CASH AND PROTECTION

IMPROVING CASH-BASED INTERVENTIONS
MULTIPURPOSE CASH GRANTS AND PROTECTION
Enhanced Response Capacity Project 2014–2015

Impact of Multipurpose Cash Assistance on Outcomes for Children in Lebanon

UNHCR
The UN Refugee Agency

LCC
LEBANON CASH CONSORTIUM
الإتحاد النقدي اللبناني

Save the Children

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Acronyms and Terms

FGD	Focus Group Discussion
HH	Household
HoH	Head of Household
IRC	International Rescue Committee
KII	Key Informant Interview
LBP	Lebanese Pound (currency)
LCC	Lebanon Cash Consortium
MCA	Multi-purpose Cash Assistance
NGO	Non-governmental Organization
SCI	Save The Children International
USD	United States Dollar
UNHCR	United Nations High Commissioner for Refugees
VASyR	Vulnerability Assessment of the Syrian Refugees
WV	World Vision

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Global Insight

Executive Summary

This report examines the impact of multi-purpose cash assistance on children, specifically looking at child outcomes and child protection outcomes, in Lebanon. The impact of the Lebanon Cash Consortium MCA program was measured using a variety of indicators for shelter quality and consistency, child education, economic activity and exploitation of children, general medical and dietary health, negative coping strategies, protection issues, psychosocial wellbeing, and family separation.

The study was based on a rigorous mixed-methods design, using surveys, key informant interviews, and focus group discussions as data collection methods. The research team developed customized tools for each data collection method as well as for each target group –children and adults. Descriptive and multiple regression analyses were used to measure impact. To measure average treatment effect, the study compared results from those receiving MCA for at least three months (beneficiary) and those that previously qualified but have not received MCA to date (control).

The conceptualization, tools, and overall research design represent key contributions to research on Syrian refugees in Lebanon. This research also has implications for the humanitarian community, especially those using cash-based programming. To the knowledge of the research team, this is the first study to rigorously compare caretakers and their children who are receiving cash to those not receiving cash, and to do so in a gender-sensitive manner.

Results from this study indicate the following impacts of LCC MCA:

Education. Figures from caretaker KIIs and surveys suggest that those receiving cash more often enroll their children in school (beneficiaries: 60.7%; control: 51.5%) their children attend school more consistently (12.3% of beneficiary group children and 27% control group children did not attend school in the winter), and, while still a barrier, engagement in child labor is less so for the beneficiary as opposed to control households.

Child labor. 9.9% of households reportedly engaged in some form of child labor, yet much of that labor is opportunistic, sporadic, and often menial. Additionally, 7.3% of beneficiary households and 13% of control households report not enrolling their children in school because they need to work. The effect of MCA on child labor is unknown at this time. More research in this area is recommended.

Health. Children are often sick, suffering from a variety of illnesses ranging from common cold symptoms to chronic illness. Data does not directly indicate that the beneficiary households are seeking more medical care, it does however suggest that the beneficiary households are more consistently seeking medical attention from qualified doctors rather than alternative sources such as traditional healers. Cash assistance is reducing the probability of experiencing a lack of resources to cover food expenses by .105, and increasing the overall diversity in children's diet by .04%.

Protection. Receiving MCA represents a 4.5%[1] reduction in protection insecurity[2] for adults. Findings reiterate that children from households receiving MCA exhibit lower levels of protection-specific insecurity.

Disability. Findings suggest that disability is a marginalized issue within the LCC framework. Only included in the targeting survey, disability is calculated as the percentage of children under 18, elderly above 59, and disabled adults in the household who "cannot go to toilet unaccompanied'.[3] Moreover,

[1] p-val = .004; controlling for observed vulnerability, location, time in Lebanon, marital status of caretaker, shelter type, number of children in HH, and clustered by sex of HoH.

[2] Physically abuse, feelings of being physical unsafe for children and adults, social cohesion, and fighting inside and outside the home.

[3] LCC Targeting Survey Visual Overview of Findings, pg 47. (2015)

a focus on households with disability was largely missing from the study inception, however, a number of disability cases organically appeared in findings. Given that disability compounds other vulnerability issues, it is clear that disability should receive greater focus during beneficiary targeting.

Psychosocial wellbeing. Receiving MCA relates to a 2.3% reduction in psychosocial issues for caretakers, an effect that is likely felt by children as well. The gendered nature of isolation and disempowerment, both elements of psychosocial wellbeing, is clear. Specifically, women and girls experience isolation and disempowerment almost twice as often as men and boys.

Absence of child protection. Child protection has been largely absent from LCC functions in any explicit manner. Instead, all child protection cases have historically been referred to the lead agency, including UNHCR, in each geographic region. There is a proposal in development that would position SCI in a more explicit leadership role as the LCC lead for child protection cases. The specifics of this proposal are unknown to the research team at this time;[4] however, immediate inclusion of a child protection lens, through consultation with SCI child protection staff as the lead experts, in all LCC programming and tools is recommended.

Inadequate size of MCA. The relatively small size of MCA assistance as compared to the cost of living in Lebanon is likely minimizing any potential impact on shelter and negative coping strategies. This is especially true given the already severe vulnerability of the beneficiary population.

[4] White, Tom and Gilbert El Elkoury. "Key Informant Interview." Skype interview. 15 Dec 2015.

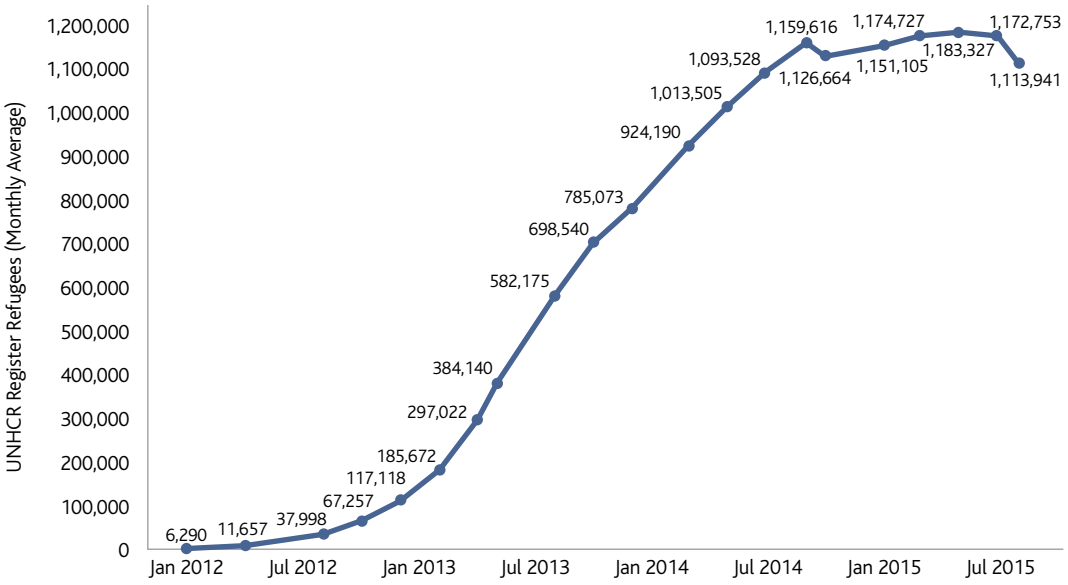
1 Introduction

To the knowledge of the research team, this report represents the culmination of a four-month study that is the first of its kind to examine the intersection of MCA and child protection outcomes. The report is structured using five sections. Introduction, background literature and data review, and study design and methodology provide a solid foundation from which findings are presented in section four. Conclusions and recommendations are offered in section five.

1.1 Background on Syrian refugee crisis in Lebanon

The United Nations High Commissioner for Refugees (UNHCR) registered a total of 4,052,011 refugees, adults and children that have fled Syria since the conflict began in 2011[5]. As of 30 September 2015, Lebanon is home to 1,078,338 UNHCR registered refugees. This influx of Syrian refugees into Lebanon began in earnest in April 2011, with the first recorded UNHCR data available in January 2012, as the conflict in Syria escalated. Within two years, nearly 300,000 refugees were officially registered with UNHCR[6]. This figure continued to climb until April 2015 with a peak of 1,185,241. From April 2015 forward, the number of UNHCR recorded refugees has significantly dropped due to (a) greater restrictions on UNHCR's ability to register new refugees, (b) an increased number of refugees either being relocated outside of Lebanon or choosing other exit locations when leaving Syria, or (c) non-renewable expired documentation.[7]

Figure 1: UNHCR Registered Refugees in Lebanon, monthly average



The chaotic nature of refugee legal status, insecure livelihoods, and lack of resources in Lebanon place families, especially children, in dire situations where they often cannot access

basic and essential goods and services, such as food, shelter, and medical treatment. In an effort to meet the needs of extremely vulnerable Syrian refugees, a multi-purpose cash assistance (MCA)

[5] UNHCR. (2015). Syria Regional Refugee Response. Retrieved 7 October 2015 from http://data.unhcr.org/syrianrefugees/regional.php

[6] UNHCR. (2015). Syria Regional Refugee Response - Lebanon. Retrieved 29 July 2015, from http://data.unhcr.org/syrianrefugees/country.php?id=122

[7] Aljazeera. (30 May 2015). *Syrians in Lebanon : 'Glass cannot fit one more drop'*. Retrieved 7 October 2015 from www.aljazeera.com/news/2015/05/syrians-lebanon-glass-fit-drop-150529082240227.html

program was implemented by the Lebanon Cash Consortium (LCC), a group consisting of ACTED, CARE, IRC, Save the Children International, Solidarités International, and World Vision.[8]

In the past, assessments have been undertaken finding a positive impact of MCA on ability to attend to basic needs such as rent, food, and medical needs in both qualitative and quantitative studies. However, while the impact of MCA is generally positive, research also shows that LCC MCA has historically reached only a small portion of the target population. Moreover, the amount of monthly assistance provided by LCC MCA is simply not enough to cover the increasing cost of living and dramatic winters in Lebanon[9]. From a recent study of household debt, as much as 90% of all surveyed households placed themselves in debt (i.e., formal and informal loans) between May and August 2015 with an even higher proportion relying on debt as an ongoing financial tool to sustain living expenses.[10] Due to such a heavy reliance on external cash, this study will explore in depth what role MCA plays on the often silenced and most vulnerable refugee population: children.

1.2 Focus on children

The United Nations reports that more than half of all Syrian refugees are under the age of 18[11], with over 75% not enrolled in school10. Many children bear the burden of heading households and contributing to family income while silenced with regards to aid – response and protection programming – and political matters. Focus group discussions from the 2015 LCC *Focus Group Discussions: Final Report* expose underlying violence against children, oftentimes as a result of economic insecurity within the household[12]. Studies from other low-income communities highlight the lengths children will go, or perhaps the lengths parents will force their children to go, in order to cover the cost of basic household needs.[13] Child labor – including recruitment in to armed groups, and early marriage at an increasingly young age have been identified as negative coping strategies and are, unfortunately, commonly found in low-income households and communities. Given evidence of chronic and chaotic displacement, combined with the lack of data on child outcomes, the research team hypothesized at the onset of this study that children are exposed to negative coping strategies at a far greater rate than we are aware. While MCA has been helpful for households as a unit by alleviating some stress burdens and reliance on negative coping strategies, this study was tasked with adding depth to previous analyses by assessing the impact of MCA on children. That is, exploring the positive and negative outcomes for children through cash-based programming.

1.3 Lebanon Cash Consortium and multi-purpose cash assistance

The Lebanon Cash Consortium (LCC) brings together six leading international NGOs to deliver MCA to socio-economically vulnerable refugee households living in Lebanon. Members of the LCC are Save the Children (Consortium Lead), International Rescue Committee (Monitoring and Evaluation and Research Lead), ACTED, Care International, Solidarités, and World Vision.

While SCI is the overall management, finance, grants and information management lead for the consortium, the IRC provides monitoring and evaluation leadership, WV manages communications, Solidarités offers technical leadership, ACTED leads on GIS mapping, and Care International manages gender mainstreaming. LCC sub-committees meet monthly.

8 *Lebanon INGO Cash Consortium Concept Note 2014*

9 International Rescue Committee (2014). *Emergency Economies "Winterization" Evaluation Report*; Lehmann, Christian, and Daniel Masterstom. *Emergency Economies: The Impact of Cash Assistance in Lebanon*. Rep. Beirut: International Rescue Committee, 2014. PDF.

10 Catsam, Marcus (Aug 2015) *LCC Targeting Survey: Visual overview of findings*

11 http://data.unhcr.org/syrianrefugees/regional.php

12 El-Helou, Zeina. (2015). *LCC Focus Group Discussions: Final Report*.

13 Vargas, Rosana, Eliana Villar, and Nicola Jones. "Cash Transfers to Tackle Childhood Poverty and Vulnerability: An Analysis of Peru's Juntos Programme." *Environment and Urbanization* 20.1 (2008): 255-73. Web.

Beneficiaries of the LCC MCA program receive a monthly installment of 174 USD. Households residing at relatively higher altitudes receive an additional 100-147 USD per month, depending on altitude, as a winter-only subsidy.[14] Initially, funding was provided to highly and severely vulnerable households for "as long as the funding pipeline allowed," or approximately six months under DFID funding in partnership with UNHCR. With additional funding, the LCC has increased the length of MCA assistance to 12 months for highly vulnerable households and indefinitely for severely vulnerable households. A new cohort of beneficiaries is added to the recipient pool every two months, at a target rate of 1000 people per cohort.[15]

The length and cohort size of the LCC MCA program is unique in number of assistance months, winter subsidy, and reach of programming given the large beneficiary pool. For all of these reasons, the potential impact of the LCC MCA is much greater than other cash-based programs. It should also be noted that some MCA beneficiaries receive additional cash-based assistance from case management agencies and other NGOs outside of the LCC.

2 Background for the study

In addition to reviewing documents sent by SCI/LCC and interviewing key staff from LCC member organizations, the research team conducted an independent review of background documentation on MCA programs and their impact on both child outcomes and child protection outcomes.

2.1 Basic needs

Data collected during FGDs in 2015 showed that households generally make collective and conscious decisions when applying MCA to basic needs for the family.12 This includes food, rent, and if possible, health-related expenses, with slight variations to basic needs during winter months due to harsher weather conditions.9 Where MCA and household income insufficiently cover the cost of basic needs, preliminary analysis of the LCC midline survey data – which included only MCA HHs with vulnerability scores ranging from 95-125 – finds that 93.07% of refugees utilize informal debt and food-on-credit accounts.[16] Moreover, the recent LCC Where's the Debt? report, conducted in July-September 2015, found that debt was used to cover the cost of food (74% of respondents), medical expenses (53%), and then rent (52%). Only 1% of respondents mentioned education as a basic need covered by debt.[17] Findings from these reports highlight the need for greater study as to the ways in which MCA is allocated to cover the cost of basic needs and how that allocation affects children.

Food

Typically, vulnerable households forgo healthier food options and/or meals in an effort to compensate for another higher-valued or urgent need. This negative coping mechanism inadvertently transfers a burden to children's health within the household. For example, data from the Cash Working Group (CWG) in Lebanon showed that approximately 86% of households experienced a lack of food or money to purchase food in the previous 30 days.[18] When purchasing food, over 40% of households reported their food purchase was done via vouchers.20 Commonly consumed food groups were low in nutrient value (bread, condiments, sugar, fats) and 60% of households did not consume any vitamin A rich fruits and vegetables. Additionally, 75% of households were classified as food insecure.20

[14] A programmatic change adopted following the findings of the Winterization report. International Rescue Committee (2014). *Emergency Economies "Winterization" Evaluation Report*

[15] White, Tom and Gilbert El Elkoury. "Key Informant Interview." Skype interview. 15 Dec 2015.

[16] LCC midline survey data, preliminary analysis. (October 2015).

[17] Global Insight & the LCC. (2015) *Where's the debt?: Analysis of the hidden debt network sustaining Syrian refugee households in Lebanon*.

[18] Avenir Analytics. (2014). Research to identify the Optimal Operational Set-up for Multi-Actor Provision of Unconditional Cash Grants to Syrian Refugees in Lebanon: Final report and recommendations. Cyprus: Author.

Adults restricted food consumption in approximately 38% of households to prioritize for children in the previous 7 days prior to the CWG survey. Feeding practices for infant and young children aged 6–23 months were adequate only 4% of the time.20 Considering that the environment in Lebanon is worsening and that households with a pregnant or lactating member represent over one-third of refugee households,20 food continues to be at the forefront when gambling with coping strategies.

Rent

Property is costly in Lebanon, especially given the influx of demand and shortage of supply, due to the small landmass.[19] Among surveyed Syrian refugees in Lebanon in 2014, 82% of households are renting mainly unfurnished shelters, with an average monthly rent of 200 USD in Beirut, Mount Lebanon, and Akkar.[20] Households who borrowed money spent approximately half of loaned funds on rent.20 Even though many shelters house multiple families, it is apparent that severely vulnerable households receiving MCA require an additional household income.

Health

Negative health outcomes in vulnerable populations are also prevalent and closely correlated with poverty, insecure environments, and poor hygiene. Half of households surveyed for the 2014 Vulnerability Assessment for Syrian Refugees (VASyR) had at least one member with specific health needs - the main need reported as chronic illness (43%) – and 70% of children under the age of 5 reported illness in the most recent 2 weeks prior to survey.[21]

With regard to personal hygiene, 40% of households did not have sufficient access to soap or "other" hygiene items, and 7% shared bathrooms with 15 or more people. In addition, 12% of households did not have access to bathrooms at all.20

While much of the Syrian refugee population has health issues, only 9% reported paying for health care.[20] The most commonly reported reason for not seeking care was the cost of medicine and doctors' fees.[12] Not seeking proper treatment can lead to infectious diseases and/or chronic ailments that will further disadvantage these communities. Children are especially vulnerable in this regard.

2.2 Education

On average, households have 2–3 children of school age (3–17 years), although 66% of children are not attending school and 44% have not attended school for over one year.20 While approximately 6% of children reportedly received informal education[22], general concerns surround inadequate curriculum and varying degrees of academic standards persist.[23] Data from focus group discussions and field surveying strongly suggest the main reason for children leaving school is lack of money.[24] The LCC *Where's the Debt?* report found that only 1% of respondents mentioned education as a basic need covered by debt when these costs were not covered by household income.[25] The overall lack of school attendance and the marginal focus on education as a basic need highlights the urgency for greater study on the allocation of household funds toward the needs of children, both as outcomes of programming and as an element of child protection.

[19] Ziad Safi. "Key Informant Interview." Skype interview. 15 Oct 2015.

[20] VASyR 2014. "Vulnerability Assessment for Syrian Refugees – DRAFT". UNHCR, WFP, UNICEF. (2014)

[21] ibid.

[22] ibid.

[23] Marta Passerini. "Key Informant Interview." Skype interview. 05 Oct 2015.

[24] *Lebanon INGO Cash Consortium Concept Note 2014; VASyR 2014*. "Vulnerability Assessment for Syrian Refugees – DRAFT". UNHCR, WFP, UNICEF. (2014)

[25] Global Insight & the LCC. (2015) *Where's the debt?: Analysis of the hidden debt network sustaining Syrian refugee households in Lebanon*.

2.3 Violence

Violence occurs to varying degrees and at varying levels, with the most common reported stressors being animosity and harassment caused by neighbors, Lebanese and otherwise. Over 66% of households felt a level of insecurity that restricted their free movement around the community.[20] During a FGD with women in Abou Samra, there were reported incidents of threats and physical violence between the Syrian refugee population and their Lebanese host community. Specifically, a "hit-and-run" car accident resulting in the death of a Syrian child was reported by the mother of the child and her neighbors who were participating in the August 2015 FGD. Although general violence is an issue, albeit sensitive and thus difficult to ascertain, data on violence against children in the community and violence within the household is largely lacking.

Due to dramatically worsening economic vulnerability, children reported being afraid of abuse in the household and/or being removed from the house.[12] While anxiety about violence and reported violence persists, the shift from in-kind to MCA has strengthened the decision-making power of heads of households, increased self-esteem, and improved overall psychosocial outcomes[12]. Though many of the psychosocial outcomes reviewed in past studies are not directly related to children, there is evidence that psychosocial improvements in adults positively affect children as well; findings which this study reinforces. This report intends to further decipher the complexity of violence and how it is associated with MCA and child protection outcomes.

3 Study design and methodology

This section outlines the study design, validation testing, sampling strategy, statistical methods, and limitations and ethical considerations for this research. This study took a mixed-methods approach with qualitative and quantitative data collected in the field. Qualitative data was analyzed using direct and summative content analytical methods. Quantitative data was first cleaned using an 11-step data cleaning procedure[26] and then analyzed using a variety of multivariate analytical methods, including t-tests and multiple regression analysis. Findings have been triangulated, where possible, with the first layer of analysis being unique quantitative data from field surveys conducted during this study, the second layer of analysis founded in qualitative data collected during KIIs and FGDs for this study, and the third layer of analysis sourced from secondary quantitative data collected by other research teams for previous studies.

This study uses the Child Protection Working Group (CPWG) definition of child protection in emergencies, which defines child protection in emergency settings as "the prevention of and response to abuse, neglect, exploitation of and violence against children in emergencies."[27]

[26] Global Insight's 11-step data cleaning procedure involves: (1) code book creation, (2) developing a data analysis plan, (3) frequency analysis, (4) recoding and careful review of coding errors, (5) descriptive analysis – including mean, standard deviation, skewness, and kurtosis – (6) review for outliers, (7) normality assessment, (8) review of missing data, (9) examination of cell/category size and distribution and collapsing categories as needed, (10) final descriptive review, and (11) testing for multicollinearity, independence, and linearity.

[27] It should be noted that this definition sits in slight contrast to the Inter-Agency Standing Committee (IASC) definition of protection, which includes "all activities aimed at obtaining full respect for the rights of the individual in accordance with the letter and the spirit of the relevant bodies of law (i.e. HR law, IHL, refugee law)." – IASC IDP Protection Policy 1999. This definition was originally adopted by a 1999 Workshop of the Inter- national Committee of the Red Cross (ICRC) on Protection.

Child protection programming includes programs run by child protection specialists, as well as child protection and child safeguarding actions that are integrated into other humanitarian sectors.

Key research question: How can positive outcomes for Syrian refugee children in Lebanon be maximized and negative outcomes/risks minimized through cash-based programming?

The research team was tasked with investigating the impact of MCA on children of refugee households in Lebanon. The impact of MCA on children was separated into seven themes:

1 Shelter – type and number/frequency of displacements.

2 Education – access to school building and available seat in school.

3 Economic activity and exploitation of children – child labor and/or other exploitation.

4 Health – general medical and reproductive health.

5 Protection – violence (within and outside the household) and early marriage.

6 Psychosocial effects as a result of financial insecurity, social cohesion issues, and poor self-esteem.

7 Separation from family and/or alternative care (foster, orphaned, forced migration).

Founded in the CPWG definition of child protection in emergencies, indicators were developed to answer the key research question as it relates to each of the seven themes listed above. These indicators are listed directly below. In addition to these indicators, a small set of indicators were developed to serve as covariates in multiple regression analysis; gender of respondent, observed vulnerability index[28], location (district), time in Lebanon, marital status of caretaker, number of children in HH, sex of HoH.

Shelter

- Type of shelter
- Problems with shelter
- Moving frequency (past 3 months)
- Reasons for moving

Education (primary school)

- % Enrolled
- % Attending
- Season pattern of attendance
- Hours attended per day
- Days attended per week
- School transportation taken
- Reasons for non-enrollment

Economic activity and exploitation

- Negative coping strategies index[29]
- Expenditure categories (children's income)

[28] To further ensure that sampled households in this study are all similarly vulnerable, the research team generated a unique vulnerability score, vulscoreobs, based solely on enumerator observations during this study. This index-based score includes observations around access to hygienic items such as soap and feminine hygiene; waste management; proximity to environmental hazards such as landslides, mines, landfills, sewages; damaged windows and doors; and accessibility to water and toilets. Vulnerability index scores range from 0 (not vulnerable) to .813 (severely vulnerable). The mean vulnerability score is .29 for the beneficiary and control households. Cronbach's Alpha score, or an index reliability score, for the vulscoreobs is .6821.

[29] Series of survey questions informed by or directly sourced from WFP 2008 "The Coping Strategies Index" Field Methods Manual. http://documents.wfp.org/stellent/groups/public/documents/manual_guide_proced/wfp211058.pdf

Health

- Frequency of sickness in children (past 3 months)
- Type of illness in children
- Reasons for medical treatment (most recent)
- Type of medical professional visited (most recent)
- Availability of reproductive health professional
- Dietary diversity
- Lack of resources to purchase food
- # of meals per day

Protection

- Protection indices (child and adult)[30]

Psychosocial wellbeing

- Psychosocial wellbeing indices (child and adult)[31]
- Expressions of isolation (KIIs)
- Disempowering language (KIIs)

Family separation

- # of children/siblings not living with family
- Location of displaced children
- % "heard of" displaced children

The study was cross-sectional in design, with differing questionnaires and surveys distributed to adults and children in FGDs, KIIs, and households in the field. Adults were defined as 18 years or older and must be caretakers of interviewed children. Children were defined as under 18 years generally, but sub-categorized into two groups – 8 to 11 years and 12 to 15 years – during FGDs.[32] The beneficiary group cases were defined as adults and children who received MCA for at least three months prior to survey or interview. The LCC criteria for receiving MCA was determined prior to this study using refugee concentration by geographic area, prioritization through pre-selection phone processing, household questionnaire designed by the Targeting Task Force, registration documentation, and a scoring formula that placed households in either highly or severely vulnerable.8 Control group cases were defined as adults and children who were previously found eligible to receive MCA but had not received assistance by the time of survey or interview due to insufficient LCC funding for the MCA programming prior to this point.

The study scope includes populations in Akkar, Bekaa Valley, and Mount Lebanon districts, further clustered by city. UNHCR's Refugee Assistance Information System (RAIS) provided data on participant information, which was randomized for selection in this study.

[30] Series of survey questions informed by or directly sourced from WV "Youth Health Behavior Survey", World Vision International (August 2014).

[31] Series of survey questions informed by UNICEF MICS surveys and WV "Youth Health Behavior Survey" (August 2014). UNICEF Lebanon Central Administration of Statistics (2011). "Multiple-Indicators Cluster Survey. Web. 17 Oct. 2015. www.unicef.org/lebanon/resources_8439.html

[32] These age-specific sub-categories were developed in consultation with SCI. 15 years was chosen an upper bound given the accepted definition of child labor focuses on children at or below 15 years. 8–11 year-old children were asked to join a separate focus group in hopes that grouping by developmental stage would allow greater participation and tailoring of tools. Save the Children Alliance. *Child Protection Monitoring Tool*. Web. 17 Oct. 2015. http://toolkit.ineesite.org/resources/ineecms/uploads/1038/Child_Protection_Monitoring_Tool.PDF

3.1 Sampling

With the support of enumerator teams from SCI, World Vision, and ACTED, the research team and enumerators conducted KIIs, FGDs, and administered surveys[33] as detailed in Table 1. The study population was stratified by regions (Akkar, Bekaa Valley, and Mount Lebanon) and further clustered by city. The beneficiary and control cases were systematically randomly selected from a list of beneficiaries and eligible households provided by RAIS via a random number generated to ensure complete randomization.

Table 1: Study Sample Detail

	KIIs				FGDs				Surveys			
	Beneficiaries		Control		Beneficiaries		Control		Beneficiaries		Control	
District	Adult	Child	Adult	Child	Adult	Child	Adult	Child	Adult	Child	Adult	Child
Akkar	19	7	10	3	1	2	1	2	80	5	77	9
Bekaa	19	7	10	3	1	2	1	2	41	13	107	13
Mt. Lebanon	19	7	10	3	1	2	1	2	19	7	57	5
Total	57	21	30	9	3	6	3	6	140	25	241	27

To ensure that sampled households in this study are all similarly vulnerable, the research team generated a unique vulnerability score, *vulscoreobs*, based solely on enumerator observations during this study. This index-based score includes observations around access to hygienic items such as soap and feminine hygiene; waste management; proximity to environmental hazards such as landslides, mines, landfills, sewages; damaged windows and doors; and accessibility to water and toilets.

[33] All tools attached as annexes at the end of this report.

Vulnerability index scores range from 0 (not vulnerable) to .813 (severely vulnerable). Visible in Table 2 below, the mean vulnerability score is the same (.29) for the beneficiary and control households in this study. This near equality in vulnerability, as verified by the LCC during initial MCA scoring and during this study, provides theoretical foundation for measuring the average treatment effect of MCA.

3.2 Survey validation

All survey questionnaires and KII and FGD guides were created in English. A bilingual (Arabic and English) translator translated the English version into Arabic. Translation of the study tools was then verified and inconsistencies fixed during transfer to the ODK platform. The survey was then informally administered twice to locate and remedy any remaining problems with content, translation, and/or the ODK software.

3.3 Enumerator training

The research team held a half-day training with the lead enumerators from SCI, World Vision, and ACTED. This training provided hands-on capacity building into KII and FGD best practices, including holding FGDs in less-formal settings such as homes and religious buildings. Potential challenges and associated solutions that might be present during data collection were also explored. Lead enumerators were then responsible for disseminating the training information to all field-based enumerators.

3.4 Limitations and ethical considerations

Inherent with any study, there were limitations to this research. Especially given that the data source was highly and severely vulnerable caretakers and their children, there were also noteworthy ethical considerations taken into account when designing this study.

Limitations:

- **Staff capacity and availability:** This is an ambitious study of a topic sensitive in nature with a population easily hidden from view. As such, a great deal of staff attention was required during training sessions and data collection. Ethical standards around consent were diligently upheld with both children and their caretakers. Given that some staff have had more experience with beneficiaries than others, the difference in trust between enumerators and households varied. This presented limitations to our data collection.
- **Sample size of child respondents:** Only 52 children were survey and 30 interviewed for this research. Though a greater number of children participated in FGDs, the sample size of child respondents does represent a limitation of this study.

Ethical Considerations:

- **Consent by children:** According to SCI-Lebanon standards of conduct, children over the age of 15 are considered able to give consent on their own behalf. FGDs, KIIS, and surveys with children 14 years and younger required consent from both the children and adult caretakers.
- **Reporting:** Cases of child abuse, exploitation, violence, and neglect identified through this research were referred to the appropriate agencies using the already established NGO referral networks in Lebanon.
- **Anonymity and confidentiality:** Especially around questions of exploitation, abuse, and violence, every effort was made to anonymize responses and respondents. All names and identifying information that could lead to individual-level identification was and continues to be held under the highest standards of confidentiality.

4 Findings

4.1 Demographics

This study randomly selected a sample of households that were (1) receiving LCC MCA (beneficiary group) and (2) not receiving MCA but were previously found eligible for assistance (control group) in three regions of Lebanon: Akkar, Mount Lebanon, and Bekaa (Table 1). The total number of households selected for this study in the beneficiary group was 140, and 241 were selected for the control group. The average age of adults in the beneficiary and control groups is 37.8 and 37.5 years, respectively. There were 80 MCA beneficiary households selected in Akkar and 77 control households from that same region, 19 MCA beneficiary and 57 control households in Mount Lebanon, and 41 MCA beneficiary and 107 control households in the Bekaa Valley. Tables 2 and 3 provide further details.

Table 2: Summary Demographics, Caretakers

	Beneficiary	Control
N	140 (36.8%)	241 (63.25%)
Age (yrs, mean)	37.8	37.5
Sex (of respondent) by location: Female (N)		
Akkar	41	50
Mt. Lebanon	8	28
Bekaa	24	49
Sex (of respondent) by location: Male (N)		
Akkar	39	27
Mt. Lebanon	11	29
Bekaa	17	58
Children in HH (mean)	3.7	3.3
Vulnerability score (mean)	0.29	0.29
Monthly assistance received (mean)	155.8 USD*	67.4 USD*
Time in Lebanon (months, mean)	36.3	44.9
Marital status (N)		
Single	8	6
Married	132	235
Residing with partner (N)		
Yes	103	188
No	18	30
Widow	11	17

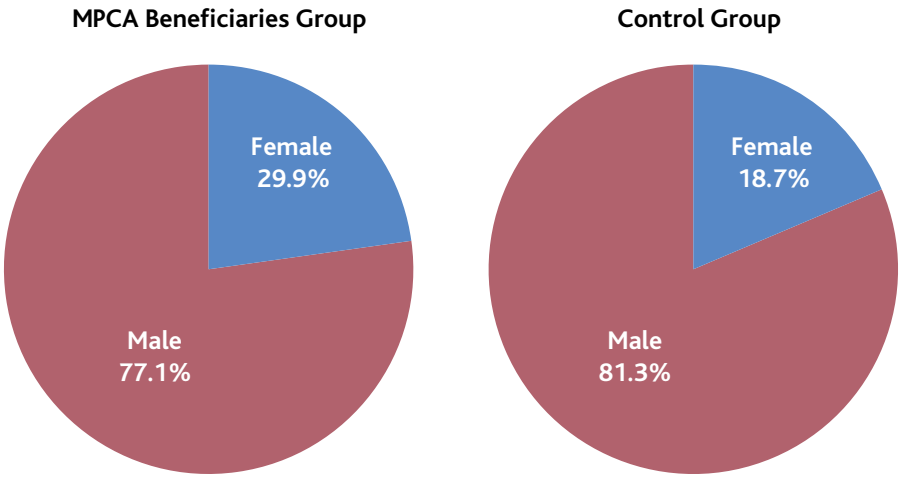
**Total assistance received does not include LCC MCA. Assistance received from WFP, UNHCR, and other NGO sources.*

Table 3: Summary Demographics, Children

	Beneficiary	Control
N	25 (48.1%)	27 (51.9%)
Sex by location: Female (N)		
Akkar	3	5
Mt. Lebanon	5	4
Bekaa	7	3
Sex by location: Male (N)		
Akkar	2	4
Mt. Lebanon	2	9
Bekaa	6	2
Time in Lebanon (months, mean)	33.6	36.5

In the beneficiary group, there were 32 female-headed households (FHHs) and 108 male-headed households. The control group included 45 FHHs and 196 male-headed households. Figure 2 provides a visual representation of the female:male-headed household ratio by beneficiary group. For this study, FHH has been defined as any household that self-identifies as lead by a female of any age. In most cases, FHHs include women who are widows, single, or not living with their spouse. In some cases, FHHs also include women who's partners are unemployed or disabled.

Figure 2: Sex-disaggregated, Head of Households



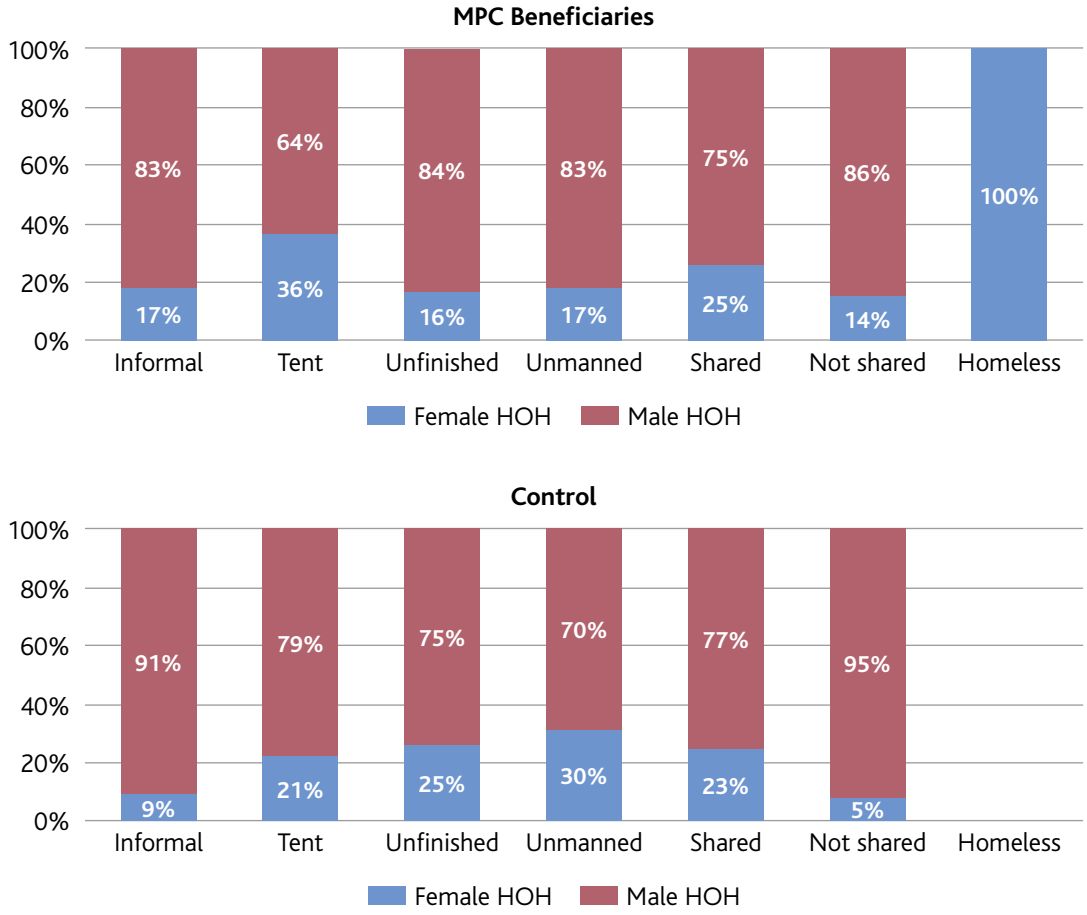
At the time of survey, the beneficiary households had lived in Lebanon for approximately 36.3 months (mean) and control households for a mean of 44.9 months. The majority of caretakers are married (beneficiary: 132, control: 235) with only a few caretakers reporting as single (beneficiary: 8, control: 6). Qualitative data explains some single females as widowed, separated from spouse with mostly the spouse "disappearing", or divorced.

Given that living conditions in conflict are chaotic and chronically insecure, the research team asked respondents if they currently reside with their partner. In the beneficiary group, 103 respondents were residing with their partners, 18 were not, and 11 were widowed. In the control group, 188 respondents reside with their partners, 30 did not, and 17 were widowed.

4.2 Shelter

The types of shelters Syrian refugee households live in varies greatly from family to family and largely depends on income and spending priorities, the number of people per household, relationships with landowners and neighbors, and overall environmental safety. Most common shelter types for households in the beneficiary group are: unshared apartments (or private apartments), tents, and shared apartments. For the control group, unfinished buildings, unshared apartments, and tents are most common (Figure 3).

Figure 3: Sex-disaggregated Shelter Type



Caretakers reported many environmental problems with their physical shelter and surrounding communities. From KIIs with both the beneficiary and control groups, the most common problems associated with shelter are rain and water leaks, overcrowding, and poor heating or "too cold", especially as winter nears. Caretakers in both study groups expressed deep concern about winter as they lack money to purchase clothes and gas for themselves and for their children.

> *[The] room is 3m×2.5m. It's a small room and we're 5 people. Most of the times, my husband sleeps on the roof, but now it's winter, so he would sleep at the doors of other house – I swear – there's not enough space for all of us here. It's difficult to breathe when we all get together inside this room. The bathroom and the kitchen are all in this room, it belonged to one person, but now look how many people live in it. We can't afford paying rent, otherwise, we would have moved elsewhere.* – Female Caretaker, 35 years old, Mt. Lebanon, Control Group

Some households have arranged an agreement with their respective landlords for property cleaning and maintaining in exchange for free rent. While this seems like an ideal situation for vulnerable households, these households are often at the mercy of their landlords should their landlords spontaneously decide to evict them. Other households report harassment from community members as well as being afraid of their surroundings. Respondents (children and adults) report that bullets shoot through their home on occasion, especially if they live near the Syrian border.

> *[I worry about] raids. And sometimes there are stray bullets here. A child was killed with one once. Here in this camp.* – Girl, 15 years, Bekaa Valley, Control Group

Case Study: Amira (beneficiary group)

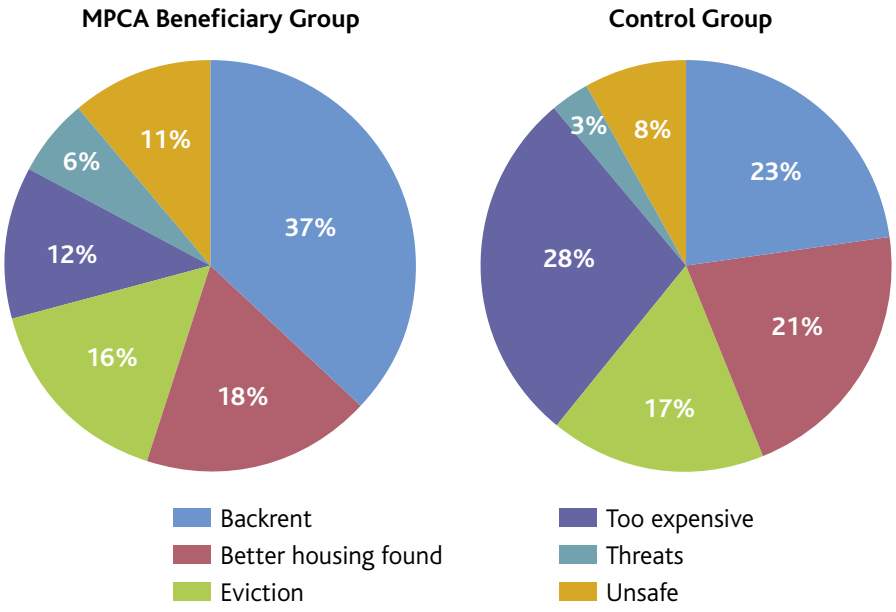
Amira (pseudonym) is 36 years old. She is married but separated from her husband. She is the head of a household of 4 young children (9, 8, 7, and 5 years), and lives in a tent she borrows from the landowner. She is currently receiving MCA from the LCC, which has helped her keep her children from needing to beg on the streets. Still, she struggles with finding schools and enough food for her family. She feels unsafe primarily due to the fighting and threats around her neighborhood, and is isolated without any friends nearby. Even under these conditions, she has decided she cannot take her family back to Syria.

> *I live in this tent but it is not mine. Some people have let us stay in here. They took pity on us. I have nowhere to go. They tried to expel us but I have persisted. I have nowhere to take the kids … We have had a lot of trouble. The owner of this plot of land came over at 3am once threatening to burn down the tent.* - Female Caretaker, 36 years old, Bekaa Valley

Both the beneficiary (49%) and control (51%) groups report 'expensive rent/no money to pay for rent' as the primary reason for moving homes in the past. However, more respondents in the beneficiary group attribute their moves to 'forced displacement' either by community-wide fires, bulldozing, or previous tenants returning.

Shelter presents challenges for caretakers in the beneficiary and control groups. These same challenges affect children's health, school attendance, psychosocial wellbeing, and social cohesion, as illustrated in qualitative data; however, quantitative data provides an unclear picture as to the exact effect of MCA. Meaning, multivariate analytical methods do not provide a consistent picture of the effect of MCA on shelter type or quality, nor the effect of MCA on frequency of household movement.

Figure 4: Reasons Attributed to Household Movement

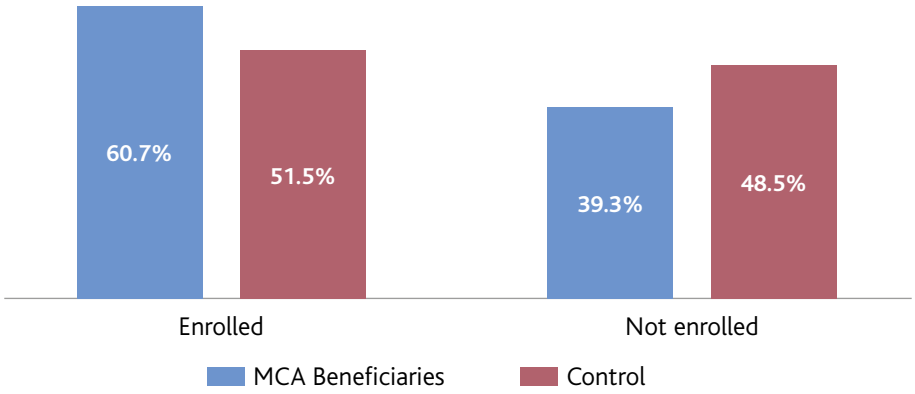


4.3 Education

Caretakers surveyed for this study report that 60.7% of children from households receiving cash assistance and 51.5% of children from control households are enrolled in school.[34] These same figures are visualized in Figure 5 below. While households in the beneficiary group enroll their children in school at higher rates than those not receiving MCA, a gendered distinction can also be drawn from the data: male caretakers report enrolling children in school 8.5% more often than female caretakers, a finding consistent across both the beneficiary and control groups. Specifically, 56.6% of male caretakers report enrolling their children in school, while only 48.1% of female caretakers report enrolling their children in school. This finding presents an interesting contradiction to previous findings on gendered decision-making, which highlight female caretakers spending cash assistance on education more than male caretakers. It is hypothesized that reasons for this contradiction can be found in women's relatively higher vulnerability around physical safety, psychosocial wellbeing, disempowerment, and isolation; all of which are explored in this section.

[34] Caretakers were asked a number of questions using the survey tools about children's education. Questions around enrollment, attendance, and type of school were separated so as to distinguish between only enrollment, enrollment and attendance, and enrollment and/or attendance at what type and quality of school.

Figure 5: Primary School Enrollment



In contrast to figures sourced at the caretaker-level, only 20% of children in beneficiary households and 59.2% of children in control households report being enrolled in school at the time of survey. This discrepancy is likely due to the small sample size of children surveyed for this study. The research team expects that children from both the beneficiary and control groups would report school enrollment at figures closer to those of their caretakers with an increased sample size to reduce the impact of outliers in the sample population.

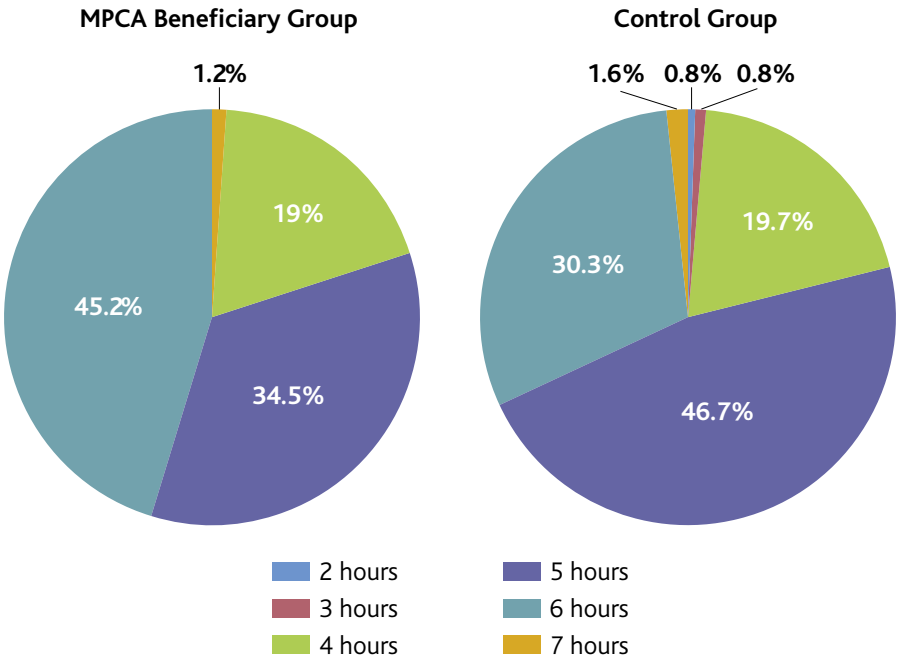
Those caretakers with children enrolled in school were also asked which type – informal, Lebanese formal, or Syrian formal – of school children in their care were enrolled at and/or attended. To this end, 12.3% of control as opposed to 8.3% of MCA recipient HH's reported that their children were enrolled/attended informal schools, the least consistent and poorest quality options.

Beyond enrollment, this study is concerned with the consistency and daily length of school attendance. To this end, caretakers report that 3.6% and 12.3% of children under their care did not attend school in the summer, from the beneficiary and control groups respectively.

Moreover, 12.3% of beneficiary group children and 27% control group children did not attend school in the winter. Since schools were commonly reported as far from home, the cold weather during winter months could attribute to this increased percentage compared to other attendance patterns.

Figure 6 provides detail into the daily length of attendance for children in both the beneficiary and control groups. The majority of children attend school between 5–6 hours per day, with 94% and 98.4% doing so 5 days per week in the beneficiary and control groups respectively.

Figure 6: Primary School Hours per Day



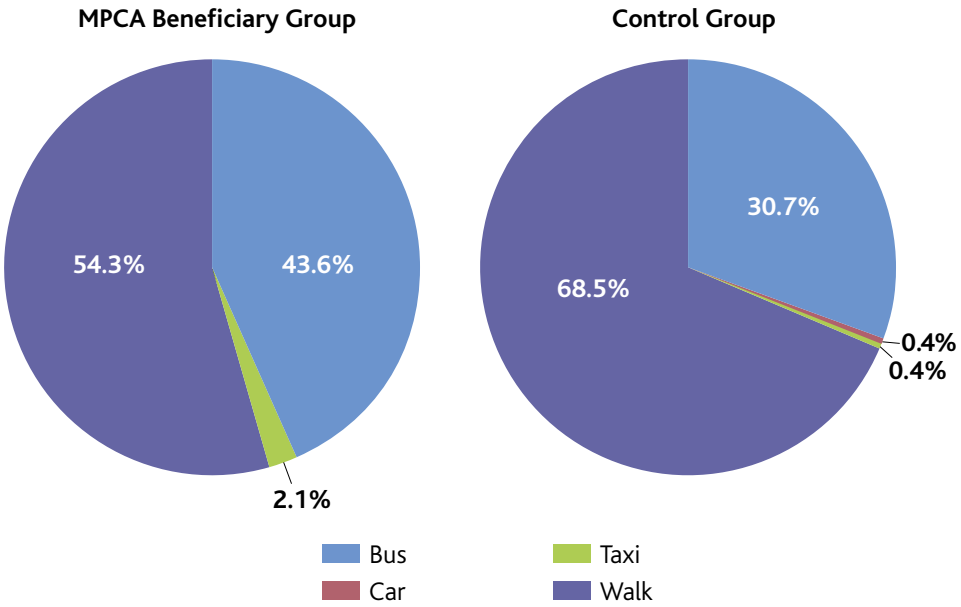
Multiple regression analysis adds depth to these findings, but does so in a paradoxical manner. Using the dichotomous variable "enrollment" as the dependent variable – while controlling for observed vulnerability[35], location, time in Lebanon, caretaker marital status, shelter type, and number of children in the household, clustering by sex of head of household – our regression analysis suggests that receiving MCA has a negative effect on enrollment, increasing the likelihood of children not being enrolled by .04%[36]. Given the very small size and counter-intuitive direction of this effect, the research team must conclude that greater research into school enrollment and attendance rates is necessary.

Caretakers were also asked how children in their care traveled to school; 54.3% of beneficiary households and 68.5% of control households report that children walk, representing the most common form of transportation to school. Bus, taxi, and private vehicle are less common, though occasionally used. Noteworthy are the security risks children take, especially when unaccompanied, if walking to school, which could be related to increased experiences with harassment, more frequent protection issues overall, and increased frequency or severity of illness due to exposure to both the extremely cold or hot environment.

[35] To further ensure that sampled households in this study are all similarly vulnerable, the research team generated a unique vulnerability score, vulscoreobs, based solely on enumerator observations during this study. This index-based score includes observations around access to hygienic items such as soap and feminine hygiene; waste management; proximity to environmental hazards such as landslides, mines, landfills, sewages; damaged windows and doors; and accessibility to water and toilets. Vulnerability index scores range from 0 (not vulnerable) to .813 (severely vulnerable). The mean vulnerability score is .29 for the beneficiary and control households. Cronbach's Alpha score, or an index reliability score, for the vulscoreobs is .6821.

[36] p-val = .913

Figure 7: Transportation Taken to Primary School

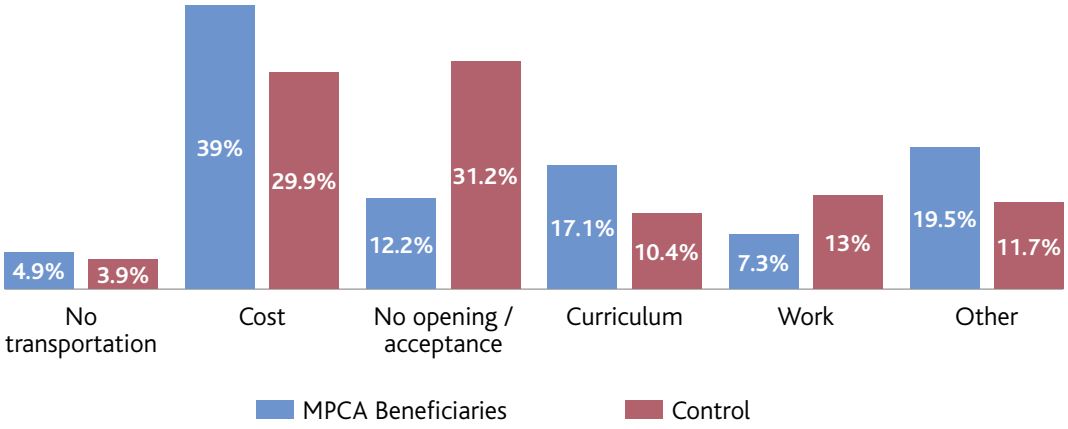


Of those not attending school or doing so inconsistently, caretakers report the cost of attendance (including transportation to and from school) and "no openings or acceptance" as the primary reasons for poor or no attendance. Echoing those surveyed, 37.5% of the beneficiary caretakers and 46.7% of control caretakers participating in KIIs stated that the cost of attendance, including transportation, was more than they could afford.

> *Do you children attend school? "Yes, they just started a few days ago. But they don't have books yet. They want money for them but we don't have any."* – Female Caretaker, 36 years old, Bekaa Valley, MCA Beneficiary

From the beneficiary (31.3%) and control (20%) groups, caretakers expressed that schools either had no openings or were not accepting children in their care. Notably, 7.3% of beneficiary surveys (3.1% of KIIs) and 13% of control surveys (6.7% of KIIs) stated that children in their care are not attending school because they are engaged in work elsewhere.

Figure 8: Reasons for Primary School Non-Enrollment



Both frequencies and percent figures from caretaker KIIs and surveys suggest that those receiving cash more often enroll their children in school, their children attend school more consistently and attended informal schools less often, and, while still a barrier, engagement in child labor is less so for the beneficiary as opposed to control households. Moreover, the cost of attendance remains a consistent challenge for caretakers despite receiving MCA. Indeed, almost 10% more beneficiary caretakers, as opposed to control caretakers, reported cost being a reason for not enrolling their children in school.

4.4 Economic Activity and Exploitation

Caretakers were asked to indicate their engagement in negative coping strategies through a series of 'yes-no' survey questions. They were first asked, "During the last 30 days, did anyone in your HH have to do one of the following things to cope with a lack of food or money to buy it?" The following list was offered verbally by enumerators, which returned a 'yes' or 'no' response from caretakers:

1 Reduce food expenditure.

2 Withdrew children from school.

3 Have school aged children (aged 15 years and under) involved in income generation.

4 HH members under the age of 18 accepting high risk, dangerous, or exploitative work.

5 Sent a child HH member to work elsewhere (not related to usual seasonal migration).

6 Marriage of children under 18.

Responses to these six survey questions were used to create an index, *copingID*[37], to illustrate household level of engagement with negative coping strategies. *CopingID* scores range from 0 (no engagement) to 1 (full engagement). Given that sex of head of household and the beneficiary group both influence household vulnerability, scores presented here have been disaggregated accordingly. From the beneficiary group, female-headed households returned a mean *copingID* score of .208 and male-headed households a mean score of .219. In contrast, control group female-headed households had a mean score of .188 and male-headed households a mean score of .203. Of note is male-headed households' overall higher engagement with negative coping strategies, potentially related less to long-term household vulnerability and more to sudden increases in vulnerability due to loss of traditional employment or increased use of grey-market employment, undocumented status (referring to legal status and UNHCR registration), or fear of reprisal from Lebanese authorities for either of the above.

Under multiple regression analysis, *copingID* displays similar and statistically significant results. Regressing *copingID* (dependent variable) on the beneficiary group, observed vulnerability, location, time in Lebanon, and shelter type, clustering the equation by sex of head of household, results suggests that the MCA has a negative relationships with *copingID*. Meaning, as the household moves from control to the beneficiary group, the household engages in an additional 1.6% of negative coping strategies[38]. This slight increase in *copingID* is likely the result of already high vulnerability experienced by households eligible for cash assistance.

[37] *copingID* scores range from 0 to 1, with a mean of .206 and a Cronbach's Alpha score, or an index reliability score, of .4595.

[38] p-val = .04

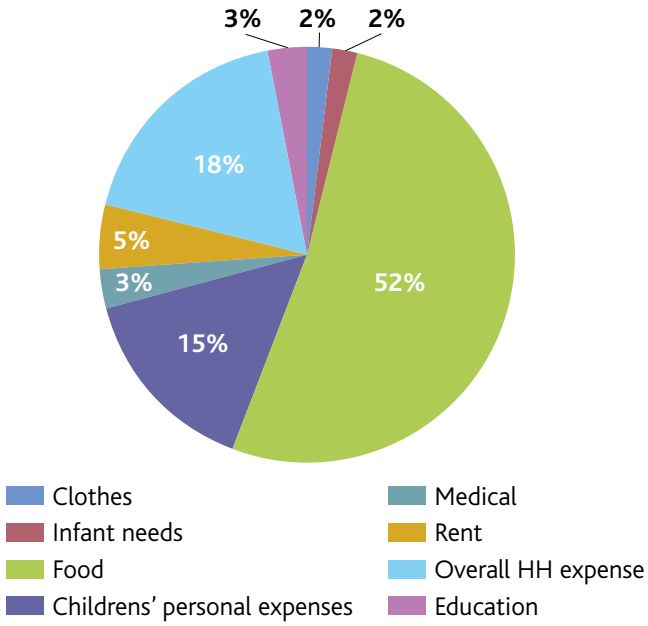
Three questions included in the *copingID* variable relate to child labor; (1) Have school aged children (aged 15 years and under) involved in income generation; (2) HH members under the age of 18 accepting high risk, dangerous, or exploitative work; (3) Sent a child HH member to work elsewhere (not related to usual seasonal migration). Survey results indicate that 9.9% of all caretakers have at least one child under the age of 18 working. Many households also stated that they would allow their children to work if it were legal and if there was work available. That said, much of the labor children are engaged with is opportunistic, sporadic, and often menial tasks.

> *One time Mo went to the building nearby, and the lady asked him to count the onions for her, and she gave him 7,000LL. So now he thinks he works. He has never worked in a restaurant … There is not really much opportunity here in Berbara. My eldest son works … Sometime he lives with us, and sometimes with his uncle in Hasroun. When the work here stops, he goes over there.* – Female Caretaker, 45 years old, Berbara, 7 children in HH, MCA Beneficiary

> *Do you work? "Yes. I'm a carpenter. (laughs) I work with the carpenter. I help him. He gives me 10,000LL a week. I just help him around, I bring things for him."* – Boy, 7 years old, Mt. Lebanon, MCA Beneficiary

Though most children are not working, according to quantitative and qualitative data sources, caretakers from both beneficiary and control groups report using children's income for food and overall household expenses. Figure 9 adds greater detail.

Figure 9: Expenditure Categories, Children's Income



Case Study: Complexities of Child Labor

In dire situations, families often send children to find work for supplemental income. There are many reasons for engagement with this negative coping strategy; parents are ill or disabled, not enough money for basic needs, children are not enrolled in school and thus have little else to occupy their time. For a control group household of 10 (2 adults, 8 children) that could not enroll their children into school because of language barriers, sending a child to work at a coffee shop in exchange for informal education from the child's boss presented a solution to more than one challenge.

> *My son, Ahmed (pseudonym, 11 years old) is not able to read [French] at all. If I were to send him to school, they would put him in 1st grade instead of 6th grade. So I decided to send him to work and his boss is a French teacher, she promised to teach him and to help him improve.* – Female Caretaker, 43 years old, Mt. Lebanon, Control Group

This household also experiences chronic health issues ranging from kidney problems to vision impairment and psychosocial vulnerability. Due to high cost of medical treatment and low income, this household has inconsistently treated their children's ailments. When asked if the caretaker takes her children to the doctor for routine check-ups, she replies, "No, we ignore the situation".

Although child labor and exploitation is of great concern in financially insecure communities, this particular household illustrates the complexities, and often compounding vulnerabilities, within which child labor is practiced.

Overall, receiving MCA displays a small and inverse relationship with negative coping strategies. Though this relationship might seem counterintuitive, results are likely related to the already severe vulnerability of the beneficiary population and the relatively small size of assistance (174 USD per month) allocated under the LCC cash assistance program given the cost of living in Lebanon. Meaning, recipients of MCA are the all extremely vulnerable, a status that is not easily overcome without a great deal of assistance, and the MCA, while helpful, does not provide the degree of assistance necessary to entirely overcome this vulnerability and end one's reliance on negative coping strategies.

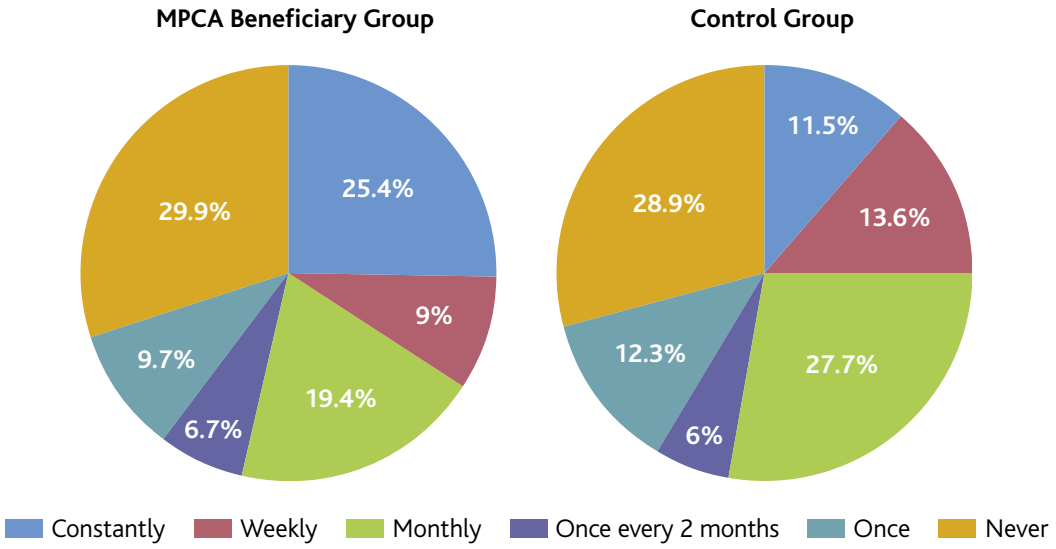
Narrowing our analytical lens to only those negative coping strategies that relate to child labor, qualitative and quantitative data demonstrates that of the 9.9% of households reportedly engaged in some form of child labor, much of that labor is opportunistic, sporadic, and often menial. The extent to which children's health, safety, morals, and/or ability to attend school is not directly known from the results of this study. We do know two things; (1) only 9.9% of households report sending their children to work, work which is largely opportunistic and menial in nature, while (2) 7.3% of beneficiary households and 13% of control households report not enrolling their children in school because they need to work. Additional research is recommended to reconcile these findings.

4.5 Health

Medical Care

Caretakers were asked how often children in their household have been sick over the most recent three months. Responses were categorized within a range from 'never' to 'constantly'. Reflecting the relative vulnerability of those receiving cash assistance, 25.4% and 11.5% of the beneficiary and control households respectively report children being constantly sick. These figures change slightly for children sick weekly, with 9% of the beneficiary and 13.6% of control households falling into this category. Figure 10 provides greater detail for each frequency category.

Figure 10: Frequency of Children's Illness, most recent 3 months



KIIs add depth to this analysis, offering details as to type of illnesses experienced by refugee children in Lebanon. Disaggregated by location, caretakers in Akkar reported that children most frequently experience cold symptoms (38.5%) – such as cough and headaches – and acute illness (23.1%) – such as infections, burns, and broken bones. In the Bekka Valley, caretakers most frequently stated that children suffer from digestive issues (25.8%) – such as diarrhea – and chronic illness (25.8%) – such as asthma, kidney pain or related illnesses, leg growth likely related to malnutrition, and jaundice. Caretakers in Mt. Lebanon expressed most often (31%) children experience cold symptoms and by chronic illness (28.6%). Table 4 provides these same details disaggregated by the beneficiary and control groups rather than location. Cold symptoms (37.3%) are most common among the beneficiary group children and chronic illness (27.8%) among control group children.

Table 4: Children's Illnesses, Summary

	Beneficiary	Control
Cold Symptoms	37.3%	19.4%
Digestive Issues	17.3%	11.1%
Acute Condition	12.0%	22.2%
Chronic Condition	22.7%	27.8%
Surgery Necessary	8.0%	13.9%
Psychosocial Issues	2.7%	5.6%

Caretakers were asked a series of questions related to their most recent visit to a medical professional for treatment of children in their care. One such question requested that caretakers select all applicable response to the question "At that time, why did your child seek medical treatment or advice?" Illustrating the compounding nature of illness for vulnerable households, 18.6% of the beneficiary and 12.4% of control households responded with two or more simultaneous reasons for seeking medical care for the children in their care.

An important detail to add here is found in the type of medical professional most recently visited. Quantitative and qualitative data from this study highlight the great concern caretakers have around medical treatment for their children. Data from KIIs for this study, suggests that, after food, medical expenses are the second most common spending priority for both beneficiary (17%) and control (14%) households. That said, the cost of medical treatment continues to be a barrier for vulnerable households in Lebanon, who consistently defer medical treatment or seek alternative treatment from sources other than medical doctors.

> *My 7-year-old daughter has asthma, so she's always sick. My son's arm broke last year, but needs surgery, it hasn't healed since then.* – Female Caretaker, 41 years old, Akkar, MCA Beneficiary

Data indicate that cash assistance is helping vulnerable households overcome this cost barrier. Indeed, 50.7% of the beneficiary households, as opposed to 46.1% of control households, most recently visited a medical doctor for treatment of children in their care. Conversely, 46.1% of control households, as opposed to 40% of beneficiary households, visited a pharmacy instead of a medical doctor for their most recent medical treatment of children in the household.

Reproductive Healthcare

Gender influences household vulnerability and also affects the type of medical treatment sought. Female caretakers were asked about the availability of reproductive health care. Only 19.2% of all female respondents (17.1% of female beneficiary caretakers and 20.3% of female control caretakers) noted that a reproductive health care professional is available to them. There is a glaring lack of access to reproductive health care across both the beneficiary and control groups; 80.8% of all female respondents do not have access to a reproductive health care professional. There are likely many reasons informing these figures, general household vulnerability, the chaos of frequent moves, and systemic gender inequality are all contributing factors.

Diet

Both quantity and diversity of diet affect the health of children and their ability to withstand illnesses mentioned above. For Syrian refugees in Lebanon, the cost of food represents the single greatest spending priority. As such, a lack of resources to cover the cost of food can have immediate and dire repercussions on refugee children. LCC MCA has had a clear positive effect in this area. Caretakers were asked, "During the last 30 days, did you experience lack of food or money to buy enough food to meet the needs of all your household members?" Multiple regression analysis of survey responses to this question illustrates the effect of cash assistance. Controlling for observed vulnerability, location, time in Lebanon, caretaker marital status, shelter type, and number of children in the household, being a MCA beneficiary reduces the probability that a household will experience a lack of resources to buy enough food for the needs of their household by .105[39]. This effect is noticeably small, yet statistically significant across many tests[40]. It is hypothesized that the small size of average MCA treatment effect in this area is due to the relatively small size of cash assistance at 174 USD per month per household. While this assistance is helping to mitigate a lack of resources, the cash is not able to entirely resolve the lack of resources for food, nor overall household vulnerability.

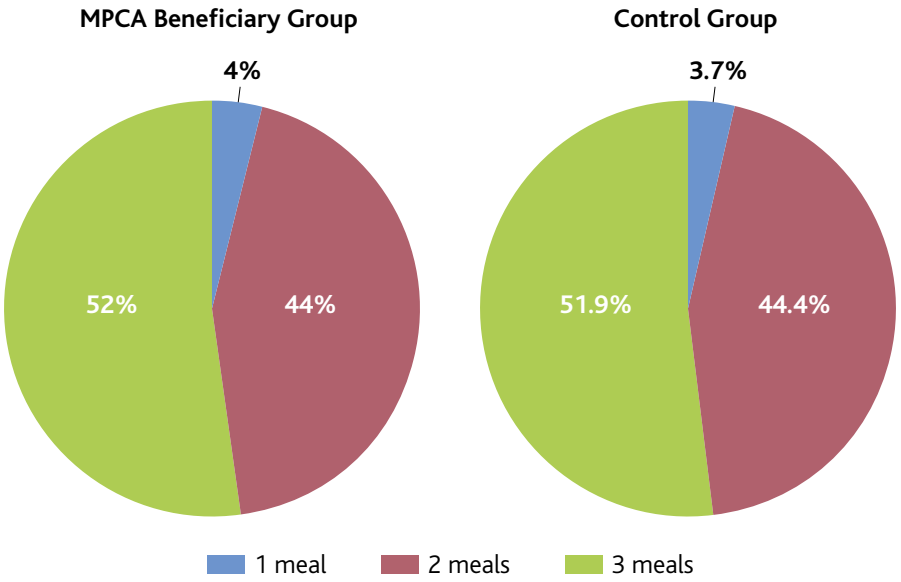
This point is made clear when looking at meal frequency and content. Children were asked how many meals they consumed per day. 44.2% of all children stated that they only ate two meals per

[39] p-val = .000

[40] Regressions conducted controlling for multiple variety of covariates, and ttest of "lack of resources" variable and MCA beneficiaries all report similar average treatment effects and p-values of .000.

day. Figure 11 disaggregates these numbers by study group. Though cash assistance is helping to increase resources for food, children from the beneficiary group report still consuming one meal per day slightly more often than control group children.

Figure 11: Meals per Day



Finally, caretakers were asked to identify the number of times per week (ranging from 0 to 7) children in their care consumed the following items: plain water, juice, dairy, sugar, bread, fruits, oil/fats, vegetables, meat, eggs, and beans/lentils. Assuming a healthy diet consists of consuming each of these items daily[41], responses were used to create a score[42] expressing the percent of full dietary diversity (ranging from 0 for total non-diversity to 1 for full diversity). Scores were analyzed using multiple regression. Results indicate that the receiving MCA increases dietary diversity by .4%[43] when controlling for observed vulnerability, location, time in Lebanon, and caretaker marital status, clustering by sex of head of household.

The health of children is a complex and important theme throughout this study. Children are often sick, suffering from a variety of illnesses ranging from common cold symptoms to chronic illness. The cost of medical care continues to be a barrier for many refugee households in Lebanon. While data does not directly indicate that the beneficiary households are seeking more medical care, it does suggest that the beneficiary households are more consistently seeking medical attention from qualified doctors rather than alternative sources. Moreover, the positive impact of cash assistance is seen in a reduced probability of experiencing a lack of resources to cover food expenses and an increased diversity in children's diet.

4.6 Protection

Children and their caretakers were asked a series of protection-based questions. Specifically, these questions aimed to measure a sense of security within the home and community for all members of the household as interrelated to child protection where relevant to children. These questions centered on psychosocial and physical wellbeing (feeling physically safe or unsafe in his/her environment).

[41] WHO (2012) Promoting a healthy diet for the WHO Eastern Mediterranean Region: user-friendly guide. pp 20–21. http://applications.emro.who.int/dsaf/emropub_2011_1274.pdf?ua=1

[42] Healthy diet scores range from .071 to .71, with a mean of .497.

[43] p-val = .032.

Due to the sensitive nature of this issue, these questions targeted abuse and violence indirectly. From these responses, indexes were created that express the overall insecurity experienced or felt by respondents. Adults were asked about themselves as well as their children using the following questions, eliciting a response of "agree" or "disagree" for each:

Adult Protection Index Questions (% answered agree: beneficiaries, control)

- Someone has been physically abused in this home. (11.4% beneficiaries, 3.7% control)
- I feel safe in my home. (92.1%, 87.6%)
- My children are safe in my home. (92.1%, 87.6%)
- I feel safe in my community. (88.6%, 85.9%)
- I get along well with my neighbors. (94.3%, 95.9%)
- The Lebanese community accepts me and my children. (84.3%, 81.7%)
- I have noticed fighting between Syrians and Lebanese people in community. (69.3%, 82.2%)

Scores range from 0 (no protection issues present) to 1 (many protection issues present and fully insecure household). Of those that reported any protection issues, the majority of caretakers received a score of .14 (57.6% of the beneficiary and 43.7% of control). 7.6% of the beneficiary and 16.1% of control households received a score of .57, which places them in the "highly insecure" category.[44] Analyzed in greater detail using multiple regression, the adult protection index[45] indicates that receiving MCA represents a 4.5%[46] reduction in protection insecurity.

The protection questions for children began first with the concept of safety. Asked whether they felt safe in their neighborhood, most children report that they feel safe most of the time. That said, 28% of the beneficiary group and 22.2% of control group children report feeling unsafe some or all of the time. During KIIs, children in the beneficiary group expressed experience equally with (a) fighting in their home and in the community and (b) harassment, including sexual harassment, from Lebanese community members. Control group children expressed a greater number of experiences with harassment, including sexual harassment, from Lebanese community members (64.7%). Responses to the question of why they felt unsafe add nuance to these findings.

> *Well we are in a camp. We're mixing with everyone. You don't know your friends from your enemies.* – Female Caretaker, 35 years old, Bekaa Valley, MCA Beneficiary

Using the survey tool, children were asked two series of questions related to protection. This first group of protection questions was used to create the index variable protectID1[47]. Scores range from 0 (no protection issues present) to 1 (six protection issues present, fully insecurity). The majority of children from both the beneficiary and control groups received a score of 0. While more beneficiary group children received scores displaying moderate insecurity (scores .2-.4, 36%) than those in the control group (14.8%), the beneficiary group children did not score higher than .4. A very small number of children in the control group, however, received scores of .6 (3.7%) and .8 (3.7%). In all, children from households receiving MCA exhibit vulnerability but lower levels of insecurity overall, which the research team believes is likely do to (1) the high vulnerability of all MCA eligible HHs and (2) the positive impact of MCA on children's protection issues, specifically reducing perceived vulnerability.

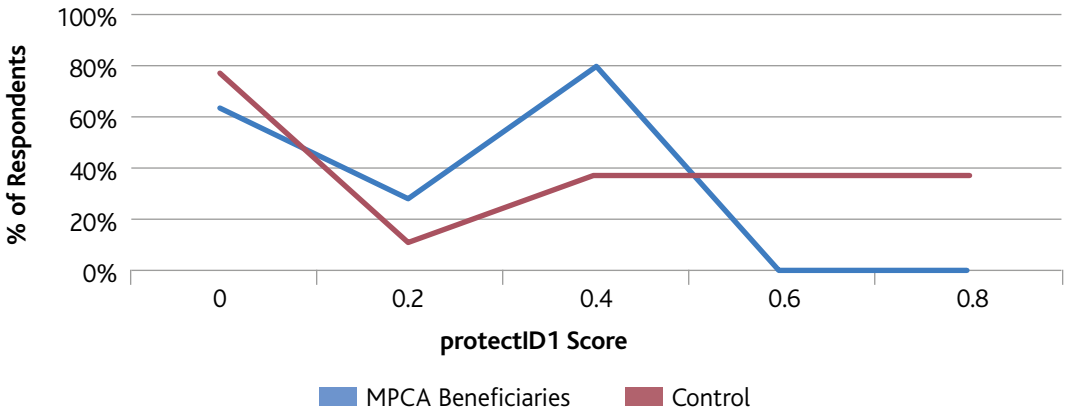
[44] Labeling scores of .3-.49 as moderately insecure, .5-.69 as highly insecure, and a score of .7 or higher as severely insecure.

[45] The adult protection index scores range from .14 to 1, with a mean of .305 and a Cronbach's Alpha score, or an index reliability score, of .7374.

[46] p-val = .004; controlling for observed vulnerability, location, time in Lebanon, marital status of caretaker, shelter type, number of children in HH, and clustered by sex of HoH.

[47] The children's protectID1 index scores range from 0 to .8, with a mean of .088 and a Cronbach's Alpha score, or an index reliability score, of .6517.

Figure 12: protectID1, Children



A second protection index, *protectID2*[48], was created using the same mathematical and labeling mechanism as protectID1. Child respondents were asked if they "agree" or "disagree" with each of the following statements:

1 I feel safe in my home.

2 I know another child that is forced to work on the streets.

3 I get along well with my neighbors.

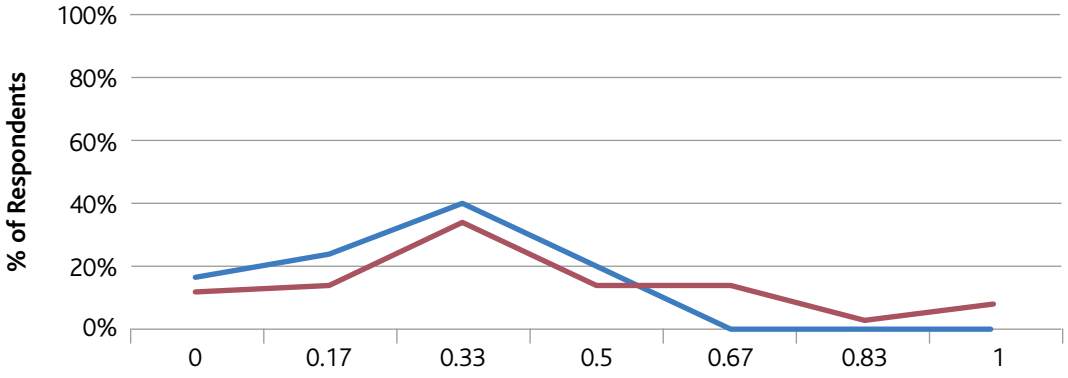
4 I only have Syrian friends.

5 I have both Lebanese and Syrian friends.

6 I have noticed fighting between Syrians and Lebanese people.

The distribution of scores from *protectID2* is outlined in Figure 13. Similar to protectID1, .5 is the highest score received by children in the beneficiary group, while 11.1% of children in the control group received a score of .83 or higher. These findings reiterate the fact that children from households receiving MCA exhibit lower levels of protection-specific insecurity.

Figure 13: protectID2, Children



[48] The children's *protectID2* index scores range from 0 to 1, with a mean of .346 and a Cronbach's Alpha score, or an index reliability score, of .6218.

Two findings are clear from the data collected for this study. First, receiving MCA positively relates to reduced protection issues for adults. While this result does not prove a causal relationship, the statistical significance of this figure is very strong, with a p-value of .004. Second, although more beneficiary group children felt unsafe some or all of the time, reduced protection issues experienced by caretakers likely reduced the protection issues experienced by children as well. Both protectID1 and *protectID2* illustrate this point; children in the beneficiary group do not receive scores higher than .4 and .5 respectively. In all, children from households receiving MCA exhibit vulnerability but lower levels of insecurity as compared to children from households that do not receive MCA.

Case Study: Disability Ignored

Households who have members with (congenital) disabilities experience compounding vulnerabilities that are largely ignored. Through KIIs, the research team found four cases that stress this point.

Case 1: 18-year old Alma is mentality disabled and lives with her father and siblings. She is eligible but is not currently receiving MCA; she is part of the control group for this study. Although Alma's specific disorder was not stated, her father responded for her during interview because she cannot. She is legally married and has an 18-month old child, yet her husband is missing. Finances are a major concern for this household, as they cannot afford to renew their documentation and purchase adequate clothing for the winter.

Case 2: A male caretaker explains that he is unable to support the medical bills for his child's partial brain paralysis. This household of 7 people (2 adults, 5 children) is eligible to receive MCA but is not currently. Moreover, the caretaker also has difficulty enrolling his children in school.

Case 3: Abdullah's (child) household struggle to enroll their children in school, especially since he has immobile legs. Abdullah needs access to schools with handicapped accommodation, but there are none available. His caretaker has made three appointments to enroll their 4 children in school only to find all three schools closed upon arrival. In addition, this household struggles to cover the cost of surgeries and medications as well as navigate discriminatory pharmacies "refusing" to give them their prescribed medications. They are receiving MCA.

Case 4: Hamza is autistic. It is difficult to enroll him in school and pay for his medical bills even though his household is receiving MCA. None of the children in this household (1 single mother, 4 children) received their updated vaccinations and his mother previously experienced a doctor mocking Hamza's mental health condition.

> *But once a doctor was mocking us. I felt hurt and I didn't even know to whom should I complain … He said that my son was crazy and begun to laugh. I was so hurt, I started to cry and I couldn't sleep for two days.* – Female Caretaker, 33 years old, Mt. Lebanon, MCA Beneficiary

The implications of these findings are clear. Disability, both physical and mental disability as separate and related categories, should receive greater focus during beneficiary targeting, at minimum. Furthermore, this focus on disability, especially as it relates to child protection, should also be accompanied with more inclusive, disability-focused programming through the LCC partner organizations.

4.7 Psychosocial Wellbeing

Both children and their caretakers were asked a series of questions to ascertain psychosocial wellbeing. Adults responded "agree" or "disagree" to the following eight questions and children the proceeding seven questions:

Adult Psychosocial Wellbeing Index Questions

1 I feel hopeful about the future.

2 I am worried about my family.

3 I have goals and dreams for my future.

4 I believe I can accomplish my goals and dreams.

5 I feel safe here.

6 There is trust between Syrians and Lebanese in my community.

7 Financial issues cause me and my family stress.

8 If one of my children are in trouble, I have the power to help them.

Child Psychosocial Wellbeing Index Questions

1 I feel hopeful about the future.

2 I am worried about my family.

3 I have goals and dreams for my future.

4 I believe I can accomplish my goals and dreams.

5 I feel safe here.

6 There is trust between Syrians and Lebanese in my community.

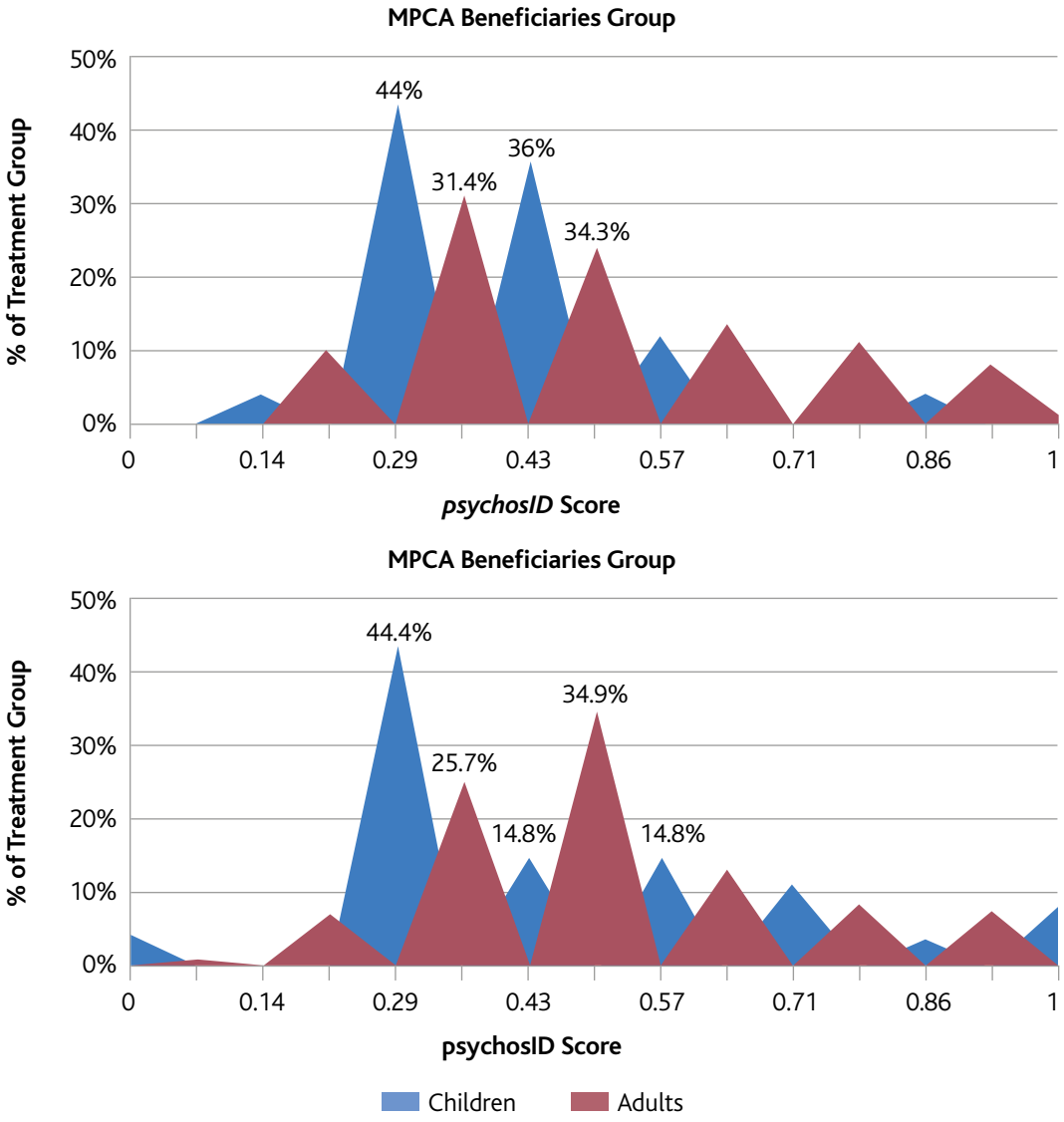
7 Financial issues cause me and my family stress.

With their responses, the *psychosID*[49] index was created to express the overall psychosocial wellbeing of children and adults. Because of differences in sample size across adult and child respondents, the *psychosID* was generated separately for children and adults. Scores range from 0 (no presence of psychosocial issues) to 1 (many psychosocial issues present, immediate attention warranted). In the beneficiary and control groups, children's scores mirrored those of adults, while also being slightly lower than those of their caretakers. Comparing caretakers and children from within the beneficiary group, most children received a score of .29 (44%) and caretakers a score of .38 (31.4%), both presenting moderate psychosocial wellbeing issues. Looking at only the control group, most children received a score of .29 (44.4%), presenting moderate psychosocial wellbeing issues, and caretakers a score of .5 (34.9%), presenting high psychosocial wellbeing issues.[50]

[49] The adult *psychosID* scores range from .125 to 1, with a mean of .522 and a Cronbach's Alpha score, or an index reliability score, of .5887. The children's *psychosID* scores range from 0 to 1, with a mean of .426 and a Cronbach's Alpha score, or an index reliability score, of .6554.

[50] Labeling scores of .3-.49 as moderate, .5-.69 as high, and a score of .7 or higher as severe.

Figure 14: psychosID, Caretakers & Children



At the highest level of *psychosID* scores, across the beneficiary and control groups, only 4% of the beneficiary group children exhibited scores in the severe category (scores of .7 or above), and of those scores the highest was .86. In contrast, 22.2% of control group children scored in the severe category, with 7.4% receiving a score of 1. This large difference in severe psychosocial wellbeing scores between beneficiary and control group children must not be overlooked when considering the positive impact of MCA on children. Given the chaotic and habitually insecure nature of refugee life, psychosocial wellbeing is an important measure of vulnerability.

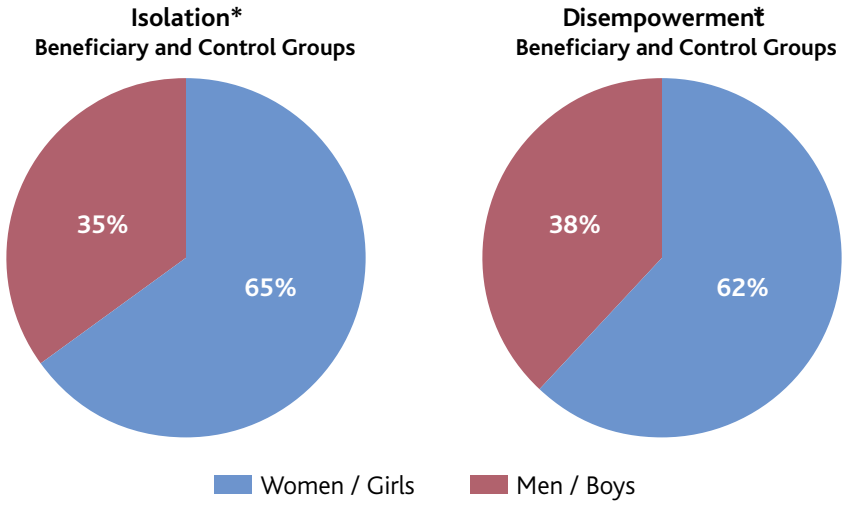
To better understand the effect of receiving MCA, the adult psychosocial index was analyzed using multiple regression. Though quite small, data indicate the average MCA effect is inversely related to the psychosocial wellbeing index, when controlling for observed vulnerability, location, time in Lebanon, caretaker marital status, shelter type, and number of children in the household, clustering by sex of head of household. Meaning, as a households moves from control to the beneficiary group, or as they receive cash assistance, caretaker psychosocial wellbeing improves. Specifically, poor scores

on the psychosocial wellbeing index scores show a decrease of 2.3%[51]. Given that data from and background research for this study suggest a link between caretaker and child psychosocial wellbeing, it is hypothesized that a similar MCA effect would present itself in analysis of child *psychosID* scores, if sample size were to allow such analysis. In all, MCA improves caretaker, and likely child, psychosocial wellbeing.

Qualitative data enables further granulation of psychosocial wellbeing. Specifically, using direct and summative content analysis approaches, qualitative data was assessed for patterns of isolation and disempowerment. Expressions of isolation and disempowerment are closely related to vulnerability. Furthermore, theory and empirical evidence from this research illustrates that isolation and disempowerment are gendered elements of psychosocial wellbeing. Meaning, expressions of isolation and disempowerment are physically felt and verbally expressed in distinct patterns by men and boys, as a group, and women and girls, as another group. Figure 15 demonstrates this point. Women and girls mentioned physical experiences with and feelings of isolation and disempowerment almost twice as many times as men and boys in this study.

> *I feel like my children's future has been lost. There's no future for them … Sometimes I feel like I'm being choked, I really feel pressured and I can't always take it. Sometimes I'll even think about going back to Syria. Maybe I'll just die with those who are losing their lives. But then I think, if I die, and my kids are alive, what will happen to them?* – Female Caretaker, 35 years old, Mt. Lebanon, MCA Beneficiary
>
> *Tell me about your dreams for the future. I don't have any. I don't want to be anything when I grow up* – Boy, 9 years old, Mt. Lebanon, Control Group

Figure 15: Sex-disaggregated Isolation & Disempowerment



** % of mentions, not individual KIIs or FGDs, from qualitative data.*

In all, receiving MCA relates to a .023[52] reduction in psychosocial issues for caretakers. This relationship is inferred to children, leading to our hypothesis that children in beneficiary households also experience increased psychosocial wellbeing, or a reduction in their *psychosID* score. From qualitative data, the gendered nature of isolation and disempowerment, both elements of psychosocial wellbeing, become clear. Specifically, women and girls experience isolation and disempowerment almost twice as often as men and boys in this study.

[51] p-val = .314.

[52] p-val = .314.

4.8 Family Separation

This study initially aimed to quantify family separation, specifically child displacement or child under 18 years of age living outside of Lebanon without parents. Both children and their caretakers were asked in surveys, KIIs, and FGDs if children or siblings under 18 years old were not living in the household. As follow up to that questions, children and caretakers were asked if any children originally from the household were now living with relatives, friends, or anyone else at the present moment. The sensitive nature of this particular topic made it difficult, if not impossible, to garner a clear answer. Most respondents stated that all family members were present in the household, while also noting that they did know of other households who had sent their children to live elsewhere with and without a guardian.

Indeed, the research team found that 48% of KII respondents have "heard of" children being sent abroad but they themselves would never do this. Only a small number of respondents stated they would send their child elsewhere, if they could afford to do so.

> *I thought of sending my son, who is 11 years old, but I couldn't for financial reasons. My son would need money to live over there. I don't have enough money. People told me that it's better to send my son then apply for reunion, it's faster this way, and that my life will be better in Europe, but I don't have enough money to live here, so how can I send my son to live over there?* – Male Caretaker, 34 years old, Mt. Lebanon, MCA Beneficiary

Many caretakers note that language and cultural differences would be challenges in Europe.

> *I feel that as Syrian, Lebanon is better for me. We share the same culture. We speak the same language, so they are more sympathetic toward us. I have never been to Europe. I don't know anything about life over there and I don't have relatives nor friends to go to. I don't know how I would go. I feel it's fine over here.* – Male Caretaker, 28 years old, Mt. Lebanon, Control Group

Early marriage is a negative coping mechanism often utilized in conflict and resource-poor settings. For this research, children and caretakers were asked if they had engaged or knew of anyone who had engaged in early marriage. All respondents were also asked what age they considered most ideal for boys and girls separately to be married. Responses to these questions provided inconclusive results with almost no early marriage detectable. While other qualitative studies have pointed to the use of early marriage as a negative coping strategy in insecure environments, quantitative data from this study do not align with these findings.

The sensitive nature of family separation and early marriage as discussion topics makes research in this area difficult. It is very possible that displacement and early marriage of children is occurring more often than we are aware. As such, the research team recommends additional research in this area.

5 Conclusions

After careful study and rigorous analysis of quantitative and qualitative data, including secondary sources, the research team concludes that LCC MCA is impacting Syrian refugee children and their caretakers in the following ways:

Education. Figures indicate those receiving cash more often enroll their children in school (beneficiaries: 60.7%; control: 51.5%) their children attend school more consistently (12.3% of beneficiary group children and 27% control group children did not attend school in the winter), and, while still a barrier, engagement in child labor is less so for the beneficiary as opposed to control households.

Health. Children are often sick, suffering from a variety of illnesses ranging from common cold symptoms to chronic illness. Data does not directly indicate that beneficiary households are seeking more medical care, it does suggest that beneficiary households are more consistently seeking medical attention from qualified doctors rather than alternative sources. Cash assistance is reducing the probability of experiencing a lack of resources to cover food expenses by .105, and increasing the overall diversity in children's diet by .04%.

Protection. Receiving MCA represents a 4.5%[53] reduction in protection insecurity[54] for adults. Findings reiterate that children from households receiving MCA exhibit lower levels of protection-specific insecurity. Both protectID1 and *protectID2* indices illustrate this point; children in the beneficiary group do not receive scores higher than .4 and .5 respectively.

Psychosocial wellbeing. Receiving MCA relates to a 2.3% reduction in psychosocial issues for caretakers, an effect that is likely felt by children as well. The gendered nature of isolation and disempowerment, both elements of psychosocial wellbeing, is clear. Specifically, women and girls experience isolation and disempowerment almost twice as often as men and boys.

Child labor. 9.9% of households reportedly engaged in some form of child labor, yet much of that labor is opportunistic, sporadic, and often menial. Additionally, 7.3% of beneficiary households and 13% of control households report not enrolling their children in school because they need to work.

5.1 Recommendations

Given the conclusions found in this report, the research team is offering the following seven recommendations for the LCC and their partners:

1 **Child protection as collaboration not full integration**. Immediate inclusion of child protection, through consultation with SCI child protection staff as the lead experts, in all LCC programming and tools is recommended. To do so, it is recommended that child protection staff work in parallel and close collaboration with cash programming staff, not full integration within the same team, to (a) allow comparative advantage in skillsets and (b) reduce an already overwhelmed system and staff; i.e. each person and department contributing in the area they are most able to do so at expert level. There is a proposal in development that would position SCI in a more explicit leadership role as the LCC lead for child protection cases. The specifics of this proposal are unknown to the research team at this time.[55]

[53] p-val = .004; controlling for observed vulnerability, location, time in Lebanon, marital status of caretaker, shelter type, number of children in HH, and clustered by sex of HoH.

[54] Physically abuse, feelings of being physical unsafe for children and adults, social cohesion, and fighting inside and outside the home.

[55] White, Tom and Gilbert El Elkoury. "Key Informant Interview." Skype interview. 15 Dec 2015.

2 **Child protection lens applied to cash-programming tools**. Building from the tools developed here, the Cash Task Force should work to apply an explicit child protection lens to all cash-programming tools. This is especially true for targeting surveys and approaches. Children should be spoken to and child-headed households targeted during eligibility survey.

3 **Expansion of child protection and cash-programming research**. Under the Child Protection Working Group[56], within the Cash Task Force, this research design should be mimicked while expanding this study to other humanitarian contexts. Expansion would allow for cross-context generalizability and greater depth and applicability of findings. A gender-sensitive approach to this research should be explicit sought.

4 **Child labor knowledge capacity building**. To tackle the underlying hazards of child labor, it is recommended that a focal point from SCI build the capacity of Syrian refugee communities to increase awareness around what constitutes child labor. Moreover, because the true size and direction of the effect of MCA on child labor is unknown at this time, additional research is recommended.

5 **Inclusion of disability**. Disability is largely missing from LCC programming and tools. At this time, disability is only included in the targeting survey and defined using the following indicator: percentage of children under 18, elderly above 59, and disabled adults in the household who "cannot go to toilet unaccompanied'.[57] Given that disability compounds other vulnerabilities, it is clear that disability should receive greater focus during beneficiary targeting and possibly garner greater weight during vulnerability scoring and within support programming. As an initial step, the LCC should work to define disability, both mental and physical.

6 **Programming to target isolation and disempowerment**. Women and girls expressed feelings of and experiences with isolation and disempowerment almost twice as often as men and boys. As such, it is strongly recommended that the LCC and its partners develop programming to address this issue. Ideas include social collectives; literacy, language, and general education clubs; and peer savings groups.

7 **Increase size of MCA**. The relatively small size of MCA assistance, as compared to the cost of living in Lebanon, is likely minimizing any potential impact on shelter and negative coping strategies. This is especially true given the already severe vulnerability of the beneficiary population. Increasing the monthly allocation of funds (currently at 174 USD) is strongly recommended. Additional research is recommended to establish an optimal monthly allocation amount.

[56] Information accessible here: http://cpwg.net

[57] LCC Targeting Survey Visual Overview of Findings, pg 47. (2015)

Appendix 1: Tools

Adult Survey

INFORMATION PANEL						
This survey is to be administered to the head of household or adult present who cares for a child that lives with them. A separate survey should be used for children.						
Region:						
City:						
Community Name:						
Cash Recipient:	Yes	No				
Day/Month/Year of interview:	/ / 2015					
Repeat greeting if not already read to this respondent: We are from the Lebanon Cash Consortium, we are conducting a survey about the situation of children, families and households. I would like to talk to you about your children's health and well-being. This survey will take about 30 minutes. All the information we obtain will remain strictly confidential and anonymous. I have this consent form here for your review and signature. Would you like me to read it to you? Will you please review and sign for me?		If greeting at the beginning of the household questionnaire has already been read to this person, then read the following: Now I would like to talk to you more about your children's health and other topics. This survey will take about 30 minutes. Again, all the information we obtain will remain strictly confidential and anonymous. I have this consent form here for your review and signature. Would you like me to read it to you? Will you please review and sign for me?				
May I start now?	Yes, permission is given.	No, permission is not given.				
Result of survey	Completed 1	Not at home 2	Refused 3	Partly Completed 4	Incapacitated 5	Other 96

	QUESTION	POSSIBLE ANSWERS							
DEMOGRAPHIC									
1	Age								
2	Sex	Female	Male						
3	Nationality	Syrian	Lebanese	Kurdish	Palestinian	Other			
4	What is your highest level of education?	Knows how to read and write	Primary School	Intermediate / Complementary School	Secondary School	Technical Course	University		
5	What type of assistance are you currently receiving? (select all that apply)	WFP	Cash for Rent	LCC Cash	UNHCR Cash	Remittences (non-institutional)	Water Voucher	Education Fees or Informal Education	Medical
		Fuel Card	Other	None					
6	How much total do you currently recieveing in assistance?	USD	DK						
7	Married	Yes	No						
8	Do you reside with your husband/wife in Lebanon?	Yes	No	Widow					
9	Relationship to HoH?	HoH	Child HoH	Wife/ Husband	Mother/ Father	Daughter/ Son	Brother/ Sister	Father-in-law/Mother-in-law	Brother-in-law/Sister-in-law
10	Sex of Head of HH	Woman	Man						

11	What is the age of the HoH?								
12	Number of children in HH (anyone under 18)								
13	Number boys in HH								
14	Ages of boys in HH								
15	Number girls in HH								
16	Ages of girls in HH								
17	Are your neighbors mostly Lebanese or Syrian?	Lebanese	Syrian	DK					
SHELTER									
18	Shelter type	Apartment not shared	Apartment shared	Unfinished building	Managed collective shelter	Unmanaged collective shelter	Informal settlement	Tent formal settlement	Homeless no shelter
19	How long have you been in Lebanon?	months	DK						
20	How many times have you moved houses since arriving in Lebanon?		DK						
21	How often have you moved houses since arriving in Lebanon?	more than every month	every month	every 2–3 months	every 3–6 months	every 6 months	DK		
22	In the most recent 3 months, how many times have you moved house?	1	2	3	4	5	More than 5		
23	If you moved house in the most recent 3 months, what are the reasons you moved? (select all that apply).	Unpaid Rent	Unsafe location	Eviction	Threats from community	Too expensive	Found better shelter		
EDUCATION									
24	Are your children enrolled in school?	Yes	No	DK					
25	If not, why?	Differences in school curriculum	No school in the area	Transportation problems	School did not allow registration/ enrolment	Not attending due to work commitments	Cultural/ religious reasons	Cost of education	Attending an informal education program
		Note in age for school	Other (please specify)						
26	How many of your children attend primary school?		DK						
27	Do they attend school all year?	Yes	Not in summer	Not in winter	DK				
28	If only attending part-time, why don't they go to school always?	Working	Domestic Responsibilities	No transportation	No room in school	Does not want to go	Moved	Bullying	Dangerous travel to school
		DK							
29	What kind of school is their primary school?	Lebanese formal	Syrian formal	Informal					
30	How many days each week do they attend primary school?		DK						

31	How many hours each day do they attend primary school?		DK						
32	How many of your children attend secondary school?		DK						
33	Do they attend school all year?	Yes	Not in summer	Not in winter	DK				
34	If only attending part-time, why don't they go to school always?	Working	Domestic Responsibil-ities	No transpor-tation	No room in school	Does not want to go	Moved	Bullying	Dangerous travel to school
		DK							
35	What kind of school is their secondary school?	Lebanese formal	Syrian formal	Informal					
36	How many days each week do they attend secondary school?		DK						
37	How many hours each day do they attend secondary school?		DK						
38	How do your children get to school? (select all that apply)	Bus	Taxi	Personal Car	Walk				

ECONOMIC ACTIVITY AND EXPLOITATION									
39	During the last 30 days, did anyone in your HH have to do one of the following things to cope with a lack of food or money to buy it?	Reduce food expenditure	Withdrew children from school	Have school aged children (aged 15 years and under) involved in income generation	HH members under the age of 18 accepting high risk, dangerous, or exploitative work	Sent a child HH member to work elsewhere (not related to usual seasonal migration)	Marriage of children under 18		
40	Do your children UNDER 11 years old work outside the home?	Yes	No	DK					
41	What types of work do they do?	Skilled trade (ex: car mechanic, barber, metal working)	Retail/shop	Garbage pickup (ex: recycling, selling garbage)	Taking care of other children	Domestic work (cleaning, etc)	Agriculture	Working in the streets (rose, tissue and gum selling, begging for money)	Hazardous work (ex: prostitution, DO NOT ASK)
		Other							
42	What happens to the money they earn?		DK						
43	Do your children OVER 11 years old work outside the home?	Yes	No	DK					
44	What types of work do they do?	Skilled trade (ex: mechanic, barber, metal working)	Retail/shop	Garbage pickup (ex: recycling, selling garbage)	Taking care of other children	Domestic work (cleaning, etc)	Agriculture	Working in the streets (rose, tissue and gum selling, begging for money)	Hazardous work (ex: prostitution, DO NOT ASK)
		Other							
45	What happens to the money they earn?		DK						

HEALTH									
46	In the last week, have any of your children had diarrhea?	Yes	No	DK					
47	In the last week, have any of your children had a cough?	Yes	No	DK					
48	Over the last three months, how often have your children been sick with any type of illness or injury?	Constantly	Once every week	Once every month	Once every 2 months	Once	Never	Other	DK
49	When was the last time one of your children sought medical treatment or advice?	Month/Year	DK						
50	Who did they seek medical treatment or advice from?	Doctor	Nurse or health worker	Pharmacy/ Shop	Mobile clinic	Friend/ Relative	Traditional healer		
51	At that time, why did your child seek medical treatment or advice?	Minor illness	Chronic disease	Broken bone	Abrasion/cut/ stabbing	Car accident	Bullet wound	Other	
52	Is there a doctor you can see for reproductive health needs?	Yes	No	DK					
53	Have you visited the reproducive health doctor ever?	Yes	No	DK					
54	If yes, have you visted time doctor in the most recent 3 months?	Yes	No	DK					
55	Do you take your daughter for check ups with that doctor also?	Yes	No	DK					
56	In the last 7 days, how many times did your children consumed the following?								
	Plain water		None	DK					
	Juice or juice drinks		None	DK					
	Dairy		None	DK					
	Infant formula		None	DK					
	Sugar, honey, jam		None	DK					
	Bread, cereal, pasta, rice, potatoes		None	DK					
	Fruits		None	DK					
	Oil, butter, other fats		None	DK					
	Vegetables		None	DK					
	Spices and condiments		None	DK					
	Meat, poultry, fish and other seafood		None	DK					
	Eggs		None	DK					
	Beans, pulses, nuts, lentils		None	DK					

57	During the last 30 days, did you experience lack of food or money to buy enough food to meet the needs of all your household members?	Yes	No	DK
58	How many times did your children eat solid, semi-solid/ soft foods during the last week?		DK	

PROTECTION				
59	In the last three months, how often do you experience yelling or arguing in your home?	Frequent	Not Often	Never
60	What is the yelling about?		DK	
61	When do you think is the best age for girl to be married?		DK	
62	When do you think is the best age for boy to be married?		DK	
63	For the following statements, please tell me if you agree or disagree with each of these statements in reference to the most recent three months:			
	Someone has been physically abused in this home.	Agree	Disagree	DK
	I feel safe in my home.	Agree	Disagree	DK
	My children are safe in my home.	Agree	Disagree	DK
	I feel safe in my community.	Agree	Disagree	DK
	I get along well with my neighbors.	Agree	Disagree	DK
	The Lebanese community accepts me and my children.	Agree	Disagree	DK
	I have noticed fighting between Syrians and Lebanese people in community.	Agree	Disagree	DK

PSYCHOSOCIAL WELLBEING							
64	For the following statements, please tell me if you agree or disagree with each of these statements in reference to the most recent three months:						
	I feel hopeful about the future.	Agree	Disagree	DK			
	I am worried about my family.	Agree	Disagree	DK			
	I have goals and dreams for my future.	Agree	Disagree	DK			
	I believe I can accomplish my goals and dreams.	Agree	Disagree	DK			
	I feel safe here.	Agree	Disagree	DK			
	There is trust between Syrians and Lebanese in my community.	Agree	Disagree	DK			
	Financial issues cause me and my family stress.	Agree	Disagree	DK			
	If one of my children are in trouble, I have the power to help them.	Agree	Disagree	DK			

FAMILY SEPARATION							
65	Do all of your children UNDER 18 years old live with you?	Yes	No	DK			
66	If no, where do they live?						
67	Do any of your children live with other relatives?	Yes	No	DK			
68	If yes, where are they located?						
69	Have any of your immediate family members moved outside of Syria or Lebanon?	Yes	No	DK			
70	If yes, how did they travel there?	Bus	Taxi	Personal Car	Boat	Plane	Walk
71	If yes, what are their ages?						
72	If any under 18 years old, did they travel with a relative?	Yes	No	DK			

ENUMERATOR OBSERVATIONS					
73	Does the HH have access to an adequate amount of water for drinking and domestic use purposes?	Yes	No	DK	
74	What is the source of HH water? (multiple choice)	Only drinking water	Only domestic use water	Yes-both	No-neither

75	Please specify:						
	How many toilets/latrines does your HH have access to?		DK				
	Do you share this/these toilets/latrines with another HH?	Yes	No	DK			
	How many people share the/ these toilets/latrines?		DK				
	What kind of toilet/latrine does the HH use?	Flush	Improvised pit latrine with cement slab or flush latrine	Traditional/ Pit latrine with no slab	Bucket	Open air	
76	Does the HH have access to the following:						
	Personal hygiene items (soap, toothbrush/paste, other personal hygiene items)	Yes	No	DK			
	Cleaning/hygiene items (laundry detergent, cleaning products etc)	Yes	No	DK			
	Female hygiene/dignity items	Yes	No	DK			
	Baby care items (diapers etc)	Yes	No	DK			
77	How is the HH waste managed?	Dumpsters/ barrels collected by municipality	Dumpsters/ barrels not collected by the municipality	Rubbish pit/ heap	Burning	Thrown in open field	Other
78	Are any of the following observable inside/outside of the HH shelter/ property?						
	Windows/doors that cannot be sealed to the elements	Yes	No	DK			
	Unsealed/leaking/damaged roof	Yes	No	DK			
	Damaged water piping/ plumbing	Yes	No	DK			
	Lack of lighting	Yes	No	DK			
	Overcrowding of settlement area	Yes	No	DK			
	Physical dangers in settlement – such as fallen debris, rubbish piles, collapsed buildings etc	Yes	No	DK			
	Settlement proximity to natural / man-made hazards – such as flood plain, landslide, mine, chemical plant, landfill etc	Yes	No	DK			
	Lack of private spaces/ facilities for men/women/ boys/girls	Yes	No	DK			
	Lack of accessibility for disabled HH/community members	Yes	No	DK			
	Open sewerage/waste water trenches/pits	Yes	No	DK			
	Other (please specify)						

Child Survey

INFORMATION PANEL						
This survey is to be administered to a child.						
Region:						
City:						
Community Name:						
Cash Recipient:	Yes	No				
Day/Month/Year of interview:	/ / 2015					
Repeat greeting if not already read to this respondent: We are from the lebanon cash consortium, we are conducting a survey about the situation of children, families and households. I would like to ask you a few questions about your life. This survey will take about 15 minutes. All the information we obtain will remain strictly confidential and anonymous.			If greeting at the beginning of the household questionnaire has already been read to this person, then read the following: Now I would like to talk to you more about your life. This survey will take about 15 minutes. Again, all the information we obtain will remain strictly confidential and anonymous.			
May I start now?	Yes, permission is given.		Yes, permission is given by guardian.		No, permission is not given.	
Consent form completed?	Yes, by older child.		Yes, permission is given by guardian.		No, permission is not given.	
Result of survey	Completed 1	Not at home 2	Refused 3	Partly Completed 4	Incapacitated 5	Other 96

	QUESTION	POSSIBLE ANSWERS							
DEMOGRAPHIC									
1	Age								
2	Sex	Female	Male						
3	Nationality	Syrian	Lebanese	Kurdish	Palestinian	Other			
4	Are you reigsterd in Lebanon with UNHCR?	Yes	No	DK					
5	Registration Number:								
6	What is your highest level of education?	Knows how to read and write	Primary School	Intermediate/ Complementary School	Secondary School	Technical Course			
7	Married	Yes	No						
8	If married, do you reside with your husband/wife in Lebanon?	Yes	No						
9	Relationship to HoH?	HoH	Child HoH	Wife/ Husband	Mother/ Father	Daughter/ Son	Brother/ Sister	Father-in-law/Mother-in-law	Brother-in-law/Sister-in-law
10	Sex of Head of HH	Woman	Man						
11	Number of children in HH								
12	Number boys in HH								
13	Ages of boys in HH								
14	Number girls in HH								
15	Ages of girls in HH								
16	Are your neighbors mostly Lebanese or Syrian?	Lebanese	Syrian	DK					

SHELTER									
17	Shelter type	Apartment not shared	Apartment shared	Unfinished building	Managed collective shelter	Unmanaged collective shelter	Informal settlement	Tent formal settlement	Homeless no shelter
18	How long have you been living in this house?	months	DK						
19	How long have you been in Lebanon?	months	DK						
20	How often have you moved houses since arriving in Lebanon?	Often	A few times	Never					
EDUCATION									
21	Do you go to school?	Yes	No	DK					
22	If yes, do you go to school all year?	Yes	Not in summer	Not in winter	DK				
23	If not attending or only attending part of the year, why?	Differences in school curriculum	No school in the area	Transportation problems	Domestic responsibilities	Not attending due to work commitments	Cultural/ religious reasons	Cost of education	Recently moved
		Dangerous to travel to school	Bullying	Not in age for school	Other (please specify)				
24	Do you go to a primary or secondary school?	Primary	Secondary	Informal	DK				
25	Is it a Lebanese or Syrian school?	Lebanese	Syrian	DK					
26	How many days each week do you attend school?		DK						
27	How many hours each day do you attend school?		DK						
28	How do you get to school?	Bus	Taxi	Personal Car	Walk				
ECONOMIC ACTIVITY & EXPLOITATION									
29	In the last 30 days, have you done paid work or received income?	Yes	No	DK					
30	If yes, in the last 30 days, how many days did you do paid work?		DK						
31	If yes, was this work during school hours?	Yes	No	DK					
32	What types of paid work do you do?	Skilled trade (ex: mechanic, barber, metal working)	Retail/shop	Garbage pickup (ex: recycling, selling garbage)	Taking care of other children	Domestic work (cleaning, etc)	Agriculture	Working in the streets (rose, tissue and gum selling, begging for money)	Hazardous work (ex: prostitution, DO NOT ASK)
		Other							
33	How much did you earn in the last 30 days?	USD	DK						
34	Do you keep all the money you earn?	Yes	No	DK					

35	What happens to the money you earn? I give it too ...	Parent/ Caregiver	Employer	Shawish	Landlord	Lender	Other (please specify)	
36	How long do you spend doing household chores each day?	Hours	DK					

HEALTH								
37	In the last week, have you had diarrhea?	Yes	No	DK				
38	In the last week, have you had a cough?	Yes	No	DK				
39	How many meals each day do you eat?	1	2	3	More than 3			
40	When was the last time you went to the doctor?	Month/year	DK					
41	At that time, why did you go to the doctor?	Minor illness	Chronic disease	Broken bone	Abrasion/cut/ stabbing	Car accident	Bullet wound	Other (please specify)

PROTECTION									
42	Do you feel safe in your neighborhood?	I feel safe most of the time.	I feel safe some of the time.	I don't feel safe.					
43	If you do not feel safe most of the time, is this due to one or more of the following reasons? (select all that apply)	Car or bus accident	No safe place to play	Trouble from gangs	Theives	Fear of being beaten up or attacked	Fear of being touched in a way that makes me uncomfortble or being forced to have sex.	Problems because of people taking drugs and alcohol	I feel excluded because I am different
		I feel safe most of the time.							
44	In the last 12 months, has anyone hurt you in any of the following ways?								
	Made me uncomfortable by standing too close or touching me	Yes	No	DK					
	Called me names or swore at me	Yes	No	DK					
	Hit or slapped me with bare hands	Yes	No	DK					
	Hit me with a belt/stick/hard object	Yes	No	DK					
	Punched, kicked or beat me up	Yes	No	DK					
	Hurt me physically in some other way	Yes	No	DK					
45	Do you ever notice yelling or arguing in your home?	Yes	No	DK					
46	How often do you notice yelling or arguing in your home?	Often	Sometimes	Never					
47	What is the yelling about?	Money	Housing	School	Children	Politics	Food	Other (please specify)	DK
48	When do you think is the best age for girl to be married?		DK						

49	When do you think is the best age for boy to be married?		DK	
50	For the following statements, please tell me if you agree or disagree with each of these statements in reference to the most recent three months:			
	I feel safe in my home.	Agree	Disagree	DK
	I know another child that is forced to work on the streets.	Agree	Disagree	DK
	I get along well with my neighbors.	Agree	Disagree	DK
	I only have Syrian friends.	Agree	Disagree	DK
	I have both Lebanese and Syrian friends.	Agree	Disagree	DK
	I have noticed fighting between Syrians and Lebanese people.	Agree	Disagree	DK

PSYCHOSOCIAL WELLBEING

51	For the following statements, please tell me if you agree or disagree with each of these statements in reference to the most recent three months:			
	I feel hopeful about the future.	Agree	Disagree	DK
	I am worried about my family.	Agree	Disagree	DK
	I have goals and dreams for my future.	Agree	Disagree	DK
	I believe I can accomplish my goals and dreams.	Agree	Disagree	DK
	I feel safe here.	Agree	Disagree	DK
	There is trust between Syrians and Lebanese in my community.	Agree	Disagree	DK
	Financial issues cause me and my family stress.	Agree	Disagree	DK

FAMILY SEPARATION

52	Do all of siblings live with you?	Yes	No	DK
53	If no, where do they live?			
54	Do any of your siblings live with other relatives?	Yes	No	DK
55	If yes, where are they located?			
56	I know another child that left their family in Lebanon to find another home outside of Lebanon.	Yes	No	DK

Questionnaire – KIIs, Adult

INFORMATION PANEL						
This questionnaire is to be administered to the head of household or adult present who cares for a child that lives with them. A separate questionnaire should be used for children.						
Region:						
City:						
Community Name:						
Cash Recipient:	Yes	No				
Day/Month/Year of interview:	/ / 2015					
Repeat greeting if not already read to this respondent: We are from the Lebanon Cash Consortium, we are conducting research about the situation of children, families and households. I would like to talk to you about your children's health and well-being. This interview will take about 30 minutes. All the information we obtain will remain strictly confidential and anonymous. I have this consent form here for your review and signature. Would you like me to read it to you? Will you please review and sign for me?			If greeting at the beginning of the household questionnaire has already been read to this person, then read the following: Now I would like to talk to you more about your children's health and other topics. This interview will take about 30 minutes. Again, all the information we obtain will remain strictly confidential and anonymous. I have this consent form here for your review and signature. Would you like me to read it to you? Will you please review and sign for me?			
May I start now?	Yes, permission is given.		No, permission is not given.			
Consent form completed?	Yes, by older child.		No, permission is not given.			
Result of survey	Completed 1	Not at home 2	Refused 3	Partly Completed 4	Incapacitated 5	Other 96

QUESTION		POSSIBLE ANSWERS							
DEMOGRAPHIC									
1	Age								
2	Sex	Women	Man	Other					
3	Nationality	Syrian	Lebanese	Kurdish	Palestinian	Other			
4	What is your highest level of education?	Knows how to read and write	Primary School	Intermediate/ Complementary School	Secondary School	Technical Course	University		
5	What type of aid are you receiving? (select all that apply)	WFP	LCC Cash	UNHCR Cash	Remittences (non-institutional)	Water Voucher	Education Fees or Informal	Medical	Other
6	Married	Yes	No						
7	Do you reside with your husband/wife in Lebanon?	Yes	No	Widow					
8	Are you the head of HH?	Yes	No						
9	Sex of Head of HH	Woman	Man	Other					
10	Number of children in HH								
11	Number boys in HH								
12	Ages of boys in HH								
13	Number girls in HH								
14	Ages of girls in HH								
15	Are your neighbors mostly Lebanese or Syrian?	Lebanese	Syrian	DK					

SHELTER									
16	Shelter type	Apartment not shared	Apartment shared	Unfinished building	Managed collective shelter	Unmanaged collective shelter	Informal settlement	Tent formal settlement	Homeless no shelter
17	How long have you been in Lebanon?	months	DK						
18	How often does it feel like you have moved houses in the most recent 3 months? Probe: How long have you been living in this house?								
19	What causes you to move houses?								
EDUCATION									
20	Are all of your children enrolled in school? Probe: In not, why?	Yes	No	DK					
21	How did you find a school for them? Probe: Tell me about what you had to do to find and enroll your children in school?								
22	Do they all attend school? Probe: If yes, what kind of school? (formal or informal, Lebanese or Syrian or mix) Probe: If no, why?								
23	Where is their school? Probe: About how far away is your children's school?								
24	What is their journey to school like? Probe: How do they get there?								
ECONOMIC ACTIVITY AND EXPLOITATION									
25	Do your children UNDER 11 years old work outside the home?	Yes	No	DK					
26	What types of work do they do?								
27	What happens to the money they earn?								
28	How much money do they earn each month?								
29	What are the first three things that you spend money on each month?								
30	Have you ever heard of any children being forced to work? Or working in harmful conditions? Probe: Can you tell me more?								

HEALTH				
31	What was the most recent medical issue your children faced?			
32	What did you do to seek medical treatment or advice?			
33	What is the most common medial issue your children face?			

PROTECTION				
34	How would you describe the atmostphere in your home? Probe: Why would you describe it that way?			
35	When do you think is the best age for girl to be married?			
36	When do you think is the best age for boy to be married?			
37	Do you feel safe here? Probe: What makes you feel that way?			
38	Do you get along with your neighbors?			
39	How do you feel the Lebanese community treats you and your children?			
40	Have you noticed fighting between Syrians and Lebanese people in the community? Probe: Can you tell me about a time when you noticed fighting?			

PSYCHOSOCIAL WELLBEING				
41	What are some the things that you worry about for your family?			
42	How do you feel about the future?			
43	If there is a child in trouble, what is the best thing their parents can do to help them if they are Syrian refugees?			

FAMILY SEPARATION				
44	Do all of your children UNDER 18 years old live with you?	Yes	No	DK
45	If no, where do they live?			
46	Do any of your children live with other relatives?	Yes	No	DK
47	If yes, where are they located?			

48	If yes, how did you or they decide who they were going to live with?	
49	If yes, how did they travel there?	
50	If yes, what are their ages?	
51	Have you ever heard of children going to live outside of Lebanon without their families? Probe: How do you you feel about children living outside of Lebanon without their families?	

Questionnaire – KIIs, Child

INFORMATION PANEL						
This survey is to be administered to a child.						
Region:						
City:						
Community Name:						
Cash Recipient:	Yes	No				
Day/Month/Year of interview:	/ / 2015					

Repeat greeting if not already read to this respondent: We are from the Lebanon Cash Consortium, we are conducting research about the situation of children, families and households. I would like to ask you a few questions about your life. This interview will take about 15 minutes. All the information we obtain will remain strictly confidential and anonymous.	If greeting at the beginning of the household questionnaire has already been read to this person, then read the following: Now I would like to talk to you more about your life. This interview will take about 15 minutes. Again, all the information we obtain will remain strictly confidential and anonymous.

May I start now?	Yes, permission is given by child.	Yes, permission is given by guardian.	No, permission is not given.		
Consent form completed?	Yes, by older child.	Yes, permission is given by guardian.	No, permission is not given.		
Result of survey	Completed 1	Not at home 2	Refused 3	Partly Completed 4	Incapacitated 5	Other 96

QUESTION		POSSIBLE ANSWERS				
DEMOGRAPHIC						
1	How old are you?					
2	Sex	Girl	Boy	Other		
3	Nationality	Syrian	Lebanese	Kurdish	Palestinian	Other
4	Who do you live with right now?					
5	Are you or have you ever been married?	Yes	No			
6	If married, do you reside with your husband/wife in Lebanon?	Yes	No			
7	Are you the head of HH?	Yes	No			

8	Sex of Head of HH	Woman	Man	Other					
9	Number of children in HH								
10	Number boys in HH								
11	Ages of boys in HH								
12	Number girls in HH								
13	Ages of girls in HH								
14	Are your neighbors mostly Lebanese or Syrian?	Lebanese	Syrian	DK					
SHELTER									
15	Shelter type	Apartment not shared	Apartment shared	Unfinished building	Managed collective shelter	Unmanaged collective shelter	Informal settlement	Tent formal settlement	Homeless no shelter
16	How long have you been in Lebanon?	months	DK						
17	How often does it feel like you have moved houses in the most recent 3 months? Probe: How long have you been living in this house?								
18	What causes you to move houses?								
EDUCATION									
19	Do you go to school?	Yes	No	DK					
20	If no, why not?								
21	If yes, do you go to school all year?								
22	Tell me about your school? Probe: How many days each week do you go to school? What kind of school (primary, secondary, Lebanese, formal) it is? Do you have friends at school? Are they from Syria too? Do any Lebanese children go to that school? Do you play with them too? How far away is your school? How do you get there?								
ECONOMIC ACTIVITY AND EXPLOITATION									
23	Do you work?	Yes	No	DK					
24	What types of work do you do?								
25	What happens to the money you earn?								
HEALTH									
26	When was the last time you were sick?								

27	What happened? What kind of illness did you have?				
28	How many meals each day do you eat?	1	2	3	More than 3

PROTECTION					
29	How would you describe your house?				
30	How would you describe your community?				
31	Do you ever hear fighting in your community? Probe: What kind of fighting?	Yes	No	DK	
32	What do you think the fighting is about?				
33	When do you think is the best age for girl to be married?		DK		
34	When do you think is the best age for boy to be married?		DK		
35	Do you feel safe here? Probe: What makes you feel that way?				
36	Who do you play with most of the time? Probe: What is your favorite game to play?				

PSYCHOSOCIAL WELLBEING					
37	Do you ever get worried or scared? Probe: What are some the things that you worry about?				
38	Tell me about your dreams for the future.				
39	What do you think you need to accomplish these dreams?				

FAMILY SEPARATION					
40	Do all of siblings live with you?	Yes	No	DK	
41	If no, where do they live?				
42	Do any of your siblings live with other relatives?	Yes	No	DK	
43	If yes, where do they live?				
44	Why do they live there?				
45	Have you ever heard other children going to live outside of Lebanon without their families? Probe: Do you think that is a good idea?				

Questionnaire – FGDs, Adult

INFORMATION PANEL		
This is a guide for FGD with adults only. It is to be used with the head of household or adult who cares for a child that lives with them. A separate guide and FGD will take place with children should be used for children.		
Region:		
City:		
Cash Recipient:	Yes	No
Day/Month/Year of FGD:	/ / 2015	

OBJECTIVE:

- To explore community's perspective on what the community's children need to be protected from
- To explore community's attitudes towards protection of children from abuse and exploitation
- To identify the possible causes of the prioritised child protection, injustice issues
- To understand the current practices of family and community members towards protecting children from abuse or exploitation
- To explore if there are any support structures available to assist families and communities to ensure a protective environment for their children (formal and traditional protection mechanisms)
- To explore what community members know about trafficking and forced migration: who is affected, causes, risks etc.
- To assess what steps community members know about and might take to mitigate the risks of trafficking and forced migration
- To understand the level of awareness on how children and the community are affected by conflict, post conflict and peace building.

Repeat greeting if not already read to this respondent: We are from the Lebanon Cash Consortium, we are conducting research about the situation of children, families and households. I would like to talk to you about your children's health and well-being. This focus group will take about 45 minutes. All the information we obtain will remain strictly confidential and anonymous. I have this consent form here for your review and signature. Would you like me to read it to you? Will you please review and sign for me?	If greeting at the beginning of the household questionnaire has already been read to this person, then read the following: Now I would like to talk to you more about your children's health and other topics. This focus group will take about 45 minutes. Again, all the information we obtain will remain strictly confidential and anonymous. I have this consent form here for your review and signature. Would you like me to read it to you? Will you please review and sign for me?

(Ask All) May I start now?	Yes, permission is given.	No, permission is not given.
(Ask all) May I record now?	Yes, by older child.	No, permission is not given.

Discussion Topic	Key Concepts to be Explored	Guide Questions	Time
1. Risks for children	a) Understand children's exposure to violence and resources for their protection b) Understand which groups of children are more vulnerable	What are the biggest threats or risks for children in this community?	30 min
		Do children here face violence or abuse? Describe the violence/abuse that children face at home, in the community and at school.	
		Are there any children that are more at risk than others? Why?	
		Who helps children when they face violence or abuse?	
		"Hazards and Resources" exercise (*see below)	
		Probes: a) What kinds of hazards are in your community (e.g., areas that can cause injury, areas that are not secure/safe at night, areas that are vulnerable to disasters)? What is the impact of the hazard on the community (who is typically impacted)? What kinds of things can be done to reduce or eliminate the hazard? b) Are there any areas where resources and hazards cross over? What happens in those areas (e.g. maybe resources are not accessible certain times of the year due to flooding, people get injured)? Are there any ways the community can reduce the hazards there (e.g. removing a safety hazard, providing security, putting up warning signs)? Is there a better way to protect the resources in that area?	

2. Problems and impacts	Understand how community members view the most important problems for children in the community	**"Problem/impact/solutions" exercise (see below)**	20 min
		What do you think is the biggest problem or challenge in this community to create a protective environment and prevent child abuse, exploitation or neglect? (probe for description of the problem)	
		After top five problems have been tallied:	
		How are children affected by _____?	
3. Forced Migration Migration	a) Understand who are the vulnerable childrens' groups living without adults b) Understand the recruitment and migration process in the community	Has anyone left the community this year? Women, men, children? Describe who they are and how they left here.	10 minutes
		Are there any children here who have been separated from their families? How many? Who cares for them?	
		How common is child migration alone? I.e. how many children left the village last year? Do both girls and boy children migrate from this village? Is it more common for boys or girls to migrate?	
		What are places that children from this village go when they migrate?	
		At what age do children generally migrate?	
		Can you tell me about the migration process – who arranges the migration? Is the person someone that the children know? Is the process different for boys and girls?	

Hazards and resources mapping exercise:

1. Using one piece of flipchart paper, draw a map of the community including schools, clinics, roads, water points, fields, offices, houses, church, market, etc in black marker.
2. Using a green marker, indicate in the specific resources (especially for children).
3. Using a red marker, indicate the hazards in red: areas of flooding, insecure areas, physical dangers, etc (especially for children).

Problems / Impact / Solutions exercise:

Explain to the group that we are now interested in their opinions about the most critical problems the children in their community is facing these days concerning child abuse, exploitation and neglect. Tell them to think about what they consider to be the most difficult challenges for children. You are going to ask each person, one by one so that everybody has a chance to give their opinion. Don't be concerned if other people have not said the same thing you are thinking – we want to know what you have on your mind.

On flip chart paper, write the problem and short description from every person, one by one. Put hash marks next to repeated answers. After every participant has spoken, tally the responses and select the top five.

Next, tell the group how they voted (which are the top 5 problems). Then go through each of the 5 problems separately and ask the group how they and their families are affected by each. Start with the top problem, then the next, and so on until the impacts of all 5 top problems have been discussed.

Next ask about solutions to the top five problems. Ask about the top problem first: what can be done to resolve this problem or to help children get through it easier? Go through each of the five problems to ask about solutions.

PLEASE NOTE: the only time the facilitator will ask for individual responses is during the first question to identify the problems. After that, impacts and solutions will be discussed by the whole group. Also, only use the flip chart paper for the problems—after the problems are tallied, do not write on the flip chart paper for impacts and solutions. Additionally, even though the facilitator (or observer) is writing on the flip chart, note takers must still continue to take full notes because many great quotes will result from this part of the FGD.

Questionnaire – FGDs, Child 8–11 years old

INFORMATION PANEL		
This is a guide for FGD with children only.		
Region:		
City:		
Cash Recipient:	Yes	No
Day/Month/Year of FGD:	/ / 2015	

OBJECTIVE:

- To explore children's perspective on what the community's children need to be protected from
- To explore children's attitudes towards protection of children from abuse and exploitation
- To identify the possible causes of the prioritised child protection, injustice issues

Repeat greeting if not already read to this respondent: We are conducting research about the situation of children, families and households. I would like to talk to you about your life. This group will be fun, we will do some activities, for about 30 minutes. All the information we obtain will remain strictly confidential and anonymous.	If greeting at the beginning of the household questionnaire has already been read to this person, then read the following: Now I would like to talk to you more about your life. This group will take about 30 minutes. Again, all the information we obtain will remain strictly confidential and anonymous.

Was consent provided by all caretakers?	Yes, consent was given.	No. (remove those without consent from the group)
(Ask All) May I start now?	Yes, permission is given.	No, permission is not given.
(Ask all) May I record now?	Yes, permission is given.	No, permission is not given.

Discussion Topic	Key Concepts to be Explored	Guide Questions	Time
1. Mapping risks for children	Understand children's exposure to violence and resources for their protection	What are the biggest threats or risks for children in this community?	20 min
		"Safe and dangerous places" exercise (*see below)	
		Probe: What makes these environments dangerous for children in this community? What makes these environments safe and protective for children in this community?	
2. Risks and protections for children	Explore different forms of abuse and exploitation children face in their daily lives and how they are protected in the community (formal and informal structures).	**Identify and Discuss**	10 min
		1. DISCUSS: After every child has presents their drawing, identify and discuss the protection risks that were shown throughout the drawings, and the strategies used by children to increase their protection. It could be helpful to write these on flipchart paper so everyone can see.	
		2. RANK: The facilitator can put three signs on the floor. On the first will write three stars '***' for most important, on second two stars '**' for medium level of importance, and on third one star '*' only a little important. The facilitator will then ask participants to vote on each identified issue by lining behind the appropriate sign when he/she calls out the issue identified. He/she then lifts cards one by one and each time participants will be asked to line behind the sign that best describes how they feel on the issue. The facilitator will note the numbers behind each sign on the flip chart and ask participants why they think the particular issue is or not most important. If other issues have come up through the discussion, facilitators should also repeat the same process for them.	

SAFE AND DANGEROUS PLACES:
1. Give each participant a sheet of paper and some crayons of different colors. Ask each person to draw the place where he or she lives—both inside and the surrounding area outside.
2. After people have completed their drawings (10 minutes), ask them to mark with one color the places inside and outside where they live that are safe areas.
3. In a different color, ask them to mark those places inside and outside that are dangerous.
4. Ask several participants to explain their drawings—be sure to select those who have not participated much in the discussion.

Questionnaire – FGDs, Child 12–15 years old

INFORMATION PANEL		
This is a guide for FGD with children only.		
Region:		
City:		
Cash Recipient:	Yes	No
Day/Month/Year of FGD:	/ / 2015	

OBJECTIVE:
• To explore children's perspective on what the community's children need to be protected from • To explore children's attitudes towards protection of children from abuse and exploitation • To identify the possible causes of the prioritised child protection, injustice issues

Repeat greeting if not already read to this respondent: We are conducting research about the situation of children, families and households. I would like to talk to you about your life. This group will be fun, we will do some activities, for about 45 minutes. All the information we obtain will remain strictly confidential and anonymous.	If greeting at the beginning of the household questionnaire has already been read to this person, then read the following: Now I would like to talk to you more about your life. This group will take about 45 minutes. Again, all the information we obtain will remain strictly confidential and anonymous.

Was consent provided by all caretakers?	Yes, consent was given.	No. (remove those without consent from the group)
(Ask All) May I start now?	Yes, permission is given.	No, permission is not given.
(Ask all) May I record now?	Yes, permission is given.	No, permission is not given.

Discussion Topic	Key Concepts to be Explored	Guide Questions	Time
1. Mapping risks for children	Understand children's exposure to violence and resources for their protection	What are the biggest threats or risks for children in this community?	30 min
		Do children here face violence or abuse? Describe the violence/abuse that children face at home, in the community and at school.	
		Are there any children that are more at risk than others? Why?	
		Who helps children when they face violence or abuse?	
		"Safe and dangerous places" exercise (*see below)	
		Probe: What makes these environments dangerous for children in this community? What makes these environments safe and protective for children in this community?	

1. Risks and protections for children	Explore different forms of abuse and exploitation children face in their daily lives and how they are protected in the community (formal and informal structures).	**Child Protection Drama** **Steps:** 1. EXPLAIN: In this activity, you will use drama to explore what girls and boys need protection from and the different ways you are being protected from these risks . 2. DIVIDE: Separate into small groups of 3–4 children, you may want to break up in to boys and girls. 3. DISCUSS AND DEVELOP: In your small groups, discuss and identify what risks you and your friends face in different settings (family, school, workplace, community, etc.). Create a brief, 5 minute drama that shows how children are better protected from such risks through different people and groups in the community 4. PERFORM: Each group performs their drama. 5. IDENTIFY & DISCUSS: After every group presents their drama, identify and discuss the protection risks that were shown through the drama, and the strategies used by children to increase their protection. It could be helpful to write these on flipchart paper so everyone can see. 6. RANK: The facilitator can put three signs on the floor. On the first will write 'most significant issue in community', on second 'important but not most important' and on third 'less important'. The facilitator will then ask participants to vote on each identified issue by lining behind the appropriate sign when he/she calls out the issue identified. He/she then lifts cards one by one and each time participants will be asked to line behind the sign that best describes how they feel on the issue. The facilitator will note the numbers behind each sign on the flip chart and ask participants why they think the particular issue is or not most important. If other issues have come up through the discussion, facilitators should also repeat the same process for them.	25 min

SAFE AND DANGEROUS PLACES:

1. Give each participant a sheet of paper and some crayons of different colors. Ask each person to draw the place where he or she lives – both inside and the surrounding area outside.
2. After people have completed their drawings (10 minutes), ask them to mark with one color the places inside and outside where they live that are safe areas.
3. In a different color, ask them to mark those places inside and outside that are dangerous.
4. Ask several participants to explain their drawings – be sure to select those who have not participated much in the discussion.

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Humanitarian Aid
and Civil Protection