "do you use community centres?" 7.7% of women responded 'yes, regularly' in the baseline and this increased to 42% in the Endline. At baseline, 2% of men said they regularly used community centres, with 25.7% reporting regular use at Endline. For men, there was an even greater increase for those responding that they 'sometimes' use the community centres; this figure increased from 4.9% at baseline, compared to 37.5% at Endline. Focus groups and interviews attribute the increases in attendance and use of services to more effective outreach and engagement in the target communities, and the associated increased awareness among beneficiaries of the services available.

Figure 29: Turkey - Baseline-Endline comparison: Utilisation of Community Centres, disaggregated by gender



According to key informants, one of the key strengths of the programme was the status of TRCS in Turkey. As an auxiliary to the Turkish government, TRCS' status allowed easier and faster access to services, e.g. to schools and TRCS school clubs, and could expedite the process around protocols with local and provincial authorities. TRCS is also the oldest and largest humanitarian organisation in the country and its presence at the community level, which meant the MADAD programme benefitted from positive relationships in the community and good communication with national, provincial and community authorities. However, slow internal processes around procurement and recruitment were cited as sometimes hampering the programme. For example, it took three years to have all programme staff recruited into their roles, which is reflective of a continued challenge with recruiting and maintaining staff on the programme.

The MADAD baseline informed programme design based on the needs identified as part of the survey, including access to healthcare and greater livelihoods support. There was a multi-pronged approach to identifying beneficiaries, which included a strong integrated system

with social workers referring people to community centres, as well as household visits and community outreach activities. Social workers screened and assessed beneficiaries to ensure they were referred to the right services.

The programme in Turkey was also effective at identifying beneficiaries and responding to their needs, as well as adapting to those needs over time. Adaptations included offering more advanced levels of Turkish courses, including vocational-specific language training, as well as tailoring services to account for different needs of men and women. The Endline survey found that 78% of women and 64.8% of men reported that RC/RC services in their community had had an impact in their lives. As outlined below, this included a positive impact on feeling better integrated with the community; improved economic opportunities and improved access to health services as a result of RC/RC support.

Figure 30: Turkey - Endline Survey: Proportion of men and women reporting impact of RC/CR services in their or their household's lives

Question 54: Have the RC/RC services in your area had any impact in your and your household's lives?

Livelihoods

In the Endline survey, 55% of respondents reported having taken part in livelihood activities and/or training courses provided by TRCS. Proportionately more women than men reported participation - 65% of women had taken part, compared to 42.9% of men. The majority of respondents reported having participated in vocational training courses, language courses for adults, and small business skills training.

Figure 31: Turkey - Endline Survey: Proportion of respondents having taken part in livelihood activities or training courses provided by the RC/RC

Question 36: Have you taken part in any livelihood activities or training courses provided by the RC/RC?

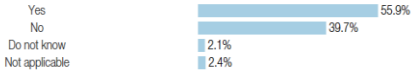
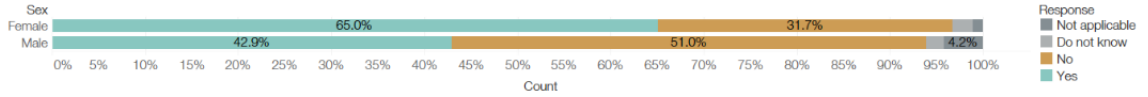


Figure 32: Turkey - Endline Survey: Proportion of women and men having taken part in livelihood activities or training courses provided by the RC/RC

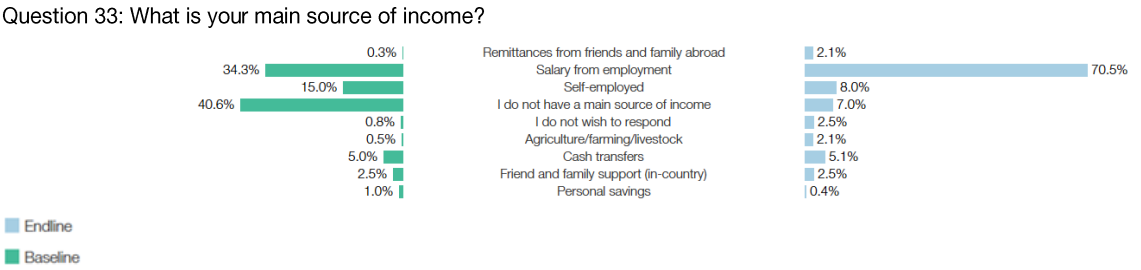
Question 36: Have you taken part in any livelihood activities or training courses provided by the RC/RC?



The main benefit resulting from these activities related to improved community relations, although job prospects (27% increase) and household income (21% increase) were also reported as having improved. There was also good complementarity between the livelihoods programme, and social cohesion and integration activities. Beneficiaries reported that livelihoods support was relevant to their needs, with variety and availability of training improving over the course of the programme. Turkish language training was reported as one of the more relevant and beneficial courses and this also improved over the course of the programme. Initially, only beginner courses were available, while more advanced courses were offered towards the latter stages of the programme, as well as more vocationally-oriented language courses. Additionally, all Turkish language training courses are now being conducted by community centre trainers certified by Ankara University which has contributed to an increase in the quality of training provided.

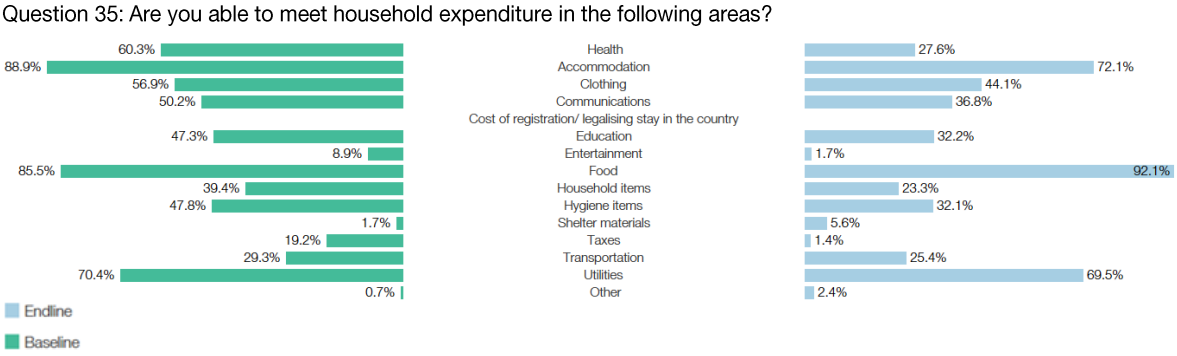
The baseline study in 2017 found that refugee unemployment was particularly high at 73%, with respondents citing language barriers and the lack of recognition of Syrian qualifications as constituting the main barriers for securing employment. The livelihoods component of programme sought to address this to increase employability of refugees. The Endline survey showed that these efforts were successful, since there was an increase in the number of respondents reporting they were in formal, informal and temporary employment. At the same time, there was a decrease in respondents reporting that they were unemployed. This was true for both male and female respondents. There was also an increase in respondents reporting 'salary from employment' as their main source of income, and a decrease in those responding 'I do not have a main source of income'; again, this was true for both male and female respondents (see Figure 33).

Figure 33: Turkey - Baseline-Endline comparison: Respondent income sources



There was a decrease in ability to meet household expenditure in most areas, except food. This could perhaps be explained by the shifts in demographics of survey respondents, and/or the economic downturn since the baseline. (see Figure 34).

Figure 34: Turkey - Baseline-Endline comparison: Respondents' abilities to meet household expenditures



There were substantial changes in reported secondary sources of income, most notably in aid from international organisations and NGOs, increasing from 0% in the baseline to 35% in the Endline. Salary from employment as a secondary income source increased from 2% in the baseline to 13% in the Endline. Cash transfers as a secondary source of income decreased substantially from 30% in the baseline to 3% in the Endline.

Programme adaptation and learning

The livelihoods component has adapted well to changing needs and context, adapting to learning and taking on board key recommendations from the MTR. For example, a key finding of the MTR was that vocational training was not sufficiently linked to the specific needs of the labour market, and that this was also not sufficiently tailored to each regional and provincial context. The programme responded by undertaking a more robust labour market analysis in each province, screening participants in advance to ensure they were suitable for the training and developing relationships with potential local employers to build a viable

recruitment network. A budget modification was permitted to facilitate this more in-depth analysis.

Each community centre now tailors its livelihoods activities to the context, based on a labour market analysis which has become more rigorous since the MTR. For example, some community centres developed vocational trainings for rural areas and some developed vocational trainings for industrial areas according to the need and demand of the city they are located. Rural areas with high demands for agricultural skills have developed vocational training in this sector, including animal husbandry and mushroom farming.

The baseline survey and initial needs assessments found that Turkish language support was a key need for beneficiaries as it affected all aspects of their lives in Turkey, from livelihoods prospects to helping their children with their schoolwork. This was set up well and also adapted over the course of the programme. For example, when the MTR found that Turkish language classes offered by the community centres only covered basic proficiency, the livelihoods programme worked with the University of Ankara to develop and offer more advanced language classes, as well as vocational language training that includes sectoral modules covering language and terminology relevant to the sector. However, implementation of the advanced language training has not been consistent. Focus groups with beneficiaries highlighted that progress has been made, but only three of the fives levels are widely available and there are still no certificates awarded when graduating from one level to another.

Training was also developed to support Syrians to gain soft skills, including Turkish working culture norms and expectations in the workplace, as well as CV writing and preparing for job interviews. Feedback from beneficiaries over the course of the programme highlighted that the duration of the courses was not sufficient, asserting that they were generally too short to provide enough depth; this was also a finding of the MTR. This was adjusted by programme staff, with sessions now longer in duration and covering more ground in each subject matter.

In addition, work permit support has helped increase the employability of Syrians who have the same skills and experience as their Turkish counterparts. TRCS incurs the cost of work permits, which means it is not passed on to the employer.

Participants were financially incentivised to attend and complete training courses. Initially, this led to some participants enrolling for and completing as many courses as possible. This was addressed by screening applicants more effectively, to ensure the courses were being attended by the most suitable participants relevant to the subject matter. Payments to attend training were appreciated by beneficiaries, as it allowed them to household and family expenses while undergoing training. This was particularly valued by women – both refugee women and those in host communities - who reported that the training made them feel productive, while financial incentives helped their confidence and self-esteem by allowing them to contribute to household expenses.

Gender

Gender was well mainstreamed across the livelihoods component from the beginning and improved further over the course of the programme. Based on the initial needs assessment and understanding of Syrian cultural norms, vocational training was tailored to gender needs. For example, the initial assessment found that women do not always feel comfortable working outside the home, so training was therefore designed to develop income generating skills that could be used within the home, or the home of other women to allow women to work collaboratively if they wished. Training included hairdressing, sewing, tailoring and handicrafts. Childcare was made available to allow women with children to participate in the sessions.

Feedback from female beneficiaries in the FGDs was generally positive in relation to livelihoods support and the impact it had on improving their economic opportunities. However, it was noted that a focus on providing training that allow women to work from home

is good in principle but it also led to a surplus of hairdressers and tailors, which makes it difficult for women to actually earn an income from these activities. Feedback from the focus groups indicated that there is now a growing number of women who would like the opportunity to work outside the home, and would like to see courses focused on administration, IT, graphic design and project management being offered.

The livelihoods component also adapted to meet the evolving needs of male beneficiaries. For example, language courses were initially being offered during the day when men were most likely to be working. Additional classes were subsequently offered in the evenings to accommodate men's working hours and allow them to attend.

Monitoring and reporting

There were two key limitations of the monitoring and reporting process in relation to the livelihoods component. The first is that reporting was generally at the output level and did not focus on higher level change. The second relates to output indicator 1, namely that vulnerable refugees and host community members would demonstrate "increased economic self-reliance." The monitoring process was not originally set up to capture whether participants of vocational trainings were subsequently able to secure employment or increase their income, and if they did whether this was helped by the training they undertook.

The monitoring process was adapted over the course of the programme to try and capture this information. The monitoring system at the outcome level was adjusted as activities evolved. TRCS staff now make follow-up calls to training participants one month after the training to check employment status. The livelihoods team also conducts household visits and check on the established small enterprises. However, this is limited by consistency and timing, and depend on participants responding to telephone calls, keeping the same telephone number, and remaining in the same area. Data from the Endline survey indicate an increase in informal, formal and temporary employment for both men and women and there is an increase in respondents reporting their main source of income is 'salary from employment;' however, this type of data was not consistently collected over the course of the programme through the monitoring process.

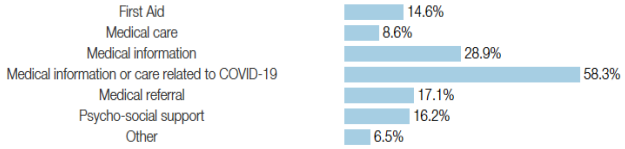
Health and PSS

The broad range of health services provided by TRCS through the community centre model was appreciated by beneficiaries in target communities. All of the services provided free of charge through the community centres would have otherwise been prohibitively expensive for beneficiaries, for example distribution of NFIs such as newborn baby parcels and PSS services. The provision of these NFIs was well integrated with health promotion and education activities. Newborn baby parcels were provided to expecting mothers following maternal and baby health sessions, and hygiene kits were provided to beneficiaries at the end of hygiene promotion sessions. Beneficiaries also appreciated the diversity of communication platforms. Participants in FGDs noted that social media engagement by TRCS for health information was reported as accessible, engaging and a source of reliable and helpful information. The Endline survey showed that respondents accessed medical information and referrals through the centres, and that the centres were particularly helpful in providing information and/or care related to COVID-19. Based on the Endline survey, the range of services accessed by beneficiaries is summarised in

Figure 35.

Figure 35: Turkey - Endline survey: Proportion of respondents or members of their household having received health services from RC/RC staff or volunteers since 2016

Question 48: Have you or members of your household received any of the following health services from RC/RC staff or volunteers?



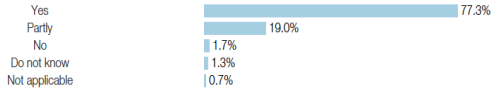
The proportion of survey respondents who reported facing barriers in accessing health services increased from 60% at baseline to 76% at Endline. The main barriers reported at both baseline and Endline baseline were cultural or communications barriers, limited services available, lack of awareness of the full range of services available and transportation barriers, mainly relating to travel distances to clinics. Knowledge of where and how to access health services was not a major barrier, and those reporting it as a barrier decreased from 3% at baseline to 1% at Endline.

Survey results suggest that awareness and access of health services improved over the course of the programme. However, feedback from the FGDs indicate that not all beneficiaries were aware of the full range of health services available. There was also some divergence in relation to health promotion and education activities. According to TRCS staff, the programme was responsive to feedback from beneficiaries and additional health education topics were introduced based on this, for example women's health, family planning and communicable diseases. However, many FGD participants from host and refugee communities were unaware of such services, and actually requested that they be made available.

There were many strengths cited across the health and PSS component, amongst others how well the services were adapted to overcome the inherent language barrier. Interpreters were provided for training and PSS sessions, and Training of Trainers was carried out for Syrian CBHFA volunteers so they in turn could train other beneficiaries in Arabic. A good example of this was first aid training. Another strength associated with the programme was the efforts made to reach vulnerable groups. For example, seasonal workers were monitored as they moved around for work and were targeted for health outreach activities and specific health campaigns, such as hygiene promotion. The community centres were also intentionally set up to provide a safe space where PSS activities were provided free of charge. PSS has indeed become quite a niche area for TRCS. PSS activities were well received by beneficiaries; feedback from the FGDs indicates that the services were relevant and well-tailored to the specific needs of the beneficiaries. The fact that PSS is free featured heavily in FGDs as it would be expensive to seek PSS services privately and often prohibitively expensive for beneficiaries. The majority of respondents in the Endline survey (77%) reported an improvement in their knowledge of hygiene practices (see Figure 36).

Figure 36: Turkey - Endline survey: Improved knowledge of hygiene practices

Question 52: If yes, do you feel your knowledge of hygiene practices has improved?



As most schools in Turkey have a TRCS club, this is a natural entry point for health activities in schools. There is strong complementarity between the health, social cohesion and protection teams; for example, whilst conducing social cohesion activities in one school, the team identified an outbreak of headlice and brought in the health team to test and treat for headlice, as well as provide education around the issue.

There were also some challenges across the health and PSS component. A key challenge was the retention of volunteers. While recruiting health volunteers from both the Syrian and Turkish communities was relatively straightforward, it proved difficult to retain them. CBHFA volunteers undergo five days of training to support the health and PSS officers. TRCS policy is to only provide transport, breakfast and lunch allowances, and only on receipt of proof of expenditure. This does not compare favourably with the incentivisation offered by other NGOs, so TRCS volunteers do not stay long-term. There are also more female volunteers than male, which poses problems when conducting household visits and other community outreach activities, as female volunteers often cannot engage with male beneficiaries.

Staffing was also a challenge. There were not always enough staff at different levels. For example, in some centres there were not enough trained staff to distribute hygiene kits and other NFIs, or there were not always enough interpreters to support health and PSS activities. This is in part due to the slow recruitment process of TRCS. Interpreters also do not always have the technical expertise for PSS activities.

Programme adaptation and learning

As with livelihoods, the health and PSS component of the programme adapted well to evolving and changing needs of beneficiaries, taking on board feedback and learning from reporting and reviews. For example, the MTR recommended an increase in the innovative use of technology and different tools for programme support and delivery. This recommendation was taken into consideration when designing a separate (to MADAD) but related project and included a budget to develop a mobile app to provide PSS support to Syrians. Technology such as social media platforms and free telephone apps were also used to support activities once COVID-19 struck, forcing a lot of face-to-face activities to cease. This worked well to an extent, but health staff reported it was difficult to get the same level of interaction for more sensitive engagements, such as online PSS sessions. However, staff have reported that online sessions have become normalised over time and are now working more effectively.

Gender was a key focus of the MTR. It found that men rarely participated in CBHFA activities and recommended that this be addressed. The timings of the activities were changed to accommodate men's working hours so that they could attend activities after work. However, although working hours were a barrier, the main barrier was more around the cultural perception that such activities were more appropriate for women, with the result that the number of men engaged in CBHFA activities did not increase substantially. Similarly, it was found that there was a lack of men engaged in PSS. Again, the timing of activities was adjusted to accommodate working hours, but it was found that men preferred to attend vocational or language sessions in the evenings, rather than PSS. TRCS staff have tried to adapt both language and vocational training in such instances to include PSS and health components to engage men, even at a less in-depth level.

Monitoring and reporting

Although monitoring and reporting improved over the course of the programme, some gaps remain. As with livelihoods, monitoring still tends to be at the activity/output level, with less emphasis on outcomes and impact. There was also no mechanism in place to follow up on health referrals. Where beneficiaries were referred for more specialised health or PSS support, there was no follow-up to check if this service was received, or if further support was required. Another constraint in relation to monitoring was that Syrian beneficiaries did

not always have the necessary language proficiency to complete surveys in Turkish. This meant that surveys could not always be filled out, which created gaps in the monitoring process.

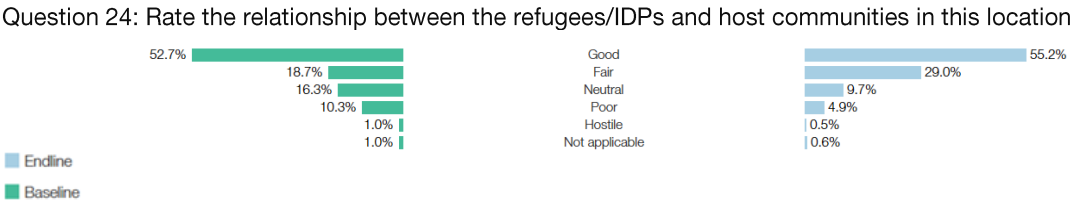
Social cohesion

Participants in both interviews and focus groups noted considerable progress in social cohesion and integration since the beginning of the programme. For many, social cohesion was still a relatively new concept, and it meant different things to different people. However, it is now much better understood and well embedded in programming, both as stand-alone components as well as a cross-cutting element of other activities such as health and livelihoods.

The Endline survey showed a substantial increase in integration and social cohesion between Syrian refugees/IDPs and host communities. Both the baseline and Endline showed high levels of interaction in social settings. However, there was a marked increase in interaction between host and refugee communities in work settings, community projects and in casual interactions. The relationship between refugees and host communities also appears to have improved. At baseline, 52% of respondents reported the relationship as being "good," compared to 55% at Endline. At the same time, the proportion of respondents who rated the relationship as "poor" decreased from 10% at baseline compared to 4% at Endline (see

Figure 37). There is also an increase in those reporting 'fair' relationships; this increase from 18.7% at the baseline to 29% at the endline. As outlined in the livelihoods section, beneficiaries participating in livelihoods activities or training courses provided by the RC/RC also noted a significant improvement in community relations as a result.

Figure 37: Turkey - Baseline-Endline comparison: Relationship between Syrian refugees/IDPs and host communities



Learning and adaptation

In the first two years of the programme, there was a far greater focus on refugee communities compared to host community, and no strategic approach to social cohesion. Over time, there was recognition that the whole community needed to be engaged if the programme was truly going to provide services of benefit to both refugee and host communities, and to enhance community ownership, empowerment and resilience.

In 2018, a CEA assessment was conducted which highlighted this, as well as the perception among the host community that the community centres were only for refugees. The assessment also included a component on communication needs, covering the kind of information both communities wanted and their preferred communication methods. The timing of the CEA assessment coincided with the MTR, which allowed TRCS staff to combine learning from both to inform programme adjustments. MTR recommendations in relation to social cohesion included encouraging greater engagement with host communities and having local communities more involved in decision making processes and countering misperceptions around refugees.

The findings of the CEA assessment dovetailed with those of the MTR and subsequent activities were designed to address these. For example, one of the findings from the CEA assessment found that Advisory Committees, comprising members from both the host and

refugee communities, were not functioning well, were mainly focused on refugees and were not very active in community centres. The Advisory Committees were subsequently restructured to have 50% membership from each community, with women well represented, and greater clarity on their role and process. The committees represent their communities and provide consistent feedback to TRCS staff on the quality of services provided, what is working well and less well, and what additional services may be required. This allows TRCS to adapt activities to meet the evolving needs of their beneficiaries as far as possible. Feedback from the key informant interviews and FGDs indicates that these committees have led to greater ownership of services and engagement by local communities, and people are much more open in expressing their needs and views on the quality and range of services available. However, limited input from host communities as part of the Endline process may have influenced this finding.

The Advisory Committees are also a good example of direct and indirect social cohesion. They advise and organise events to bring people together and also, by virtue of the make-up of the group, work collaboratively on key issues relevant to the local community as a whole. The members are community representatives but also community mobilisers and influencers. For example, positive interaction through the Advisory Committees allows members of the host communities to counter any misconceptions that people may have about refugees. Youth clubs comprising male and female youth aged 14-18 have also been established to organise different activities and feed back to TRCS staff on youth engagement activities.

Children from host and refugee communities who participated in FGDs are of the opinion that general social cohesion and integration have improved. Children from host communities reported helping Syrian children with the Turkish language, working together in classroom settings and playing together both at school and at home. Children from refugee communities were positive about the impact of the community centres in their lives and on their general integration, including Turkish lessons, education support and recreational activities.

Whilst there were already some activities implemented in schools to address peer bullying and stigma faced by Syrian children, this was strengthened following the MTR. Parents, teachers and students were engaged in a holistic manner as part of the social cohesion component of the programme to allow parents and teachers to identify signs of bullying and safe ways to intervene, and to allow false facts and misconceptions amongst children to be countered. Age-specific modules were designed for children and youth. These were initially delivered in one-off sessions but were later delivered over several sessions to ensure uptake of key messages. Feedback from the FGDs with adult refugee communities showed that peer bullying is still prevalent in schools for children of all ages, and most beneficiaries were not aware of the school-based programme initiatives to counter bullying.

HNS capacity building

Training across livelihoods, health and PSS, and social cohesion has led to an increase in confidence for TRCS staff and volunteers in both their day-to-day activities and their interaction with beneficiaries. Staff and volunteers were positive about the variety and quality of training provided. Capacity building activities were considered relevant to support the MADAD programme, and also developed new, transferrable skills that were useful for their current activities and future roles.

According to TRCS staff, PSS training was well received and was sufficiently tailored to the context to deal with Syrian refugees in Turkey. CBHFA training was equally well received, especially by volunteers and community members. Once trained, they were able to become community mobilisers, identifying health issues and needs in the communities and sharing information with peers. There is a good support system and on-the-job training in place. TRCS health officers initially supervise the volunteers, for example on household visits, and provide feedback for improvement, before they operate on their own.

CEA training for staff and volunteers was also considered relevant and effective. The cascade nature of the training worked well logistically; staff were trained centrally and then in turn ran sessions with smaller groups at the community centres. The skills learned helped with social cohesion and allowed this to be mainstreamed across other activities, including health and livelihoods. Training included a focus on cultural awareness and how to communicate and engage effectively with different demographics within the communities, as well as behaviour and social change communication strategies to encourage more positive attitudes and behaviour within the communities. Accountability to beneficiaries was also a highly valued, emphasising the importance of feedback and complaints mechanisms and how to deal effectively with arising issues.

Uptake of skills from training sessions is monitored both formally and informally. Beneficiary satisfaction surveys are conducted once per year in every community centre and indicate how activities are going, and satisfaction with services provided. This helps inform volunteer and staff training needs, both in terms of new training sessions and refresher training. Staff also report their perceived training needs, and this is taken into account when developing training plans.

COVID-19

Turkey did not escape the global disruption caused by the COVID-19 pandemic. Community centres were forced to close, which had a big impact on the MADAD programme and the community centre model. Closure of the centres meant all face-to-face training, health and PSS activities and general activities had to stop. Many beneficiaries from both host and refugee communities lost their jobs, which had an impact on livelihoods and income. Students were also affected. Many do not have access to internet or computers outside of the community centres, which made it difficult or impossible to keep up with their studies.

TRCS staff adapted quickly and sought to move activities online, where possible. However, both staff and beneficiaries reported challenges in trying to conduct health, PSS and livelihoods activities online. Virtual engagement impacted the quality and reach of activities and made PSS support particularly difficult. In some cases, PSS activities were not running at all, which left many adults and children vulnerable. However, TRCS staff and volunteers worked hard to provide relevant and up-to-date information on how to prevent COVID-19, and on how to access testing and treatment for local communities and refugees. This was appreciated by beneficiaries, who reported accessing useful information through social media platforms supported by TRCS.

Sustainability

Sustainability of the MADAD programme was a key concern for many key informants. There is no definitive exit strategy for activities conducted at the country level; rather, the strategy is to secure further funding to continue the work started under MADAD. Some activities may need to stop or be scaled down if sufficient funding is not secured. However, the community centre model is considered sustainable as it is not just DRC funding activities through the MADAD programme; many donors including UNICEF and the World Bank provide various streams of funding for the centres and their programmes which means the centres will not close or shut down.

As part of Outcome 3, capacity building was considered a key enabler for sustainability. A substantial portion of MADAD funding was invested in upskilling staff and volunteers in various technical and thematic areas, and to provide transferrable skills that participants reported would improve their future performance and opportunities. Social cohesion activities also created sustainable pathways to increased integration, especially for children in schools and through the community centres. By providing safe spaces and platforms for engagement, including recreational trips and community events, people from both host and refugee

communities have greater opportunities for meaningful engagement through which to build sustainable relationships.

Conclusion

Overall, the MADAD programme in Turkey was considered a success by both staff and volunteers, as well as beneficiaries from the host and refugee communities. This was evidenced in key informant interviews, focus group discussions and the Endline survey. Almost three quarters (72%) of respondents to the Endline survey said that TRCS services have had an impact in their lives, which could be seen across livelihoods, health and social cohesion aspects.

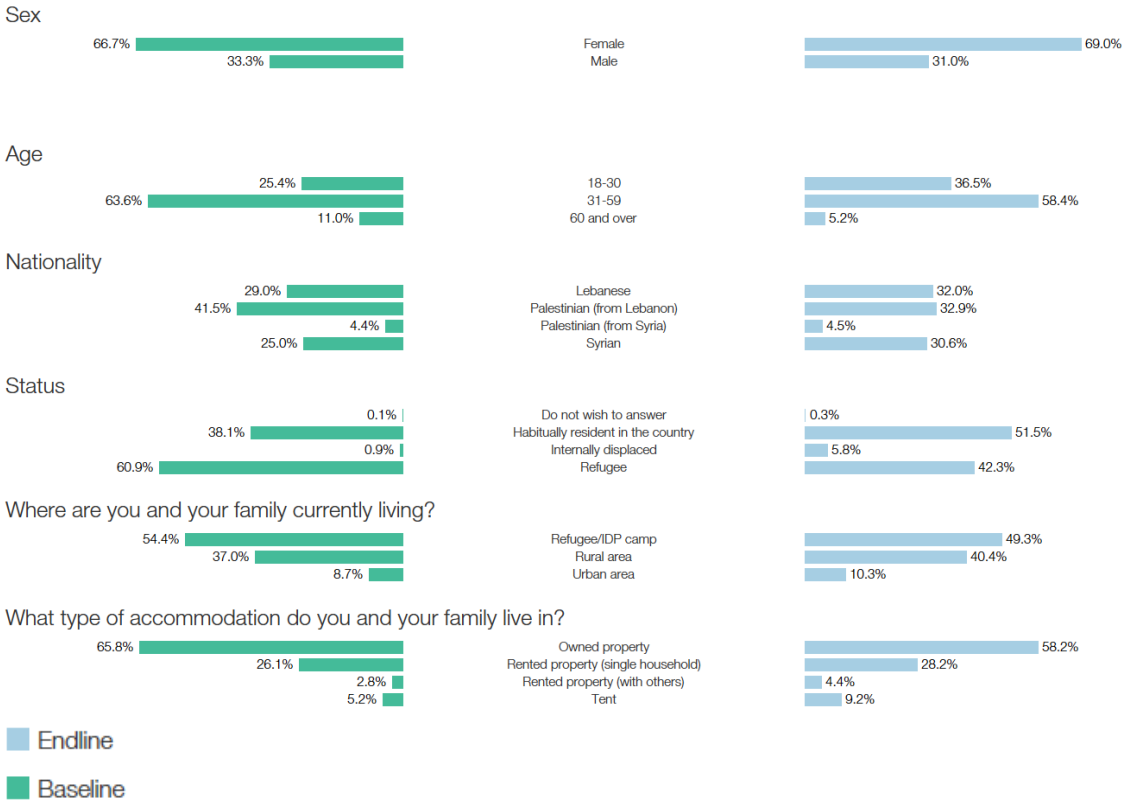
As a result of activities funded by the MADAD programme, livelihoods have improved for both Turkish and Syrian refugees, access to good quality health services has increased, and PSS activities have provided invaluable support to adults and children. For many, MADAD supported community centres were life-changing. The programme was well tailored to the needs of both communities and to the specific needs of women and children, and adapted well to these evolving needs over the course of the programme.

Capacity building and training activities for staff and volunteers improved skills and knowledge, provided new skills in relevant areas and increased confidence and capacity to interact with and engage refugees and vulnerable populations. This increase in capacity contributed to the overall sustainability of the programme. Although the centres were forced to close due to COVID-19, staff and volunteers adapted well, moving activities online where possible and striving to provide local communities with up-to-date information on the disease, including how to prevent it and how to access testing and treatment.

Lebanon

The findings and conclusions are drawn from a range of sources to ensure validity. The household survey conducted in Lebanon received a total of 718 responses, broken down into 412 responses from LRC and 301 responses from PRCS (further demographic breakdown in Figure 38 below). A hybrid model of eight remote FGDs for PRCS beneficiaries and ten telephone interviews for LRC beneficiaries were conducted. LRC beneficiaries were engaged across four locations: Kfar Chelane, Aamar Al Baykat, Hawoush Al Rafika and Ghazieh. PRCS beneficiaries were engaged across five locations: Ain Al Helweh, Nahr El Bared, Borj Al Barajneh, Borj A Chemali and Baalbek. All interviews and FGDs were disaggregated by age, gender and nationality. Twenty programme staff were interviewed from both HNS, all RC/RC partners and the EUTF as a donor. Additionally, four remote FGDs were conducted with HNS staff and volunteers who received training under Outcome 3.

Figure 38: Lebanon - Baseline-Endline comparison: no. of survey respondents by sex, nationality, civil status and living location



MADAD Programme in Lebanon

Table 5: Lebanon Programme Overview

Partner	Society	Activities
Lead Partner	NLRC	Country programme management
Host National Society	LRC	CBFHA, BTS, EMS, DRR, Outcome 3 capacity building
	PRCS	CBHFA, Outcome 3 capacity building
Other partners	Swiss RC	Blood Drives
	Spanish RC	CBHFA and Outcome 3 capacity building
	GRC	DRR
	DRC	PSS
	SRC	CBHFA, Outcome 3 capacity building

Lebanon Programme Budget	Target No. of Beneficiaries to be Reached	Actual No. of Beneficiaries Reached (October 2020)
EUR 7,837,215.	393,949	523,275

Context

Lebanon represents the second largest of the five country programmes implemented under *Addressing vulnerabilities of refugees and host communities in five countries affected by the Syria Crisis.* In Lebanon, the programme has addressed the needs of Syrian refugees, Palestinian Refugees from Lebanon (PRL), Palestinian Refugees from Syria (PRS) and the Lebanese host community. The Lebanese component was implemented by the programme's largest consortium in terms of number of partners with the NLRC as the country lead to the two partnerships: SpRC, GRC, DRC and SwissRC working with the Lebanese Red Cross; and the SRC working with the Lebanon branch of the Palestinian Red Crescent Society. The programme has reached 245,788 male beneficiaries and 277,487 female beneficiaries. 99,455 Syrians, 418,101 members of the Lebanese community and 6709 beneficiaries of other nationalities, including PRS and PRL, have been reached.

There are currently 914,648 registered Syrian refugees in Lebanon, although the official figure is 1.5 million; and there are 34,000 PRS in the country.[17] The main challenges facing Syrian refugees in Lebanon are residency permits, mobility and negative perceptions.[18] PRS and PRL face barriers related to their status and access to the labour market, with the Ministry of Labour requiring Palestinian workers to obtain a work permit in order to gain employment in to restricting their access to certain professions. 55 per cent do not possess valid regular residency documents.[19] Refugee populations are also prevented from accessing national

[17] Lebanon Crisis Response Plan 2017-2020 (2018 Update)
[18] 3RP Regional Strategic Overview, 2020-2021
[19] UNRWA (2020) '2020 Syria Regional Crisis Emergency Appeal'

health care systems in addition to the health system being highly privatised. Security checks, surveillance and confinement to camps remains an additional barrier for Palestinian refugees in Lebanon and from Syria.

The Lebanese implementation context has been increasingly complex since October 2019 following a series of national crises including the economic crisis and most recently COVID-19 and the explosion in Beirut in August 2020. The economic crisis continues to drive beneficiaries evolving needs and has complicated operations for both HNS' in areas such as procurement. Many activities have been delayed or disrupted due to COVID-19 but are on track for completion at the end of 2020. COVID-19 and the explosion in Beirut have highlighted the increased capacity and resilience of the RC/RC movement in Lebanon as a result of the MADAD programme.

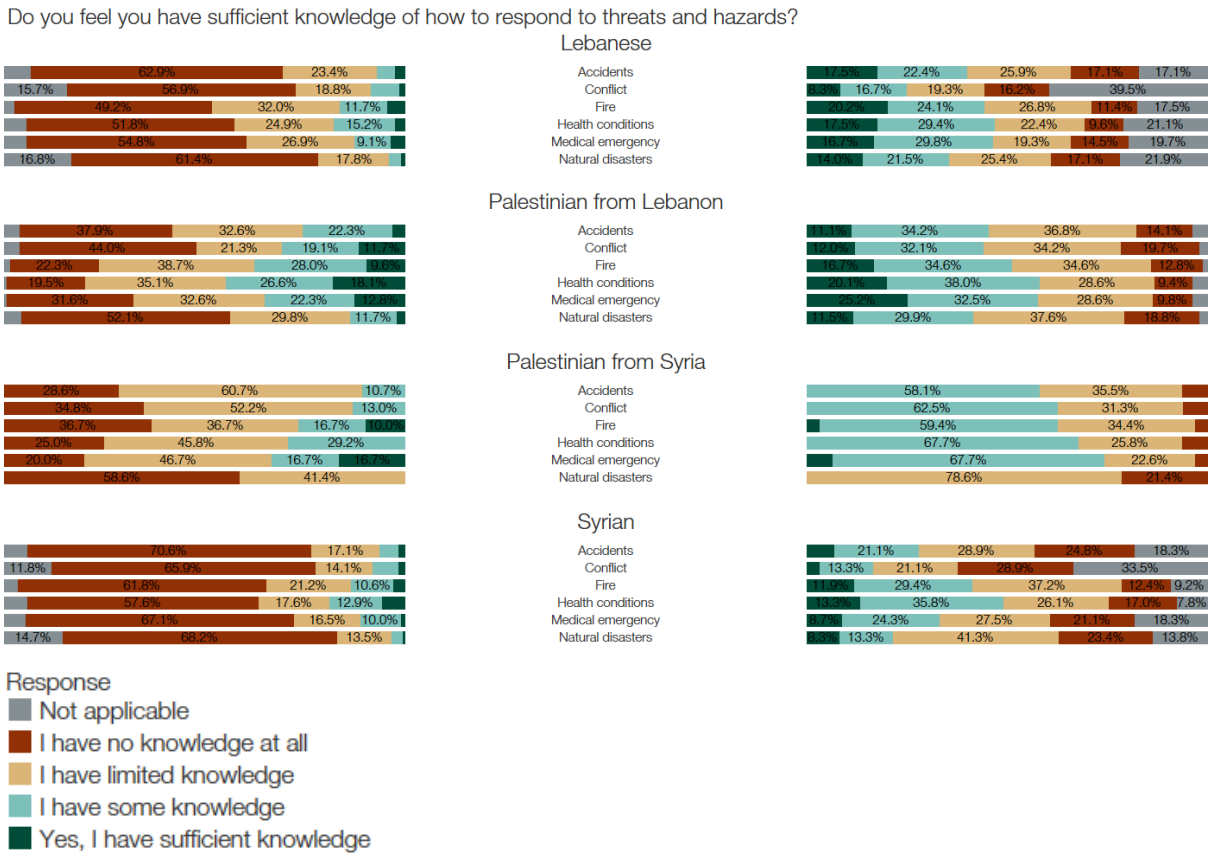
Disaster Risk Reduction (DRR)

The purpose of DRR is to make both refugees and host communities safer and more resilient by developing their risk reduction capacity of community memebrs to respond to hazards through identification of risks and threats. This included first aid and fire fighting training, awareness sessions, evacuation planning and training and provision of necessary equipment. The overall aim has been to enable communities to independently identify and mitigate risks. LRC in partnership with the German Red Cross have used MADAD as an opportunity to expand their existing DRR activities into new areas, taking a community-based response to DRR involving joint identification, planning, and response. LRC conducted needs assessments with community members and reviewed it on a regular basis to make sure it remains relevant. Each action plan was tailored to each community. LRC treated as an entry point for DRR activities with local communities.

PRCS and LRC have trained many first responders to tackle risks and hazards within camps as well as conducting awareness sessions. Their work is closely tied with the training of first aiders, discussed under the health component. In total, PRCS have trained and equipped 32 teams first responder teams have been trained and equipped during the programme. PRCS has retained 142 active volunteers.

Endline data shows that beneficiaries identify the biggest risks and hazards affecting communities in Lebanon are fire, accidents, health conditions and medical emergency. On aggregate, respondents show significant improvements in their knowledge on response to threats and hazards. However, improvements are generally driven by Syrian or Lebanese responders; the proportion of PRL and PRS respondents reporting they have 'no knowledge' has actually increased from the baseline. More Lebanese than Syrians have 'sufficient' or 'some knowledge' across the categories of fire, medical emergency, accidents, natural hazardsand conflict, which reflects a greater increase from the baseline awareness. In other words, Lebanese respondents have derived a greater benefit from the programme in terms of increased knowledge on the DRR capacity building areas. This is supported by qualitative data from FDGs in which Lebanese respondents more easily identified the risks and hazards impacting their communities and referenced how RC/RC had built their capacity to respond to these. The exception is for health conditions, where the picture is less clear cut (see Health). Of those who reported having 'no knowledge' on responding to risks and hazards, there were more Syrians than Lebanese. This is the opposite result to the baseline figures, reflecting beneficiary interview and FGD responses that suggest more Lebanese were directly involved in DRR activities than Syrians.

Figure 39: Lebanon – Baseline-Endline comparison: Percentage of beneficiaries with knowledge on responding to threats and hazards, by nationality



The only areas in which PRS report 'sufficient knowledge' is responding to fire and medical emergency. In all other areas they report 'some knowledge' or less. This is a decrease on the baseline. Across all categories, more PRS than PRL report having 'some' or 'sufficient' knowledge. The proportion of PRS and PRL respondents reporting that they have received no information on how to respond has actually increased between the baseline and Endline studies. Across all categories, more PRS than PRL report having 'some' or 'sufficient' knowledge.

DRR activities and first responder training has targeted both men and women. There are some trends relating to sex across the main areas where beneficiaries received information on responding to threats and hazards: The number of men who have learned about medical emergencies and health conditions has remained largely static between the baseline and Endline while the number of women increasing their knowledge has increased substantially. The number of men who reported learning about how to respond to accidents is lower than the baseline while the number of women is significantly higher than the baseline. The number of men who have received information about responding to fire has decreased while the number of women has remained largely static. Decreases in the number of men who report improved knowledge in these areas could be linked to a lower level of responses from men at the Endline compared to the baseline however the data overwhelmingly suggests that more women than men have been reached by these activities.

In FGDs and beneficiary interviews, Lebanese respondents reported taking part in DRR activities including community meetings. These meetings brought together key stakeholders in the community including the municipal council, school directors, mayors in addition to LRC volunteers and Lebanese and Syrian beneficiaries. Beneficiaries who had participated in these sessions, and other DRR activities, spoke readily about risks and hazards while those who had not participated had more trouble identifying risks that affected their communities.

This suggests that for those who have been involved in such activities, they have been beneficial. DRR activities have empowered communities to identify risks and hazards and respond to them. Some communities have identified specific risks and developed mitigation plans. Two examples include a community that has developed a response strategy for flooding and another which has developed a response strategy for wildfire.

Syrian beneficiaries were less involved in DRR activities and community planning meetings. Anecdotal examples reported by beneficiaries illustrated their individual experiences of this. Only one Syrian interviewee took part in a meeting and stated that the Syrians in attendance did not speak, and some participants were opposed to their presence due to ongoing tensions and perceptions of discrimination between the Syrian and Lebanese communities A Lebanese interviewee stated that Syrians were not invited to planning meetings in their community because they were not seen as key decision makers. This suggests a shortfall in the integration and social cohesion objectives of the programme. Equally, it is problematic as Syrian beneficiaries spoke openly about the challenges they faced from fire, conflict and precarious housing conditions. This suggests that there was a need for DRR activities amongst Syrians that the programme has not fully addressed. In comparison, Lebanese beneficiaries stated the greatest challenges they faced were the economy, livelihoods and education rather than DRR related problems. Concern was also raised at a management level that while MADAD allowed DRR activities to be expanded to new areas of Lebanon, they had not shown a significant change in the type of DRR activities that the RC/RC movement has implemented in Lebanon since 2012, calling relevance into question.

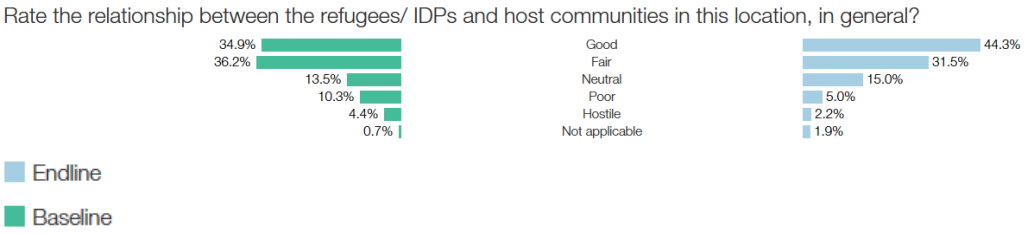
A clear success is the 32 teams of first responders trained by LRC and PRCS under MADAD. PRCS beneficiaries discussed the importance of having trained first responders embedded in their communities. First responders' presence in camps mean that incidents can be dealt with quicker, particularly at times when PRCS's access to camps is barred. First responder training has also been tailored to local context, addressing the main risks and threats faced by each community. For instance, some volunteers received first aid training while in others received training focused on fire and response to armed conflict. Training has also been tailored to the needs and capacity of different age groups with children receiving training on evacuation procedures and younger adults trained as first responders.

Some challenges were raised around operationalising this training. While beneficiaries have been provided with good knowledge on responding to risks and hazards and all teams were initially fully equipped, several participants stated that their communities often lacked sufficient equipment and budget needed to respond in practice. This may point to a decline in consumable material equipment over time and the lack of a budget to replenish this, which undermines the ongoing sustainability of the first response teams. Others stated that although they had received training, they did not feel experienced enough to put this into practice. Although a large number of first responders are now embedded in communities, this calls into question sustainability if communities are not, or do not feel, fully equipped to respond independently.

Social Cohesion

Social cohesion and integration between refugee and host communities has improved over the duration of the MADAD programme. 87.4% of Endline respondents report feeling better integrated with their community, with 44.3% rating the refugee relationship as good and 31.5% rating it as fair. The number of beneficiaries who rate their community relationship has as poor or hostile has reduced. Of those who stated, 'I feel better integrated with my community' – 34% Lebanese, 31% Syrian, 30% PRL and a minority PRS.

Figure 40: Lebanon - Baseline-Endline comparison: Quality of the relationship between refugees and host community



RC/RC are seen as neutral service providers and MADAD actively engaged with all factions of communities. MADAD activities have provided a place for community members from all backgrounds to meet each other and promote integration. For example, PRCS volunteers and first responders have been recruited from a range of backgrounds providing access to and integration with different communities. Beneficiaries stated that LRC and PRCS activities provided a space for cohesion and getting to know people of other nationalities. PRCS staff and beneficiaries did recognise that programme activities had brought together beneficiaries from different backgrounds and improved relations in camps.

However, it is difficult to attribute improved social cohesion and integration fully to the MADAD activities. Many beneficiaries did not recognise social cohesion as part of the activities they took part in, whether as an explicit purpose or indirect effect. It is also hard to say if all groups have been brought together by the programme. For example, both LRC and PRCS staff suggest that within the programme there was a lack of interaction between the host community and refugees who live in camps or informal tented settlements. There remain ongoing tensions between these groups. Other staff suggested that while there may be better relations and integration on an individual level, it is difficult to observe this on a system level. Many beneficiaries still cited tensions between communities. Syrian refugee and PRS beneficiaries discussed ongoing discrimination from the host community while Lebanese and PRL members referred to competition for aid between refugees and vulnerable members of their own communities. Host community beneficiaries were generally reluctant to discuss discrimination and provided very mixed responses on their personal integration with the refugee community. There remain evident tensions between PRL and PRS around perceived competition for aid, although there was a recognition that RC/RC treats beneficiaries more equally than other NGOs.

The success of the programme in meeting social cohesion goals in Lebanon must be caveated by two factors: the Lebanese context and LRC's decision not to make social cohesion a focus of the programme. The wider Lebanese context, which has become increasingly fragile since 2019 with economic crisis, social and political crisis, Covid-19 and the explosion in Beirut in August 2020. There has been a significant increase livelihoods challenges amongst both the host community and Syrian community This has contributed to increased instability and tensions within and between communities while the wider system does not allow for integration of refugees Given the relative size of Lebanon's refugee population (over 20% of the national population) there is great potential for the situation to deteriorate into conflict and social breakdown. This undermines the extent to which MADAD activities can affect social cohesion and integration in the broader system as there is an uphill struggle against contextual factors with relatively grassroots activities in which social cohesion was not a stated goal in LRC's activities.

This evaluation does recognise the decision of LRC not to focus on social cohesion and that this is pertinent given the challenges of the Lebanese context and their focus on continuing existing approaches rather than pivoting to social cohesion, which would represent a challenging goal, does show strength in terms of a localisation approach. However, this does

raise difficulties in assessing the programme against its overall results framework in which social cohesion is an overarching goal of the programme and in this respect it cannot be said that the goal was achieved in Lebanon. While this was an active choice of programme design in Lebanon it raises question for RC/RC as a whole on the extent to which they are comfortable with programme activities not supporting goals and funding not being spent on its intended purpose i.e. providing support and integration for Syrian refugees and their host communities. While localisation is important, from the perspective of the results framework this remains a challenge.

Health

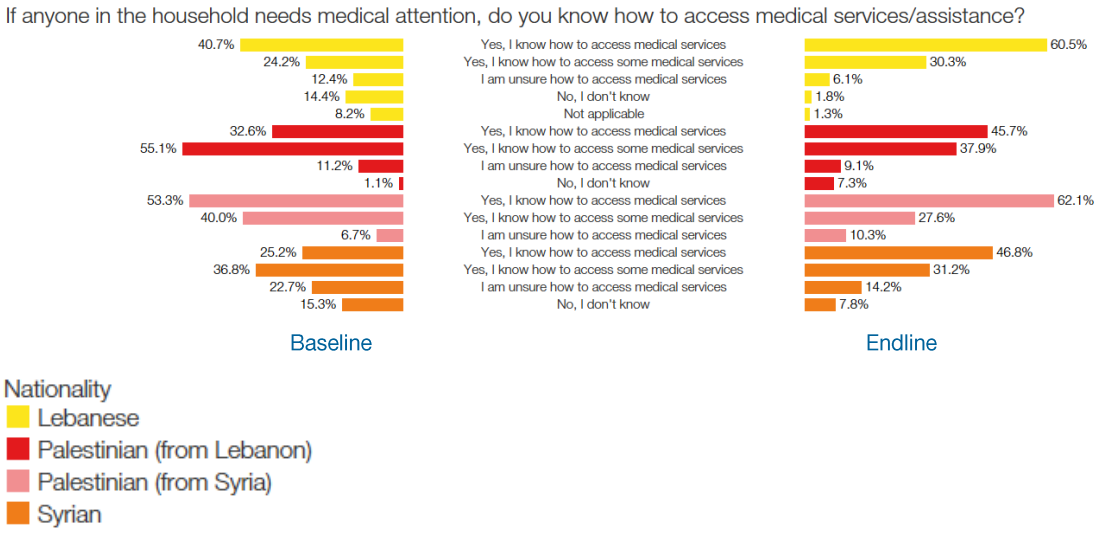
Improved Health Knowledge and Access to Services

Improvement in health awareness and access to health services is the area in which the MADAD programme has had the most evident effect. The health component included a range of activities within CBHFA, the training of first aiders within communities, and building on the existing blood transfusion service and ambulance dispatch service. The programme has reached a large number of beneficiaries: 30,436 were reached through health education activities and 298,332 were reached by medical services.

When asked how RC/RC support had impacted their and their household's lives, improved access to health services was the most common area of improvement. Support for this was consistent across the four major nationalities: Syrian, Lebanese, PRL and PRS. There has been an increase in knowledge of how to access medical services and assistance over the course of the programme. 84.4% 'know how to access' or 'know how to access some' services compared to 76.9% in the baseline. 9.8% remain unsure while 5.8% do now know how to access medical services.

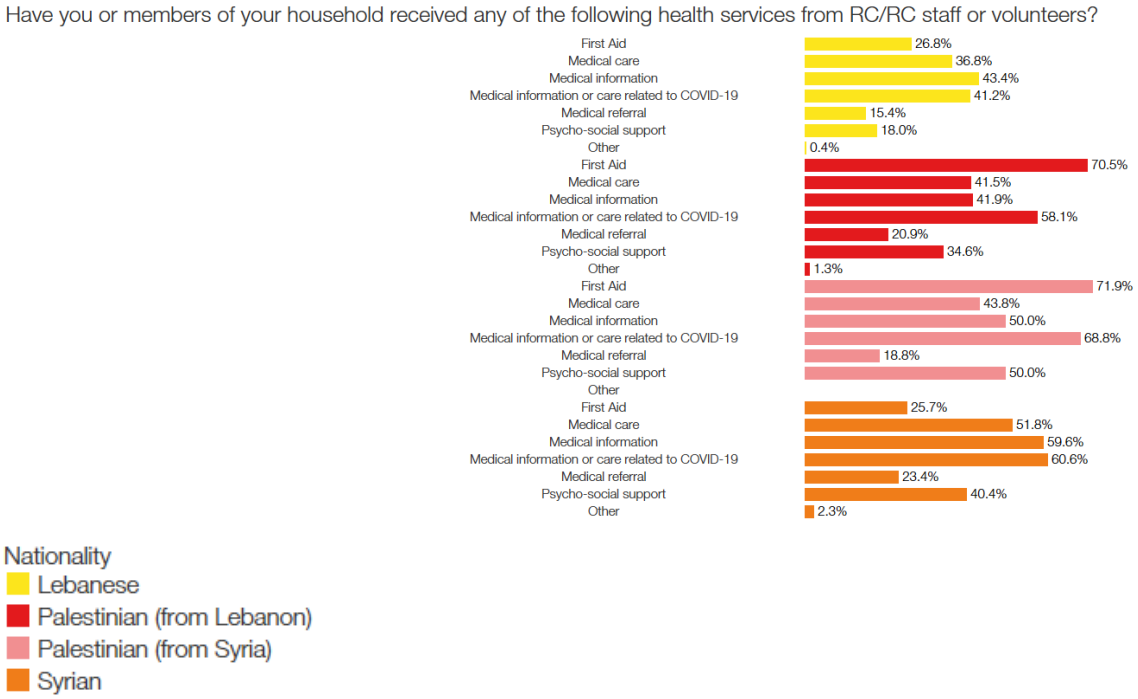
Lebanese and Syrian respondents showed increased knowledge on how to access medical services or assistance, whereas for PRS and PRL, the overall proportion of those able to 'access' or 'access some' medical services has slightly fallen. The vast majority of PRL, PRS and Syrians reported that this knowledge was provided or partly provided by RC/RC staff and volunteers. Most Lebanese respondents reported that they knew how to access services although 36.7% stated that this was not due to the LRC. This suggests that through MADAD, LRC and PRCS have been successful in providing greater awareness of healthcare access to their beneficiaries, particularly important given their limited access to national healthcare providers.

Figure 41: Lebanon - Baseline-Endline comparison: beneficiary knowledge levels on access to medical services



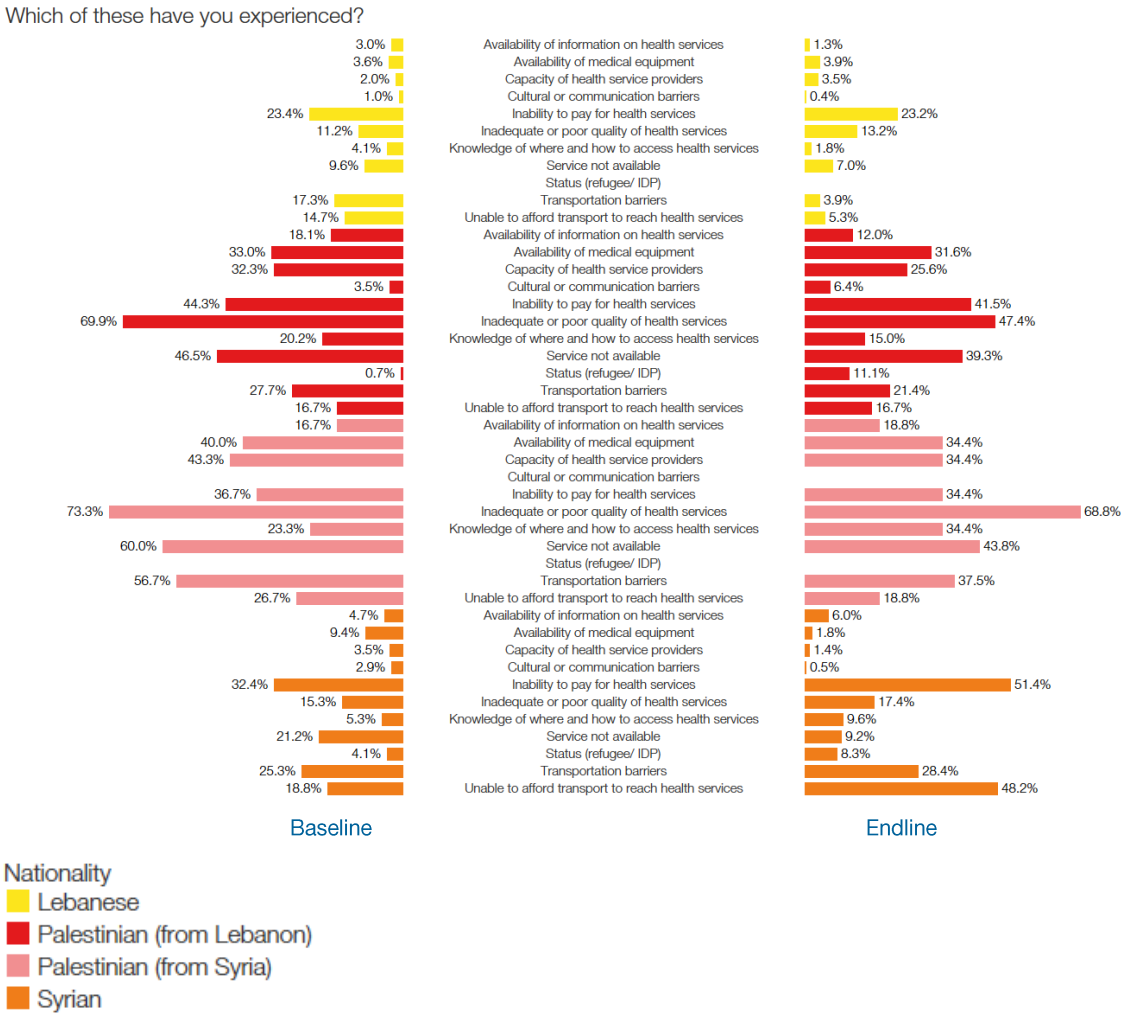
Knowledge of how to access all types services has increased since the baseline. Large numbers of participants have received PSS, medical information, medical care or first aid from RC/RC. Different nationalities reported different levels of interaction with services. Syrians were the largest group who reported receiving medical care or medical information, with PRS and PRL also over-represented. This shows that overall, refugee populations have been the primary beneficiaries of these services. PRL comprised the vast majority of those who reported accessing first aid. Although PRS were the smallest proportion of those who accesses this service, their proportion in relation to their overall survey participation is high. This reflects the strong focus PRCS have placed on first aid and first aid training amongst their beneficiaries.

Figure 42: Lebanon – Endline: health services received from RC/RC staff and volunteers



Most respondents in the Endline do still face barriers to accessing health services, although this has decreased since the baseline. The fact that the majority still face barriers must be contextualised in the wider Lebanese context in which refugees' legal access to healthcare is limited while increasing prices mean many Lebanese can no longer afford private medical care. Over 55% of Lebanese respondents report no barriers no accessing healthcare, 38% report some barriers and a minority report many barriers. In contrast, the situation has **worsened** for Syrians and PRS with an increase in those who report facing many barriers. The biggest issue is inability to pay for services. Of those who said they could not afford health care, 41% were Syrians, a higher proportion than the baseline. This was followed by PRL although this was a decrease since the baseline while PRS remained static. Results of PRCS beneficiaries must be contextualised within the ongoing support of UNRWA health services. There was an increase in the proportion of Lebanese who reported being unable to afford healthcare PRS are most affected by inadequate or poor-quality health services. The third largest issue was those unable to afford transport to reach health services and Syrian refugees comprised 64% of those who faced this challenge, an increase since the baseline.

Figure 43: Lebanon - Baseline-Endline comparison: barriers to health services



CBHFA and First Aid

CBHFA have been effective in providing communities with increased health and hygiene knowledge and knowledge about how to access to services. CBHFA activities were based on needs assessments conducted by LRC and PRCS and updated over the duration of the programme. Awareness sessions were tailored to the local context in each camp and to the needs of different beneficiary age groups. Sessions included chronic illnesses, non-communicable diseases (NCDs), smoking, menstruation, support for the elderly, and COVID-19 awareness and mitigation. Awareness raising sessions were the most commonly cited activities in FGDs and interviews. Participants reported that the awareness sessions and knowledge building are critical for long-term support and capacity development. They stated they will always be able to use the knowledge they have gained and are better prepared to respond to emergencies themselves. FGD participants and beneficiary interviews provided several examples of assisting elderly relatives and those with NCDs using the information gained from awareness sessions.

Awareness sessions had good reach within most communities and were generally considered to be held in accessible locations. Home visits were useful in reaching vulnerable beneficiaries and were valuable for the elderly and Syrian women who face mobility challenges in attending sessions outside their homes. Those who attended awareness sessions or accessed health services were predominantly women. There is a clear trend amongst LRC and PRCS's female beneficiaries that the activities are not only informative but provide a source of relief and an opportunity to socialise.

However, these sessions were not considered relevant or were not well attended by all beneficiary groups. Although LRC did provide services for Syrians living in collective shelters and ITS through a range of approaches (including home visits, public awareness sessions and remote awareness sessions during Covid-19) Syrian refugees living in more remote and precarious conditions, such as informal tented settlements (ITS), were less likely to participate or know about the awareness sessions compared with other beneficiaries engaged during the data collection. FGD participants from one camp suggested that at the beginning of the programme residents did not see the relevance of awareness sessions as their needs were primarily socio-economic and safety and security was a bigger problem. This attitude has changed over the course of the programme and they now place greater value on health knowledge and how it can improve capability and capacity to respond to accidents and emergencies in the camps. This is reflected in the wider Lebanese context where Syrian, PRS and PRL respondents were likely to cite basic subsistence and security as the main challenges they faced rather than health concerns. Nonetheless, the overall attitude towards CBHFA is positive and beneficiaries view it as a valuable service.

Increased health service provision is also one of the programme's successes. Both the LRC and PRCS beneficiaries attribute information provided about local health and access to medical services to RC/RC. Under MADAD, both HNS built on their existing health services and were able to expand these into new areas. LRC provide many services including family medicine doctors, free vaccinations, first aid kits, some medications for chronic illnesses including diabetes and hypertension, and in some areas hygiene kits, first aid equipment such as thermometers and winter clothes for the Syrian population. PRCS has been able to provide new medical equipment and medicine, equip an ambulance and support the provision of menstruation kits as a result of MADAD. Provision to both refugees and host communities appears to have been equitable and beneficiaries praised RC/RC as a neutral service provider who helps all regardless of nationality. This is in contrast to perceived bias of other NGOs cited by beneficiaries.

LRC's screening campaign reached many beneficiaries and provided a free service to those who would not ordinarily be able to access this service. This has provided greater health awareness for individuals although a notable gap remains around beneficiaries' ability to access necessary care following their screening results. Following recommendations from the ROM, PRCS has established a medical referral service, allowing them to connect with other health service providers and fill a gap in their offering. Based on an observed need amongst the community, PRCS also established a referral service for domestic violence victims and upskilled their social workers on response to this issue. There is clearly a high-level of trust towards both LRC and PRCS as health care providers.

However, several beneficiaries raised the challenge that they still cannot access all their required medication through RC/RC services. Beneficiaries had a positive attitude towards PRCS health services but talked more about UNRWA or other NGOs as their primary healthcare provider. PRCS are seen as a first response team rather than a medical provider and their beneficiaries were more likely to discuss awareness and information sessions. Notably, PRL were much more aware of PRCS's health services than PRS. A small number of Lebanese beneficiaries expressed that distribution of kits should be made available to vulnerable Lebanese as well as Syrians, but the overall sentiment was that provision of services is balanced. Some Syrian beneficiaries stated that the services provided were welcome but not enough to meet their basic needs

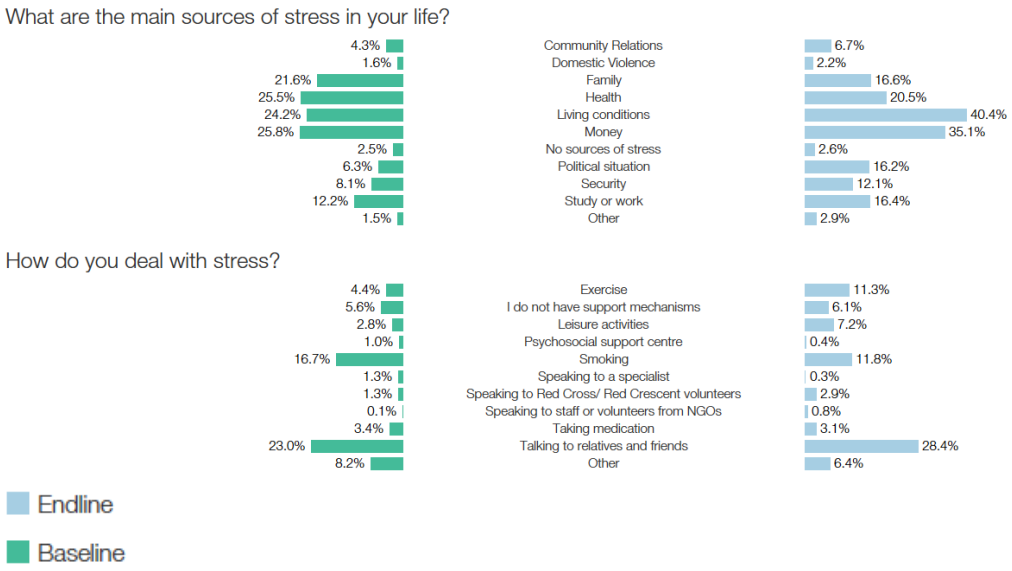
The training of first aiders was a major component of the health programme for both HNS. Overall, 422 volunteers and community mobilisers have been trained in CBHFA and first aid. First aid training is one of the most commonly cited activity amongst beneficiaries and volunteers. Beneficiaries who had received the training stated that it had helped them to respond to medical emergency while those who had not directly received the training suggest that it has improved the overall capacity of their community to respond to accidents and

emergencies. Beneficiaries were able to provide examples of where they had put their first aid training into practice. The development of the first aid force has also strengthened the ties of the host national societies with the communities in which they work, increasing trust. It has also contributed to integration and social cohesion by providing an opportunity to beneficiaries from different communities to interact in a positive, neutral environment.

PSS

PSS was implemented by LRC and was not part of PRCS activities. PSS has reached 3066 beneficiaries.. The Endline shows the main sources of stress in beneficiaries' lives are living conditions and money, both reflecting a significant increase since the baseline. Concerns around political situation, security and study or work have also increased. Respondents suggested that their main way of dealing with stress was to talk to relatives and friends, an approach which has gained popularity since the baseline. The number of respondents citing exercise as a coping mechanism has increased while those citing smoking as a coping mechanism has decreased. This could reflect the impact of health awareness sessions delivered under CBHFA.

Figure 44: Lebanon - Baseline-Endline comparison: beneficiaries' main sources of stress



Women and those in the 18-30 age group discussed their attendance at PSS sessions most and generally spoke about this positively. The most cited topics were positive thinking, motivation and supporting girls beginning menstruation. However, most beneficiaries in interviews or FGDs had not participated in PSS activities or were unsure what these were. In Lebanon, PSS was not a standalone component but integrated into other activities CBHFA activities. This helps explain why beneficiaries do not discuss PSS explicitly or recognise it as an activity that they have received.

In terms of nationality it is unclear who has benefitted most from PSS activities. The Endline PSS services appear to be concentrated amongst refugee populations. Syrians were the largest proportion of beneficiaries who reported accessing these services while PRS are also over-represented here. However, management staff suggested that PSS support and engagement amongst Syrian beneficiaries was not as high as they would have liked.

It is therefore difficult to judge the impact of PSS on beneficiaries. Additionally, the impact of the PSS component is hard to assess given increasing levels of instability and stress in the Lebanese context over the duration of the programme. PSS activities were implemented alongside growing stresses of economic instability, livelihood concerns and COVID-19 which

beneficiaries frequently cited as major challenges in their lives, making it more difficult to observe benefits amongst beneficiaries

There is a sense amongst staff that the PSS component was a missed opportunity. It did not capture the level of Syrian beneficiaries they would have liked and although MADAD allowed PSS provision to expand into nine new areas of the country, it did not significantly meet the needs of beneficiaries engaged in activities, particularly members of the Syrian community. A potential explanation for this is that PSS was integrated with other activities rather than being a standalone component. This reduced effectiveness in targeting activities at particular beneficiaries who may have needed this support most and providing in-depth support in this area. This is reflected in the point that beneficiaries struggled to identify the integrated PSS support they had received through activities they participated in.

Hygiene Promotion

MADAD's hygiene promotion activities have also been successful in raising awareness amongst beneficiaries. In total, 29,150 beneficiaries were reached by hygiene promotion activities. 79.5% of Endline respondents said their knowledge of hygiene practices has improved as a result of RC/RC's hygiene promotion activities. Activities were clearly relevant to local populations with hygiene and cleanliness flagged as common challenges in the FGDs, particularly amongst children and in camps.

Both LRC and PRCS have tailored activities to the needs of different beneficiary groups, ensuring wide coverage across the communities. For example, sessions with school children were complemented by awareness raising sessions with mothers to ensure that practices taught in schools can be implemented at home. Many FGD participants reported receiving hygiene kits from their HNS although many Syrian participants stated that these kits should be provided more regularly and were not sufficient to meet their needs. This is linked to the fact that Syrians in particular reported needing greater support to meet their basic needs in comparison to the host community.

Blood Transfusion and EMS

The two major successes of the health programme in Lebanon are LRC's Blood Transfusion Service and the consolidation of the national ambulance service and its centralised dispatch centre. Through MADAD, LRC has established a voluntary blood donation service with safe, readily available blood stocks available for communities. As a direct result of MADAD, LRC has been able to run nearly 200 blood drives a year compared to an average of 50 blood drives the one or two blood drives per year that were conducted before MADAD. They have established a 38.8% voluntary blood donation rate, a concept that has been popularised under the programme. The service has reduced under COVID-19 however the attitudinal change towards blood donation is a long-lasting success of the programme.

MADAD has allowed EMS to consolidate their emergency dispatch team and ambulance service into a more efficient and responsive system. MADAD provided the funds to implement a new dispatch system and consolidated 2 secondary centres into a main dispatch centre with increased capacity. In addition the service has 2 other regional dispatch centres and one backup overflow centre which will be retained. The main centre receives around 2000 calls a day and LRC has increased its workforce to ten dispatchers per team, with training and support. This is one of the strongest sustainable changes of the programme due to the investment in modern facilities and proper training of staff which has institutionalised knowledge of operations. The service is used nationally and its strength recognised through the awarding of additionally funds under MADAD II, directly from the EUTF to LRC.

COVID-19

In 2020, the health programme pivoted to include a COVID-19 response. The response has been strong across communities and has included: awareness on medical information and COVID-specific hygiene practices, the distribution of hygiene products and masks, and cleaning of camps. The LRC ambulance service is responsible for transporting COVID-19 patients. There has also been a strong effort to reach vulnerable members of the community with this support such as the elderly. PRCS has used its in-camp presence to aid the response. It has increased the presence of first responders and set up checkpoints for temperature checks and distribution of hygiene provisions as well as sanitising camps. RC/RC is viewed as a trusted provider of information on COVID-19.

In the Endline, the area which most beneficiaries had received information on was medical information and care relating to COVID-19. The largest proportions of respondents who reported receiving COVID-19 information and care were Syrians, and PRL. Overall, the refugee population appears to have been more engaged by this service than the host community. Notably, PRCS beneficiaries were far more aware of the COVID-19 response and services than LRC beneficiaries. This could be due to PRCS's long term presence in the camps meaning they could quickly pivot activities to a direct response. In contrast, MADAD has been implemented in new LRC locations and relies on cooperation with local community leaders and municipality representatives for access to community. This could mean the extent of their responses may not be as obvious to beneficiaries.

HNS Capacity Building

Both Host National Societies have greatly improved their capacity as a result of the MADAD programme. Capacity building focused on volunteer recruitment and management, staff and volunteer training, the development of peer support systems at LRC, and financial and management capacity building for LRC and PRCS staff. 2375 staff and volunteers received training under MADAD and 85% demonstrate adequate levels of knowledge and skills following training. It is important to note that LRC training took place as part of general capacity building for the organisation rather than the direct implementation of MADAD. As such was not tailored to the Outcome 3 objective of better identification and engagement of vulnerable beneficiaries but did show increased capacity around volunteer management and peer support.

LRC has implemented a standardised volunteer recruitment and management process under MADAD, with the support of the Spanish Red Cross. This implemented clear guidelines and standards and processes such as recruitment needs assessment in-depth screening of potential volunteers, training and induction sessions, and follow-up with volunteers. There is a clear exit process including an exit interview to understand why volunteers leave LRC. Before MADAD, volunteer recruitment and management differed by LRC department and was less understood by potential volunteers.

LRC have recruited volunteers from the communities in which they work. Access to a pool of community volunteers is a new concept for LRC, introduced by MADAD. This has improved their capacity by expanding the volume of activities they can run as well as deepening their understanding and assessment of communities' needs, which are communicated to LRC by their volunteers. The presence of first aiders and first responders in communities has strengthened both LRC and communities' response capacity and supports a more trusting relationship between each. Equally, younger beneficiaries reported that volunteering had provided them with a sense of purpose and giving back to their community. All volunteers have undergone extensive training to allow them to implement their respective activities and FGD participants reported increased confidence as a result of this. Community volunteers are now able to work independently and run activities without the support of LRC staff, an improvement over the duration of the programme.

LRC has developed a clearer picture of volunteer's challenges and motivations in order to address the drivers of high turnover. Frequently cited reasons for volunteers leaving LRC included lack of time, lack of understanding about what volunteering would entail, poor management, lack of motivation and a stressful work environment. These have been addressed through better training across the organisation, including an introduction session that articulates volunteer's rights and responsibilities. Volunteers are also better support through the peer support system discussed below. At the leadership level LRC has introduced training on volunteer management and the fundamentals of motivation. There is a recognition that the system can only be successful if supported by LRC's management and there has been a concerted effort to secure buy-in and understanding of the importance of standardised, comprehensive volunteer management processes.

LRC introduced a strong peer support process for staff and volunteers and have established Designated Peer Supporters across 26 EMS stations. PSS was more obviously successful amongst staff and volunteers than amongst beneficiaries. Staff and volunteers reported a significant organisational and attitudinal shift towards mental health as a result of MADAD activities. Mental health is no longer a taboo subject and there is a more supportive working environment with buy-in from the leadership level. MADAD allowed LRC to introduce a tailored peer support approach which has succeeded where previous, less bespoke, approaches have failed to take hold. Peer support groups have been established at all LRC stations and are now able to operate independently without independent facilitation. Staff and volunteers stated that had this system not been in place during the COVID-19 and Beirut explosion responses, they would have lost many volunteers due to stress. This has cemented the importance of peer support and discussing mental health amongst staff and volunteers.

PRCS has also invested in recruiting, training and upskilling its volunteer base through MADAD. They have delivered refresher training to over 300 existing volunteers in addition to recruiting and training new volunteers through a clear recruitment and screening process. Training received by volunteers under MADAD covered a range of topics including core CBHFA, duties and rights of volunteers, an introduction to the RC/RC movement and security and safety training. PRCS have also provided first aid training and retained 25 regular first responders who demonstrated their capability in response to the Beirut explosion and COVID-19 response.

PRCS volunteers had very positive feedback on the process and had developed their skills in new areas such as first aid. Some had also trained as first aid coordinators and trainers through the programme. Volunteers reported improved confidence as a result of the training and felt better prepared to engage large and diverse groups. Through regular interaction with beneficiaries they developed a clear picture of their needs. PRCS volunteers also received PSS training which they credited with helping them understand their community's problems better and helped them to engage with beneficiaries.

Similar to LRC, volunteers from beneficiary communities have added a new dimension to PRCS's capabilities. First responders allow a quicker PRCS response when camps are closed, and local knowledge has created a stronger network with other service providers in camps. First aiders and first responders have been critical in raising PRCS's profile and building trust with communities. Volunteers also reported confidence in identifying the needs of vulnerable groups and linked this with being embedded in communities and regularly interacting with beneficiaries.

Both LRC and PRCS have further professionalised their management, procurement and financial processes as a result of MADAD, even though this was not a direct aim of the programme. This trend was observed at a management level and staff make reference to finance and management training they received under the programme and the experience they have gained on the job by working to the programme's management and reporting requirements. A clear illustration of improved management and implementation capacity is

the fact that LRC will independently implement activities in partnership with EUTF with a new round of MADAD funding.

Conclusion

The programme has had some notable successes in Lebanon. Together, the programme components have taken a holistic approach to addressing beneficiary needs and engaging them in multiple activities. This was particularly successful in providing a clearer idea of who was most vulnerable and enabling their inclusion in the most relevant activities and services. Activities were developed following needs assessments and were tailored to the challenges affecting each community. Most beneficiaries stated that services were easily accessible with the exception of some Syrian women who find it harder to access services away from their homes, those living in ITS, and Syrians living in particularly remote areas. The main drawback of the programme is the relatively low levels of Syrians who have been engaged across programme in comparison to the Lebanese host community.

Improved HNS capacity is evident in terms of volunteer recruitment and management and improved HNS capacity to respond to emergencies. Building a network of volunteers is a key programme success. Community volunteers are instrumental in raising new needs and target groups in each context. Equally, volunteers have increased community capacity and resilience by embedding knowledge of health, emergency response and DRR in communities, making them more self-sufficient. This has boosted RC/RC's reputation amongst communities andimproved trust and respect.

Health and hygiene awareness have increased across beneficiary groups, and communities are better prepared to provide emergency medical response through the first aid teams. There was also been a noticeable change in health behaviours and beneficiaries' lifestyles.Activities have been well tailored to local needs and beneficiaries expressed few problems in accessing these. Notable successes of the health component are the Blood Transfusion Service and upgrading of LRC's ambulance dispatch service. PSS remains an area that could be expanded through reaching a greater number and more diverse range of beneficiaries. Given ongoing instability in Lebanon, this service could be highly valuable to a range of beneficiaries.

Although DRR activities did not engage the Syrian community as much as the Lebanese host community, activities were well-tailored to meet local needs and supported identification of risks and hazards. In order to ensure capacity and resilience are sustainable, communities need to be have a budget for replenishing consumable material . This is essential for them to operationalise theirknowledge to develop greater trust from communities that first responders can continue to provide support.

Despite successes, MADAD has become less relevant over time. Changes in the wider Lebanese context calls into questions whether the programme activities address the most pressing beneficiary needs. Syrians, PRL and PRS cited basic subsistence, livelihoods and labour market access, infrastructure and safe and secure housing as the major challenges they faced. Lebanese beneficiaries cited livelihoods and education as their biggest challenges. These challenges are driven by Lebanon's current economic crisis. These challenges were also recognised as the root cause of community tensions which MADAD aimed to reduce. These major challenges are not the focus of MADAD and have not been incorporated into programming as they have arisen. However, it is recognised that these are highly politicised areas and as such RC/RC's ability to provide a response would be severely constrained. To an extent this is recognised by beneficiaries as when asked what they would like RC/RC to provide, beyond humanitarian assistance, they do not request support in these areas and overall are content with the services they receive.

Iraq

The findings and conclusions in this country report are drawn from a range of sources to ensure validity, including a comprehensive document review, semi-structured interviews with programme staff and beneficiaries, as well as household, health and livelihoods surveys. The household survey conducted in Iraq received a total of 625 responses (372 females and 253 males). NorCross administered 385 surveys focusing on health activities, and FRC administered 240 surveys focusing on livelihoods activities (see Figure 45 for a further demographic breakdown of survey respondents).[20] The Endline survey in Iraq received 100 fewer responses than baseline which is accounted for in the following analysis and findings. In addition, 12 telephone interviews were carried out with programme beneficiaries and two with programme staff, and KIIs were conducted with ten programme staff from all four RC/RC partners, ranging from the country programme manager to programme officer level.

Figure 45: Iraq - Baseline-Endline comparison of survey respondents by sex, nationality, civil status and living location

[20] The cohort of respondents for the Endline were not the same as those surveyed for the baseline. Therefore, the analysis gives a snapshot of the people surveyed now and then (and not a change for the same cohort).

MADAD programme in Iraq

Table 6: Iraq Programme Overview

Partner	Society	Activities
Lead Partner	NorCross	Health and WASH
Host National Society	IRCS	Health, WASH and Livelihoods
Other partners	FRC	Livelihoods
	SRC	Capacity Building
	DRC	Reporting

Iraq Programme Budget	Target No. of Beneficiaries to be Reached	Actual No. of Beneficiaries Reached (October 2020)
EUR 2,886,889	75,500	85,274

The MADAD programme in Iraq, implemented by three Red Cross and Red Crescent (RC/RC) partners alongside the IRCS, focused on health and livelihood activities aimed at beneficiaries, and capacity building activities aimed at RC/RC staff and volunteers.

Medical service provision in Iraq included emergency care provided through ambulance emergency and referral services and stabilisation rooms, as well as training of six CERTs. Health and hygiene awareness activities were undertaken with refugees and IDPs in 11 camps, and hygiene kits were distributed in six camps. RC/RC partners also worked to improve WASH infrastructure in four schools and 11 primary health care facilities.

Livelihoods activities in Iraq focused on professional skills, vocational or business development training courses and support to start small business or apprenticeships. Social cohesion and community building activities were integrated as part of health and livelihood activities. As part of Outcome 3 to strengthen the capacity of the IRCS, a range of training courses were offered to RC/RC staff and volunteers including first aid, hygiene promotion and volunteer management, recruitment and retention.

The activities in Iraq were implemented in an extremely challenging context with numerous crises affecting the programme. There are currently 245,810 registered Syrian refugees in Iraq, including approximately 17,500 Syrians who fled to the Kurdistan region of Iraq towards the end of 2019 as a result of increased hostilities in north-east Syria.[21] The programme was implemented during Daesh/ISIS operations in the north of the country, particularly affecting activities in Erbil and causing large, unforeseen movements of IDPs which placed additional strain on camps already struggling with capacity due to the influx of Syrian refugees.

In addition, the referendum on Kurdistan's independence in September 2017 caused conflict, political unrest and an economic slowdown following the trade embargoes implemented by Turkey and Iran in response. Most recently, the COVID-19 pandemic worsened the economic crisis. Unemployment amongst host, refugee and IDP communities in the country increased, and further strain was placed on Iraq's health infrastructure.

Against this backdrop, and despite an initial delay in implementation, the MADAD programme in Iraq surpassed its target of 75,500 beneficiaries, with 85,274 beneficiaries having been reached as of October.[22] The following sections outline in more detail the evaluation's key

[21] 3RP Regional Strategic Overview, 2020-2021
[22] Figures are quoted from the MADAD dashboard and are not fully verifiable.

findings and conclusions against each of the activities in Iraq, as well the key operational strengths and weaknesses.

Health

Health activities in Iraq included medical service provision, as well as emergency care provided through ambulance emergency and referral services, and stabilisation rooms in six Primary Health Care Centres in five selected camps in Erbil and Dohuk. A total of 414 community volunteers were trained to provide emergency medical services in teams, in CBHFA, and to carry out health awareness activities such as door-to-door visits and focus group discussions. These activities were undertaken in 11 camps with a reported 40,015 beneficiaries reached through health education activities.[23]

In the regional baseline assessment and MTR, beneficiaries identified the lack of availability of health services, as well as transport costs to travel to health facilities, as major barriers to accessing healthcare in Iraq. The cost and/or availability of medicines was also highlighted as a barrier by both beneficiaries and by IRCS staff. In refugee camps, the most prominent risk identified related to health conditions stemming from the deterioration of hygiene conditions.

A baseline study of beneficiary needs was conducted prior to the programme, drawing on secondary data from UN agencies and needs assessments in the communities. Health activities were targeted accordingly to ensure that gaps in health services were addressed. A set of criteria were developed to guide the needs assessments and identify the most vulnerable beneficiaries. The criteria included camp population size, distance from the nearest medical centre, other NGOs with a health or hygiene focus present and the number of medically vulnerable people present in the community. In KIIs, both RC/RC staff and beneficiaries confirmed that community members that were most in need were being identified, and services provided to them.

Regular camp visits and surveys were also implemented to continuously monitor beneficiary needs and programming gaps, complementing the initial needs assessments. Post-service surveys identified whether beneficiaries were satisfied with the health services provided. KOBO Toolbox was used successfully to enable daily monitoring of health activities, with aggregated reports allowing information and lessons related to the health component to be shared amongst staff and partners.

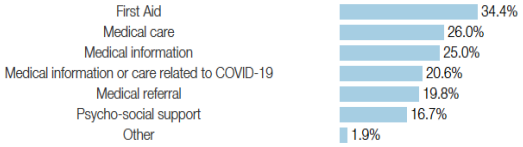
RC/RC partners also ensured strong external coherence by coordinating with other actors in the health sector, including local health directorates, UN agencies and local NGOs, which helped to ensure that services were not duplicating those provided by other actors.

Implementation of the health component began with the distribution of first aid kits, as well as health and first aid awareness activities to improve community-based health. These were provided across the camps and other programme locations to refugee, IDP and host communities, with vulnerable communities (vulnerable communities classed as those living in the largest camps with the least NGOS with health or hygiene focus present, the furthest from the nearest medical centre, and the greatest number of medically vulnerable people present) specifically targeted. The topics of the sessions were adapted according to the needs and emerging health issues in the camps, including most recently for COVID-19. Figure 46 indicates that a significant number of respondents received both general medical information from the RC/RC, as well as specific information on COVID-19. This attests to the wide reach of the awareness activities.

[23] Figures are quoted from the MADAD dashboard and are not fully verifiable. For example, beneficiaries attending more than one activity may have been double counted. Therefore, the figures should only serve as an indication.

Figure 46: Iraq – Endline: RC/RC health services accessed by beneficiaries

Question: Have you or members of your household received any of the following health services from RC/RC staff or volunteers?



Emergency medical services, ambulance services and first aid kits provided by the RC/RC were found to be well targeted and accessible by both beneficiaries and RC/RC staff. It provided essential services to IDP, refugee and host communities where few services otherwise existed. Having identified gaps in staff capacity and medical equipment in the medical centres, the RC/RC trained paramedics and provided medical equipment to improve the capacity of selected medical centres. By training community volunteers, the RC/RC was also able to gain insight into the needs of the community, thereby being better able to tailor and target services.

Despite these activities, the Endline survey results show that beneficiaries who reportedly faced barriers to accessing health services still viewed the capacity of health service providers, as well as the availability and quality of health services as the most significant barriers to accessing health services (see Figure 48). However, Figure 47 shows that there was a significant decrease in the overall number of survey respondents that faced barriers in accessing health services. In particular, there was a significant increase in the numbers of beneficiaries able to pay for health services, and transportation barriers and costs had been reduced. The telephone interviews highlighted mixed awareness amongst beneficiaries of the RC/RC health services provided, despite reports that the services were largely accessible for the communities. Beneficiaries also noted that the availability of medicine in the health centres was limited, with only over-the-counter medicines available, and no medicines at all at certain times.

Figure 47: Iraq - Baseline-Endline comparison of percentage of survey respondents facing barriers to accessing health services

Question: Do you face barriers in accessing health services?

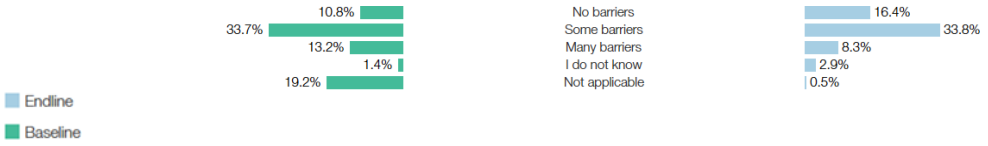
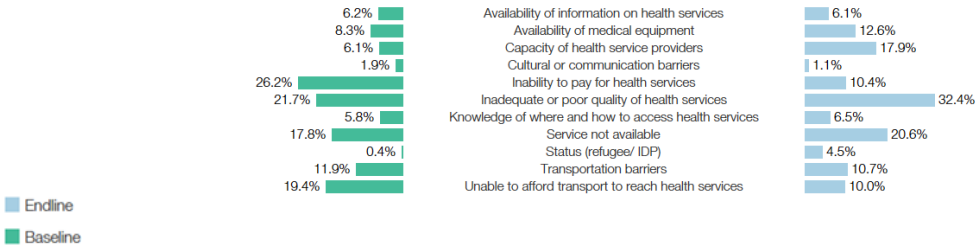


Figure 48: Iraq - Baseline-Endline comparison of barriers to respondents' accessing health services

Question: If you do face barriers, which of these are you experienced?



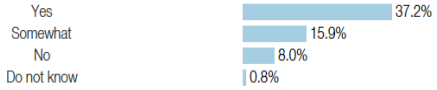
Although the medical activities in the camps were designed to meet immediate needs and not as permanent services, the sustainability of health outcomes was ensured to some extent as the equipment, including the ambulance equipment and incinerators can still service the communities, primary healthcare centres remain operational and training was provided for health staff to use the equipment. For example, NorCross provided equipment for existing ambulances used by Department of Health in the camps as well as training for health staff. The community members trained as first responders will also retain their skills and will likely

remain in the camps. For example, beneficiaries reported being able to treat neighbours and family members with the first aid skills learned on RC/RC training courses.

The skills acquired by staff and volunteers will need updating and there could have been improved planning for this as well as for the maintenance of equipment but it is likely that some of the health and emergency response capacity will be sustainable after the close of the programme, given the right conditions including the resources and skills to service and maintain equipment and continued refresher trainings. However, further funding is not available to continue employing many of the volunteers and first responders following the end of the programme, decreasing the likelihood of health outcomes being sustained.

Figure 49: Iraq – Endline: Percentage of respondents reporting that COVID-19 has made it more difficult to access primary health care services

Question: Has the COVID-19 pandemic made it more difficult for you or anyone in your household to access primary health care services?



In addition, the COVID-19 pandemic is likely to place severe strain on the capacity of the healthcare system and the survey data highlights that the pandemic has already decreased the ability of beneficiaries and their households to access primary healthcare services (see Figure 49). The RC/RC staff interviewed highlighted concerns that the programme was finishing at a moment when health activities such as as the provision of PPE and medication, are critical to stem the spread of the virus and protect health outcomes in the affected communities.

WASH

WASH activities aimed at improving sanitation in the communities included the reconstruction of 11 primary health care centres, the upgrading of W.C. systems in schools, the provision incinerators to dispose of medical waste in primary health care centres and a range of hygiene promotion activities. There were also a number of hygiene promotion activities carried out including door-to-door and focus group discussion hygiene awareness sessions and the distribution of hygiene kits to beneficiaries in 6 camps. In total, 12,989 beneficiaries were reported to have attended hygiene promotion activities.[24]

The Endline survey results highlight strong results in relation to the hygiene awareness activities in that a significant number of survey respondents had taken part in the activities, as shown in **Error! Reference source not found.** Figure 51indicates that 49.5% of respondents that had participated in the hygiene promotion activities felt that their knowledge of hygiene practices had improved, and 47.6% felt their knowledge had partly improved. Beneficiaries involved in the telephone interviews reported that hygiene conditions in the camps were generally not a cause for concern, with the community taking responsibility for cleaning communal spaces. Beneficiaries also reported that camps were generally clean despite some specific issues, including poor sewerage systems.

[24] Figures are quoted from the MADAD dashboard and are not fully verifiable.

Figure 50: Iraq – Endline: Percentage of respondents that partook in hygiene promotion activities

Question: Did you participate in, or have you been reached by any of the following hygiene promotion activities provided by RC/RC staff or volunteers?

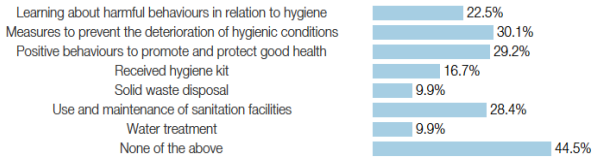
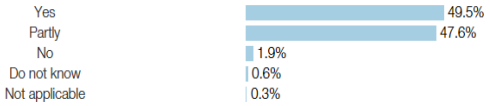


Figure 51: Iraq – Endline: Percentage of participants that indicated improvement in their hygiene practices as a result of RC/RC hygiene promotion activities

Question: If yes, do you feel like your knowledge of hygiene practices has improved?



Due to the remote data collection, the evaluation team was not able to see the WASH infrastructure developed under MADAD in person and the selected indicators for the programme did not capture results and outcomes generated by WASH activities such as the renovation and refurbishment of health centres. However anecdotal evidence suggests that the renovated primary healthcare centres have been of high value and have enabled improved provision of medical services, especially during the COVID-19 response. The activities were also implemented alongside several strong sustainability measures including the training of health staff to operate the medical incinerators and the investments in infrastructure such as the WASH facilities in 4 schools. However, stakeholders indicated that WASH activities are stopping when beneficiary needs are at their highest due to COVID, especially regarding hygiene awareness activities.

Livelihoods

Livelihoods activities in Iraq were focused on professional skills, vocational or business development training courses, as well as support to start small business or apprenticeships with vetted private sector organisations. The overall number of livelihood activities initially planned was reduced in order to free up funding to support the start-up of small business, and to support existing businesses. Activities took place in Duhok, Erbil and Zakho targeting Syrian refugees, Iraqi IDPs and the host community.

Livelihoods and economic resilience were key challenges in Iraq. The baseline assessment found that for Syrian refugees, the main barriers encountered in accessing economic opportunities included mobility, residence cards, security and access to credit.[25] It also found that the lack of livelihoods opportunities led to other challenges; compared to other programme countries, respondents in Iraq were least able to afford accommodation and other household expenditure items. Amongst refugees, Iraqi IDPs and habitual residents, the majority of households had only one member in employment at baseline.

To ensure the relevance of livelihood activities, the IRCS and FRC conducted a labour market assessment, focusing on women and youth employability, existing skills and capacities, as well as interest among the target groups. Interventions were then designed based on existing skills, needs identified in the target population and the demands of the market. This led to the curriculum offered by the three vocational training centres being revised in line with the market assessment. In terms of external coherence, the FRC coordinated with UN working groups and Action Against Hunger (ACF) on livelihoods activities, adjusting and targeting the training accordingly.

[25] 3RP Regional Strategic Overview, 2020-2021

There was an initial delay in the delivery of the labour market assessment and the selection and refurbishment of the vocational training centres, causing the livelihoods activities in Iraq to start 16 months behind schedule which was addressed and raised as a main concern in both ROM and MTR. Training courses include 15 different types of professional skills, as well as vocational or business development, with modules also covering general life skills. A total of 374 individuals participated in the trainings (just short of the target of 400), of which 230 (61%) were women. Beneficiaries were able to access the trainings through the vocational training centres and also reported that in some instances they were provided buses to access the courses. In general, beneficiaries interviewed by telephone reported that they had heard about the trainings via word of mouth. In addition to the training courses, 447 beneficiaries were financially supported to start small businesses, well surpassing the target of 100. This was made possible by the budget reallocation. Monitoring was implemented to track the type of businesses established and income generated.

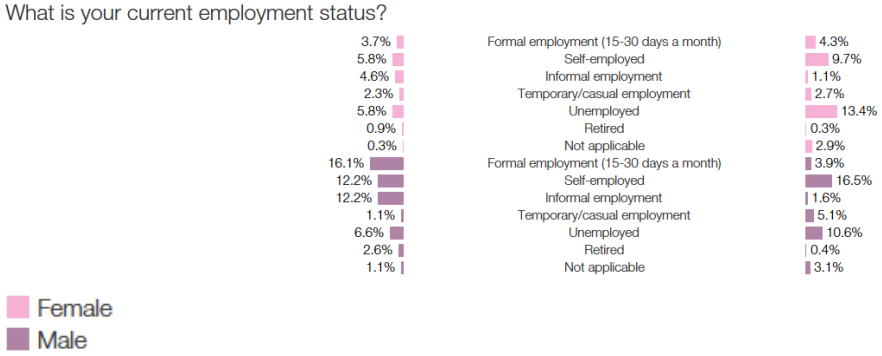
The training courses achieved strong results, with attendees learning new skills or enhancing existing skills, enabling them to take advantage of a range of employment or other income generating opportunities. Attendees reported that the skills gained were relevant, with trainings providing business and employment specific skills such as CV writing, searching and applying for job opportunities, as well as general life skills. A survey conducted by the RC/RC in December 2019 found that 94% of the 64 training participants stated that they had learned new skills during the apprenticeship period.[26] Telephone interviews and case studies provided by the RC/RC provided numerous examples of beneficiaries that were able to secure employment in hairdressing salons or data entry positions, amongst others, following the trainings. The training modules, especially marketing, were well received and participants noted that they acquired useful, lasting skills.

The business start-up approach taken in Iraq was successful in ensuring that the skills acquired through trainings were utilised, and that beneficiaries received the support required to pursue income generating activities. A number of beneficiaries were able to open their own businesses, including bakeries, hair salons, tailors and phone maintenance businesses amongst others. A survey was conducted by the FRC/IRCS in July 2020 to track the businesses that were set up as a result of the training and business support grants. It found that 95 out of 110 respondents who started businesses (86%) were still functioning, earning an average income of 180,950 Iraq Dinars per month.[27]

Figure 52 and Figure 53 illustrate that, although formal employment rates decreased substantially from the time of the baseline survey to the Endline, self-employment rates increased considerably, especially amongst women. At the time of the Endline survey, self-employment had become the primary source of income amongst survey respondents.

Figure 52: Iraq - Baseline-Endline comparison of Respondents' Current Employment Status

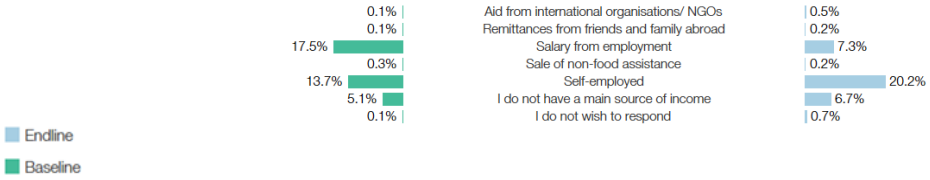
Question: What is your current employment status?



[26] Apprenticeship final evaluation report (Dec 2019). Data source provided by the RC/RC and not verifiable.
[27] Business Support Grants PDM (July 2020). Data source provided by the RC/RC and not verifiable.

Figure 53: Iraq - Baseline-Endline comparison of respondent's' Main Source of Income

Question: What is your main source of income?

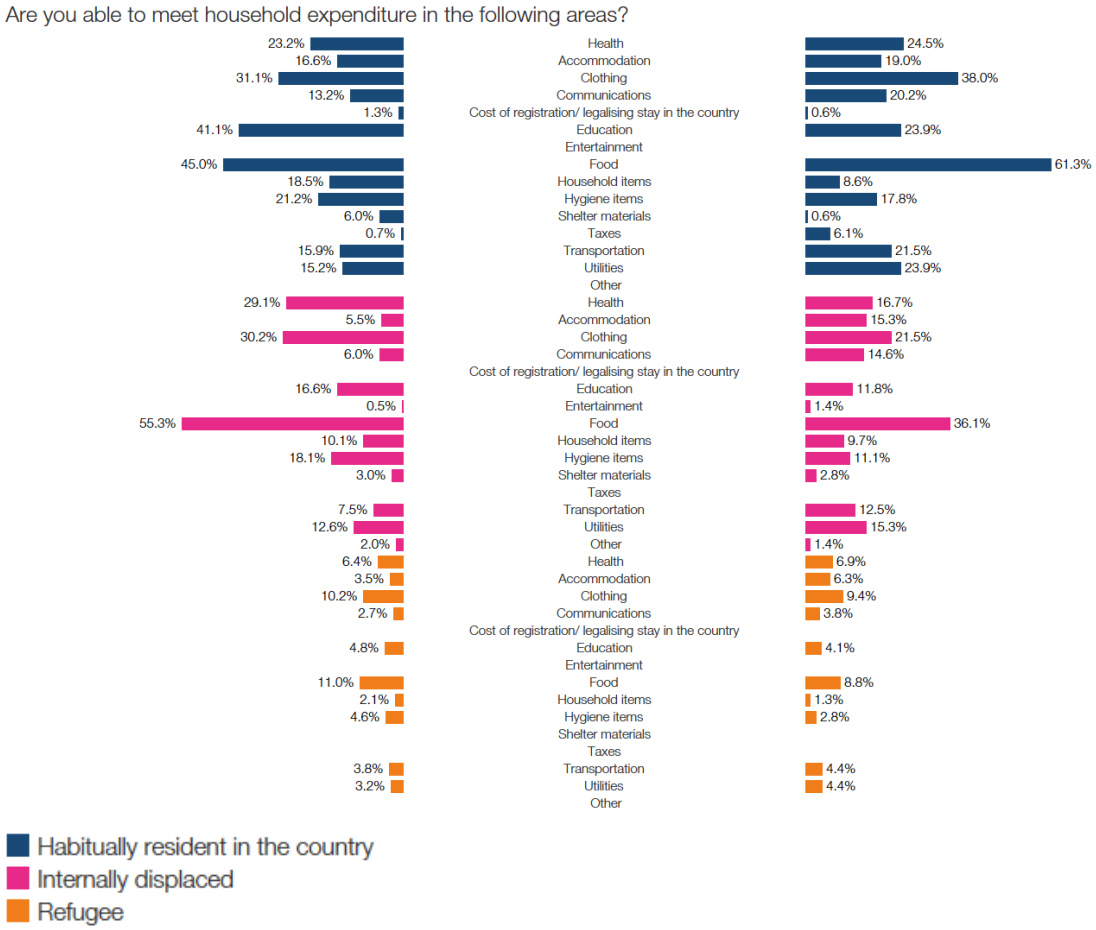


Through securing employment or developing other income generating activities following the RC/RC livelihood activities, beneficiaries reported that they were able to increase their household income, contributing to their ability to meet living costs and support other household members. .

Figure 54 illustrates that there was a substantial increase in the number of survey respondents across host, IDP and refugee communities able to meet their accommodation and utility costs, despite the decreased ability to meet expenditure in other household areas such as food, education and utilities. In addition, Figure 45 highlights that there was a notable increase in the proportion of refugees who were living in rented properties and who, to a lesser extent, owned property, signalling that they were better able to afford accommodation costs.

Figure 54: Iraq - Baseline-Endline comparison of the proportion of refugees, IDPS and habitual residents able to meet household expenditure in specific areas

Proportion of respondents who answered "yes" to the question: Are you able to meet household expenditure in the following areas?



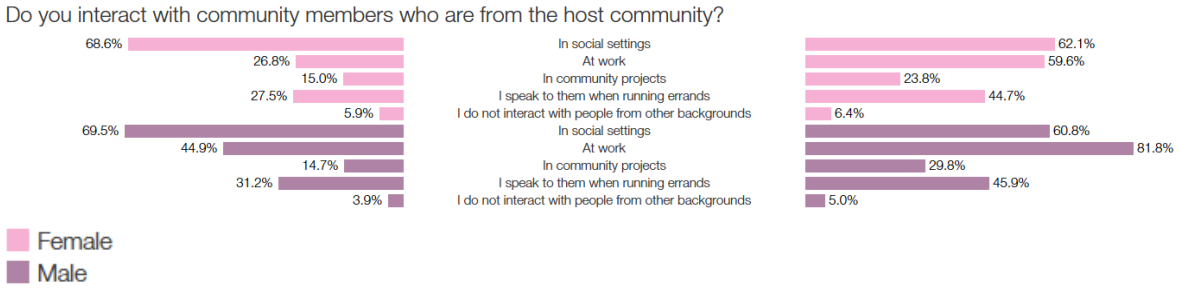
The vocational trainings also contributed to several unexpected, positive psychosocial outcomes. Telephone interviews with beneficiaries and the survey conducted by the RC/RC

following the trainings showed that participants' psychosocial wellbeing improved as a result of the trainings. They were reportedly feeling more relaxed and gained a sense of purpose. This was particularly true of female participants, who reported that the trainings provided a relaxed social space outside of the household in which they could socialise and build networks in their communities, while also learning skills that could help generate an income.

Figure 55 illustrates that there was a substantial increase in the number of women socialising with other community members at work.

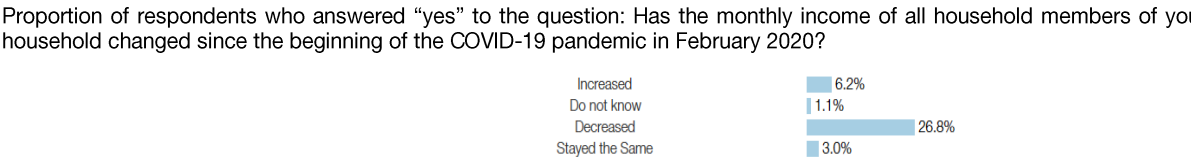
Another unexpected outcome of the livelihoods activities was the improved social relations between communities as a result of the vocational training. Evidence from telephone interviews with beneficiaries, KIIs and the RC/RC survey demonstrate that the vocational training courses provided a space for members of the host, IDP and refugee communities to interact and network with each other.[28] Compared to the baseline, the Endline survey data show that interactions between IDPs/refugees and the host community decreased in social settings, but that it increased substantially in work environments and in community projects (see Figure 55 below).

Figure 55: Iraq - Baseline-Endline comparison of interaction between IDPs/Refugees and host community members, disaggregated by sex



The sustainability of the outcomes related to the livelihoods and economic resilience programme component in Iraq are severely under threat due to the COVID-19 pandemic and the associated curfew. According to the Endline survey results and COVID Business Impact Survey,[29] over two thirds of respondents have experienced a decrease in their household income since the beginning of the pandemic (see Figure 56 below). Beneficiaries interviewed by telephone generally reported that the pandemic had caused loss of employment and income generating opportunities, including the loss of businesses developed following the vocational training and business start-up activities. The most commonly cited challenge to sustaining or reopening businesses was the inability to pay rent for premises.

Figure 56: Iraq – Endline: Percentage of respondents with a change in income since February 2020



The RC/RC has provided multi-purpose cash assistance in response to the crisis, helping beneficiaries to meet their short-term living costs. However, the cash assistance is unlikely to provide sustainable, long-term economic resilience. Despite this, the equipment provided to public vocational training centres provides an environment for further livelihoods trainings to take place. In addition, should there be an economic recovery, the business and life skills

[28] Apprenticeship final evaluation report (Dec 2019). Data source provided by the RC/RC and not verifiable.
[29] Covid Business Impact Survey Results (April 2020). Survey administered by the FRC/IRCS MADAD livelihoods team in May 2020 for 121 functioning small businesses out of a planned 138 businesses known to be functioning in Dec-Jan 2020.

beneficiaries gained in the trainings will remain useful and can be utilised to find and take advantage of future employment and income generating opportunities. In addition,

HNS Capacity Building

According to the baseline survey, basic trainings on PSS, hygiene, first aid and livelihoods had been provided to staff and volunteers in Iraq. However, trainings on gender and social inclusion were considered a gap. In response, the SRC implemented a range of capacity building activities in Iraq based on an initial needs assessments, aimed at improving the capacity of the Host National Society and community volunteers. A total of 242 staff and volunteers were trained in livelihoods, conflict resolution, mediation skills, and volunteer management, and 95% of participants demonstrated.[30]

The capacity building component was seen as effective by the stakeholders involved, with staff and volunteer capacity built in numerous areas including gender analysis, child protection and stakeholder engagement, as well as in health and livelihoods activities. Awareness and sensitisation trainings aimed at enabling volunteers and staff to reach and work with vulnerable groups were considered especially successful. Attendees reportedly gained capacity in identifying the needs of, and working with, vulnerable groups, particularly understanding the different approaches required when working with IDP and refugee communities.

RC/RC staff and volunteers reported that the gender training enhanced participants' skills and understanding of gender sensitivity, including in implementing different strategies to ensure gender balance in projects and in implementing GBV and awareness programmes. Gender and diversity monitoring carried out by the SRC following the trainings found that the identification of beneficiary needs had improved but that activities could still have benefitted from more in-depth beneficiary needs assessments before implementation. However, it was found that the use of disaggregated data had improved following the trainings. For example, after project staff started analysing sex- and age-disaggregated data they had collected, they found that the activities were more accessible to women and thus the timing of some activities were subsequently adapted to achieve a better gender balance.

Participants also reported that the trainings contributed to improved social cohesion and psychosocial wellbeing. A mix of IRCS volunteers, staff and local community volunteers attended trainings, providing a space for them to mix, which enhanced social cohesion. In addition, peer support was effectively employed during the trainings, helping to promote feelings of togetherness and improved psychosocial wellbeing. Participants also reported that the trainings, particularly the livelihood Training conducted in Q1 2020, provided them with valuable skills to find and take advantage of employment opportunities, for example CV writing, job interview preparation and searching for and applying to job opportunities.

The sustainability of the capacity-building outcomes is uncertain. There was a lack of funding for follow-up training, which limited more sustained and targeted capacity building activities. The capacity building activities took place at the beginning of programme implementation and despite some further training for public health staff working in the referral health facilities and in the camps in 2019 as well as for IRCS volunteers in Q1 2020, stakeholders remarked that there was little focused capacity building following initial trainings. In addition, interviewees felt that the programme duration and the numerous external setbacks meant that the HNS did not gain the required capacity to sustain benefits long term, especially in light of the COVID-19 pandemic and the additional strain that this has placed on their services.

[30] Figures are from the MADAD dashboard and are not verifiable.

Operations

The partnership management in Iraq was seen by stakeholders as highly effective, with regular communications and cohesive implementation of activities between the partners. The four partners were all represented in a steering committee, as well as working groups and regular meetings with both internal and external partners, leading to strong communications between the societies and other organisations working in the region. It was decided that the RC/RC partners would attribute single outcomes to the European RC/RC partners, while the FRC would undertake livelihoods activities and NorCross health and WASH-related activities. This was aimed at reducing the risk of duplication in implementation and to make use of the partner's comparative advantages and expertise, as well as maximising opportunities for capacity building.

The efficiency with which the programme was delivered could have been improved. Funding delays from the EU MADAD fund severely impacted implementation. It caused lengthy delays in the programme start-up, which had a knock-on effect throughout. The delays also created difficulties in motivating and retaining volunteers. The complicated and lengthy approval procedures for programme allocations created further delays in implementation, limiting programme effectiveness and impact.

Conclusion

Overall, the findings show that the MADAD activities implemented in Iraq achieved important results in a challenging and volatile context with all partners showing great agility. The 85,274 beneficiaries who were reached surpassed the initial target and activities were generally found to be relevant and effective in achieving their expected outcomes, although sustainability challenges prevail. In terms of health activities, relevance was ensured using needs assessments based on specifically developed vulnerability criteria, continuous monitoring of community needs and strong coordination with other health actors in the region. Despite limitations such as lack of medicine and a lack of awareness of RC/RC services amongst beneficiaries, RC/RC health activities appear to have addressed some of the major barriers to beneficiaries accessing healthcare. However, whether this leads to long-term improved health outcomes is doubtful given the lack of sustainable funding to support continuing health activities, as well as the ongoing effects of the COVID-19 pandemic.

Livelihood activities were found to be largely relevant, mainly because they were based on needs assessments that analysed existing skills, target population needs and market demands. The programme, albeit small in scale, produced valuable results amongst members of all communities, improving the employability of participants and enabling participants to develop the skills needed to start their own businesses which, in turn, improved their ability to meet essential living costs. The livelihood activities also produced several unexpected positive outcomes, including empowering women to pursue income generating activities, as well as improving social cohesion and psychosocial wellbeing in the communities. However, the outcomes of the livelihood activities are severely threatened by the economic slowdown associated with the COVID-19 pandemic. Although beneficiaries have been provided with multi-purpose cash assistance, business support and a range of long-lasting livelihood-related skills, many have reported already losing employment or their businesses since the beginning of the COVID-19 pandemic.

Capacity building activities were also based on a needs assessment and identified gaps in existing capacities amongst both IRCS staff and volunteers, as well as community volunteers. The trainings focused on gender analysis, child protection and stakeholder engagement, following the initial trainings in hygiene, first aid and livelihoods. Participants gained improved awareness and sensitivity to beneficiary needs through the trainings, including improved ability to identify and work with vulnerable groups, particularly IDP and refugee communities. In addition, the trainings improved social cohesion and psychosocial wellbeing by providing

participants a space to engage with other community members, as well as a sense of purpose. However, the sustainability of these is again in question due to a lack of funding to carry out follow-up trainings which could have contributed to longer term capacity building.

In terms of impact, Figure 57 and

Figure 58 show the responses of beneficiaries when questioned on the impact of RC/RC services in the Endline survey. As shown in Figure 57, just under two thirds of respondents agreed that RC/RC services had had an impact upon their or their household's lives. Improved access to health services was the most commonly cited impact, whilst improved economic opportunities and better integration in their community were also widely selected as positive impacts as a result of RC/RC services (see

Figure 58).

Figure 57: Iraq - Endline Survey: RC/RC service impact on respondent lives

Question: Have the RC/RC services in your area had any impact in you and your household's lives?

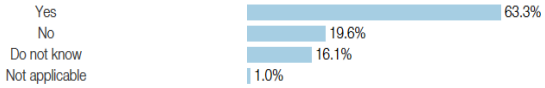
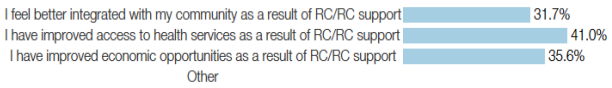


Figure 58: Iraq - Endline Survey: Impacts of RC/RC Services on beneficiaries and their households

Question: If RC/RC had an impact on you and your households' lives, which options best describe this impact?

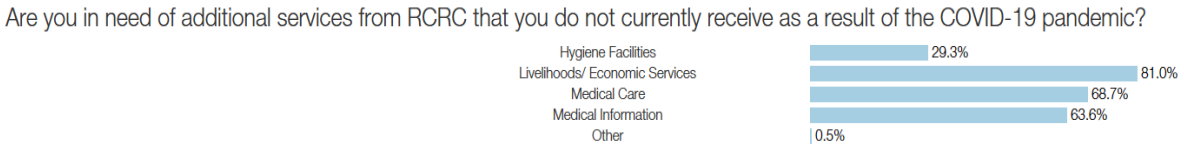


Overall, this highlights the important results achieved by the MADAD programme across the three primary outcomes in Iraq, despite a fragile and volatile operating context. There were also several measures implemented under a transition plan in Iraq to support the sustainability of these outcomes. This included investments in infrastructure and equipment for both medical services and vocational training centres as well as the training of staff and community volunteers to ensure that skills remain in place in the communities. However, the financial sustainability of several programme activities is limited, with health and hygiene awareness activities as well as continued support for newly established businesses set to finish without further funding.

In addition, the effects of the COVID-19 pandemic seriously threaten the positive outcomes in health, economic resilience and social cohesion. As illustrated in Figure 59, the pandemic not only emphasised the importance of the services that had been provided by the programme, but also highlights how it has influenced beneficiaries' vulnerability and needs. The effects of the pandemic are particularly likely to negatively impact the health and livelihoods outcomes achieved by the MADAD programme in Iraq.

Figure 59: Iraq – Endline: Additional RC/RC Services needed as a result of COVID-19 pandemic

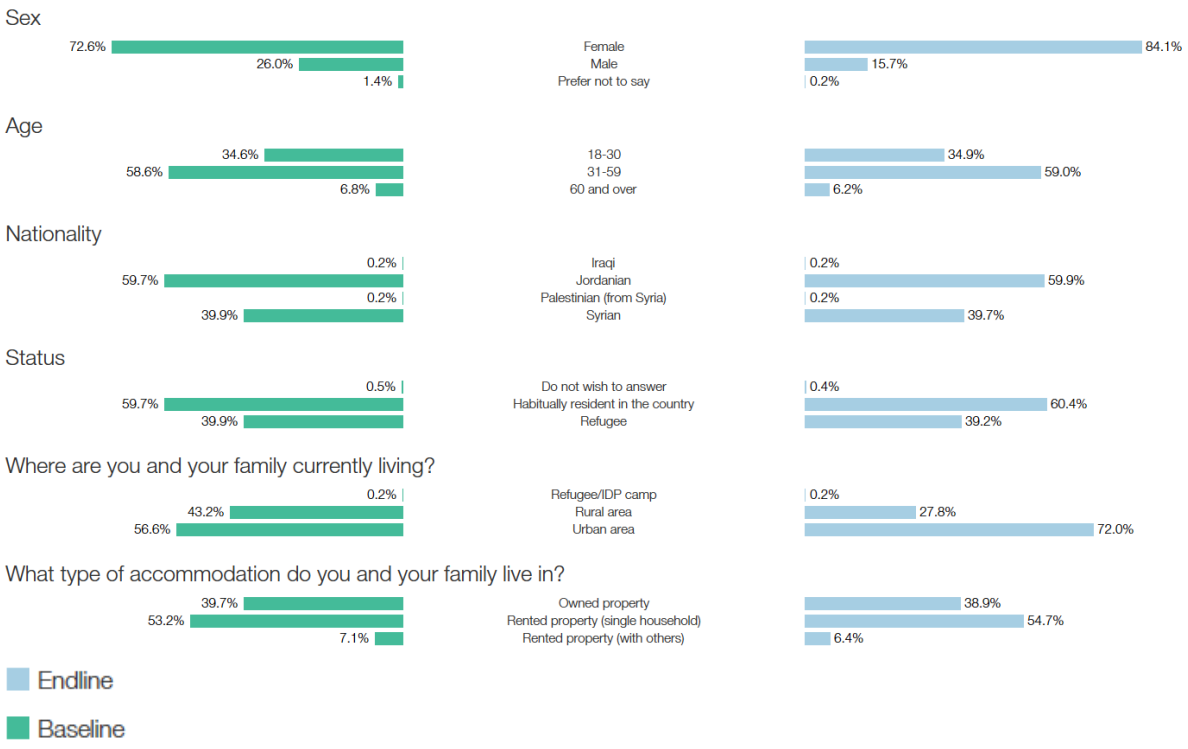
Question: Are you in need of additional services from RC/RC that you do not currently receive as a result of the COVID-19 pandemic?



Jordan

The findings and conclusions are drawn from a range of sources to ensure validity. The household survey conducted in Jordan received a total of 536 responses (further demographic breakdown in Figure 60). Eight in-person FGDs were conducted with beneficiaries in Jordan. FGDs were carried out in Amman and Ajloun. Some limitations were experienced during the evaluation's data collection phase relating to the set-up of beneficiary FGDs and they were not disaggregated by gender or nationality except for the two which were disaggregated by gender. Consequently, it is difficult to draw trends from these FGDs relating to gender or nationality groups or on social cohesion as this could not be discussed openly. FGD participants were either health or livelihoods beneficiaries and as such there is limited qualitative data from beneficiaries on CDPs, first aid training and social cohesion. These components have been analysed through triangulation of the KIIs and survey data with limited inputs from the beneficiary FGDs. Nine programme staff were interviewed from both HNS, all RC/RC partners and the EUTF as a donor. Additionally, two remote FGDs were conducted with HNS staff and volunteers who received training under Outcome 3.

Figure 60: Jordan - Baseline-Endline comparison of survey respondents by sex, nationality, civil status and living location



MADAD programme in Jordan

Table 7: Jordan Programme Overview

Partner	Society	Activities
Lead Partner	IFRC MENA	Country programme management, Livelihoods, Community Projects
Host National Society	JRCS	CBFHA, Livelihoods, Community Projects, Outcome 3 capacity building

Jordan Programme Budget	Target No. of Beneficiaries to be Reached	Actual No. of Beneficiaries Reached (October 2020)
EUR 3,088,971.	174,193	179,172

Context

In Jordan, the *Addressing vulnerabilities of refugees and host communities in five countries affected by the Syria Crisis (MADAD)* programme, has been implemented by IFRC MENA as country lead in partnership with the JRCS. The programme aimed to address the needs of Syrian refugees and the Jordanian host community through health, livelihoods and community projects components. Capacity building activities were implemented for JRCS staff and volunteers under Outcome 3 of the programme. The breakdown of beneficiaries reached equates to a total of 97,808 female beneficiaries and 81,904 male beneficiaries and 55,019 Syrians and 106,853 Jordanians.

There are currently 659,673 registered Syrian refugees in Jordan.[31] The main challenges facing Syrian refugees and the host community, identified at the baseline, were access to economic opportunities, and exclusion from the host community, which increased refugee vulnerability. The livelihoods programme aimed to address these key challenges and included a focus on women's access to the labour market and reducing tensions between the Syrian and Jordanian community relating to economic opportunities. The health component aimed to improve health and hygiene knowledge amongst beneficiaries and improve community capacity to respond to health needs by training first aid volunteers. Hosting a large refugee population has strained Jordanian infrastructure and created tensions between the Syrian refugee and host communities; the programme has sought to address these tensions through community projects to establish shared infrastructure and facilities.

[31] UNHCR. Syria Regional Refugee Response Portal – Jordan. 2020 http://data2.unhcr.org/en/situations/syria/location/36

The programme experienced implementation delays as the DRC and FRC left the country as bilateral and implementing partners before the beginning of the programme. Consequently, the Jordan country programme is the only country programme supported by IFRC rather than a national RC/RC partner. This has created a different dynamic for the Jordan country programme compared to other country programmes stemming from the different ways of working of an international NGO lead as opposed a RC/RC national partner.

The programme has evolved in response to changes in the RC/RC consortium and the broader Jordanian context. The livelihoods component has evolved as the Jordanian government introduced work permits across five sectors during programme implementation and allowed Syrians to establish small businesses from home. The change of consortium partners at the beginning of the programme necessitated changes in the health component's design. PSS activities were replaced with a larger CBFHA component and the rescoping of the community development programme. Finally, the COVID-19 pandemic caused delays to the livelihoods and community projects components as well as necessitating adaption of the health component to provide information and care related to COVID-19. Nonetheless, the programme remains on track to meet its targets by the end of 2020.

Livelihoods

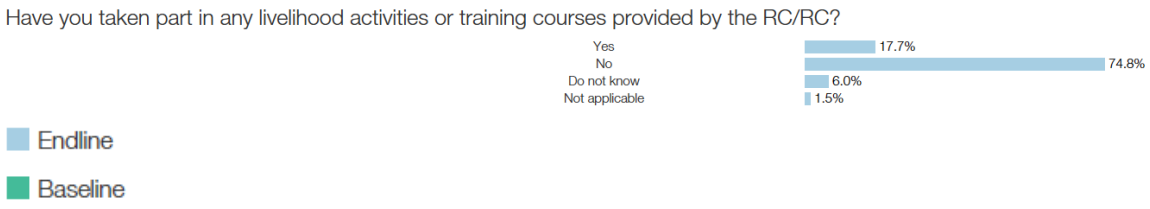
The livelihoods component in Jordan focused on providing beneficiaries with support to start or scale income generating activities including small businesses from home and providing vocational training and business skills development courses. The livelihoods activities have represented a learning curve for JRCS and IFRC however the activities have developed significantly over the course of MADAD and continue to be modernised and tailored in line with beneficiaries' needs and labour market demands. The main challenges lie in ensuring activities provide pathways to employment and beneficiaries can translate their learning into income generating activities.

Participation and Benefits

To date, 184 Syrian refugees and 146 host community members were supported in starting or scaling up income generating activities while 244 Syrian refugees and 187 host beneficiaries participated professional skills, vocational or business development training courses. There is an ongoing need for livelihoods support in Jordan. The challenges around livelihoods and access to income generating opportunities identified in the baseline remain. Most beneficiaries who took part in the FGDs reported economic uncertainty and access to livelihood opportunities as the main challenges they faced. This has grown worse in 2020 following the COVID-19 pandemic. The Endline shows that 81.2% of respondents' monthly income had decreased since the beginning of the pandemic. Syrians were worst affected with 88.7% of Syrians reporting a decrease in income compared with 76% of Jordanian.

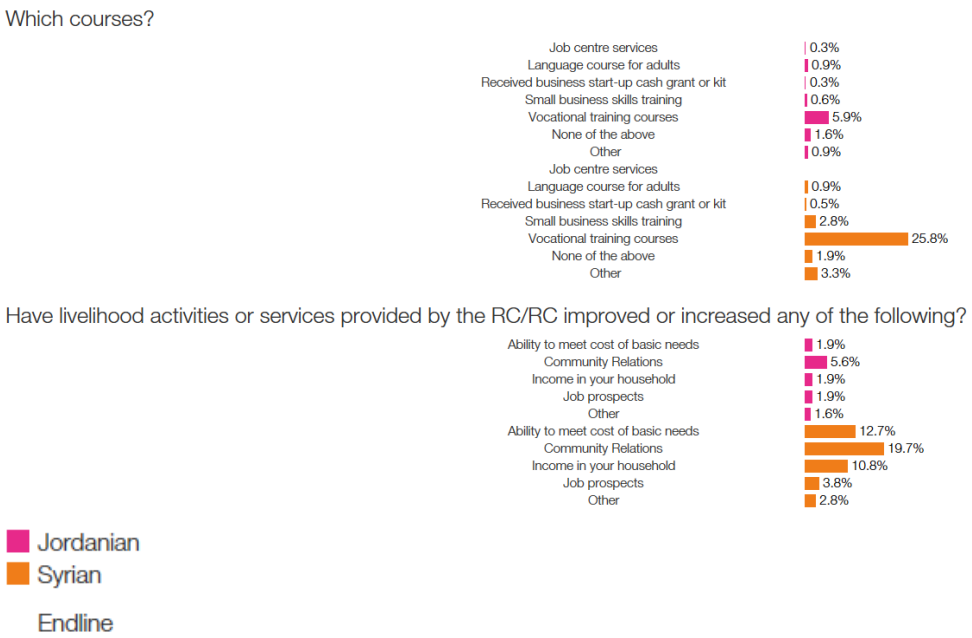
Only 17.7% of Endline respondents had taken part in livelihoods activities provided by RC/RC. The majority had taken part in vocational training courses and small numbers had taken part in small business skills training. English language training was delivered as a sub-training under the graphic design and health care provider trainings held in Ajloun. those who had taken part, the majority reported an increase in their ability to meet the cost of basic needs and an increase in household income, suggesting that beneficiaries have been successful in translating their learnings into income generating opportunities. However, only a small number report that they had improved their job prospects as a result of the livelihoods activities suggesting that the activities are better at supporting self-employment rather than enabling beneficiaries to find jobs.

Figure 61: Jordan – Endline: Percentage of beneficiaries who have taken part in livelihoods activities or training courses



Syrians comprise the majority of those who report taking part in small business skills training and vocational training courses – 31.5% of Syrians compared to 8.7% of Jordanians. Jordanians comprised the majority of those who had taken part in language courses for adults. Syrians also reported greater success at translating learnings into income generating activities and improved social cohesion. Of the Syrians who took part in livelihoods activities, 40.3% reported an improvement in their ability to meet the cost of basic needs and 34.3% reported increases in household income. This compares with 21.4% of Jordanians in both categories. 70% of those who reported better community relations were also Syrian. However, more Jordanians who took part in livelihoods activities reported that participation had improved their job prospects – 21.4% of Jordanians compared with 11.9% of Syrians. This could suggest that while Syrians have benefitted from livelihoods activities, their employment opportunities within the Jordanian context remain limited, meaning that Jordanians who can access the whole labour market are more likely to see improved job prospects.

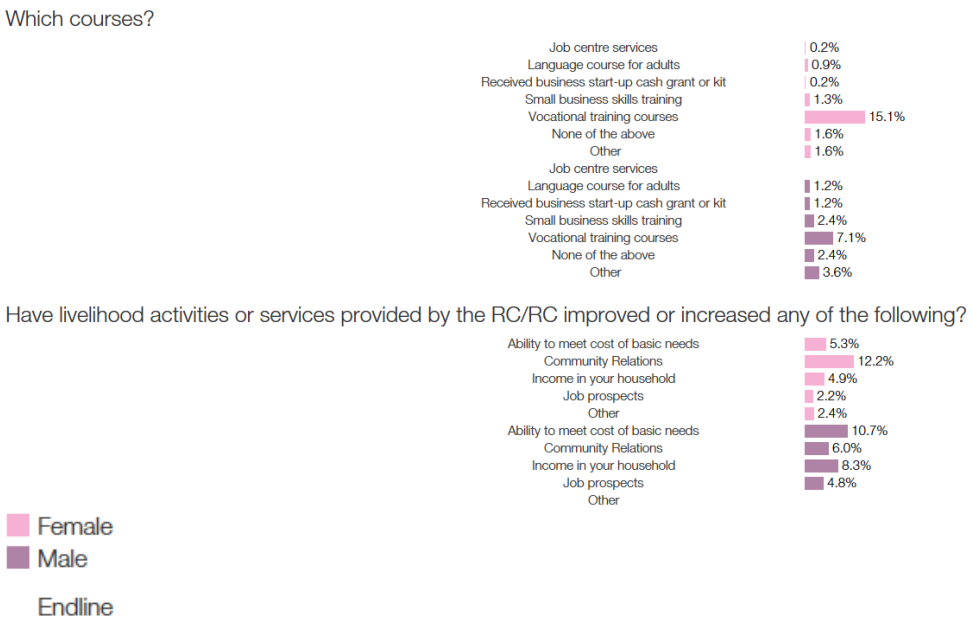
Figure 62: Jordan – Endline: Livelihood activity participation and perceived benefits, by nationality



There is also a clear trend with regards to gender. The majority of those who took part in vocational training programmes were women. 81% of female livelihoods beneficiaries took part in vocational training compared to 54% of male livelihoods beneficiaries. Men were more likely to take part in small business skills training (18.2% of men who took part in the livelihoods programme compared to 7.1% of women.) However, the Endline suggests that proportionately men benefit more from livelihoods activities than women. 81.8% of men reported improvements in their ability to meet the cost of basic needs, 63.6% reported an increase in household income and 36.4% reported improved job prospects. This compares to 28.6%, 26.2% and 11.9% of women across the same categories, respectively. The only area where women benefitted more than men is improvements in community relations where 65.5% of female livelihoods beneficiaries reported an improvement compared to 45.5% of male livelihoods beneficiaries. Therefore, although more women take part in courses, when

men do take part, they are more likely to see tangible benefits. This could reflect ongoing barriers surrounding women's access to the labour market.

Figure 63: Jordan – Endline: Livelihood activity participation and perceived benefits, by gender



Successes and Modernisation

The success of the livelihoods programme is mixed. However, there are some clear success stories. Beneficiaries in FGDs generally spoke positively about vocational trainings; women spoke more favourably about the activities than men. Some FGD participants also cited examples of where they, or people they know, have benefitted from training and small business start-up support. Examples included beneficiaries who have started shops or run businesses from home, such as sewing workshops. Others discussed finding employment in salons and barber shops. Most participants stated that they had been provided with the necessary tools and equipment following their training. Beneficiaries suggested the most influential factor in their success was the follow up and support provided by JRCS and IFRC. Examples of 'follow up' were the provision of mentoring or financial support to start a business, support to find a job, and the provision of tools and equipment. KII participants, both programme staff and training provider representatives, stated that the MADAD livelihoods activities also have lower drop-out rates than other NGOs offering training in the same areas. The programme did initially experience high drop out rates across their courses however reasons for drop out were identified and resolved. This included a focus on addressing barriers to access. For example, they have provided transport to activities.

A positive unintended consequence is that the livelihoods activities have addressed social cohesion, in addition to supporting access to income generating opportunities. This

successfully targeted tensions between the Syrian refugee community and the Jordanian host community in relation to competition for employment and labour market access. Activities provided a space for beneficiaries of from different backgrounds to meet and get to know each other. This has been successful, with a majority of participants reporting an improvement in community relations resulting from participation in livelihoods activities.

Following the MTR and ROM recommendations, the livelihoods programme has been modernised to provide better employment prospects for beneficiaries. This is a key success of the programme and illustrates how the programme has become increasingly relevant. There was a notable shift away from more traditional vocational training offered by the JRCS training centre. The programme now offers a wider range of courses that align with market demands in areas such as technology, design, and in professions that allow beneficiaries to work from home or as freelancers. These 'modern' training courses are used to complement the more traditional courses offered by the JRCS training centre. For example, under MADAD JRCS began providing marketing and business skills training for women, addressing an emerging need that while many women took part in handicraft courses they did not have the skills and knowledge to market their products and increase their income. This extra training intends to equip them with these skills so that they can translate their learnings into income generation. This training is ongoing, and the results are not yet clear at the time of the evaluation.

Challenges

However, a livelihoods programme of this scale and nature represents a learning curve for both IFRC MENA and JRCS. Although activities are based on labour market assessments, there remains concern about how well the livelihoods offering responds to market demand and how often labour market assessments are updated. A particular challenge is the use of a VCA tool to identify beneficiaries needs as this is more appropriate for assessing resilience rather than livelihoods requirements.

A key part of the modernisation strategy involved forming partnerships with local training providers. This has developed JRCS's capacity by expanding their training offering, allowing more flexible response to market demands, and developing new approaches to support beneficiaries which can be integrated into future programming. It has also developed JRCS's networks and provided experience in managing contractors. FGD participants praised the partnership with external organisations as it has allowed them to achieve accreditations which are more likely to open employment opportunities.

However, there are unintended consequences of modernising the vocational training programme, including the potential exclusion of vulnerable groups. The more modern courses require higher levels of education which vulnerable beneficiaries, in particular women, may not have. Courses that respond purely to labour market demand may not account for the ongoing barriers many women and other vulnerable groups face in accessing the labour market. Throughout the programme, JRCS have faced challenges engaging Syrian women. These stem from cultural barriers, including male relatives' reluctance to let women participate in courses, as well as Syrian women's preference for more traditional vocational training, such as sewing and handicrafts, in sectors where there was not a market demand. This undermines the effectiveness training for income generation in the longer-term, reflecting the trend of women finding it harder to access income generating activities following vocational training. JRCS continue to provide smaller traditional courses while directing women to courses where there is a greater market demand. Nonetheless, cultural barriers do not align with the programme modernisation. Providing a balanced course offering that responds to both the labour market and is accessible for vulnerable beneficiaries will be a challenge for any future livelihoods programme.

A further accessibility issue lies in the time commitment training courses require from beneficiaries. While beneficiaries are doing vocational training, they cannot work. This has

limited the ability of RC/RC to conduct longer and more advanced trainings that would better prepare beneficiaries for the job market. Stakeholders suggested that they would ideally run comprehensive six-month trainings, but beneficiaries can only commit to two to three-month programmes. This means that trainings do not reach their potential in providing meaningful paths to employment. Therefore, balancing employment prospects with current livelihood demands is a challenge.

A future programme should focus on more regular labour market assessment and respond more flexibly to labour market needs. There is a need to continue to offer more advanced courses that build on vocational training already undertaken or offer beneficiaries the opportunity to develop in new areas. This is the most common request from beneficiaries discussing the livelihoods activities with a focus on areas such as marketing, accounting and technology. There is a clear desire from both beneficiaries and RC/RC staff to offer a more explicit focus on self-reliance with pathways to labour market participation that ensure a higher chance of employability. This could involve internships or other activities that connect beneficiaries directly with employers, which is something covered by other training providers in Jordan but remains a gap in the MADAD offering.

Community Projects

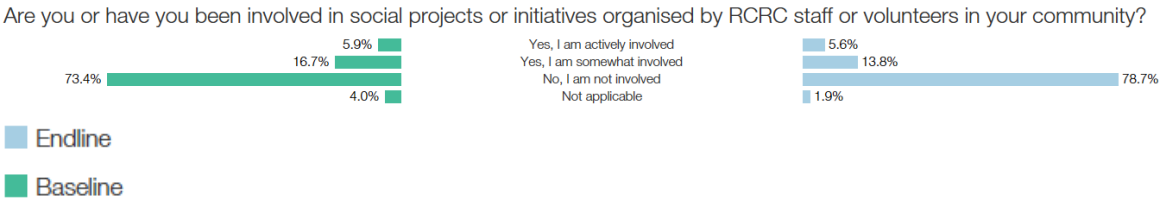
The purpose of the community projects component was to address tensions between the host and refugee communities by establishing shared projects and facilities for the use of both communities. Specifically, the community projects addressed the infrastructure strain placed on Jordanian services from hosting a large refugee population. 1334 refugee and host community members were involved in assessment, planning and implementation of CDPs. In total, JRCS have implemented seven community projects which directly benefit 25,431 people. At the time of data collection projects are currently run across two governorates. Subsequently community projects were scoped in Zarqa Governorate and implementation began in November 2020. The overall impact of the community projects is hard to assess, partly due to the facilities being relatively new and partly due to limited data on beneficiaries' perceptions of these projects. Views from other stakeholders are mixed with some flagging successes while others are dissatisfied with the project's overall scope and impact.

Participation and Social Cohesion

Endline respondents credit community projects with improving relations in their community. 51.92% strongly agreed and 38.46% agreed that the community projects had improved relations. All Syrian respondents agreed that these projects have improved community relations with over half of respondents 'strongly agreeing'. Over half of Jordanians also strongly agreed however 8.2% strongly disagreed. Women look more favourably on community project's contribution to improved community relations although they are not as directly involved with these projects than men. The majority of men support the idea that the projects have improved community relations, although 13.79% disagree.

This suggests the community projects have progressed against their aim of promoting social cohesion. However, there is not substantive data to support this as the numbers of Endline respondents who reported taking part in community projects are low while the FGDs were unable to explore social cohesion and integration in detail. Beyond the cases of specific individuals referenced below, it is difficult to attribute the community-wide change, illustrated in the Endline, entirely to MADAD. While there has been an improvement in community relations there is limited evidence to relate this directly to the MADAD activities on a systematic level. This point is supported by RC/RC staff who additionally credited activities and events beyond MADAD with reducing tensions between the refugee and host communities.

Figure 64: Jordan - Baseline-Endline comparison of beneficiary involvement in social/community projects



Less Endline respondents reported being involved in community projects than baseline respondents. The main reasons beneficiaries cited for not being involved in community projects were lack of awareness of the projects, lack of time, and lack of interest in involvement. Additionally, women cited that projects did not always take place at a convenient time or location, reflecting trends elsewhere on the challenges of engaging female beneficiaries in activities outside their home or RC/RC centres.

RC/RC staff report reduced tension between communities because the projects have created shared services, removing perceptions that refugees receive support at the expense of the host community. Projects focused on a range of services including creating recycling centres, development of public gardens, and local libraries. These have been used to support other areas of the MADAD programme by providing venues for CBHFA activities. This represents a joined-up response ensuring beneficiaries benefit from multiple aspects of the programme. Beneficiaries participating in the FGDs participated primarily in the health and livelihoods components so were not familiar with community projects. Only one beneficiary discussed a community project they were involved in: the creation of a recycling hanger and provision of equipment. Although the project was not fully operational at the time of data collection the beneficiariy spoke positively about its potential to provide employment for people of all nationalities.

JRCS's strong relationships with local authorities were pivotal in providing an entry point for negotiations and engagement. The projects have also supported JRCS's capacity development by strengthening their networks and working relationship with new local authorities. This promotes cohesion between JRCS and local leaders as well as cohesion amongst communities. The projects also have potential for longer term sustainability; JRCS are in the process of negotiating MoUs with local authorities to ensure ongoing support and financing of the projects once MADAD finishes

Challenges

The community project component has experienced several challenges. Stakeholders raised concerns around the use of the VCA tool for scoping and planning community projects. As this tool mainly targets community resilience it was not the effective in assessing needs and priorities relating to infrastructure or social cohesion. Another ongoing challenge has been the relationship with local authorities. There have been delays in implementation because of long negotiations and bureaucratic processes needed to sign off on projects. Learning to manage these processes has been a learning curve for JRCS.

The programme design and structure has undermined the potential impact of this part of the programme. This component was affected by the withdrawal of the French Red Cross and implementation and scaling were difficult at the beginning of the programme. Some stakeholders suggested that there was not enough technical support in this component. Additionally, the original design limited the ability of partners to adapt the community projects component to the evolving Jordanian context, where needs have changed significantly since inception. In the initial design community development activities were focused on renovating refugee housing. These were planned as relatively small projects with a spending cap. It has been difficult to alter this spending cap and to scale projects to address the needs of a whole community. While this has been mitigated by combining communities under shared projects, it remains a challenge. Some senior stakeholders are dissatisfied with the scope of the community projects. One stakeholder suggested that if the projects could have reached more

people they would represent better value for money, but they have been limited to smaller initiatives.

COVID-19 has delayed the implementation of some planned projects and consequently the target number of beneficiaries has not yet been met. The programme has adapted to ensure that the budget can still be spent. JRCS have scoped additional projects in new governorates, which they had not intended to cover under MADAD.

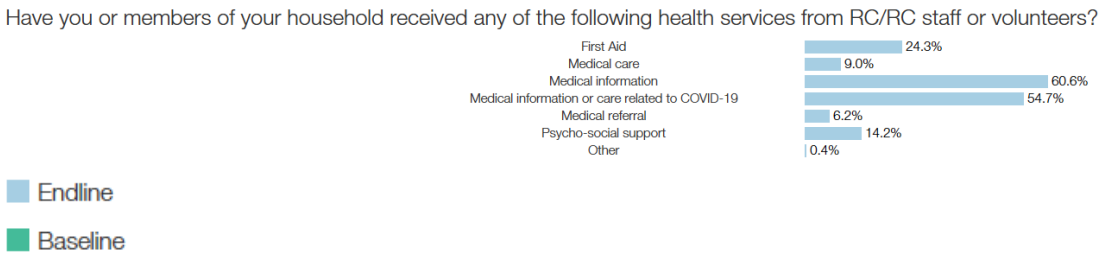
Health

The health component had some notable successes. This is largely due to the focus on CBHFA activities, an area in which JRCS has significant experience, which has notably increased beneficiaries' health and hygiene knowledge. However, gaps and challenges, such as PSS and a formal referral system, do remain in the health activities which undermine impact. Overall success is hard to gauge given that the programme has been implemented in a context where there are growing barriers to health care.

Increased Health Awareness and Barriers

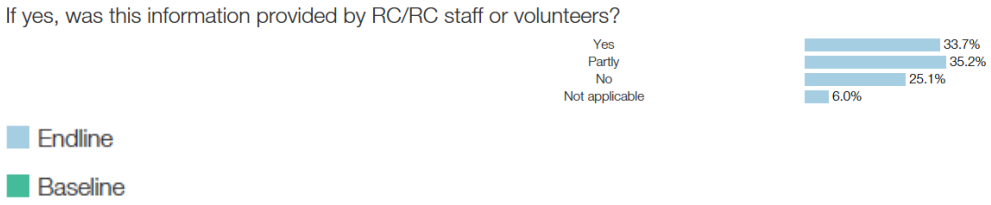
The health component in Jordan has primarily focused on CBHFA including health awareness raising and hygiene promotion. Health awareness activities have been tailored to the needs of each community and included topics such as NCDs, drug use and road safety. Individual hygiene kits and fruit bags were distributed to beneficiaries via the awareness sessions. There has also been a campaign to promote good hygiene practices amongst school children. Overall, 151,818 beneficiaries have been reached through health education activities. Community volunteers were also trained in CBHFA, with the programme reporting 279 volunteers and community mobilisers with improved knowledge of CBHFA. The Endline shows the most common services received from RC/RC under MADAD were medical information and care related to COVID-19, first aid and medical care.

Figure 65: Jordan – Endline: medical services received from RC/RC staff or volunteers



Overall, knowledge about health and hygiene has improved over the duration of the MADAD programme, particularly amongst female beneficiaries and Syrian beneficiaries. 60.1% of Endline respondents stated that they knew how to access medical services and assistance, an increase since the baseline. The MADAD activities have contributed to this increased understanding. 36.4% of beneficiaries reported that information on how to access medical services was provided by RC/RC staff and 30.8% reported that it was partly provided by RC/RC staff. 71.7% of Endline respondents reported that their hygiene practices had improved as a result of MADAD awareness raising. 24.7% stated that their hygiene practices had partly improved.

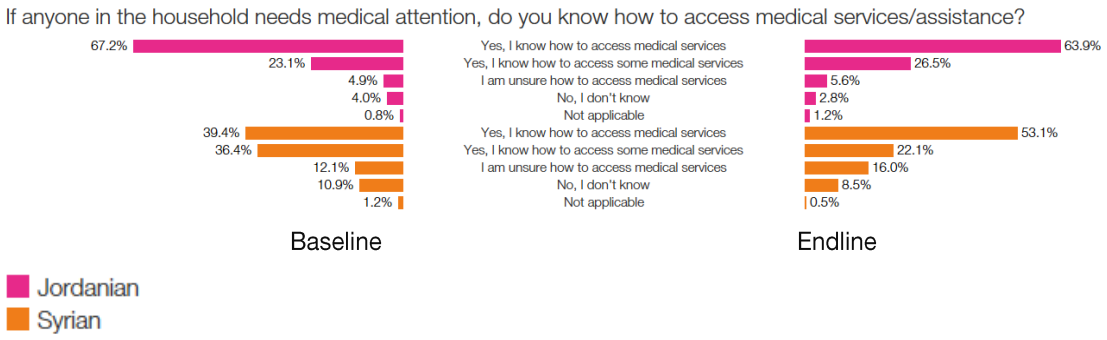
Figure 66: Jordan - Baseline-Endline comparison of beneficiaries' awareness of access to services and provision of information be RC/RC staff and volunteers



More women than men report that their knowledge has improved as a result of the health and hygiene awareness sessions and women have been more active participants in the health and hygiene activities. However, a higher proportion of men who were involved in health activities report that improved access to health services as a result of RC/RC support – 59% of men compared with 54.3% of women.

Syrians report better increase health awareness. The majority of Syrians report that their knowledge on how to access medical services was provided by RC/RC and this is larger than the proportion of Jordanians who report the same (although this is also a majority of Jordanian respondents). Compared with the baseline, more Syrians report that they know how to access services compared to Jordanians, the percentage of whom report that they know how to access services has decreased. This suggests that Syrians are better engaged by awareness sessions on certain topics provided under CBHFA but are less clear on practical service access. Jordanians have been less engaged overall.

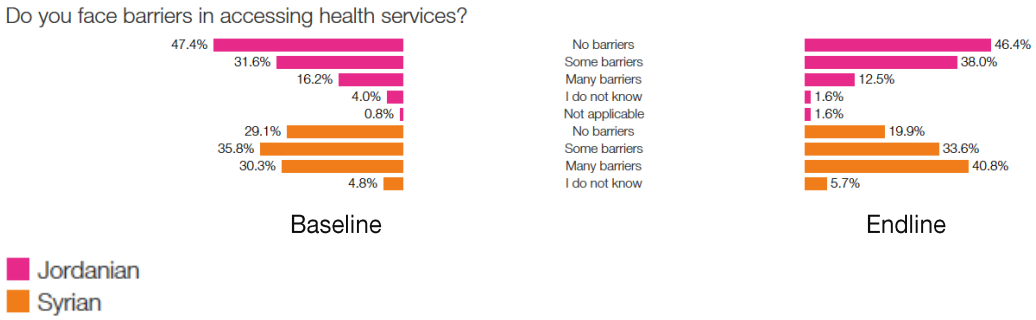
Figure 67: Jordan - Baseline-Endline comparison of beneficiary knowledge on access to medical services



Barriers to healthcare have increased since the baseline; the number facing many barriers has marginally increased with a larger increase in those reporting some barriers. This could offset the benefits of increased health and hygiene knowledge. There has been a significant increase in those who cannot afford healthcare. This trend is also reflected by beneficiaries in the FGDs who state that unemployment and economic challenges impact their ability to pay for healthcare. There has also been an increase in those reporting inadequate or poor-quality health services. Access to healthcare has worsened in 2020 with 56.3% reporting that COVID-19 has made it more difficult for them or their household to access healthcare. This complicates the picture of how far MADAD has contributed to healthcare access.

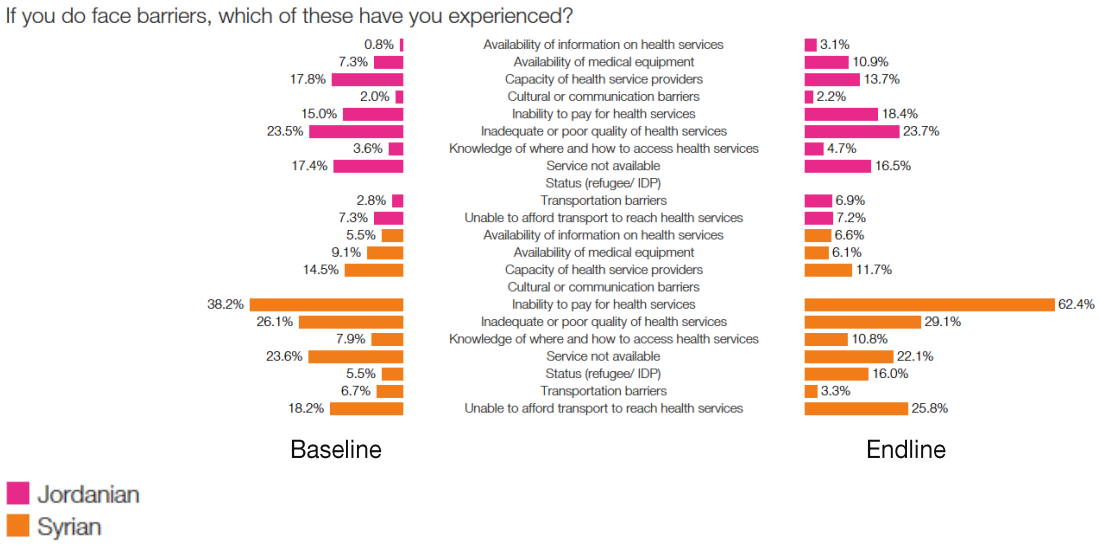
Syrians and Jordanians experience healthcare barriers different. The Jordanian experience is mixed. Access to healthcare has improved overall however there is an increase in those reporting 'some barriers.' There is a decrease in those reporting 'many barriers.' The main challenges for Jordanians are inability to pay for healthcare and the availability of services, both of which have worsened since the baseline. Overall, the numbers of Jordanians reporting challenges are lower than the numbers of Syrians.

Figure 68: Jordan - Baseline-Endline comparison of barriers to accessing health services



There has been an increase in Syrians reporting 'many barriers' to accessing healthcare. 84.7% of Syrians at the Endline reported that they were unable to pay for healthcare compared to 57.8% at the baseline. This has been a challenge since the Jordanian government removed the subsidiary for refugee healthcare. 35% in the Endline reported that they were unable to afford transport to reach health services compared with 27.5% in the baseline, and 39.5% reported inadequate or poor services, although this remains steady in comparison to the baseline. Syrians report that COVID-19 has made it more difficult (63.4%) or somewhat difficult (19.7%) for them to access primary health care compared with Jordanians – 51.4% reported it had become 'more difficult' and 23.1% 'somewhat more difficult' to access healthcare. This reflects an emerging need amongst Syrian beneficiaries for greater support in accessing primary healthcare both in terms of services available and financial support. This suggests that in order to remain relevant to beneficiary needs, a future programme should concentrate on gaps around access to healthcare. It emphasises the importance of a holistic approach through joined up health and livelihoods components.

Figure 69: Jordan - Baseline-Endline comparison of inadequate or poor-quality health services



CBHFA

The CBHFA component has worked well and addressed the issues facing each community. The CBHFA activities were an expansion of JRCS's existing health activities and MADAD funding allowed these to be expanded into new areas. This was not originally intended as part of the programme but was introduced following the withdrawal of the original programme partners in 2017 and subsequent adaption of the programme. CBHFA activities have been straightforward to implement as they scaled up operations that JRCS was familiar with. The programme has exceeded its targets on beneficiary engagement in this area.

Activities were based on needs assessments conducted at the beginning of the programme and reviewed throughout. This knowledge was supplemented by community needs identified by volunteers. Health awareness sessions were differentiated by age groups and the content was tailored to the health needs of each group and community. Following recommendations in the MTR and ROM, programme materials have been updated to better reflect each implementation context and to make them more appropriate for the target audience. The programme has also adapted well to COVID-19, providing beneficiaries with clear hygiene and medical information.

Beneficiaries spoke positively about the health and hygiene awareness sessions and RC/RC are viewed as a fair and neutral service provider. In some communities, behaviour change has been observed following the sessions. For example, in one community women have formed a walking group. Hygiene promotion in schools has been particularly effective with both mothers and teachers reporting improvements. Beneficiaries also praised home visits as an approach for reaching vulnerable community members and activities were considered easily accessible.

There is a gendered element to the CBHFA activities. Women are more active participants than men. The ROM indicated that male beneficiaries were excluded from CBHFA due to activities taking place during the day and the perception that these activities were for women. JRCS began holding events on Saturday or directly at men's places of work rectify this but have not seen a large increase in the number of men engaged. This was reflected in the FGDs where women knew more about the health activities, were more active in attending awareness sessions, and spoke more positively about the activities than men.

Provision of Medical Services

There was also negative feedback on the MADAD health component, primarily relating to inadequate services. As reflected in the Endline, access to medical services is a growing issue, particularly for more vulnerable community members. The main criticism was that the programme provided awareness raising but not tangible services. FDG participants requested financial support to access to healthcare and better medication provision. The demand for in-kind support is growing due to COVID-19's impact on beneficiaries' livelihoods. The lack of material healthcare provision under MADAD raised issues when engaging with vulnerable beneficiaries. These beneficiaries did not feel that awareness sessions met their needs or were unable to attend them. They were only interested in home visits if this provided in-kind assistance rather than information. However, this is a point of expectation management of beneficiaries, recognising that it was not the intention of MADAD to provide medical services or in-kind assistance to beneficiaries. Indeed, this has improved over time as beneficiaries have gained a greater understanding of what is provided by CBHFA. Through MADAD, RC/RC has worked to build trust with these beneficiaries and make their offering more relevant in terms of medical information that can be provided in place of services and illustrating to beneficiaries the value of this information in improving lifestyle and health behaviours.

Several beneficiaries also complained that JRCS medical centres did not offer a range of services that addressed their needs, such as inadequate testing and screening for illnesses. Beneficiaries in Amman complained that the services were not enough to meet community demand. This sentiment was acknowledged by RC/RC staff who cited limited MADAD budget as undermining their ability to fully respond to beneficiaries needs and that it was not the intention of MADAD to provide access to medical services

There are two main gaps in service provision that limit how impactfully the programme can meet beneficiaries' needs. These are the lack of PSS and the lack of a medical referral system. The original programme design contained a PSS component for Jordan however this was removed with the withdrawal of the FRC and DRC at the beginning of the programme. It was not replaced due to lack of technical expertise in the Jordan consortium. This left a gap

in the response as PSS is an important need across refugee communities. The programme tried to introduce a medical referral system at JRCS centres but did not have the budget and staff capacity to support this. This issue has been mitigated by establishing relationships with other NGOs who provide health services and making referrals to them. However, it represents a gap in RC/RC's own services and undermines their ability to follow up with beneficiaries who have been referred to other providers, hindering ongoing support.

HNS Capacity Building

JRCS's capacity development under Outcome 3 has been successful. A culture of community volunteering has been enhance and volunteers understand and are integrated with communities, including vulnerable beneficiaries. JRCS have also undergone capacity development as an organisation including raising their profile and developing their capability and service offering.

Volunteer Recruitment and Training

JRCS's capacity development under Outcome 3 has been successful. Capacity development was illustrated in recruitment and training of community volunteers and the development of JRCS's organisational capabilities. 89 staff and volunteers have received training under MADAD. Programme reporting shows 89% demonstrate adequate levels of knowledge and skills following their training. Six of the volunteers trained are Syrian refugees.

The programme has engaged community volunteers from a range of backgrounds including both the Syrian refugee and Jordanian host communities. Volunteers take part in comprehensive training including CBHFA and Life Skills, which focuses on engagement with different groups and includes facilitation and public speaking training. Life Skills was a popular training amongst FGD participants who gained personal as well as professional skills. Many volunteers also received project management training including planning, project design, M&E and results management and are equipped to design and run their own activity sessions. As a result of the MADAD training, volunteers reported that they were more confident in engaging with vulnerable groups and conducting home visits. Participants specifically reported improved confidence in engaging with refugee communities.

JRCS has recruited volunteers from the communities in which they work; several are Syrian refugees. Volunteers are often beneficiaries of other programme activities and these events have been used as a forum to recruit volunteers. At the start of the programme, JRCS experienced a high turnover of volunteers. The main drivers of turnover were that volunteers did not understand their role and responsibilities when they joined, they did not enjoy conducting home visits, and they did not feel their work was meaningful. JRCS has worked to address these challenges and has lowered the turnover rate. The training programme now ensures volunteers have a clear idea of their role and responsibilities before they begin work and prepares them to better engage beneficiaries through approaches such as home visits. They have worked to demonstrate impact to the volunteers to increase their motivation and this appears to have been successful; volunteers reported high satisfaction with their work and felt they had improved the lives of beneficiaries. However, JRCS staff reported lower levels of confidence in volunteer management and recruitment and cited this as an area for further support in any future programme.

There is clear added value in the community volunteers, for the volunteers themselves JRCS as an organisation, and for communities. Two refugee volunteers reported that before joining JRCS they were shy and struggled to engage with the wider community. They felt at a disadvantage as they had not finished their education in Syria. Through volunteering they have become more competent and developed a range of new skills. The programme has promoted a culture of volunteering. There is a pattern of volunteers encourage other beneficiaries to become volunteers based on the positive experience they have had working

with JRCS. They reported that volunteering provided them with good opportunities and are committed to spreading this culture within their communities.

Through the recruitment and training of refugees as volunteers, the Syrian community's capacity has been strengthened. These communities will continue to collectively benefit from the skills and knowledge MADAD has imparted to volunteers who can run activities and provide support independently of the programme. Volunteers reported a strong connection with the communities they worked in and were committed to improving the situation for those living there. In turn, they felt widely accepted by the communities. This has built essential links between JRCS and beneficiaries and raised the profile and trust of the organisation. It has supported because volunteers are essential in identifying vulnerable people and their needs through their direct relationships with communities.

JRCS Capacity Building

JRCS have clearly built capacity on an organisational level. They have improved financial management and reporting and have strengthened their procurement and contract management capabilities through their work with training providers under the livelihoods component. They have thought creatively and expanded their range of offerings, illustrated through the community projects and the modernisation of the livelihoods programme. Staff also have a clearer sense of different approaches that can be taken to engage beneficiary groups. JRCS's profile has also been raised by the programme and they have stronger networks with local authorities as well as increased trust in communities. The access which JRCS has to local decision makers has been critical to the success of the programme.

JRCS staff have received training to support the implementation of the MADAD programme. Training including facilitation, conducting house visits, project management, data collection, SWOT analysis and advanced livelihoods training. Staff reported that training had improved their engagement with different communities and helped them to better communicate with beneficiaries. Staff had received similar training prior to MADAD but stated the MADAD training had improved their engagement with refugees in particular and made them more effective at identifying beneficiary needs.

However, on an individual level capacity building has not been so strong, with gaps reported in the training. A significant gap was volunteer management and recruitment. Staff felt they should have received more support on this given the programme's focus on volunteer development. Other gaps identified were around reporting and financial management. This has been an area in which JRCS has had to quickly upskill to meet EU reporting standards and staff reported a need for greater support at an early stage.

Additionally, JRCS staff reported lower levels of confidence than volunteers following training and programme implementation. They felt less confident in supporting or training others to take on a similar role as they did not feel secure in their knowledge across all programme areas. They requested additional support to help them achieve this level of knowledge. The main reason for this, and main critique of the MADAD staff training, is that training sessions were too short to cover the level of detail required and staff did not receive refresher training. Participants reported a strong emphasis on informal 'learning by doing' to supplement training courses as the classroom did not prepare them for all scenarios they faced in the field.

Conclusion

The MADAD programme in Jordan has made good progress towards achieving programme goals through its focus on health, livelihoods, improving community resilience and reducing social tension. There is also evidence that JRCS has developed its capacity to engage vulnerable groups amongst the refugee and host community. The programme had good

reach into communities and has engaged well with women and Syrian refugees in particular. Beneficiaries were well familiar with RC/RC services and found them accessible.

Seventy per cent of Endline respondents reported that RC/RC services in their area had an impact on their and their household's lives. This represents a majority of bother Syrian and Jordanian respondents. Improved social cohesion was particularly well reported amongst female beneficiaries. The biggest impact reported was that beneficiaries felt better integrated with their community as result of RC/RC activities, suggesting that the programme has made progress in its aim of integration and social cohesion between refugee and host communities. Community volunteers have been agents for social cohesion and report strong integration and trust with the communities in which they work. However, beyond this evidence that attributes social cohesion to MADAD is largely anecdotal and it is hard to assess the extent to which social cohesion on a systemic level has been achieved. External factors are also likely to have affected social cohesion.

The livelihoods programme has developed well over the duration of MADAD and continues to evolve. A future programme should focus on more regular labour market assessment and respond more flexibly to labour market needs. There is a need to continue to offer more advanced courses that build on vocational training already undertaken or offer beneficiaries the opportunity to develop in new areas. The livelihoods component has adapted well to changes in the implementation context, such as the expansion of refugee access to the labour market, and to recommendations made by the ROM and MTR. Activities are relevant to market demands and the programme can be commended for its modernisation and partnerships with local service providers. Female beneficiaries have been well engaged despite initial challenges however greater focus needs to be given to ensuring women can translate their training into income-generating activities. Beneficiaries also credited the programme with improving integration and social cohesion, directly addressing tensions around employment identified in the Baseline. However, livelihoods remains an area for ongoing improvement. This is the most common request from beneficiaries discussing the livelihoods activities with a focus on areas such as marketing, accounting and technology. There is a clear desire from both beneficiaries and RC/RC staff to offer a more explicit focus on self-reliance with pathways to labour market participation that ensure a higher chance of employability. This could involve internships or other activities that connect beneficiaries directly with employers, which is something covered by other training providers in Jordan but remains a gap in the MADAD offering.

CBHFA activities have also been successful. Beneficiaries reported improved access to health services as a result of RC/RC support and improved health and hygiene knowledge. MADAD has allowed JRCS to scale up existing CBHFA activities and expand into new areas. The health education activities reached the largest number of beneficiaries across the programme and 279 volunteers and community mobilisers demonstrate improved CBHFA knowledge, better equipping communities to respond to health risks. However, access to health services has worsened over the programme due to external factors. This includes livelihoods challenges for both refugee and host communities as well as the COVID-19 related barriers. This means that while knowledge within communities has improved due to MADAD, it has countered by greater difficulties in accessing healthcare overall. Additional medical care services were frequently requested by beneficiaries engaged in the FGDs.

There have been challenges in the health component. Despite recommendations of the ROM and MTR, health activities remain an overwhelmingly female domain; efforts to engage more men have had limited success. Men are less familiar with the health activities and speak less positively of them; there remains a perception that these activities are for women. Vulnerable beneficiaries have also been less willing to engage due to the focus on awareness raising rather than in-kind assistance. This calls into question the relevance of the health activities to the most vulnerable groups.

Two significant gaps are the lack of PSS activities and the lack of a medical referral system. These undermine the programme's relevance. PSS activities were included in the original programme design and remain an area of significant demand for refugee communities. This service was requested by beneficiaries in FGDs. The lack of a referral system also limits the ability to provide, or direct beneficiaries, towards needed medical care which correlates with challenges of meeting vulnerable beneficiaries, health needs.

The community projects which have been implemented have worked well. They address infrastructure strain and align with community's needs. This in turn has increased their capacity and providing safe community spaces. The programme has shown adaptability here through exploring alternative ways to spend the budget when some projects were halted due to COVID-19. Implementing community projects has also built JRCS's capacity and enhanced working relationships with local authorities. Beneficiaries spoke positively about the projects and the fact they provided opportunities for people of all backgrounds.

However, programme design undermined the effectiveness of the community projects component. This has been a learning curve for implementing partners and would have benefitted from more technical support on project identification and working with local authorities. Additionally, greater flexibility in the programme design could have allowed the implementation of larger projects for more beneficiaries as capped budgets have limited the projects to relatively small endeavours.

JRCS's capacity development is a major success of the programme. There is clear added value of the community volunteers developed by the programme. Their knowledge and capability contribute to communities' capacity and resilience. Volunteers have communities' trust and a strong understanding of community needs. Their insights allow JRCS to better tailor programme activities, particularly to the needs of vulnerable groups. Volunteers are well-trained and report confidence in conducting activities and identifying and engaging with different beneficiary groups, including the most vulnerable.

JRCS as an organisation have also developed capacity under the programme. This includes their ability to engage the refugee community and other vulnerable groups and management processes such as finance and procurement. They have also enhanced their relationships with local authorities through the community projects and the livelihoods component has developed their partnerships with local service providers. On an individual level staff require further training to develop confidence levels, particularly in volunteer management.

Egypt

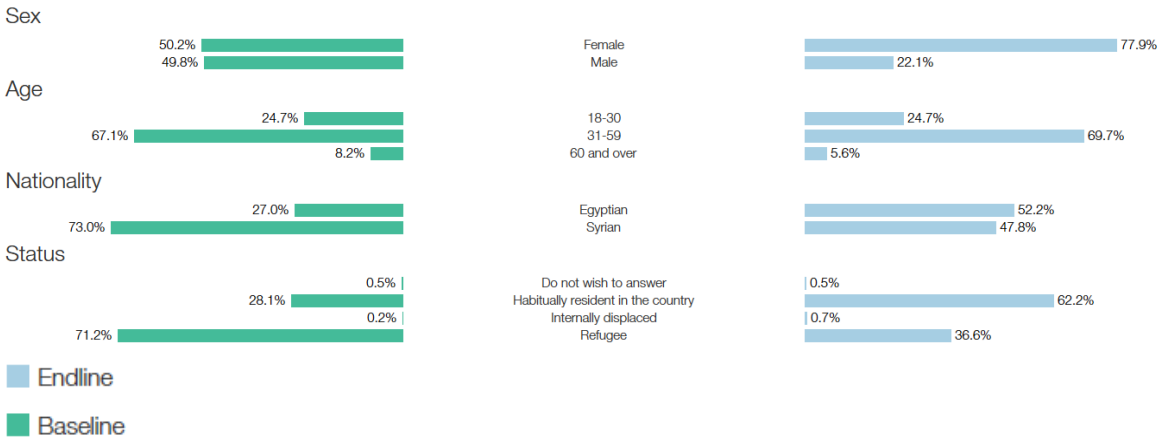
The country findings for Egypt are drawn from a comprehensive document review, seven semi-structured interviews with key informants, eight focus group discussions with both host and refugee communities, and an Endline survey that engaged 425 programme beneficiaries. A further breakdown of information sources is provided in the table below.

Table 8: Egypt Data Collection

8 Key Informant Interviews (KIIs)	Included stakeholders from: • Egyptian Red Crescent • German Red Cross • Swiss Red Cross • Community leaders
8 Focus Group Discussions	Included discussions with: • Female representatives from host communities engaged in livelihoods activities • Female representatives from refugee communities engaged in livelihoods activities • Male representatives from host communities engaged in livelihoods activities • Male representatives from refugee communities engaged in livelihoods activities • Female representatives from host communities engaged in health activities • Female representatives from refugee communities engaged in health activities • Male representatives from host communities engaged in health activities • Male representatives from refugee communities engaged in health activities
Endline survey	• 425 respondents, including 320 female/95 male respondents, 200 Syrian/225 Egyptian respondents and 270 habitually resident in the country/155 refugees • Compared with 825 total respondents for the baseline, which included 415 female/410 male respondents, 600 Syrian/225 Egyptian respondents and 230 habitually resident in the country/595 refugees • The number of respondents differed from the baseline; 825 respondents to the baseline and 425 to the Endline. Comparisons can still be made, and conclusions drawn, as long as this difference is taken into account.

The figure below provides an overview of the demographic profiles of Endline survey respondents compared to the baseline.

Figure 70: Egypt - No. of survey responses by sex, nationality, respondent status and accommodation type



MADAD programme in Egypt

Table 9: Egypt Programme Overview

Egypt Programme Budget	Target No. of Beneficiaries to be Reached	Actual No. of Beneficiaries Reached (October 2020)
EUR 1,071,659.	70,800	70,974

Context

When the MADAD programme began in 2016, there were 116,000 registered Syrian refugees in Egypt.[32] There are currently 129,210 registered refugees in Egypt from Syria[33]. Both the baseline and Endline surveys showed that the majority of Syrian refugees live in urban areas, although the Endline showed an increase in those now living in rural areas. In Egypt, the baseline showed that the main challenges facing Syrian refugees in relation to accessing economic opportunities primarily centred on residency permits;[34] this challenge has remained the same over the timeline of the programme.

Programme overview

With a budget of EUR 1,071,659 the Egypt programme was the smallest of the five country programmes implemented as part of the RC/RC MADAD. As part of the programme, ERCS - supported by the GRC and Swiss RC - improving the livelihoods and health of Syrian refugees in Egypt. Health activities were designed and implemented in three areas of Greater Cairo and in Alexandria, and the livelihoods programme focused on communities in three areas of Greater Cairo. The programme sought to establish, equip and operate three vocational centres in Greater Cairo. ERCS youth clubs were leveraged to attract youth and provide behavioural and educational activities to facilitate social inclusion. Based on market studies, training was planned to focus on IT, electronics and handicrafts to allow for informal income generation as legal access to employment opportunities was limited and the Labour Law for non-Egyptians was unlikely to change over the lifecycle of the MADAD programme. Courses were designed to be gender neutral and provided free of charge.

[32] UNHCR operations report, 2016: https://reporting.unhcr.org/node/2540?y=2016#year
[33] 3RP Regional Strategic Overview, 2020-2021
[34] 3RP Regional Strategic Overview, 2020-2021

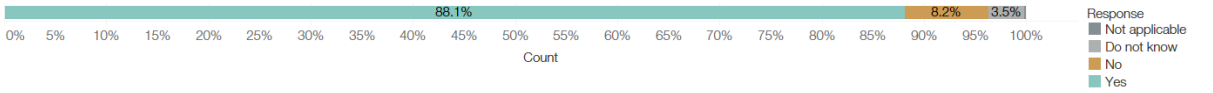
Despite legal constraints, integration of Syrian refugees was considered relatively straightforward, given Egypt's long history with Syrian migrants and refugees. This meant that access to livelihood opportunities and health services was less complicated in many cases, although employment opportunities in the formal sector remain limited for Syrians in Egypt. For example, male Syrians could find work as informal daily labourers quite easily. Due to security concerns, females and youth preferred home-based work and this was considered in the design of the trainings offered.

Health services were provided free of charge to beneficiaries and included access to two clinics in Alexandria, and a mobile health clinic in Greater Cairo. The mobile clinic also operated in Alexandria once COVID-19 struck, providing beneficiaries there with health services free of charge.

Since the beginning of the programme, a total of 70,974 beneficiaries for both health and livelihoods components have been reached, exceeding the target of 70,800. This includes 27,434 male beneficiaries and 43,540 female beneficiaries. The majority of beneficiaries were Egyptian; when disaggregated by community, the data shows 16,623 Syrians and 50,981 Egyptians benefited from the programme, with 3,370 from 'other' communities.

Overall, the programme has had an influence on the lives of beneficiaries. The vast majority (88%) of all respondents to the Endline survey reported that ERCS services in their area had an impact on their lives or their household's lives. When disaggregated by nationality, the data shows that both Syrians and Egyptians were equally positive about this impact; 88% of Egyptians and 87% of Syrians reported an impact on their lives. The biggest impact was around improved access to health services as a result of ERCS support, with improved economic opportunities also reported. This positive impact was also highlighted through focus groups with beneficiaries, who noted that the programme had had a positive influence on many aspects of their lives, and the lives of their families. Figure 71 summarises respondents' answers to a survey question about the programme's impact.

Figure 71: Egypt - Endline Survey: Proportion of respondents reporting impact of RC/CR services in their or their household's lives?

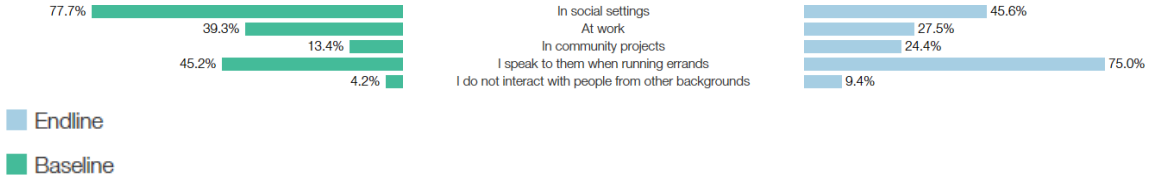


The programme in Egypt experienced significant start-up delays, and encountered several challenges relating to procurement and recruitment. For example, the ERC MADAD project manager was only hired in 2018 and the full-time livelihoods programme officer was only recruited into the role in 2019. Discussions about applicable procurement regulations between ERCS and GRC contributed to delays in procurement processes and led to a delay in the procurement of key equipment for the programme. This included the vehicle for the mobile health clinic, which was only procured and operationalised 18 months after the official programme start. Although health targets were still met despite the delay, key informants pointed to the fact that many more beneficiaries could have been reached if procurement had been timely, and all staff and equipment in place at the beginning of the programme.

Social cohesion was not an explicit component of the MADAD programme in Egypt, although it was expected that livelihood and health activities would contribute to social cohesion and integration. However, the Endline survey showed that there was less interaction between Syrian refugees and members of the host community compared to the beginning of the programme, with a decrease in interactions in social settings, at work, in community projects and when running errands. There was also no substantial difference between the baseline and the Endline survey in those reporting that they do not interact with people from other backgrounds. Feedback from the FGDs with Syrian refugees reinforced this; beneficiaries reported that there is no real meaningful interaction with the host community beyond exchanging pleasantries and casual interaction, and this has not changed or progressed

since the beginning of the MADAD programme. Figure 72 compares the answers of respondents to the baseline and Endline surveys to a question about interaction between Syrian refugees and members of host communities.

Figure 72: Egypt - Baseline-Endline comparison: Proportion of respondents reporting interaction with community members from host communities



Livelihoods

Livelihoods activities were conducted in three areas of Greater Cairo (6th of October, 10th of Ramadan and Obour). One-third (33%) of respondents in the Endline survey reported participating in livelihood activities or training courses provided by ERCS, almost all of whom reported participating in vocational training activities. Of the remainder, 46% have never taken part, and 2% were not sure whether or not they have taken part.

The initial needs assessment for the livelihoods component, which informed programme design and the identification of beneficiaries, indicated that women needed more livelihoods support than men, and that Syrians were in greater need of the same type of support than Egyptians. This initial focus likely contributed to the results of the Endline survey in relation to data disaggregated by sex and nationality, which show that:

- More women than men participated in livelihoods training. The proportion of women who reported taking part was twice that of men; 44% of women surveyed reported taking part, with just 22% of men surveyed reporting participation.
- There were also more Syrians participating in vocational training activities than Egyptians; 52% of Syrians surveyed reported taking part in training, with just 15% of Egyptians reporting participation.

Of all respondents who took part in vocational training, 14% reported an increase in job prospects; 13% reported an increase in income; and 6% reported an increase in their ability to meet the cost of basic needs, including food, healthcare and accommodation.

Figure 73 and Figure 74 summarise key Endline survey results pertaining to livelihoods.

Figure 73: Egypt - Endline Survey: Proportion of women and men who have participated in livelihood activities and training courses provided by RC/RC

Question: Have you taken part in any livelihood activities or training courses provided by RC/RC?

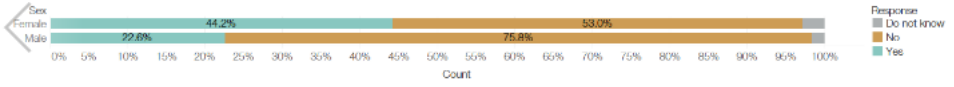
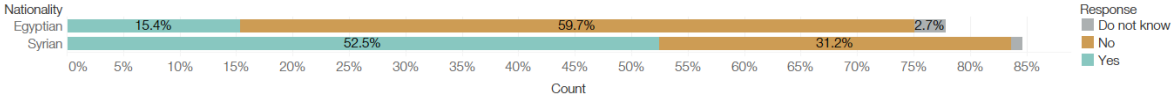


Figure 74: Egypt - Endline survey: Proportion of Syrians and Egyptians who have participated in livelihood activities and training courses provided by RC/RC

Question: Have you taken part in any livelihood activities or training courses provided by RC/RC?



Learning and programme adaptation

The programme sought to adapt to the evolving needs and feedback of beneficiaries over time. The baseline assessment conducted by IOD PARC showed that 150 out of 825 (18%)

surveyed were unemployed and the livelihoods component sought to address this and increase employment for beneficiaries. This included a market analysis to inform the development of livelihoods activities and vocational training. However, one of the key findings of the MTR was that vocational training was not based on a rigorous labour market analysis and that the livelihoods programme was too narrow in its scope. Based on data gathered through KIIs, efforts were made to strengthen the market analysis but one of the key challenges facing Syrians in Egypt is the fact they cannot access formal employment, which was beyond the control of the MADAD programme. The Endline survey showed that 155 out of 425 (36%) respondents still reported being unemployed, which was an increase in those reporting unemployment status compared to the baseline, although it should be noted that the endline sample of 425 includes also many Egyptians who do not have restrictions for formal work.

Once the full-time livelihoods programme officer came on board in 2019, a new assessment process for beneficiaries of the livelihoods programme was introduced using a household economy approach. This allowed for more targeted screening of beneficiaries and included an analysis of their education, skills and experience to ensure they were participating in the most appropriate training.

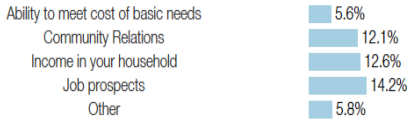
Furthermore, it ensured greater balance of participation within the training courses and sought to improve participants' successful completion of the courses. ERCS also sought to increase their livelihoods engagement beyond vocational training courses. This included organising jobs fairs, developing networks with local employers in the informal market and providing training on CV development and interview preparation. Feedback from beneficiaries through the FGDs, however, indicated that these efforts were made too late to have any real impact; for example, there was only one jobs fair organised and this was limited in scope and attendance by key audiences. More job fairs were planned, but were postponed due to Covid-19.

Another key finding from the MTR was that vocational training was not leading to increased employment and income for participants. Part of the challenge relating to this was the initial set-up of the monitoring process; the indicator relating to increased income was not clear or well understood by programme staff, and there was no budget allocated for data collection against the indicator. Therefore, it was difficult from the outset to demonstrate to what extent the MADAD livelihoods intervention was leading to an increase in beneficiaries' income. The MTR found contributing factors to the lack of an increase in income related to weak linkages between the training provided and labour market needs, and the lack of screening of training participants which led to beneficiaries participating in training courses for which they were underqualified or lacked the prerequisite experience.

Based on information gained through the KIIs, it was established that this MTR finding was addressed using a multi-pronged approach. ERCS monitoring processes were adapted so that ERCS volunteers followed up with graduates of training programmes and asked a series of structured questions to determine if they had experienced an increase in income as a result of, or partly due to, the training they had undertaken through ERCS. According to key informants, the data collected in this way indicated that approximately 5% of training participants experienced an increase in income[35]; this compared with 13% of respondents to the Endline survey reporting an increase in income following participation in ERCS vocational training activities. Figure 75 provides an overview of respondents' views of the extent to which livelihood activities and services improved various aspects of their socio-economic situation.

[35] This data has not been seen by the evaluation team; the figure was reported through KIIs

Figure 75: Egypt - Endline survey: Proportion of respondents reporting improvements in their socio-economic situation following participation in RC/RC livelihood activities or services



Of those reporting an increase in income due to livelihoods activities as part of the Endline survey, more Syrians reported an increase than Egyptians, with the ratio sitting at approximately 75:25. There was also a big difference in the data disaggregated by sex, with women comprising 83% of those reporting an increase in income as a result of vocational training and/or livelihoods training provided by ERCS. Programme staff reported that the new pre-training assessment process introduced in 2019 improved labour market analysis and relationship building activities with local employers helped to improve these ratios in favour of Syrians and women. Figure 76 and Figure 77 summarise the impact of livelihoods activities and training on participants from different nationalities, and for men and women, respectively.

Figure 76: Egypt - Endline survey: Proportion of Syrian refugees and Egyptians reporting improvements in their socio-economic situation due to participation in livelihood activities or services provided by the RC/RC

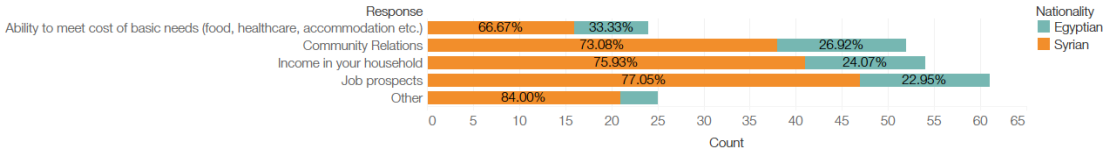


Figure 77: Egypt - Endline survey: Proportion of men and women reporting improvements in their socio-economic situation due to participation in livelihood activities or services provided by the RC/RC

The baseline showed that, of those surveyed, Syrians were most in need of ERCS livelihoods assistance. Therefore, since the programme was initially set up to benefit Syrians, livelihood activities were implemented in communities with high Syrian populations. This created a natural limitation to involving Egyptians, which proved difficult to address. The MTR found that there was a lack of Egyptian people engaged in vocational training. However, ERCS strengthened their livelihood activities and training offers for Egyptian participants by developing the Wedge Employment Track, which is an initiative designed to support participants with skills such as improved CV design, support on how to find and apply for jobs, and prepare for interviews. As this support was more geared towards the formal labour market, it was more beneficial for Egyptians.

The livelihoods component is on track to meet its targets. It sought to adapt to evolving needs over time, and incorporated learning from the MTR, Nevertheless, there were gaps in programme design that limited adaptive livelihoods programming. This included a lack of budget for post-training support. There were no funds available to support entrepreneurs or beneficiaries after training, and this was widely cited by both staff and beneficiaries as a major gap. This meant there was no seed capital available for small business start-ups or for equipment needed for beneficiaries for income generation. For example, many female beneficiaries participated in hairdressing and sewing training, but there were no financial resources to provide them with hairdressing tools or a sewing machine and materials following the training.

Despite learning from the MTR and attempts to address feedback from beneficiaries in relation to the content and duration of training, many beneficiaries said they did not see any significant changes, and training courses remained limited in depth and duration, with limited topics available. Beneficiaries reported that the training was not in-depth enough for them to develop the level of skill required for employment; for example, a two-week computer literacy course cannot provide enough depth to secure a job that requires computer skills. Both staff and beneficiaries reported that it would have been better to have fewer participants in livelihoods activities and training, but to increase spending per beneficiary to allow for seed capital/resources for post-training. Also, a greater variety of courses could be run for a longer duration to provide beneficiaries with the necessary skills required to seek gainful employment, and generate income for themselves and their households.

Gender

The livelihoods component of the MADAD programme was generally well set up to consider gender from the outset. It adapted well over the course of the programme to evolving needs, and to emerging lessons.

Vocational training was gender-sensitive and took into account cultural norms and preferences, including that both Egyptian and Syrian women generally prefer to work from home. Courses were tailored to suit this, including hairdressing, sewing and tailoring courses. There are some cases where gender barriers in livelihoods training and employment were successfully broken down. For example, mobile phone repair and maintenance is generally considered a male-dominated field but there have been several women from both communities undertaking training, and who are now employed in this area. Computer literacy courses were also offered to women; however, there was a disconnect between these courses and employability and income generation. For example, a woman who took a two or four-week computer course for the first time and did not own a computer of her own was unlikely to experience an increase in her chances of employment in this field.

One of the findings from the MTR highlighted that there were more women engaged in vocational training than men, and recommended that this be addressed. This was in part due to the initial needs assessment which showed that women needed more livelihoods support than men. The programme addressed the finding by introducing more vocational courses suited to men, based on the more rigorous labour market analysis outlined above. These courses included mobile phone repair and maintenance, as well as IT and computer courses. It is therefore encouraging that almost one-quarter (22%) of male respondents to the Endline survey reportedly participated in vocation training or livelihoods courses provided by ERCS.

Health

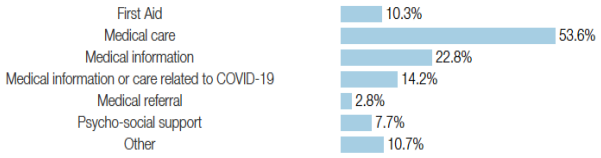
Feedback from staff, volunteers and beneficiaries indicated that health was the strongest component of the MADAD programme. Despite significant delays in the health programme's start-up – it took 18 months to procure and operationalise the mobile clinic – good progress was made towards reaching targets. While targets for health service provision were not reached, targets for health awareness raising were exceeded. According to programme staff, they would have been able to reach an even greater number of beneficiaries, had the equipment and staff been in place from the beginning.

The health component responded well to the specific needs of the target communities, and adapted well over time to these needs as they evolved. This was done in a variety of ways, including surveys with beneficiaries after they had used a particular service to test their satisfaction with existing services and to ask what additional services they would like have available. Responses to these surveys were entered into a database and analysed over time. Community leaders were also given opportunities to provide feedback on all services, including health. A good example of how feedback from all sources was used in practice was

the adjustment of services offered through the mobile clinics. Additional medical specialities, in particular cardiologists and female gynaecologists, were added to the medical convoy based on general and gender-specific feedback.

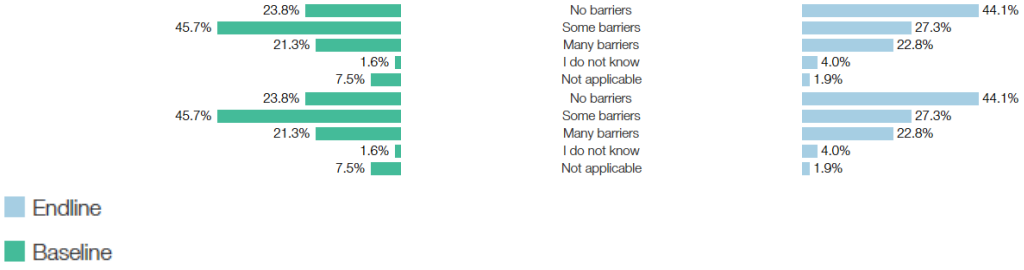
The Endline survey showed that beneficiaries were availing of a broad range of services available through the health component of the MADAD programme. These included medical care and medical information, including information or care relevant to COVID-19 services.

Figure 78: Egypt - Endline survey: Proportion of households where members used health services provided by RC/RC staff or volunteers



The Endline survey showed that there was an increase in respondents able to access free health care, as well as an increase in those reporting that they and their families had access to discounted and/or subsidized services for their primary health care needs. There was also an increase in respondents reporting they do not face barriers in accessing health services. While 25.8% of respondents reportedly facing 'no barriers' in the baseline; this increased to 44.9% for the Endline, and the increase was especially notable amongst women. The number of respondents reporting they face 'many barriers' stayed the same, with 23% reporting facing many barriers in the baseline and 23.3% reporting the same at the Endline. These barriers included lack of public hospitals within communities, cost of private services, perceived low quality of free/public services, cost and availability of transport, as well as long waiting times at clinics and long waiting lists for specialist services. Figure 79 compares the proportion of respondents who reportedly experienced barriers to accessing health services as baseline and Endline, respectively.

Figure 79: Egypt - Baseline-Endline comparison: Proportion of respondents reporting barriers to accessing health services



There was a slight decrease around understanding of how to access medical services if anyone in the household needs medical attention. In the baseline, 47.7% of respondents knew how to access medical services and 23% knew how to access some medical services. This decreased to 44.9% and 16.2% respectively for the Endline. Of those who did know how to access medical services, 48.5% responded that this information was provided by ERCS staff or volunteers.

Figure 80: Egypt - Baseline-Endline comparison: Proportion of respondents who knew how to access medical services

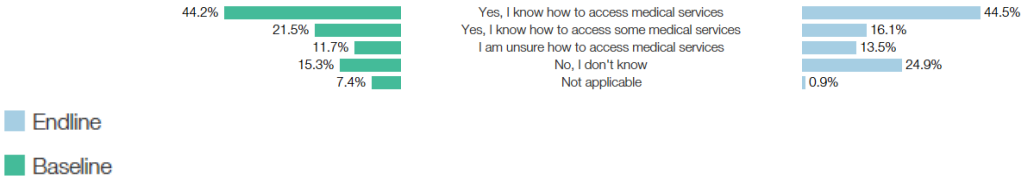
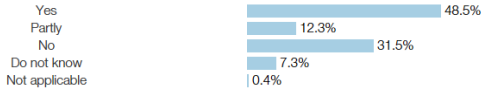


Figure 81: Egypt - Endline survey: RC/RC staff and volunteers as sources of information on how to access health services

Question: If you know how to access medical services, was this information provided by RC/RC staff or volunteers?



Feedback from staff through KIIs indicated that data collection and monitoring processes were not well established in the beginning. At times, too much data was collected and a lack of ability to analyse and review caused delays. Feedback also indicated that surveys involving many beneficiaries did not allow for depth of detail or analysis. It was suggested that targeting a smaller number of beneficiaries for the health programme would allow more time and resources to be spent per beneficiary. It would have been beneficial to increase the spending per beneficiary on medication and medical services.

Learning and programme adaptations

The health component sought to be responsive to both the initial and evolving needs of beneficiaries and target communities over the course of the programme. This included health education and hygiene promotion needs, as well as needs in relation to medical services. The MTR found that the range of health education topics was limited and recommended that the range of topics available be broadened, with inclusion of topics such as non-communicable diseases, drug addiction and domestic violence. Programme staff reported making these changes and developing materials on these topics to offer as part of the health education programme. However, feedback from beneficiaries through the focus groups indicated that there was little awareness of these new topics. In fact, a greater variety of topics was requested. This is supported by the findings of the Endline survey, with respondents indicating an interest in learning about topics such as positive behaviours to promote and protect good health; learning about harmful behaviours in relation to hygiene and solid waste disposal, and water treatment.

The MTR also found that there was a need for more first aid training for target communities. The was challenging because first aid training was not included in the original programme plan, and there was therefore no budget against it. Regardless, the staff did adapt within the existing budget to run short seminars on requested topics relating to first aid.

Gender

Gender was generally well mainstreamed into the health component of the MADAD programme. Gender considerations were included in feedback surveys with beneficiaries, which allowed concerns or challenges to be addressed. Household visits were also conducted by gender-balanced teams of volunteers and staff. The medical convoy was originally set up to respond to the needs of both men and women, including gynaecologists and paediatricians. Feedback over time showed an increase in men requesting cardiology services and these were added to the clinic rotation, while female gynaecologists were also included in response to the needs of women.

The MTR found that men did not regularly engage in certain aspects of the health programme, including health education and hygiene promotion activities. Staff tried to adapt by scheduling health education activities and seminars outside of work hours. However, there was no significant increase in male attendance as it was found that health education was traditionally perceived as a female-oriented activity for women to attend and share information with the wider household.

As previously noted, the Endline showed that beneficiaries are now facing fewer barriers in accessing health services, with 44.9% experiencing ‘no barriers’ in the Endline, compared with 25.8% in the baseline. When disaggregated by sex, this showed that women now face

substantially fewer barriers than in 2016, when 19.9% said they faced no barriers, compared with 47.4% in 2020. The number of female respondents facing 'many barriers' also decreased from 27% at the baseline to 22.6% at the Endline. One of the barriers that has reduced related to cost. Feedback from female beneficiaries accessing health services indicated that free medical services have been a great relief, as well as discounted services at nearby medical centres offering services beyond the capacity of ERCS upon referral. Two of the remaining barriers related to the demand for wider medical specialities and the long wait time to see doctors at the centres.

COVID-19

COVID-19 was a major disruptor for the MADAD programme in Egypt, particularly for the livelihoods component. Most training stopped for four months due to the pandemic. ERCS staff reported that some training was adapted and offered online where possible. However, feedback from beneficiaries in the FGDs was that there were no courses online and that training had stopped completely. This indicates that courses were not broadly offered online and/or this was not well communicated to participants. Monitoring was also not adapted for online training, so there is little data available on how many participants attended or completed various online courses, and no pre- or post-training satisfaction surveys were recorded.

The health component adapted better, though health activities were suspended from March to June which did lead to significant disruption. The mobile convoy started to include Alexandria, and health and safety measures were developed and implemented quickly for ERCS staff and volunteers. Feedback from the FGDs with beneficiaries indicated that more information and awareness sessions on prevention, symptoms and treatment would have been helpful.

Sustainability

Sustainability is one of the primary concerns of staff, volunteers and beneficiaries. This is particularly true for the health component. Medical services and medication are provided for free, and many beneficiaries now depend on these services. Beneficiaries, particularly those from Syria, also rely heavily on the livelihoods training to allow them to gain new skills that would enable them to seek gainful employment, and so provide for themselves and their households.

Feedback from all stakeholders indicated that there are very few organisations in Egypt providing this level of services for vulnerable groups, and that vulnerability will increase without the continuation of services provided as part of the MADAD programme. As the exit strategy has not yet been finalised, efforts are being made to secure funding to continue the services provided under MADAD; however, this has not yet been confirmed and is a source of concern for both staff and beneficiaries given the vulnerability of the target populations.

One positive point is the integration of the mobile clinic into future ERCS health programmes, which should contribute to the sustainability of community health service provision beyond MADAD.

Conclusion

Overall, the MADAD programme achieved its objectives and targets in Egypt. The health component was particularly strong. Despite delays in procuring and operationalising the mobile clinic, this service exceeded targets and provided services relevant to the needs of beneficiaries across the board, including Syrians and Egyptians, and men and women. The livelihoods component performed less strongly due to the lack of a full-time livelihoods officer

until 2019, and also due to initial weak linkages between labour market needs and vocational trainings offered, though this improved over time.

Both the livelihoods and health components sought to adapt over the course of the programme based on the evolving needs of beneficiaries, while findings and recommendations from the MTR were addressed.

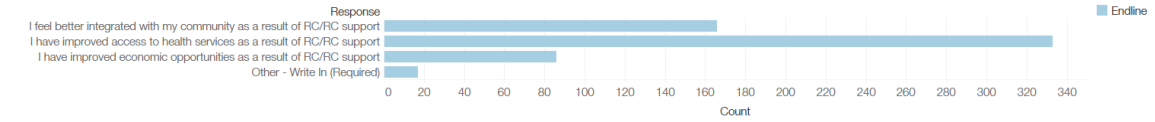
The programme experienced disruption as a result of COVID-19, with livelihoods activities particularly affected as training sessions could no longer take place in person and information about online training seemingly not reaching potential participants. The mobile clinic service adapted to be able to include Alexandria in its rotation, and ensuring that protective measures for staff, volunteers and beneficiaries were introduced rapidly. Sustainability of the programme is of concern for many, with no exit strategy for the programme and a reliance on successful funding applications to allow services to continue.

The programme is evidently appreciated by beneficiaries. The Endline survey showed that ERCS services have had an impact on 88% of respondents' lives, including 88.9% of women and 85.3% of men; and 88% of Egyptians and 87% of Syrians. Only 8% of respondents said these services have had no impact on them at all.

The biggest impact for all respondents related to improved access to health services, with 330 out of 425 (76%) respondents reporting improved access. This compares with 85 out of 425 (20%) of respondents reporting improved economic opportunities as a result of ERCS support[36]. The programme also contributed to respondents' social integration, with 50% indicating that programme activities and services have helped them to better integrate in their communities (see Figure 82).

Figure 82: Egypt - Endline survey Question 55E: Impact of RC/RC services on the lives of respondents and their households

Question: If the programme has had an impact on you and your household, which options best describe this impact?



[36] It should be noted again here that not all the survey respondents participated in the livelihood activities. The majority received health services and thus were not best placed to comment on improved economic opportunities.

Annex 2: Selected regional data

Overall regional data

Figure 83: Baseline-Endline Comparison: Number of family members living in household per age category

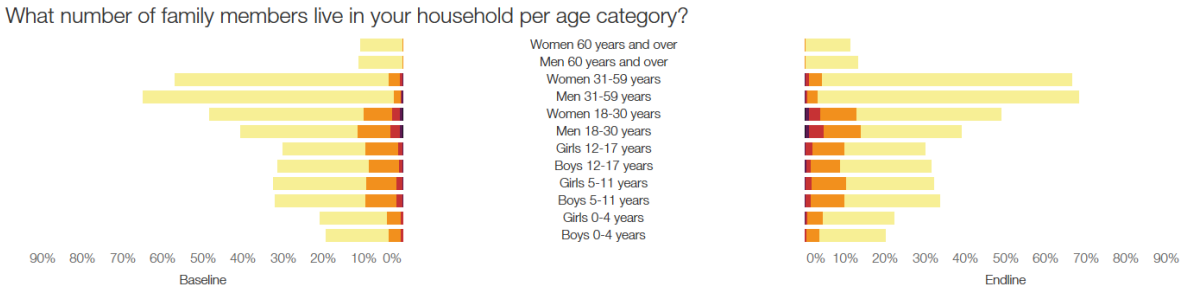


Figure 84: Baseline-Endline Comparison: Area in which respondents are currently living

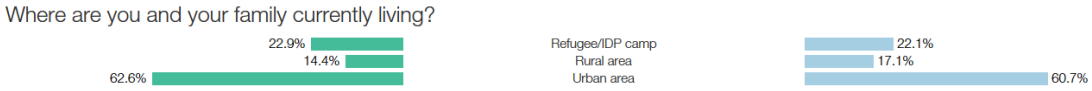


Figure 85: Baseline-Endline Comparison: Respondent type of accommodation

Figure 86: Baseline-Endline Comparison: Type of hazards/risks affecting respondent's communities

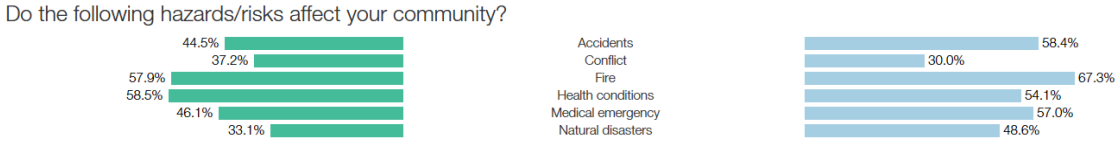


Figure 87: Baseline-Endline Comparison: Respondent knowledge levels on how to respond to threats and hazards

Figure 88: Baseline-Endline Comparison: Information received from RC/RC staff or volunteers on how to respond to threats and hazards

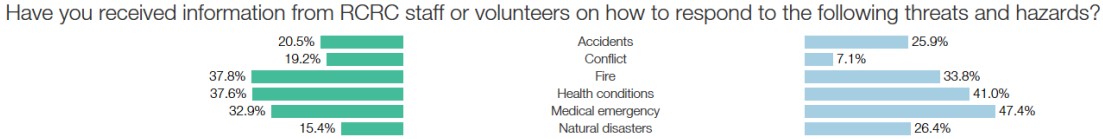


Figure 89: Baseline-Endline Comparison: Respondent involvement in social projects or initatives organised by RC/RC staff or volunteers

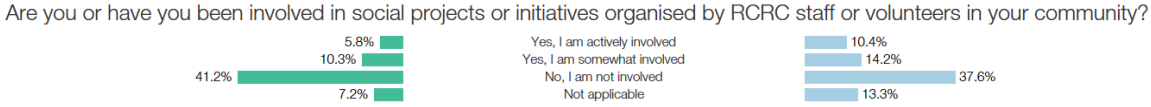


Figure 90: Baseline-Endline Comparison: Types of community development projects that the communities have benefitted from

Figure 91: Baseline-Endline Comparison: Refugee/IDP interaction with the host community

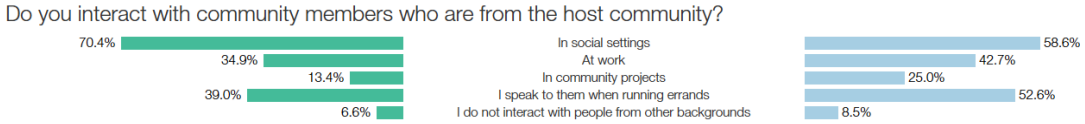


Figure 92: Baseline-Endline Comparison: Host community member interaction with refugee/IDP community members

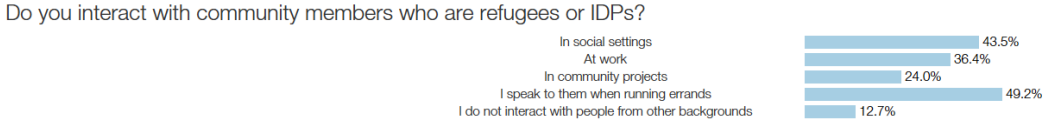


Figure 93: Baseline-Endline Comparison: Host-Refugee/IDP community relations

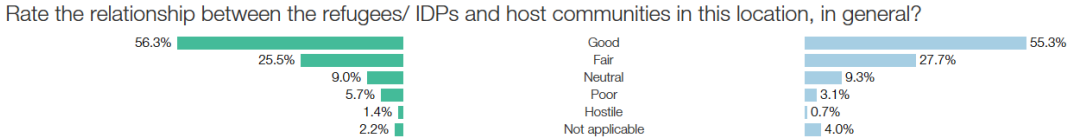


Figure 94: Baseline-Endline Comparison: Respondent use of community centres

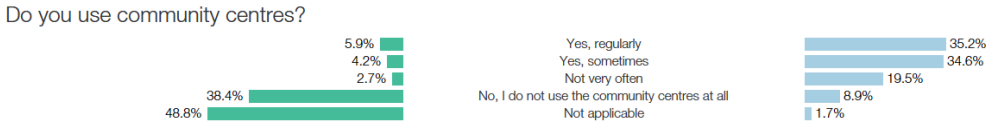


Figure 95: Baseline-Endline Comparison: Services accessed at community centres

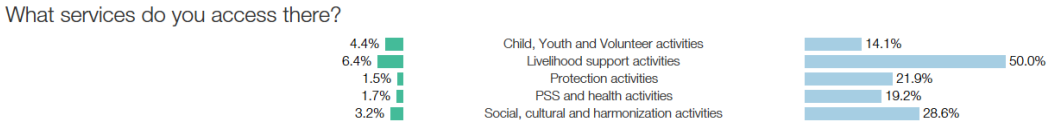


Figure 96: Baseline-Endline Comparison: Respondents' current employment status

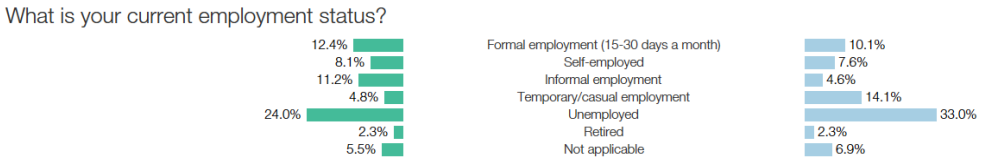


Figure 97: Baseline-Endline Comparison: Number of people in the household working per age category

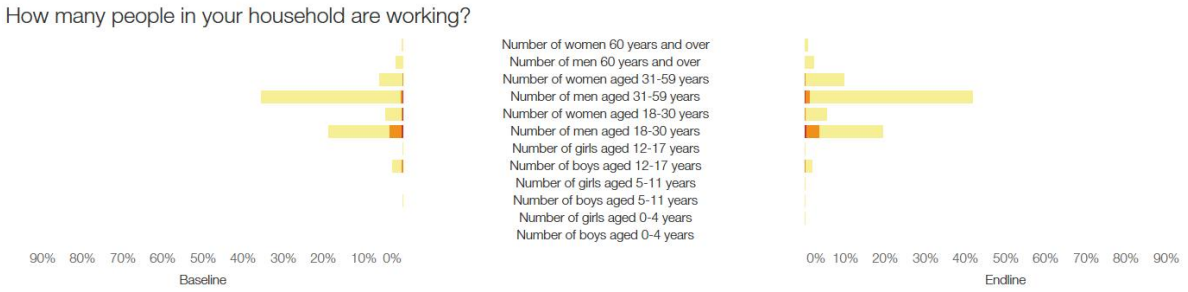


Figure 98: Baseline-Endline Comparison: Members of household with bank account/ cooperative/ other savings account

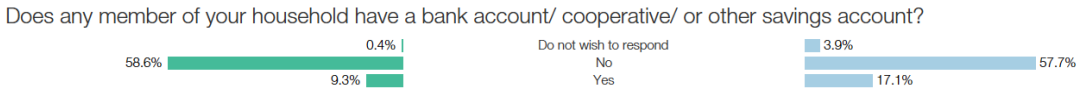


Figure 99: Endline: Changes in income since the beginning of the COVID-19 pandemic in February 2020

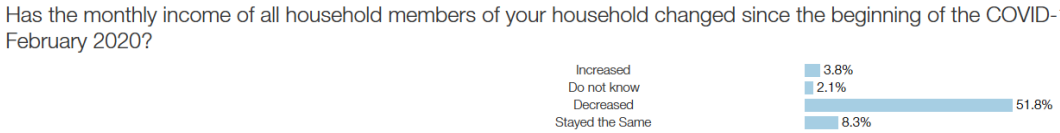


Figure 100: Baseline-Endline Comparison: Main source of income

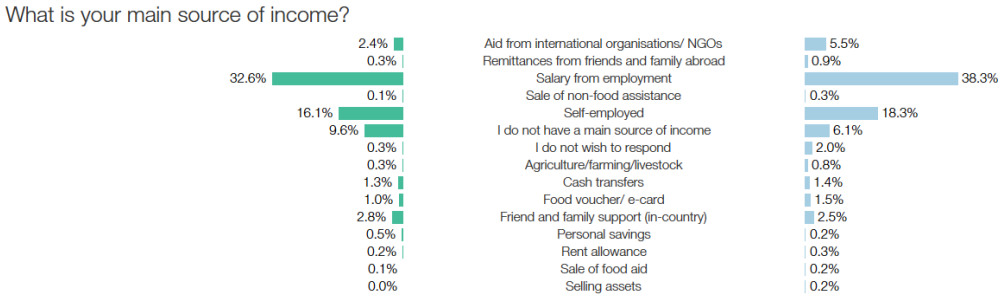


Figure 101: Baseline-Endline Comparison: Secondary Sources of income

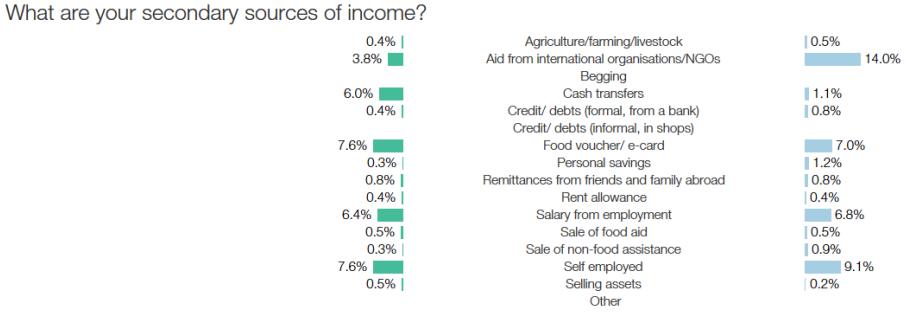


Figure 102: Baseline-Endline Comparison: Ability to meet household expenditure

Figure 103: Baseline-Endline Comparison: Participation in livelihood activities or training courses provided by the RC/RC

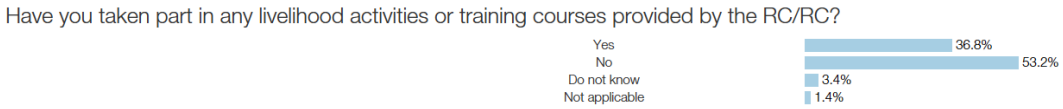


Figure 104: Endline: Livelihoods activities or training courses that respondents participated in

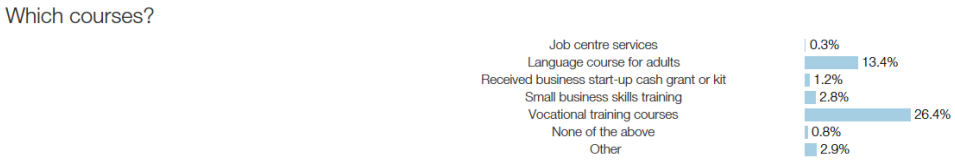


Figure 105: Baseline-Endline Comparison: Effects of RC/RC livelihood activities or services

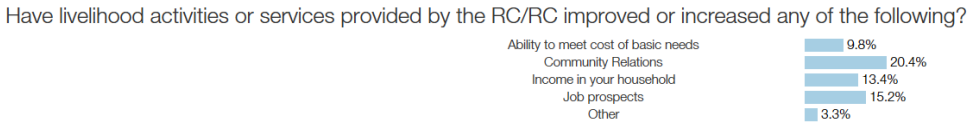


Figure 106: Baseline-Endline Comparison: Respondent arrangements for accessing primary healthcare

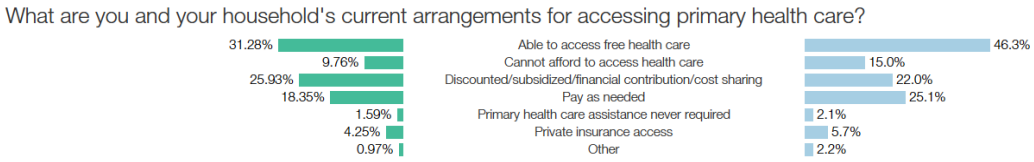


Figure 107: Baseline-Endline Comparison: Secondary/ specialized or hospitalization health assistance

Figure 108: Baseline-Endline Comparison: Barriers in accessing health services

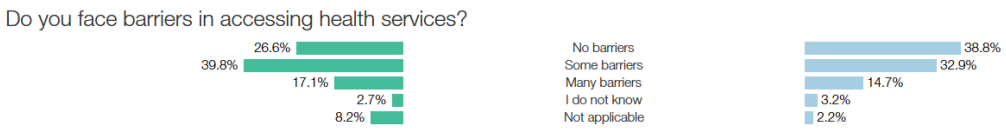


Figure 109: Baseline-Endline Comparison: Barriers experienced in accessing health services

Which barriers have you experienced?

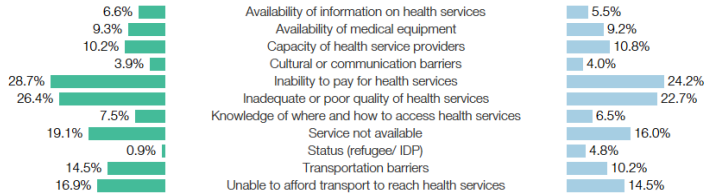


Figure 110: COVID-19 effects on accessing primary healthcare services

Has the COVID-19 pandemic made it more difficult for you or anyone in your household to access to primary health care services?

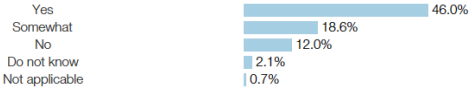


Figure 111: Endline: Knowledge on how to access medical services/assistance

If anyone in the household needs medical attention, do you know how to access medical services/assistance?

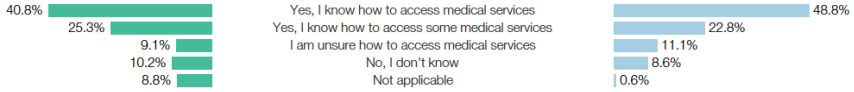


Figure 112: Endline: Knowledge provided by RC/RC staff or volunteers on how to access medical services/assistance

Was this information provided by RC/RC staff or volunteers?

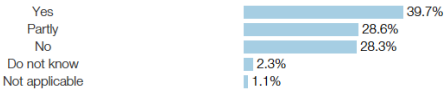


Figure 113: Baseline-Endline Comparison: Awareness on accessing specific medical services

Are you aware of where you can access the following services?

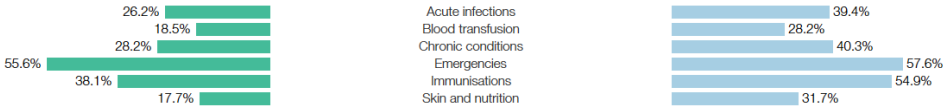


Figure 114: Endline: Information provided by RC/RC staff or volunteers on how to access specific medical services

Was this information provided by RC/RC staff or volunteers?

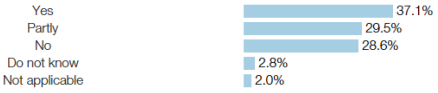


Figure 115: Endline: Health Services received by RC/RC staff or volunteers

Have you or members of your household received any of the following health services from RC/RC staff or volunteers?

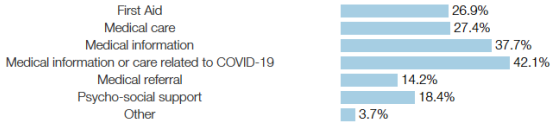


Figure 116: Baseline-Endline Comparison: Main sources of stress amongst respondents

What are the main sources of stress in your life?

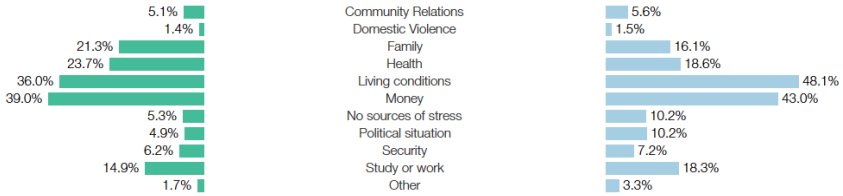


Figure 117: Baseline-Endline Comparison: Stress coping mechanisms

How do you deal with stress?

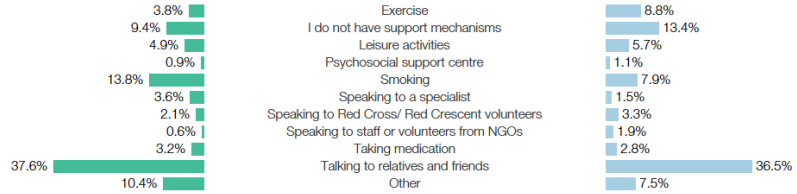


Figure 118: Endline: Participation in RC/RC hygiene promotion activities

Did you participate in or have you been reached by any of the following hygiene promotion activities provided by RCRC staff or volunteers?

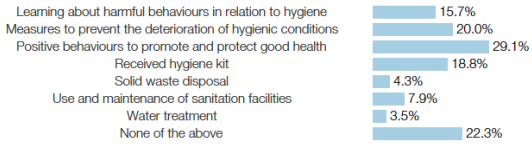
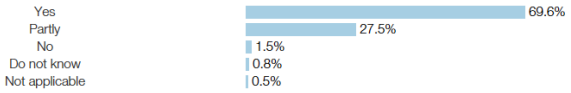


Figure 119: Baseline-Endline Comparison: Improved knowledge of hygiene pratices

Do you feel like your knowledge of hygiene practices has improved?



Did you participate in or have you been reached by any of the following hygiene promotion activities provided by RCRC staff or volunteers?

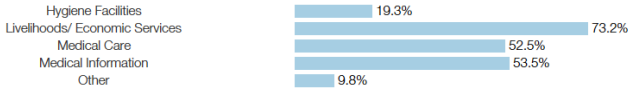


Figure 120: Endline: Impact of RC/RC Services

Have the RC/RC services in your area had any impact in your or your household's lives?

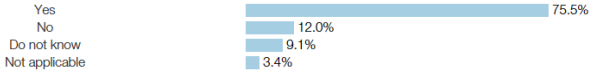
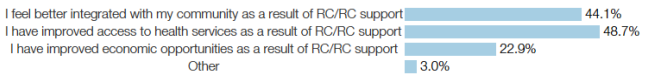


Figure 121: Baseline-Endline Comparison: Impact of RC/RC services on respondents' lives

If yes, which options best describe the impact of RC/RC services on you or your household's lives?



Sex-disaggregated regional data

Figure 122: Legend

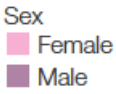


Figure 123: Do you interact with community members who are from the host community? Question posed to refugees and IDPs by sex at baseline and Endline

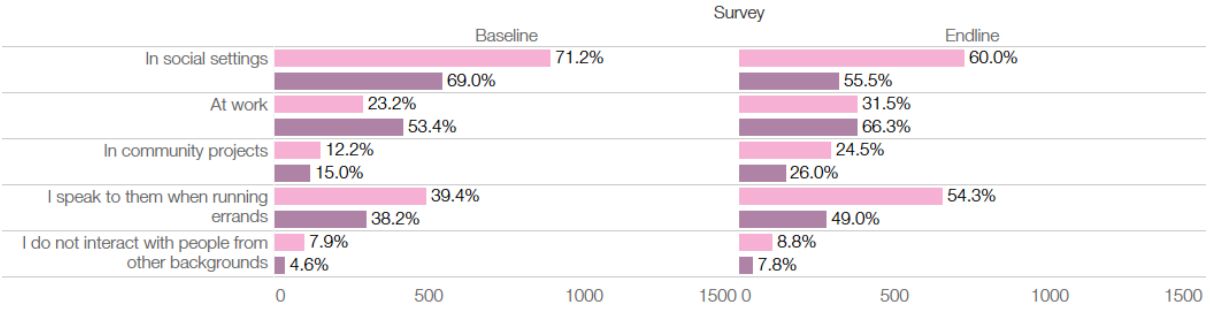


Figure 124: Do you interact with community members who are refugees/ IDPs? Question posed to host communities by sex at Endline

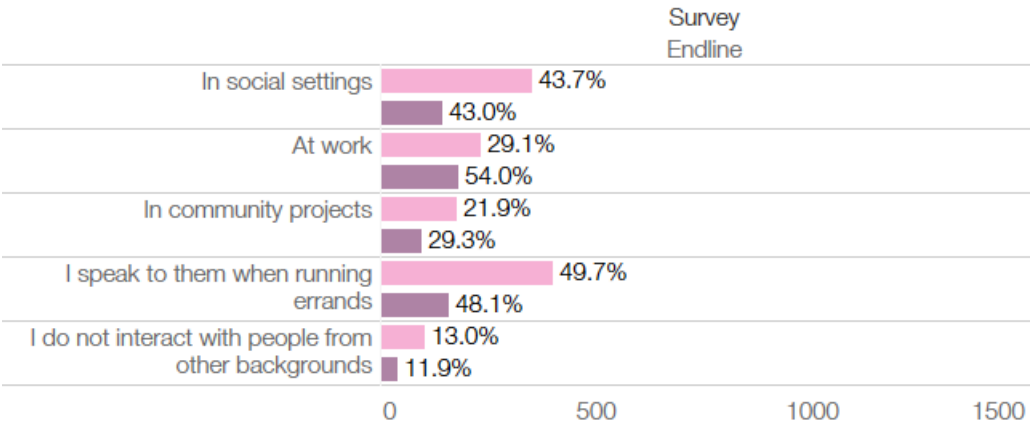


Figure 125: Rate the relationship between refugees/ IDPs and host communities in this location, in general at baseline and Endline by sex

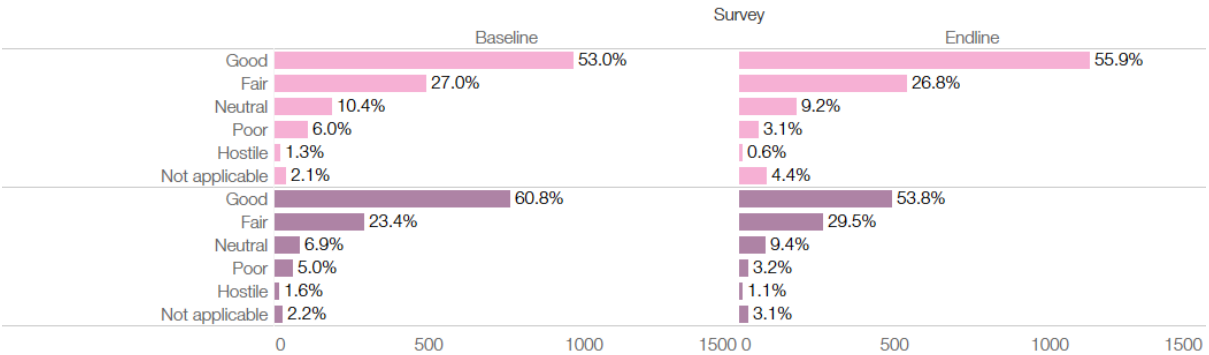


Figure 126: Are you able to meet household expenditure in the following areas? Disaggregated by sex at baseline and Endline

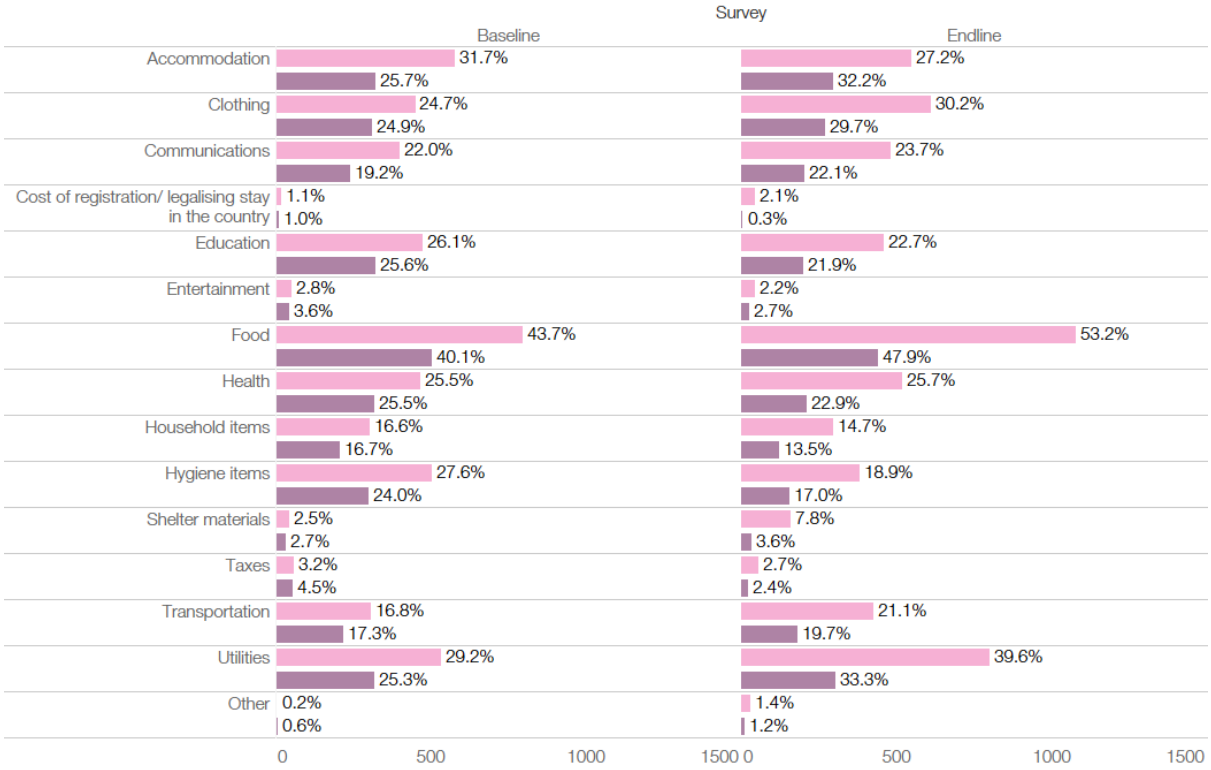


Figure 127: What are your household's current arrangements for accessing primary health care? Disaggregated by sex at baseline and Endline

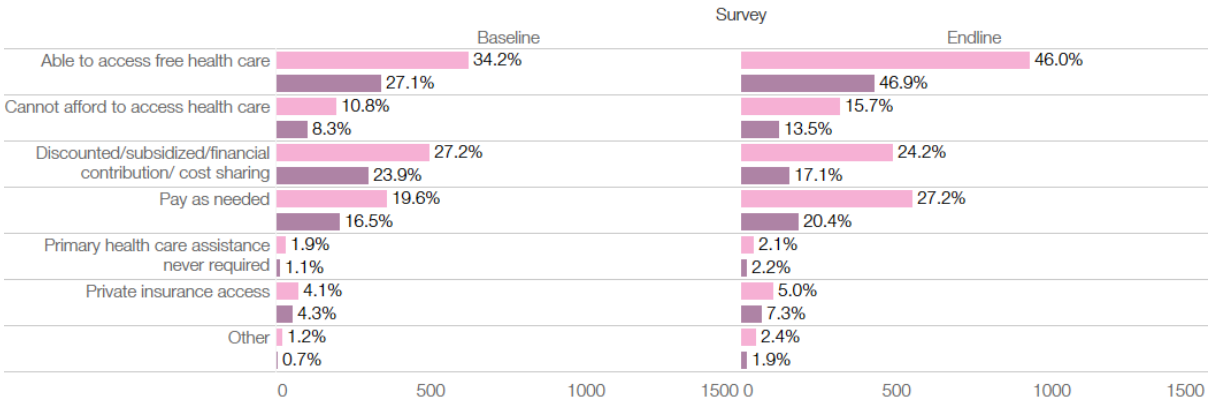


Figure 128: Do you face barriers in accessing health services? At baseline and Endline by sex

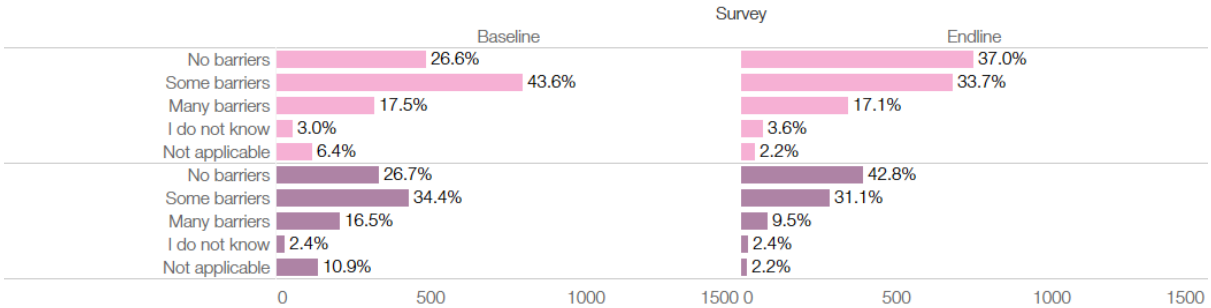


Figure 129: If you do face barriers, which of these have you experienced? At baseline and Endline by sex

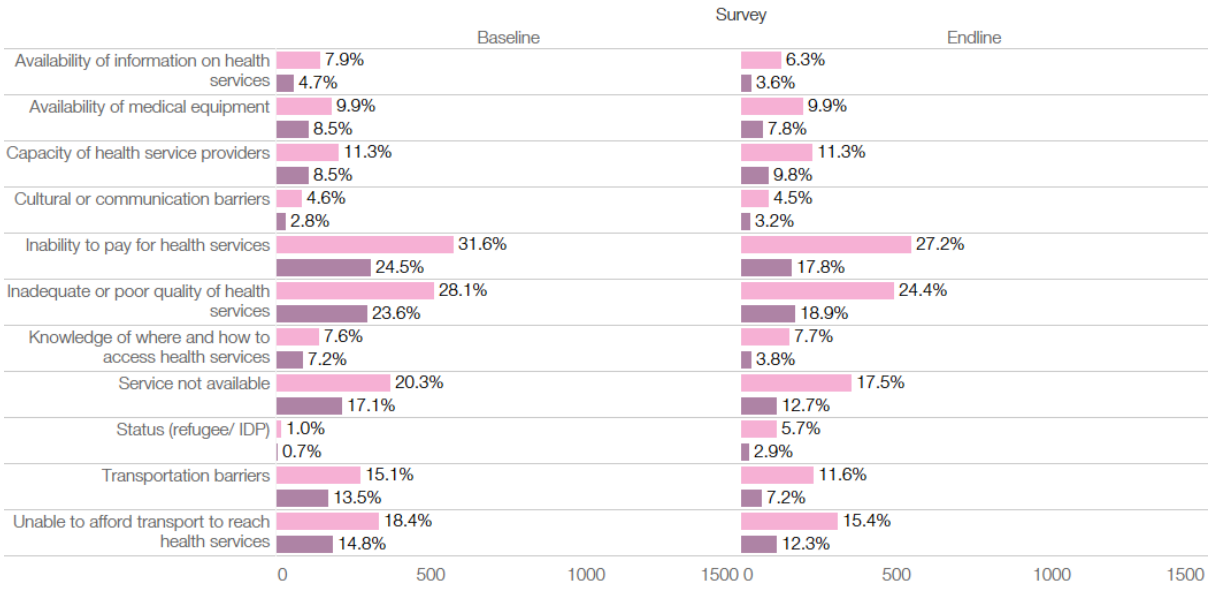


Figure 130: Have the RC/RC services in your area had any impact on your or your household's lives? At Endline by sex

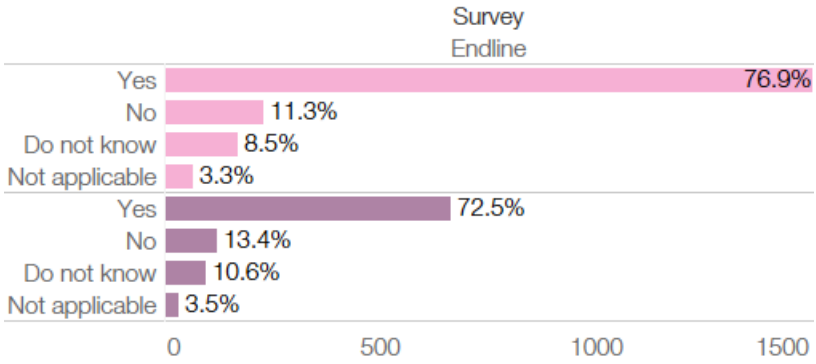
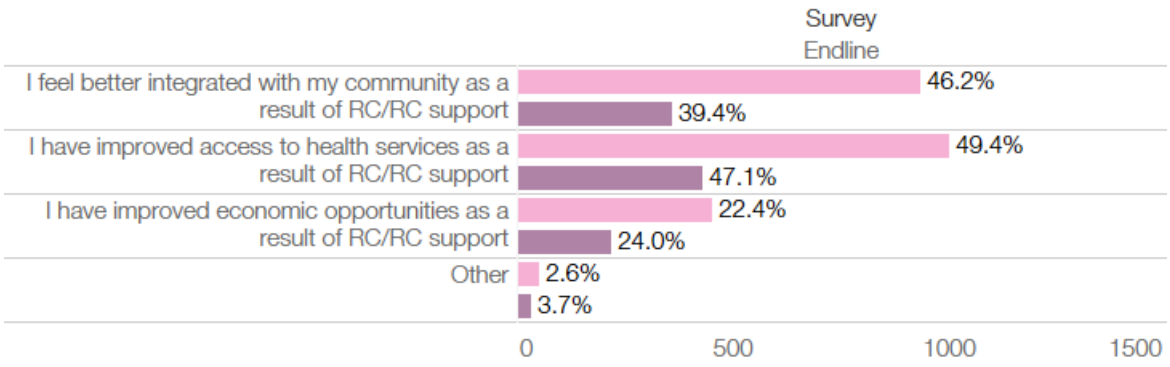


Figure 131: If yes, which option best describes the impact of RC/RC services on your or your household's lives? At Endline by sex



Nationality-disaggregated regional data

Figure 132: Do you interact with community members who are from the host community? Question posed to refugees/ IDPs disaggregated by nationality at baseline and Endline

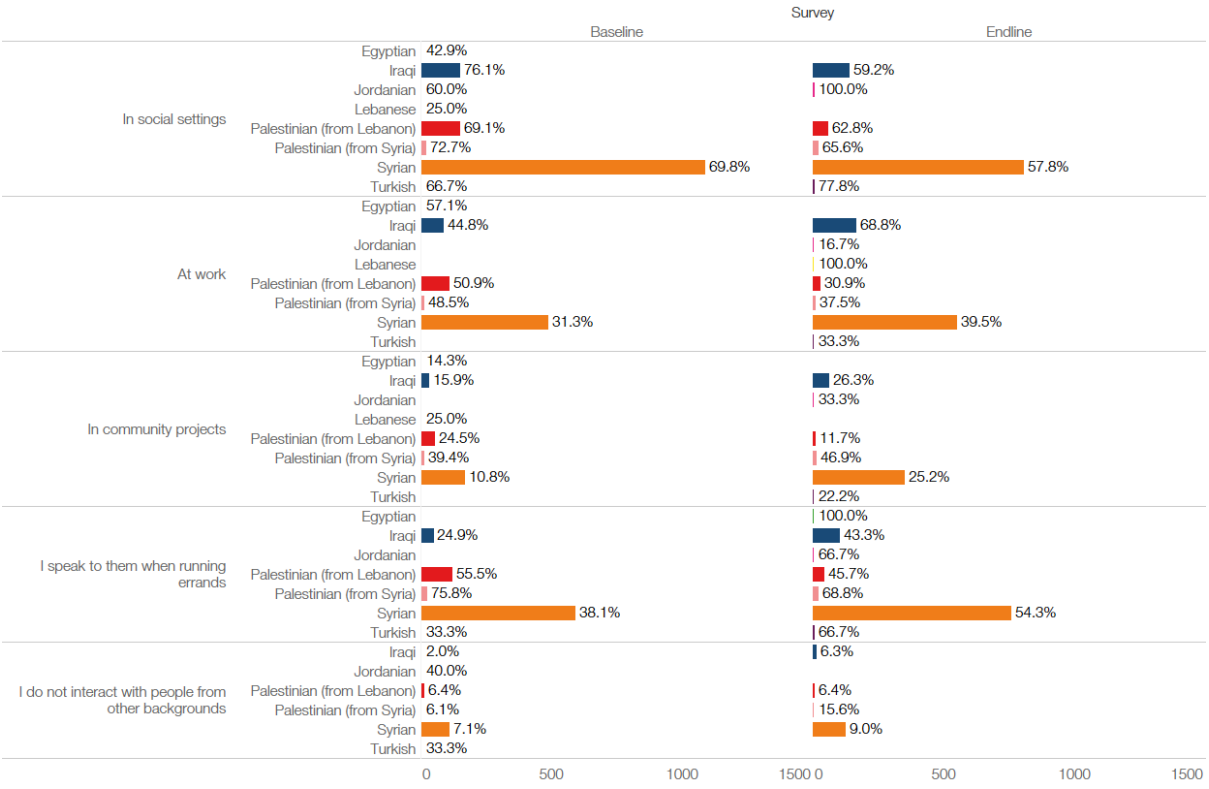


Figure 133: Do you interact with community members who are refugees/ IDPs? Question posed to host community members disaggregated by nationality at Endline

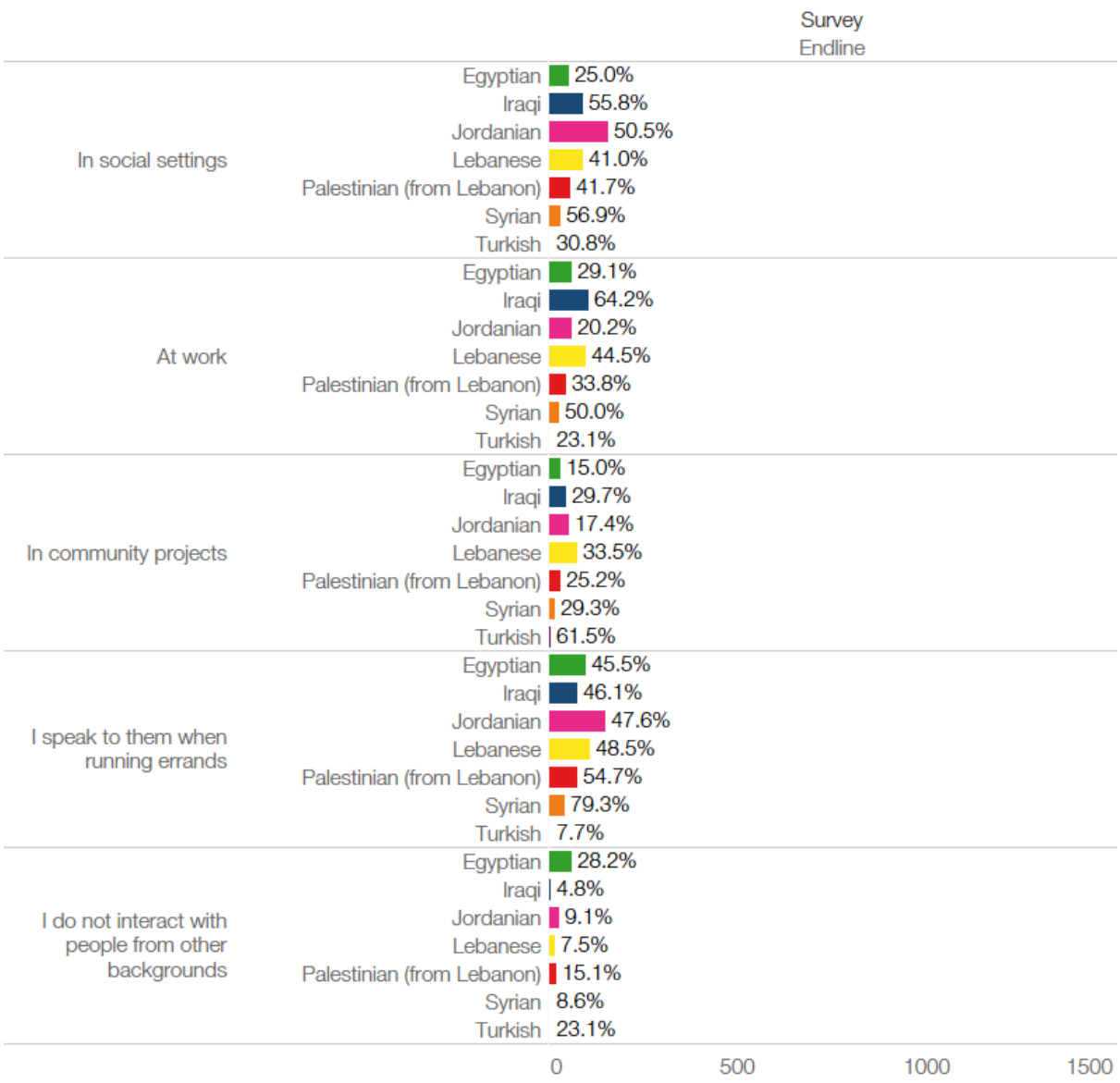


Figure 134: Rate the relationship between refugees/ IDPs and host communities in this location, in general at baseline and Endline by nationality

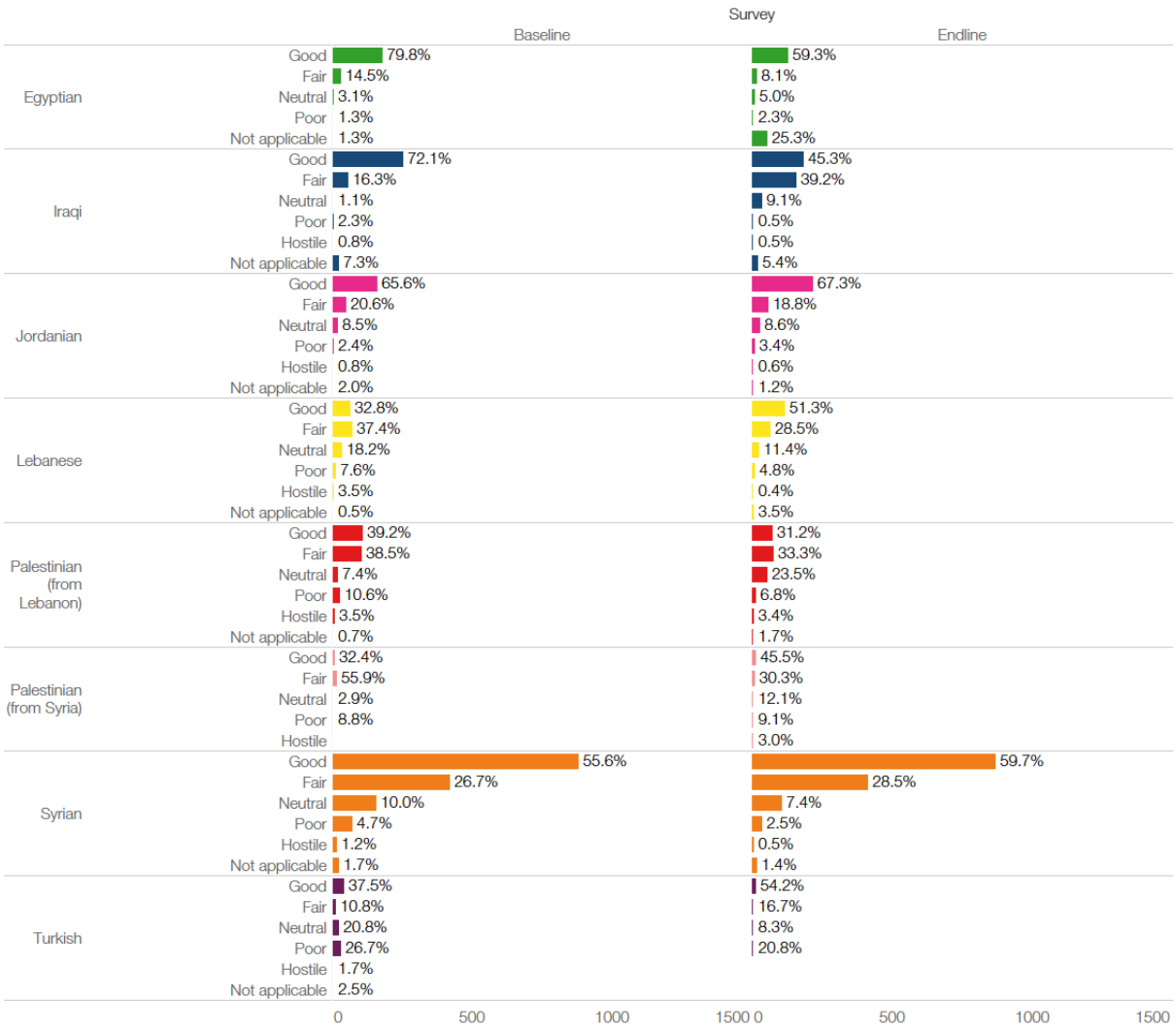


Figure 135: Are you able to meet household expenditure in the following areas? Disaggregated by nationality at baseline and Endline

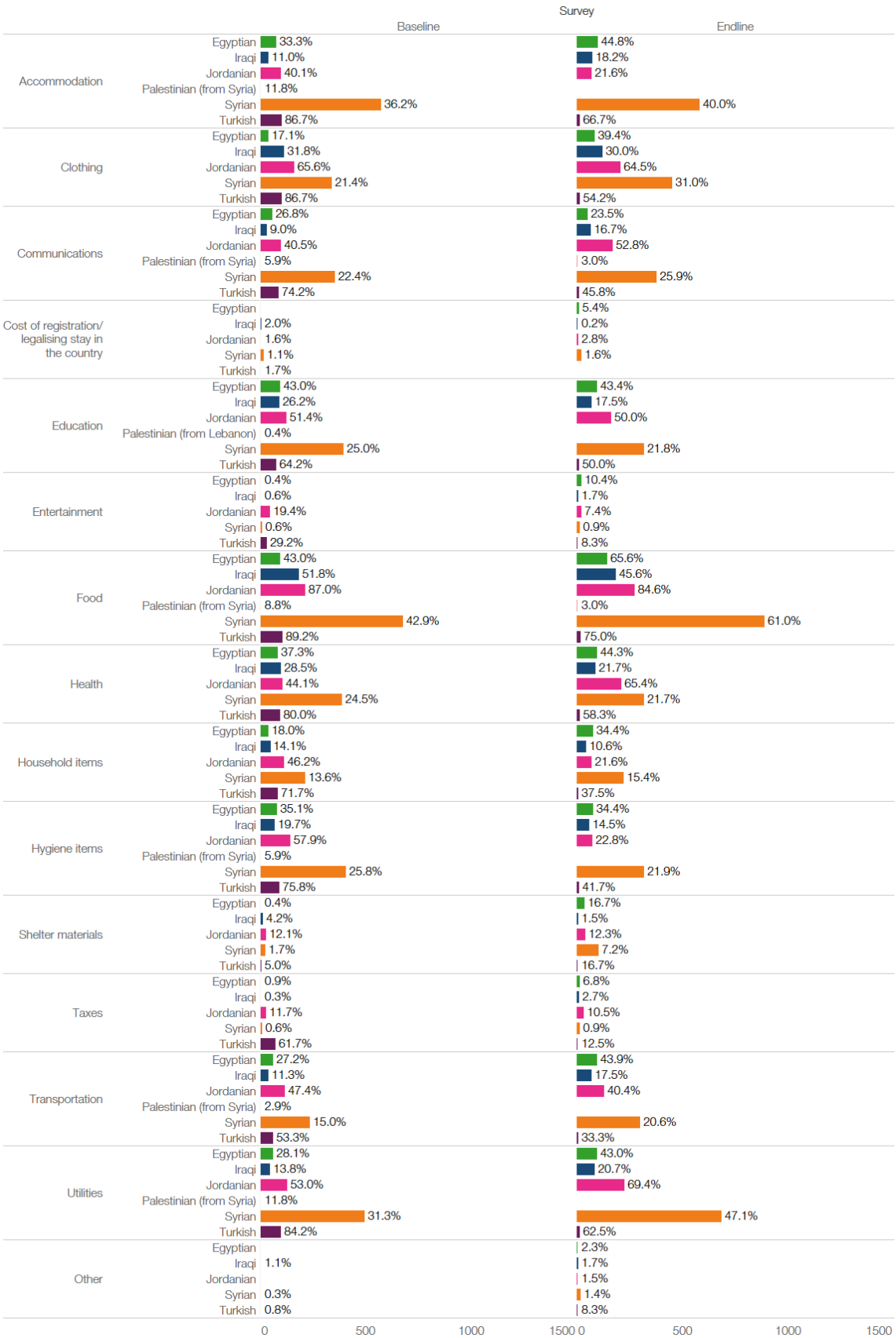


Figure 136: What are your household's current arrangements for accessing primary health care? Disaggregated by nationality at baseline and Endline

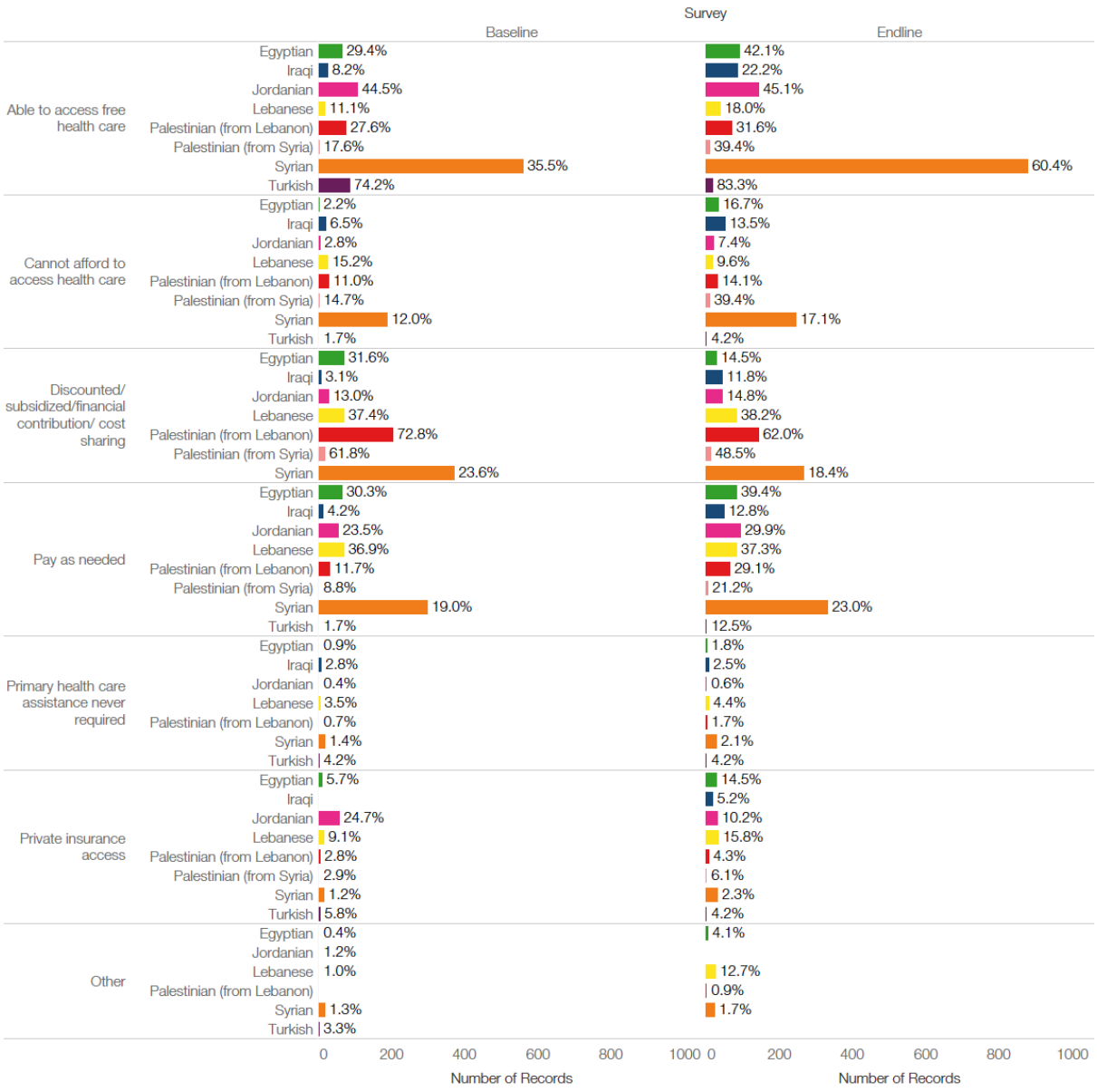


Figure 137: Do you face barriers in accessing health services? Disaggregated by nationality at baseline and Endline

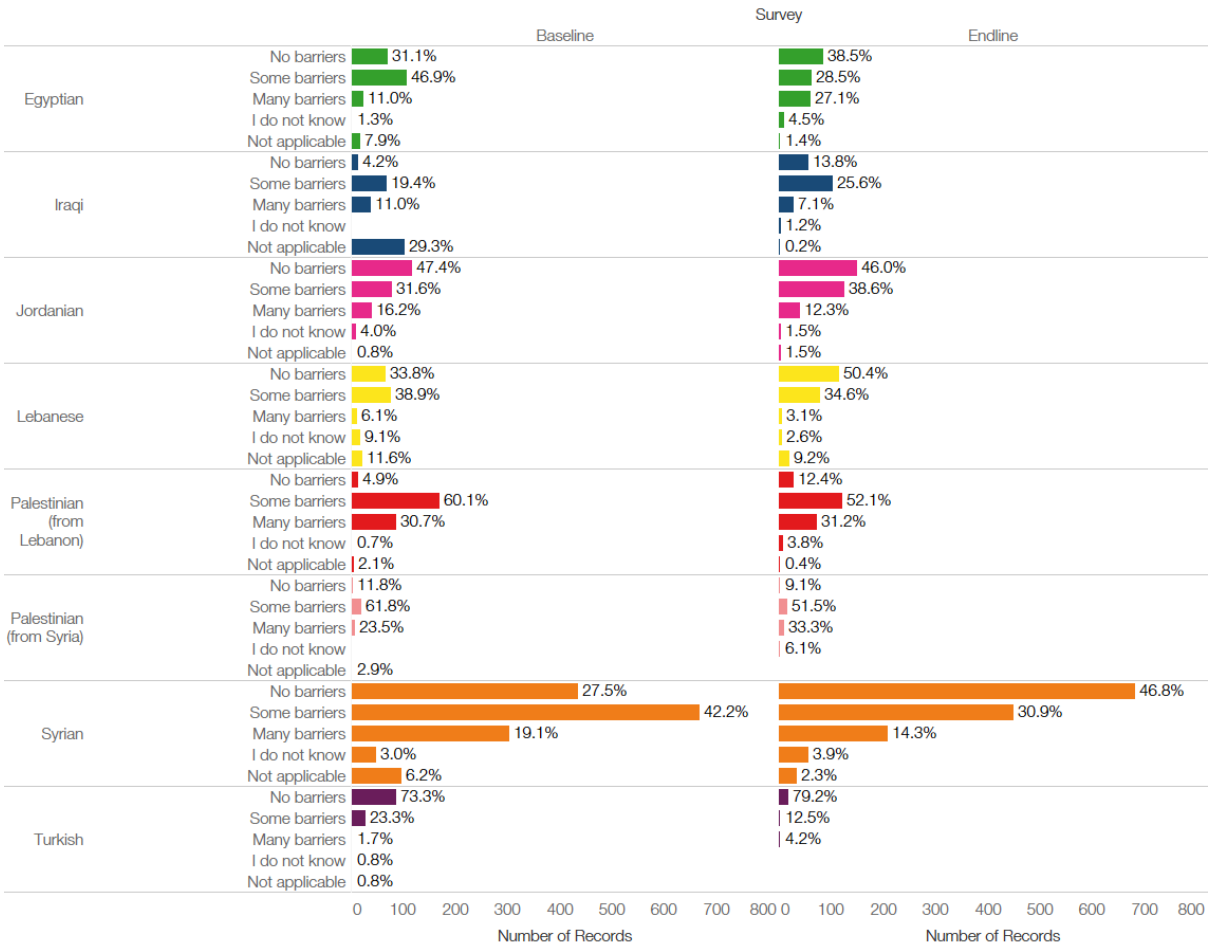


Figure 138: If you do face barriers, which of these have you experienced? Disaggregated by nationality at baseline and Endline

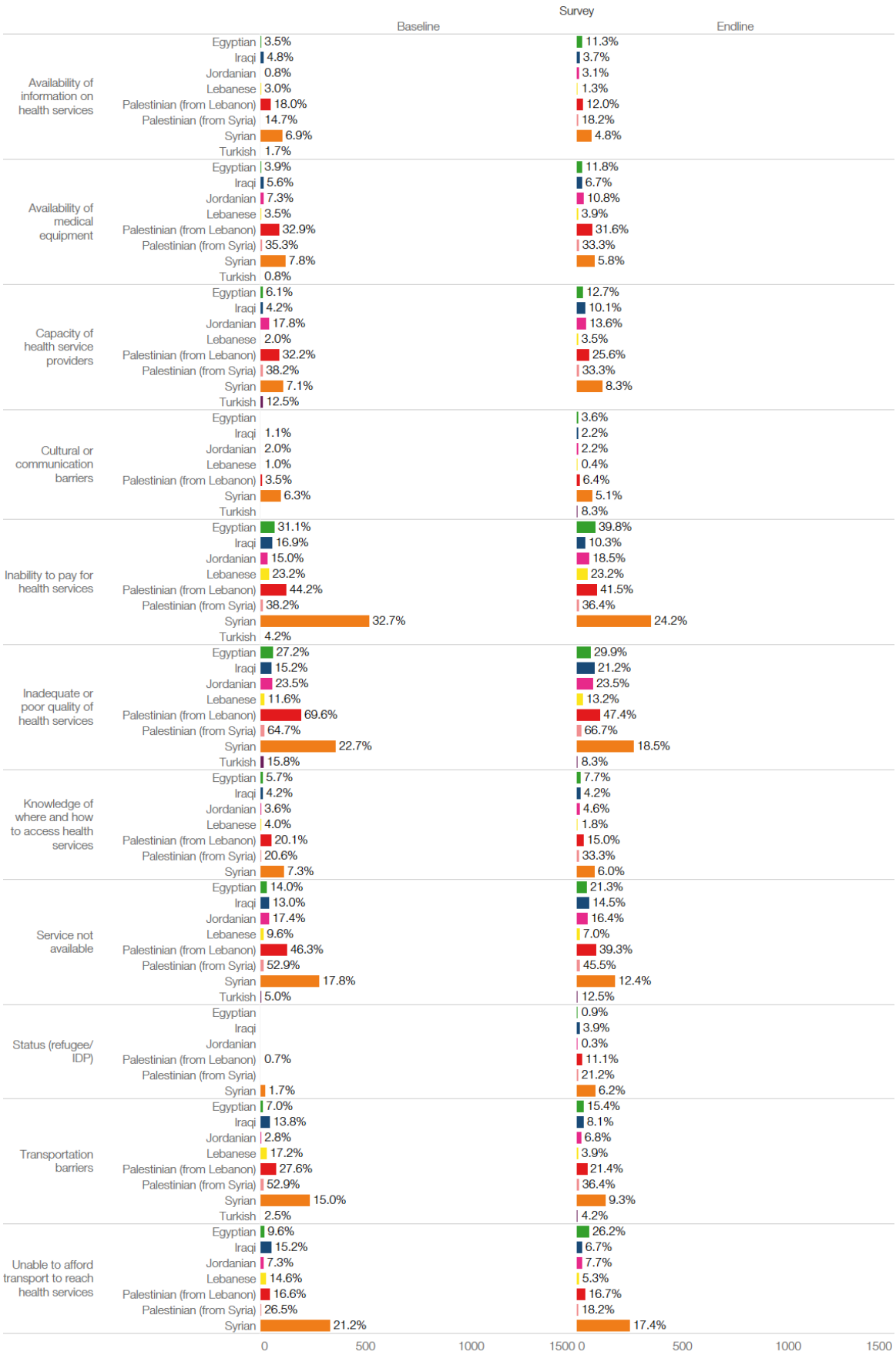


Figure 139: Have RC/RC services in your area had any impact on you or your household's lives? Disaggregated by nationality at Endline

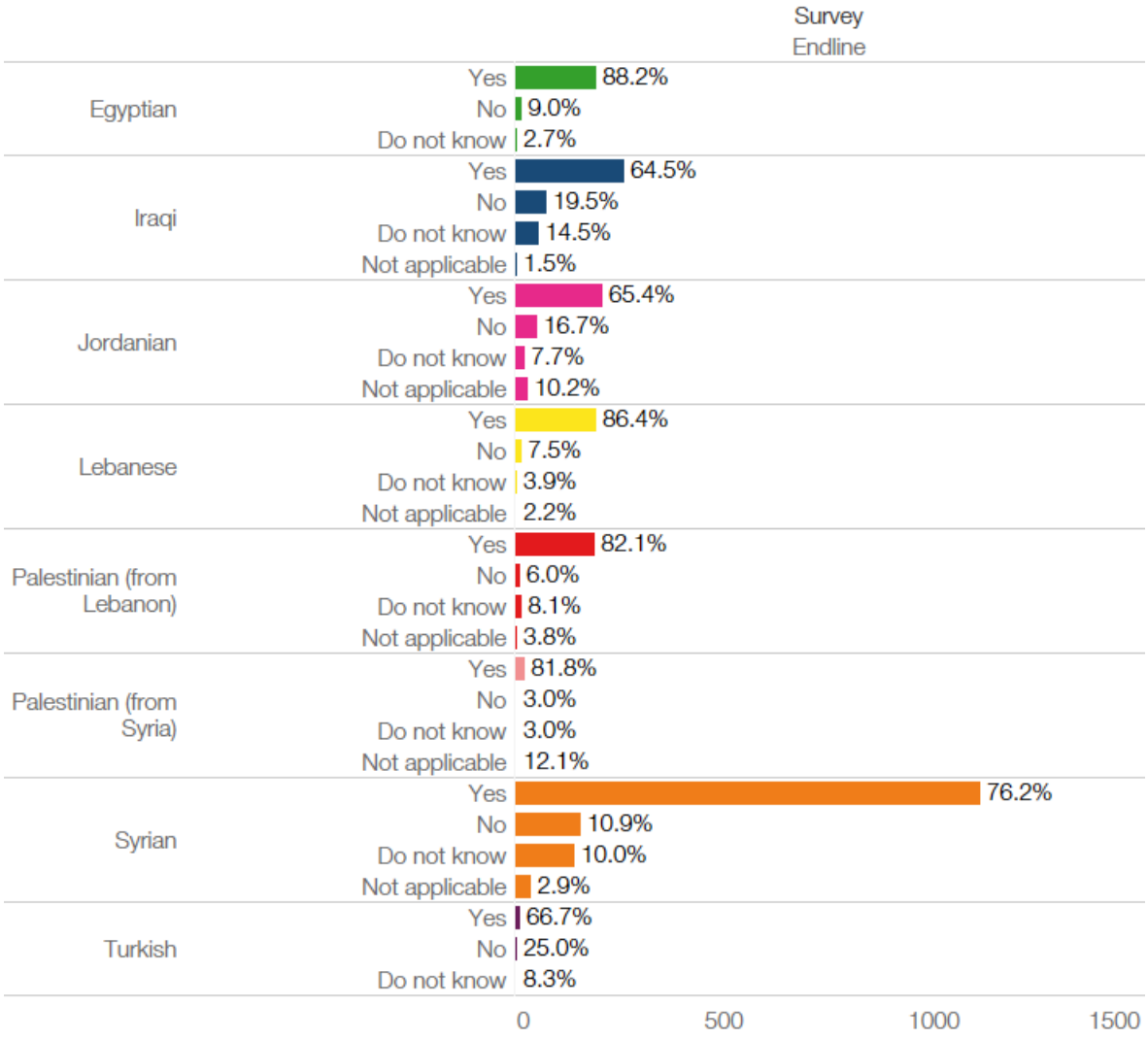
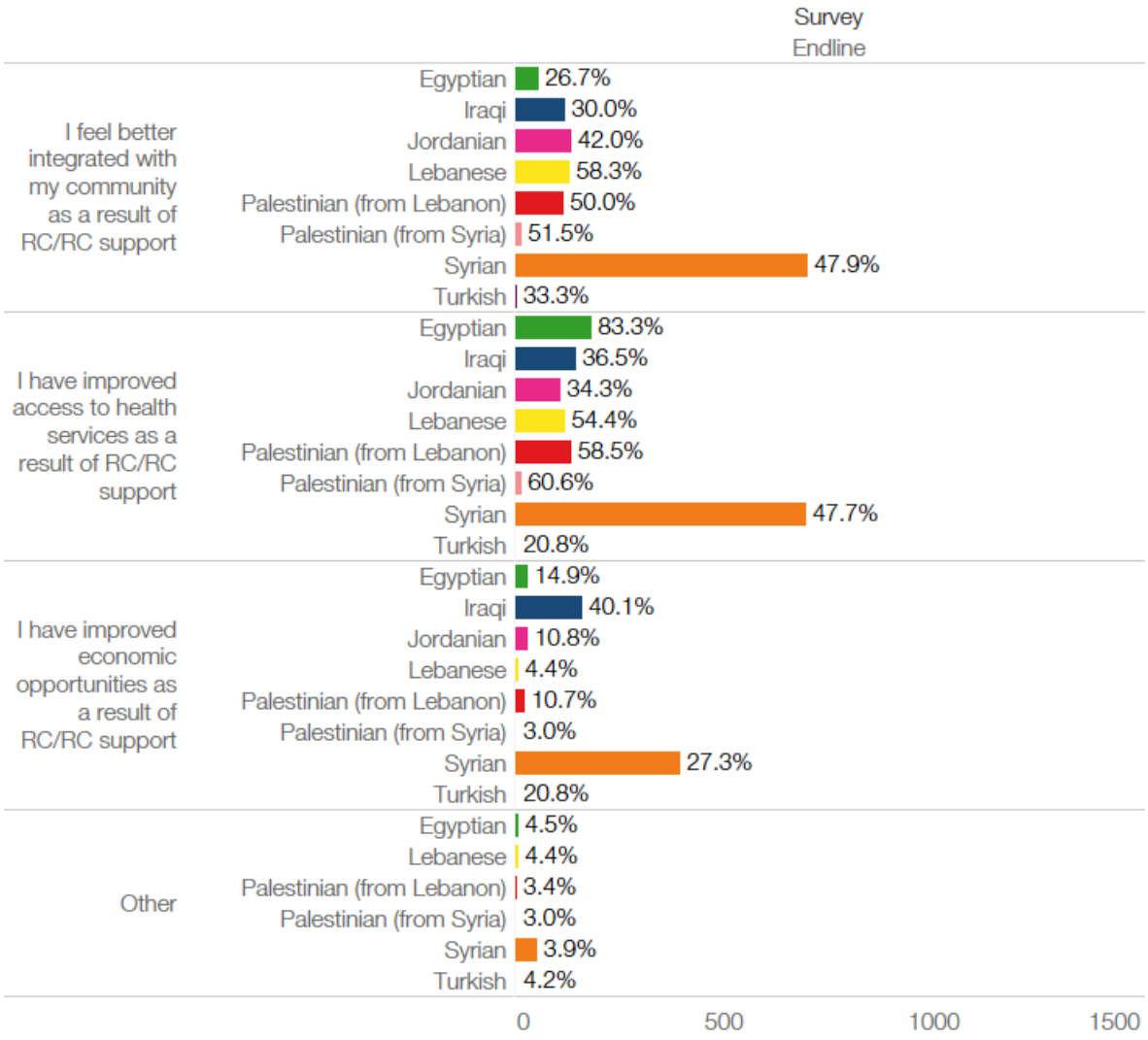


Figure 140: If yes, which options best describe the impact of RC/RC services on you or your household's lives? Disaggregated by nationality at Endline



Annex 3: Evaluation Matrix

Evaluation criteria	Evaluation question	Areas of inquiry	Targeted stakeholders	Data collection tools
Relevance	1. Were the programme's interventions relevant to the needs of the target group, including vulnerable beneficiaries?	• Needs assessment • Beneficiary categorisation (refugee/ IDP/ HC, age, gender and disability)	Programme partners Beneficiaries External stakeholders (e.g. other EUTF implementing partners)	KIIs FGDs Endline survey Document review
	2. To what extent was the programme successful in identifying target beneficiaries?	• Targeting of most vulnerable as per programme categorisation • Access constraints to target groups	Programme partners Beneficiaries	KIIs FGDs Endline survey Document review
Effectiveness	3. Were RC/RC approaches effective in meeting the needs of vulnerable groups?	• Adaptation of approaches to identified needs • Tailoring to protracted contexts	Programme partners RC/RC staff and volunteers Beneficiaries	KIIs FGDs Endline survey Document review
	4. Was the programme successful in securing the participation of target beneficiaries?	• Activity implementation across groups and communities	Programme partners RC/RC staff and volunteers Beneficiaries	KIIs FGDs Endline survey Document review
	5. What are the unintended changes caused by the programme?	• Positive consequences • Negative consequences	Programme partners RC/RC staff and volunteers Beneficiaries	KIIs FGDs Endline survey Document review
Efficiency	6. Has programme governance and set-up been adequate to support efficient implementation?	• Contract management • Country lead set-up and capacity for programme management • Number of partners • Size of consortium	Programme partners External stakeholders (e.g. EUTF)	KIIs Document review

	7. Does the programme employ monitoring information and analysis for course correction?	• Learning from internal processes (e.g. MTR, regular monitoring) • Learning from external processes (ROM missions, QIN reporting)	Programme partners	KIIs Document review
	8. Has financial management and cash flow of the programme been efficient?	• Contracting and payments from funder • Financial management and cash flow within consortium	Programme partners External stakeholders (e.g. EUTF)	KIIs Document review
	9. To what extent has the programme strengthened RC/RC HNS capacity?	• Provision of services and reach to most vulnerable groups • Practices including peer support and care and engaging refugees as volunteers • Volunteer management and retention	Programme partners RC/RC staff and volunteers	KIIs FGDs Document review
	10. What has been the level of achievement against the Communication and Visibility plan?	• *Communication as One Movement* • *Learnings and insights from processes, products and activities in communications and visibility efforts*	*Programme partners*	*KIIs (through incorporation of specific survey-style questions)*
Impact	11. To what extent do target populations have improved health, health knowledge and psychosocial wellbeing as a result of support received from this programme?	• Differences across target categories • Differences between countries • Differences in intervention types	Programme partners RC/RC staff and volunteers Beneficiaries	KIIs FGDs Endline survey Document review
	12. To what extent have employability and income generating activities improved the livelihoods of target populations?	• Differences across target categories • Differences between countries	Programme partners RC/RC staff and volunteers Beneficiaries	KIIs FGDs Endline survey Document review

		• Differences in intervention types		
	13. To what extent has the programme improved well-being, resilience and peaceful co-existence between target populations?	• Resilience to risks and local conflicts • Integration • Social cohesion	Programme partners RC/RC staff and volunteers Beneficiaries	KIIs FGDs Endline survey Document review
Coherence	14. What is the added value of a regional programme?	• Level of internal coordination • Challenges of regional approach • Coherence and coordination with other programmes and approaches	Programme partners External stakeholders (e.g. other EUTF implementing partners)	KIIs Document review
Sustainability	15. To what extent are programme benefits likely to be sustainable?	• Health interventions (access to services + knowledge) • Income generation (employability + other types of support) • Social cohesion • Alternative approaches between countries and by other actors	Programme partners RC/RC staff and volunteers Beneficiaries External stakeholders (e.g. other EUTF implementing partners)	KIIs FGDs Endline survey Document review

Annex 4: List of documents consulted

Document Title	Document Date
Apprenticeship final evaluation report	Dec 2019
Business Support Grants PDM_	July 2020
Case study of Amira Erbil Syrian refugee, beauty salon	N.D.
Case study of Feryal Mahmood Qaem,Refugee, Sewing,Zakho	N.D.
Case study of Ghasan Mohammed, Refugee, Electrical maintenance, Duhok	N.D.
Case study of Jasim Mohamed Taha Ahmed-Erbil	N.D.
Case study of Saad Mohammed Ali ,IDP,Phone maintenance, Zakho	N.D.
Case study of Shayma Ismail, IDP, Sewing, Duhok	N.D.
Comments_Survey Enumerator Training Workshop_130820	13.08.2020
Country Evaluation Turkey 2019, SUMAF – TF-MADAD/2017/T04.30	25.10.2019
COVID Business Impact Survey Results_April 2020	April 2020
Iraq - Business Impact Surveys- data overall, refugee, IDP, women	May 2020
MADAD Annual Report Y1 (incl. interim financial report and interim report) - Deloitte	14.08.2018
MADAD Annual Report Y2 (incl. financial report, EVR, financial forecast Y3, narrative report, updated activity plan and updated logframe – Deloitte	28.02.2019
MADAD Annual Report Y3 (incl. financial report, narrative report, updated activity plan, updated logframe, EVR, financial forecast) - Deloitte	28.02.2020
MADAD Dashboard Master File	29.10.2020
MADAD Dashboard Master File	02.10.2020
MADAD Dashboard Master File	18.03.2020
MADAD Internal Midterm Review	17.12.2018
MADAD Internal Midterm Review Annex 1 - consolidated country response to ROM and MTR	17.12.2018
MADAD Quarterly Reporting - Egypt	2017 - 2019
MADAD Quarterly Reporting - Iraq	2017 - 2019
MADAD Quarterly Reporting - Jordan	2017 - 2019
MADAD Quarterly Reporting - Lebanon	2017 - 2019
MADAD Quarterly Reporting - Turkey	2017 - 2019
MADAD Regional Baseline Report (incl, final report, logframe with baseline values, MADAD intervention logic, MADAD Results Framework, MADAD operational criteria for project selection)	08.12.2017

MADAD Revised Document of Action (incl. budget and justifications, logframe, request for NCE, Letter to DRC, Letter to EUTF and signed addendum)	17.06.2019
Multi-Purpose Cash Assistance PDM_July 2020	July 2020
Regional Midterm Review_final aide memoire 17.12.2018	17.12.2018
ROM Report 2018, Monitoring Question and Response Sheet – Egypt and Turkey ROM T04 30 DRC	28.11.2018
ROM Report 2018, Monitoring Question and Response Sheet - Iraq ROM T04 30 DRC	26.11.2018
ROM Report 2018, Monitoring Question and Response Sheet – Lebanon and Jordan ROM T04 30 DRC	13.12.2018
Round 1 SB 6-month monitoring report_ Jan 2020	Jan 2020

Annex 5: List of people interviewed

Name	Position	Organisation/ Country
Birgitte B. Ebbesen	International Director	DRC
Ilaria Ravai	Regional P-MEAL Advisor	DRC
Jakob Harbo	Head of Partnership and Compliance	DRC
Karina Mortensen	Head of International Finance	DRC
Robyn Kerrison	PSS Country Delegate for Lebanon	DRC
Tina Breum Mariegaard	Senior Consortium Coordinator	DRC
	Community Leader	Egypt
	Partner Organisation Representative	Egypt
Ahmed Ragaey	Project manager of MADAD	ERCS
Maison Mohamed	Community Leader in October Hub	ERCS
Muhammad Esherbini	Livelihoods Programme Officer	ERCS
Salma Sallout	Health officer, assistant project manager for health component	ERCS
Giorgia Garofalo	Officer for EU Trust Fund overseeing livelihoods and social protection	EUTF
Marie Rosa Vettoretto	Officer for EU Trust Fund overseeing health	EUTF
Maxime Montagner	International Aid / Cooperation Officer	EUTF
Paola Pallotto	Programme Manager and Monitoring & Evaluation Coordinator	EUTF
Sara Campinoti	Programme Manager, EU Response to the Syrian Crisis and Migration, EU Delegation to Lebanon	EUTF
Steven De Vriendt	Programme Manager	EUTF
Ville Suutarinen	Prog Manager for Migration in the EU Delegation in Cairo	EUTF
Chiranjibi Rijal	Livelihood Project Manager Iraq	FRC
Rasha Hijazi	Member of Ghazieh Municipal Council	Ghazieh Municipal Council
Christophe Arnold	Country Manager Lebanon	GRC
Lourdes Perez-Garcia	Head of office, country coordinator representing the Swiss and German Red Cross	GRC
Regina Kandler	Programme Coordinator	GRC

Barış Deyirmenci	Programme Officer, Turkey	IFRC
Dina Jalookh	Livelihoods Officer Jordan	IFRC
Enrico Papitto	Grant Manager and Jordan MADAD Country Lead	IFRC
Muftah Etwilb	Head of Country Office in Jordan	IFRC
Sayeeda Farhana	Community Engagement and Accountability Delegate	IFRC
Shafiquzzaman Rabbani	Programme Coordinator and Country Lead for MADAD in Turkey	IFRC
Aram Kalhor	Health Officer	IRCS
Hawre Ehsen	Healthcare Implementor	IRCS
Ramadeen Teeli	Programme Executive	IRCS
Saman Hamad	Programme Executive	IRCS
Yunis Abdessalam	Healthcare Implementor	IRCS
Ibrahim Ajlouni	MADAD Project Officer	JRCS
Mamdouh Al-Hadid	Head of Programmes	JRCS
Mutlaq El-Hadid	Head of Disaster Management Unit	JRCS
Nasser Chami	Head of Municipality in Kfar Chelane, MSD Component	Kfar Chelane Municipal Council
Berna Beyrouthy	Training Manager	LRC
Cynthia Bakkalian	PMER Coordinator (DRR Unit)	LRC
Hassan Saad	Deputy Director of EMS	LRC
Randa Khayat	Project Coordinator for MADAD Health Component	LRC
Rania Hibri	PSS Manager	LRC
Rita Feghali	Director of Blood Transfusion Service	LRC
Sabine Karout	MADAD Coordinator	LRC
Jasone Garcia Amezqueta	Country Lead for Lebanon	NLRC
Abdalla Mkanna	Iraq Country Programme Manager	NorCross
Idris Azabou	Iraq Country Program Manager and Health Delegate	NorCross
Rana Kabalan	Representative of Norwegian Red Cross for the Middle-east and North Africa	NorCross
Mufeed Dawoud	Corporate Director	Pilot Academy (Jordan)
Saleh Mohmad	Social Worker	PRCS
Sirine Abou Hatab	MADAD Project Coordinator	PRCS

Ana Remodios Lopez Garcia	Country Representative Lebanon	SpRC
Hannah Persson	Protection gender and diversity community engagement specialist	SRC
Jim Bengtsson	Project Manager	SRC
Damla Çalık	Protection Programme Officer	TRCS
Gülgez Ağbaba Eroğlu	Şanlıurfa Community Centre Manager	TRCS
Kamil Erdem	Programme Coordinator	TRCS
Merthan Gözener	Livelihood Project Coordinator	TRCS
Mine Akdoğan	Health and Psychosocial Support Programme Manager	TRCS
Semih Paslı	Social Cohesion Officer	TRCS
Semra Taşkıran	Community Centre Manager, Mardin	TRCS
Fatih Volkan Yamaner	Assistant Expert	Turkish Ministry of Family, Labour and Social Services
Mahmut Karaahmetoğlu	Assistant Expert	Turkish Ministry of Family, Labour and Social Services
Muhammed Ceren	Coordinator	Turkish Ministry of Health
Hilal Büke	Research	Turkish Ministry of National Education

Annex 6: Terms of Reference

Terms of Reference (TOR):
Final Evaluation, End line and Learning (FEEL)

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

Final version:
Kindly note that the TOR are subject to final approval from donor. Adjustments may be made as a result of dialogue with selected consultant(s) during final selection (February/March 2020)

Coordinator:
Danish Red Cross (DRC)

Partners:
Egypt Red Crescent Society / French Red Cross/German Red Cross / IRCS / 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, Jordan, Iraq, Turkey and Egypt

Background

In December 2014, the European Commission launched the "EU Regional Trust Fund in Response to the Syrian crisis" (known as the "MADAD" Trust Fund) as a joint European response to the Syrian crisis and the pressure it places on Syria's neighbours. The overall objective of the Trust Fund is to provide a coherent and reinforced aid response to the Syrian crisis on a regional scale, responding 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[37].

Funded under the EU Trust Fund, the Red Cross/Red Crescent (RC/RC) 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[38].

The total budget of the program is 53.000.000 EUR. The Action has been implemented, albeit with delay in start-up in 2017, quite successfully across multiple contexts with various institutional challenges and varying needs of vulnerable persons from Syria, as well as in the host communities. This has been tested and confirmed during the baseline process, the internal midterm review (MTR) and the result-oriented monitoring (ROM) commissioned by the EU.

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

The RC/RC MADAD program officially began implementation in December 2016 and was originally scheduled to be implemented in 36 months. For various reasons, the implementation on the ground, with few exceptions, did not start until end 2017 and in June 2019, the program was granted an extension at no additional cost. Consequently, the program will run until 31st December 2020 with an adjusted timeframe of 48.5 months. 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".*

This is to happen through the achievement of three specific objectives described below.

i. 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 provides economic opportunities to refugees and host community members in Egypt, Iraq, Jordan and Turkey. The communities are provided with a diverse range of employment and income opportunities through livelihood programming, support to public vocational training 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), contingency plans,

[37] For further information: https://ec.europa.eu/trustfund-syria-region/content/home_en
[38] For more information: https://redcross.eu/projects/madad-responding-to-the-syrian-crisis-together

public awareness and public education in risk reduction, evacuation plans; training in in risk reduction, first aid, safe shelter awareness.

ii. Specific Objective 2: "*Refugees from Syria and host communities have improved health and psychosocial well-being (all countries)".*
   - The Action provides better community access to health care in all five countries. The Action works 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 sustainable sanitation systems.

iii. Specific Objective 3: *"RC/RC 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)".*
   - The Action 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 involved RC/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.

The end of implementation regionally is 31st December 2020. However, the country components of the Action are scheduled to end at different timeframes according to the table below.

Country	End date Q1 2020	End date Q2 2020	End date Q3 2020	End date Q4 2020	Final reporting Q1 & 2 2021
Iraq	X				X
Jordan		X			X
Egypt			X		X
Lebanon			X		X
Turkey				X	X

The design of any bid to support the RC/RC with the FEEL must take this timeline into account in design of methodology, data collection and resource allocation.

Key MEAL milestones in the Action to date:

The following key monitoring, evaluation, accountability and learning (MEAL) milestones have been carried out during implementation of the Action.

The FEEL must build on these three instrumental processes.

i. Baseline: In 2017, a regional baseline had been completed to measure and benchmark key indicators for the program.
ii. Result Oriented Monitoring (ROM): In October 2018, EUTF commissioned Particip to perform ROM on the Action.
iii. Internal midterm review (MTR): In July-November 2018, the RC/RC partners implemented an internal midterm review.

The key MEAL procedures have provided the Action and the partners behind the implementation of its activities with great insights that have guided the operation on the ground. However, there have also been limitations in the processes in terms of testing and measuring the entire *Theory of Change* underpinning the program.

It is expected that the FEEL will measure all indicators as necessary, including the Overall Objective, and will assess the extent to which the Action has achieved or contributed towards intended changes even in cases where the indicators have not been fully operationalised.

More specifically the FEEL must:

i. Evaluate the impact of the program, including its contribution to social cohesion in conflict affected communities, and identify whether and how changes in social cohesion may have occurred.
ii. Measure the changes at objective level and map how these have occurred in the five countries.
iii. Harmonise and align the measurement of indicator 3.2 in all countries (*RC/RC Host National Societies staff and volunteers who reported improved competence and confidence in reaching out to most vulnerable groups*).

Finally, the key MEAL milestones performed during implementation of the Action included two sector evaluations performed by EUTF (not specific to the Action) on livelihood and health performed in 2018 and 2019 respectively[39]. These may be taken into consideration as background, but it is not expected that the FEEL links directly to these.

Purpose and scope of the FEEL:

The FEEL is being undertaken with the dual purpose of accountability and learning in mind. On the side of accountability, the main purpose is to assess the **Action's impact** (contribution to the overall objective) and degree to which outcomes (specific objectives) have been achieved. Secondly, the FEEL should establish whether the program **has achieved its targets.** Finally, on the side of learning, the FEEL should document the **main learning elements** of the program. The FEEL includes a track of evaluation and

[39] Available here: https://ec.europa.eu/trustfund-syria-region/content/monitoring-evaluation_en

document learning on the communication and visibility activities under the Action. The consultant(s) will have to be prepared to accommodate some questions related to this area while the responsibility for this exercise will stay with Danish Red Cross staff. Further details on this workstream in annex 1 below.

Detailed ongoing program monitoring has focused on output level (expected results). The FEEL will therefore complement this by assessing the degree to which the program has achieved its higher-level objectives and the factors contributing to or hindering this and provide evidence for this as well as document the learning from this program at technical and institutional level.

Any bid to support the DRC on the FEEL should relate to the following evaluation and learning questions. These may be further qualified, grouped and confirmed during phase 1 of the FEEL described under methodology below, however they must be built into the design of this assignment.

Evaluation and accountability questions

i. To what extent has the Action improved the wellbeing, resilience and peaceful co-existence among vulnerable refugee and host communities in countries affected by the Syria crisis? What external factors have significantly influenced this?
ii. To examine extent the Action's interventions where the relevance to the needs of the target group, including the particular needs of vulnerable beneficiaries?
iii. How has the program contributed to greater integration and social cohesion as a result of intentional strategies or program activities more broadly?
iv. Is the Action likely to have contributed to stability in targeted areas of the region?
v. To what extent are refugees from Syria and host communities more self-reliant and resilient to prevalent risks and local conflicts as a result of the support received from the Action?
vi. To what extent has the program secured participation in activity implementation across different groups and communities (including beneficiary selection, adaption of approaches etc)[40].
vii. How relevant were the livelihoods-related trainings in each context? How could the relevance of future livelihoods-related training be improved?
viii. How effective has the program been in improving the livelihoods for the beneficiaries (in terms of income and/or employability)? Which approaches to enhance employability were more effective for achieving employment outcomes, and why? To what extent are promising practices seen as replicable in different contexts?
ix. To what extent will the income generating activities started by beneficiaries be sustainable in the short/ medium/ long term? What (if any) strategies implemented by the program may have contributed to the sustainability of income generating activities? What could have been done differently to improve sustainability of income generating activities?
x. To what extent do refugees from Syria and host communities have improved health and psychosocial well-being as a result of the support received from this Action?
xi. Regarding access to health, different approaches were taken in each country. The evaluation should include an overall assessment of the contribution of the program to access to health, as well as an analysis of the contribution of the different approaches taken in each country toward health access (including referrals) and potential contribution to improved health for beneficiaries[41].

[40] In Lebanon the VCA approach was adopted; in Jordan this was through community/micro projects, and in Turkey this was through the implementation of the CEA approach.
[41] In Lebanon health interventions have focused mainly on ambulance service and blood drives. In Iraq provision of ambulances and equipping health centres in refugee/IDP camps was the focus. In Egypt mobile health clinics were piloted. While in Turkey two health centres were supported under MADAD. Across all countries, including Jordan, the RC/RC CBHFA approach was adopted.

xii. Explore what changes may have come about as a result of improved knowledge around health (changes in practices, changes in health seeking behaviour etc).

xiii. To what extent have RC/RC Host National Societies in the region strengthened their capacity to provide services? To what extent have Host National Societies enhanced their ability to reach out to most vulnerable groups within the refugees and host communities (Iraq, Jordan, Lebanon, Turkey and Egypt). These questions should explore strengthened capacity through intentional capacity building efforts as well as other mechanisms[42].

xiv. To what extent has the program succeeded in reaching the most vulnerable people?

xv. How has the program contributed to strengthened capacity in volunteer management and retention? What are promising practices in this area, including those related to volunteer peer support and care, and to engaging refugees as volunteers?

xvi. What are the unintended (positive or negative) changes caused by the Action?

xvii. What has been the level of achievement against the agreed purpose and goals described in the Communication and Visibility plan (more specifically described in Annex 1 to the TOR)?

xviii. List not exhaustive

Learning questions

i. What recommendations can be made to strengthen the sustainability of the activities, results and structures engaged under the program? (including engagement and coordination with other stakeholders, capacity building etc)

ii. What is the perceived value-added and/or challenges of a regional program?

iii. What are the perceived benefits and challenges associated with a large-scale consortium managed by a contract holder and five country leads for a total of 15 partners across two RC/RC regions?

iv. What recommendations can be made to improve the process of designing large-scale programs?

v. What learnings have emerged around the financial management and cash flow of the program?

vi. To what extent and in what ways have the RC/RC partners in this consortium improved their ability to implement large-scale regional consortia?

vii. How effective are RC/RC approaches in meeting the needs of vulnerable groups in protracted crisis situations?

viii. To what extent and in what ways have the RC/RC partners improved their ability in livelihoods programming and with implementation of community/micro projects?

ix. To what extent have the RC/RC partners succeeded in communicating as one movement/consortium (the visibility component)?

x. To what extent has the Action been implemented efficiently and effectively?

xi. What are the essential valuable learnings and insights from the processes, products and activities that have been main factors in the communication and visibility efforts? This should include recommendations for future planning of communication activities related to large scale programs with partners from many countries and with different conditions for communicating in public.

xii. To what extent have the MADAD partners responded to the learnings and recommendations from the mid-term review (MTR)?

xiii. List not exhaustive.

[42] No capacity building component (Outcome 3) was implemented in Egypt.

Suggested methodology:

The consultancy assignment is expected to include at least five phases as reflected below. All phases should be finally confirmed with the consultant and reference group during the inception phase. This will include a clear role and responsibility division between the consultant(s) and RC/RC staff, including communication and visibility staff, assigned to the process.

Phase I: Inception phase including final confirmation of terms, evaluation and learning questions, composition of the technical reference group and steering group, desk review and methodology design:

The consultant(s) will conduct an initial desk review of existing relevant documentation for the Action. This includes the Document of Action, the regional and country logframes, program M&E framework, MADAD dashboard and indicator tracking tools (ITTs) along with baseline reports/inquiry matrix, ROM reports, MTR report and methodology manual, relevant sector evaluations and assessments performed. The consultant(s) will base the suggested strategy, methodology and tools on the information presented in these, particularly considering the necessity to adopt common tools for all countries and to extract comparable data for aggregation into regional figures.

The consultant(s) and the RC/RC team will attend a "Methodology and Tools Workshop" led by the consultant, to prepare the review matrix, confirm learning and evaluation questions and define the methodology and the tools to be used for data collection. The inception phase will be concluded with the delivery of an inception report and a methodology manual delivered to DRC.

Phase II: Data collection

In collaboration with RC/RC FEEL team, the consultant(s) will conduct a jointly designed, planned and coordinated data collection process. Across the different partners, the consultant(s) will ensure consistency of approach, methodology, tools and techniques for data collection at field level. The consultant(s) will collaborate and communicate with DRC to coordinate the enumerator recruitment and training, data collection and entry.

i. The data collection should be realized in the 5 countries respecting the country teams' individual plans for end of implementation of activities (see above).
ii. The country teams will be responsible for the data collection process according to agreed upon roles and responsibilities during inception phase.
iii. Data should at least be disaggregated according to age, gender, country, refugee and host communities and sector /type of assistance received.

Phase III: Data analysis

The consultant(s) will analyze the collected data at country and regional level. The consultant(s) will also analyze data to inform recommendations and shape responses to evaluation and learning questions.

Phase IV: Deliverables and development of end products

The consultant(s) will liaise with DRC and the steering group in the process of developing end products. For the report, a first draft will be shared with the partners for consultation and previous approval before it is finalized. Specifically, the consultant(s) will produce:

i. Five country reports and one synthesis report.
ii. One presentation of findings in ppt-format.

iii. The draft reports will be prepared by the consultant(s) and delivered to all MADAD partners for factual validation and comments.
iv. On the basis of this feedback, and taking into consideration the comments received, the consultant(s) will prepare the final version of the reports.
v. Report on the Communication & visibility sub-component (developed by DRC)

Phase V: Debriefing and dissemination of learnings

A final presentation of the findings to all partners will take place at the end of the 2020.

Coordination and management of the FEEL:

The resources allocated by the partners of the Action will come in three categories:

i. Steering committee responsible for the overall management of the FEEL.
ii. Technical reference group constituting MEAL staff allocated to support qualification of terms, methodology development and QA of the reports (supporting phases 1, 3 and 4 above)
iii. Enumerators and data collectors (supporting phase 2 above).

The steering committee will oversee administration and overall coordination, including monitoring progress of the evaluation. The main functions of the steering committee will be to:

i. Select external consultant(s);
ii. Review and comment on the inception report and approve the proposed evaluation strategy;

The main functions of the technical reference group are:

i. Support with participation and allocation of resources for phases 1 including in country participation in relevant methodology design workshop as well as planning and execution of data collection and review of findings.
ii. Review and comment on the draft evaluation report.
iii. Establish a dissemination and utilization strategy.
iv. To facilitate the gathering of data necessary for the evaluation.
v. To participate in the validation of evaluation findings, and to ensure that they are factually accurate.
vi. To contribute to the management response.
vii. To act on the relevant recommendations.

Duration and deadlines:

DRC foresees that the inception phase would take 30 days, field visits and data collection might take up to 45 days in total (a maximum of one week per country) and data analysis and development if final product might require an additional 30 days.

The assignment is expected to commence in March 2020 (after submission of the annual report) taking into consideration Ramadhan in April-May 2020.

Budget and financial provisions:

To be defined.

Evaluation principles:

The views expressed in the report shall be the independent and candid professional opinion of the consultant/s. The evaluation will be guided by the following ethical considerations:

i. Openness about information given, to the highest possible degree to all involved parties.
ii. Public access to the results when there are no special considerations against this.
iii. Reliability and independence. The evaluation should be conducted so that findings and conclusions are correct and trustworthy.

Contact details in Danish Red Cross:

Questions and concerns regarding this task can be raised to

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Annex 1:
Suggested methodology for the evaluation of the Communication and Visibility sub-project

Background

This part of the FEEL is considered a sperate workstream and is expected to be carried out by the communication department in DRC in close coordination with the general FEEL-process.

Baseline and objectives of the communication and visibility work

Objectives for C&V actions as described in the Communication & Visibility plan (July 2018):

i. Raise awareness about challenges needs and potential solutions to the refugee crisis created by the Syrian conflict.
ii. Influence public opinion and works against polarization of opinions on refugee and IDP related issues.
iii. Increase private and public support for RC/RC national societies to meet the needs of Syrian refugees.

KPIs are set for reach in European and host countries partner societies >31.000.000 including the full range of different channels and media-platforms.

Proposed evaluation outcome

i. The main objective of the evaluation is to assess the impact of the communication component against the agreed purpose and goals as described in the C&V plan.
ii. The second objective is to collect valuable learnings and insights from the processes, products and activities that have been main factors in the communication efforts.
iii. Third, the evaluation aims at providing key learnings and recommendations for future planning of communication activities related to large scale programs with partners from many countries and with different conditions for communicating in public.
iv. Finally, the evaluation is focused on learnings about organizing and carrying out coordinated communication efforts. This part will be further extended and validated in a special version dedicated the RC/RC movement, but is included here because it draws from the same data-collection as the main part of the evaluation.

General questions to be asked:

i. To what extent has the European RC/RC partners included and disseminated MADAD key messages in their national communication?
ii. To what degree did the MADAD Communication Plan provide tools relevant to the context and capacities of National Society in relation to communications?
iii. How have different National Societies utilized traditional media, social media, and other approaches to reach the goals stated under the communication component of the project?
iv. To what extent has visibility goals in terms of reach been achieved?
v. To what extent has the MADAD communication succeeded in influencing public opinion on Syrian refugees and refugee related agendas in the region and in Europe?
vi. To what extent has MADAD communication helped national societies to increase private and public support.
vii. Anchoring of joint communication objectives in partnering RC/RC national societies in the MADAD partnership – how was it done and how did it work?
viii. Identification of organizational barriers and obstacles for joint communication initiatives among RC/RC partners in the MADAD partnership.

ix. Identification of organizational conditions and set up to handle and successfully carry out communication initiatives that involve several national societies.

Discussion themes for a C&V communication workshop in 2020:

i. How to ensure commitment to shared communication goals in different national societies who participate in partnerships included?
ii. How to support aligned and coordinated communication initiatives in several national societies?
iii. How to prioritize communication as part of large scale programs?
iv. How can complex international movements (like the RC/RC) be prepared to meet expectations and demands for communication included in e.g. EU-trust fund financed programs or other large scale programs with many partners?

Evaluation design and methodology

The evaluation will consist of four elements:

i. Digital tracking and monitoring of published material in all participating partner countries and collected mainly from the partner national societies own reporting.
ii. Survey among communication professionals from the RC/RC partners
iii. In depth interviews with a few main players in the partnership communication efforts.
iv. Output from workshop discussions based on collected evaluation material from the above mentioned sources and questions.

Digital tracking and estimated reach

Collection of reach from partner national societies in the RC/RC MADAD partnership will provide a basis for estimation of the impact achieved by the communication efforts.
Quantitative measures collected currently by tracking and monitoring through the program-period will give basic answers to questions 0-2:

i. Reach being reported from European partners quarterly for social and editorial media plus vr-experience and teaching material/interactive movie.
ii. Tracking of media coverage linked to RC/RC MADAD activities
iii. Listing of VIP and high level influencer events
iv. Tracking of partners' use of the MADAD resource-site based on google analytics.
v. Tracking of users of the interactive movie Brothers across borders

Survey among participating communication professionals

A survey run in Q2 2020 answered by appointed communication officers and communication responsible key staff members in all partner national societies will provide input for answering questions 3 and 4. A questionnaire will focus on assessment of quality and relevance of content, available channels to convey content to public plus timing and framing of key messages. Included is also the status of the national society as source of information for national and regional media and the general media attitude to the key messages.

Validation by qualitative interviews with key actors

Qualitative interviews with 3-5 persons in charge of the MADAD communication activities from each national society will serve to validate the above material and shape possible answers to the insight theme of organizational issues related to communication. The interviews will also contribute to create a frame of questions to be discussed on the planned communication evaluation meeting Q2 2020.

Communication workshop Q2/Q3 2020

Before a one-day Brussels-based workshop all partners will receive a draft evaluation of the communication efforts carried out as part of the MADAD partnership. The workshop will focus on discussions to identify key learnings from the communication activities during the original and extended program period and on

further validating and discussing the collected data. Following the workshop, the key leanings and findings will be edited, finalized and conveyed to all partners.

Annex 7: Table of Figures and Tables