

Action Document for EU Trust Fund to be used for the decisions of the Operational Board

1. IDENTIFICATION

Title/Number	Regional Health programme for displaced populations and host communities in neighbouring countries affected by the Syrian crisis		
Total cost	Total estimated cost: EUR 59,000,000 Total amount drawn from the Trust Fund: EUR 59,000,000		
Aid method / Method of implementation	Project Approach Direct management – grants – direct award		
DAC-code	122	Sector	Health

2. RATIONALE AND CONTEXT

2.1. Summary of the action and its objectives

The proposed action is based on the resilience and livelihoods needs of displaced populations and host communities as identified in Regional Refugee & Resilience Plan 2015-2016 (<http://www.3rpsyriacrisis.org/>) and the national response plans of the main host countries Lebanon, Jordan, Turkey, and Iraq. It builds on several concept notes submitted by different networks and partnerships of European CSOs to the Madad Fund in the field of Health support for the a.m. target groups and countries.

The **Overall Objective** of the programme is to increase access to quality and equitable health care for refugees and impacted local populations both through direct interventions and through bolstering national systems and capacities in in Lebanon, Jordan, Iraq, Egypt and Turkey.

The **Specific Objectives** are:

- Refugees from Syria, displaced populations and host communities in Turkey, Lebanon, Jordan, Egypt and Iraq have improved access to health care with a particular focus on their psychosocial well-being.
- Red Cross & Red Crescent (RCRC) Societies and national health systems in the region have strengthened their capacity and enhanced their ability to reach out to most vulnerable groups within the refugee and host communities
- Increased access and strengthened local capacity to deliver general primary and secondary health, and reproductive health (RH) and psychosocial services especially to those affected by Sexual Gender Based Violence (SGBV) and/or conflict.

In particular, the proposed action contributes to the implementation of *[EU regional strategy for Syria and Iraq as well as the ISIL/Da'esh threat](#)* under section 2.1.5 - *Strengthen local resilience capacities in Syria, Iraq and the affected neighbouring countries*, i.a. by

- *building upon existing joint humanitarian aid/development frameworks in the field and establish joint programming in Syria, Iraq, Jordan, Lebanon and Turkey;*

- *using the ‘Madad fund’ for stabilisation and resilience aid to refugee and host communities in Iraq, Lebanon, Jordan, Turkey, and*
- *in Iraq, providing seed money in the effort to link development with humanitarian assistance. Such linkages need to build on existing support and be widened as soon as possible to support conditions of protracted displacement and in preparation for the IDPs return to their homes, in order to lay the foundations for stability and sustainable economic growth.*

2.2. Context

According to the Regional Refugee & Resilience Plan 2015-2016 (<http://www.3rpsyriacrisis.org/>), all indicators are that the human costs of the Syria crisis will continue to grow in 2015 and 2016, with continuing population movements, and deepening vulnerabilities.

The overall planning assumptions for 2016 are that armed conflict and insecurity will continue inside Syria; that an effective overall peace agreement will not yet be achieved and implemented; and that refugees will continue to flee Syria and seek international protection, despite measures to restrict admission in some countries in the region. Additional Syrian refugees have arrived in the five host countries during 2015, which – very close to the forecast 10 months ago of 4.27 million by end-2015 – has brought the total regional refugee population up to 4.29 million by November 2015. More than half of these refugees are children.

As middle-income countries, the countries neighbouring Syria have significant government capabilities and growing civil societies. Nevertheless, the crisis is severely straining the coping abilities of millions of vulnerable people in these impacted communities. Many refugees are living in already poor areas where there are limited livelihood opportunities, and where housing and social services are stretched, exacerbating vulnerabilities among the local population. Conflict in Iraq has compounded the difficulties for refugees and impacted communities there, with the two displaced populations overlapping and placing a large burden on local services (inflow of nearly 250,000 Syrian refugees and more than 2.8 million IDPs in Iraq).¹

On 15 December 2014, the **Lebanon** Crisis Response Plan (LCRP) was launched. The LCRP requirements are for USD 2.1 billion, including USD 1.4 billion for the refugee component and USD 724 million for the resilience/ stabilization component. The Government of Lebanon's requirement included in the total is USD 169 million. Lebanon will support the expansion of temporary income-generating opportunities at scale for stabilization, linked with the priorities of local economic development and longer-term planning at local and national level. The 2016 LCRP was released on 15th December 2015.

In **Jordan**, the Government on 18 October launched the Jordan Response Plan (JRP) for the years 2016 – 18 (<http://www.jrpj.org>), which is rather articulated and sets clear outputs in the area of livelihood and resilience, with the following specific objectives:

- Improve availability, access and utilisation of quality food for vulnerable women, girls, boys and men affected by the Syrian crisis.
- Increase income generation and employment for vulnerable Jordanian men and women leading to sustainable economic;
- Strengthen resilience of local governance system and communities to crisis with particular focus on social cohesion.

¹ Kurdistan Region of Iraq, economic and social impact assessment of the Syrian conflict and ISIS crisis - World Bank, 2014

For the resilience-related needs relevant to the Madad Fund, the new 3-year JRP indicates for 2016 alone needs of USD 250m for education, 183m for health, 266m for livelihoods and food security, and 310m for WASH.

JRP 2016-2018 Budget Requirements per year – USD (Table 1.1a)

Sector	2016	2017	2018	Total (2016-2018)
Education	250,638,101	281,204,375	323,130,296	854,972,772
Energy	107,400,000	111,075,000	87,000,000	305,475,000
Environment	2,900,000	8,150,000	2,300,000	13,350,000
Health	183,660,762	178,840,190	170,085,832	532,586,785
Justice	11,402,000	9,252,000	8,300,000	28,954,000
Livelihoods and Food Security	266,527,304	274,253,649	272,140,971	812,921,924
Local Governance and Municipal Services	69,163,402	76,361,270	58,227,216	203,751,888
Shelter	32,157,984	32,080,853	25,056,207	89,295,044
Social Protection	420,385,331	374,365,034	323,477,528	1,118,227,893
Transport	28,300,000	33,600,000	16,300,000	78,200,000
WASH	310,800,000	322,520,000	261,760,000	895,080,000
Management	1,420,000	1,140,000	740,000	3,300,000
Sub Total: JRP Programmatic Response	1,684,754,884	1,702,842,372	1,548,518,050	4,936,115,306
Subsidies for Syrian Refugees	213,214,431	222,409,642	232,725,266	668,349,339
Security Support	448,216,824	454,082,611	430,294,742	1,332,594,177
Accelerated Infrastructure Depreciation	258,640,000	274,158,400	290,607,904	823,406,304
Income Loss	125,702,797	125,554,907	125,721,274	376,978,978
Sub Total: Direct Budget Support	1,045,774,052	1,076,205,560	1,079,349,186	3,201,328,798
Total JRP Budget	2,730,528,936	2,779,047,932	2,627,867,236	8,137,444,104

In terms of the 2015 JRP results, much has been achieved over the past year despite severe funding shortfalls. For example:

- Access to education improved: more than 143,000 Syrian refugee boys and girls enrolled in public schools this year, and 50,000 Syrian boys and girls have been provided with remedial education.
- Access to Justice has improved: 70,000 Syrian refugees and Jordanians in host communities reached with legal advice and/or information.
- Communicable disease control has been strengthened: over 100,000 Syrian children under five were vaccinated against polio.

However, these successes have been achieved against a background of increased vulnerability. Many refugee families have spent their savings, sold their assets, and lost access to their support networks, forcing them to take extreme measures in order to cope. Meanwhile, vulnerable Jordanians living in communities with high concentrations of refugees are being increasingly affected. The Comprehensive Vulnerability Assessment carried out between April and July 2015, under MOPIC supervision, found severe vulnerability levels across four key service delivery sectors; education, health, solid waste management and WASH, particularly in areas with high concentrations of Syrians. Although vulnerability is increasing, aid funding is reducing. About 34.5 % of the total USD2.99 billion JRP2015 requirements has so far been committed for 2015, indicating that for the fourth year; two thirds of needs at a minimum remain unfunded.

JRP 2016-18 Budget Requirements per component – USD (table 1.1b)

Sector	Refugee Response	Resilience Response	Grand Total
Education	353,588,092	501,384,680	854,972,772
Energy	144,975,000	160,500,000	305,475,000
Environment	NA	13,350,000	13,350,000
Health	224,745,940	307,840,845	532,586,785
Justice	4,404,000	24,550,000	28,954,000
Livelihoods and Food Security	631,860,073	181,061,851	812,921,924
Local Governance and Municipal Services	NA	203,751,888	203,751,888
Shelter	28,003,155	61,291,889	89,295,044
Social Protection	901,042,039	217,185,854	1,118,227,893
Transport	NA	78,200,000	78,200,000
WASH	162,360,000	732,720,000	895,080,000
Management	NA	3,300,000	3,300,000
Sub Total: JRP Programmatic Response	2,450,978,299	2,485,137,007	4,936,115,306
Subsidies for Syrian Refugees	NA	NA	668,349,339
Security Support	NA	NA	1,332,594,177
Accelerated Infrastructure Depreciation	NA	NA	823,406,304
Income Loss	NA	NA	376,978,978
Sub Total: Direct Budget Support	NA	NA	3,201,328,798
Total JRP Budget Requirements	NA	NA	8,137,444,104

The **Turkey** Chapter of the 3RP foresees a total budget of USD 624 million including USD 460 million for the refugee component and **USD 164 million for the resilience component. Turkey's Country Plan provides for a nearly threefold increase in spending on livelihoods**, compared to the RRP6, and reflects Turkey's commitment to development that builds resilience. Spending on livelihoods accounts for nine per cent of total planned spending; roughly 81 per cent of funding for livelihoods aims to build resilience. In governorates with a high concentration of Syrian refugees and in refugee camps in south-eastern Turkey, new livelihoods generating initiatives will be launched, and existing ones will be expanded, with new investments to boost job creation. In all cases, implementing livelihoods initiatives and projects requires finding a productive combination of strengthening the capacity of available institutions, the engagement of the private sector in financing innovative initiatives and identification of key growth sectors, including those for women.

In **Iraq**, the 3RP seeks a total of USD 426 million, made up of USD 318 million for the refugee component and USD 108 million for the resilience component. Iraq's plan was developed in the context of ongoing major internal displacement in that country. In Iraq, nine per cent of all interventions of the 3RP are focussed on livelihoods. As part of the short-term response, there is still a need for cash assistance activities, such as cash-for work, particularly for the most vulnerable households. However, the overall strategy acknowledges the need to shift to more sustainable support, with a market-oriented approach, strengthening the local economy as a whole to support the creation of jobs through the development of the private sector. Consequently, partnerships with the private sector for the development of market systems will be strengthened.

However, as of late September 2015, the resilience pillar in the 3RP remained even more underfunded than the humanitarian refugee pillar, with an average of around 15% of required funding having been committed.

2.2.1. Sector context: policies and challenges

Throughout the region, national health services provide significant health care to Syrian refugees. The increasing demands, however, are stretching local health systems, which have insufficient personnel, medical supplies, and inadequate service delivery (including language and communications constraints). The strain on health services is also affecting local communities. Vulnerable populations

are at increased risk of communicable diseases due to unfavourable environmental conditions (such as limited access to safe/adequate water and sanitation, poor vector control, and sub-standard housing) and limited access to basic health services, such as child immunization.

Health status in the region

Outbreaks of polio in northern Syria and Iraq precipitated a regional response of mass immunization campaigns in affected and high-risk areas in Egypt, Iraq, Jordan, Lebanon, Syria and Turkey throughout 2014. Other diseases are also increasingly prevalent, such as Acute Respiratory Infections and diarrhoea in children in Iraq. The management of non-communicable diseases (NCDs) is a significant challenge. Nearly 30 per cent of refugees in Jordan suffer from NCDs such as hypertension or diabetes.

Extra care and support are needed for survivors of torture and violence who are suffering from post-traumatic stress disorder (PTSD), anxiety or depression, as well as for those with other mental health conditions. A comprehensive care approach at the primary, secondary and tertiary levels, including referrals to wider psychosocial services, is required. Access to adequate and appropriate reproductive health care is a continuing need. To ensure that these needs are met, it is necessary to improve capacities for basic and comprehensive emergency obstetric and neonatal care at primary, secondary and tertiary health care locations. In countries where reproductive health care is readily available, such as Turkey, it is normally the most used of primary health care services. However, in other countries, there is low utilization of antenatal care and high rates of caesarean sections.

In most areas, there is limited access to and availability of clinical management of rape services and wider gender-based violence services. The main nutrition concern among refugees is micronutrient deficiency such as iron deficiency. In Jordan, for example, prevalence is high for both those in camps and those in communities. Global acute malnutrition rates are at acceptable levels, below five per cent among refugees. Inappropriate infant and young child feeding have also been recorded. Given the diverse mechanisms of health support across the region, the 3RP emphasizes the need to increase access to quality and equitable health care for refugee and impacted local populations both through direct interventions and through bolstering national systems and capacities. Improvements will be directed towards strengthening routine immunization and campaigns especially for polio and measles, which continue to threaten the region.

New born and child health needs to be addressed through capacity building and delivery of integrated packages at health facility and community level. Mechanisms to address communicable disease outbreaks through early warning and response systems, and to increase capacity of health information systems, need to be improved. Access to reproductive health care, including clinical management of rape services and referral mechanisms to SGBV psychosocial services will remain a priority. NCD management and mental health care across the service levels require significantly greater support both through direct service delivery and increasing technical capacity of national systems.

In Lebanon, Health services are characterised by a dominant private sector. The primary health care (PHC) system is mainly operated by the NGO sector and based on user fees. Persons displaced from Syria and Lebanese alike are expected to cover the costs of consultations and diagnostics, which can be well beyond their means. Secondary and tertiary care facilities offer around 13,000 hospital beds (85% are private sector). The surplus of medical doctors and shortage of nurses and paramedical staff, leads to a very high cost for health services, both for persons displaced from Syria and for the Lebanese population.

Available data indicates that common childhood illnesses, non-communicable diseases (including cardiovascular diseases, dyslipidaemia, diabetes, and asthma) and mental illnesses are priority conditions for both Lebanese and persons displaced from Syria. The youth population is also affected, especially as public schools have a reduced capacity to maintain the school health program (medical screening for students, health awareness activities and school health environment interventions).

In 2014, health care for Syrian de facto refugees was supported through PHC services and hospital admissions subsidized through UNHCR partners and other humanitarian actors. Of the conditions covered by UNHCR for secondary health care, 48 per cent are linked to obstetric care. For secondary and tertiary health care, UNHCR introduced an innovative use of the private sector country wide in

January 2014. A Third Party Administrator (TPA) ensures the management of hospital admissions, with reimbursement rates for specific service packages based on the MOPH flat rates. The EU Instrument for Stability (IFS) funds support to the Lebanese primary health system to prevent or mitigate conflict in health settings. Priority attention was given to outbreak control: significant support was provided: to expand the Early Warning and Response System (EWARS); and intensify vaccination activities especially for children under five (50 per cent boys, 50 per cent girls). The MOPH accelerated the expansion of its PHC network in terms of accredited PHC network facilities and the provision of standardized priority health services.

A Health Access and Utilization survey conducted among Syrian refugees living in urban communities in **Jordan** showed a decrease in access to curative and preventative health care. This was the first health survey to be carried out since the Ministry of Health (MoH) changed its policy in November 2014 from providing free public health care services to Syrian refugees to services offered at a subsidized rate. According to the survey, **58.3 per cent of adults with chronic conditions were unable to access health care services as needed due to their inability to pay the high fees.** This is a marked increase from 23.7 per cent in 2014. Access to childhood vaccination was good with an increase from 55 per cent (in 2014) to 76 per cent (in 2015) of children under five having an immunization card.

To address the financial and health system barriers, the study recommended the need for pilot provision of cash to refugees to offset the cost of accessing health services at MoH facilities and to strengthen links with agencies providing cash assistance to support transport costs to access health services for vulnerable refugees. The survey also highlighted the need to improve refugee knowledge of available services including continued awareness raising for refugees about the new health policy and eligibility criteria for accessing health care through 3RP Partner-supported services. Improvement of clinical support such as further documenting the needs of refugees post-injury including gaps in provision of assistive devices, physiotherapy, rehabilitation and home nursing was also recommended.

In Iraq, the increasing numbers of refugees in camps and in impacted communities, the unexpected influx of 850,000 IDPs to KRG since June 2014 and the additional displacement in Anbar, affected and overstretched the health sector. The inability to pass a budget from the GoI to the KRG significantly reduced available funds for the Ministry of Health, which impacted refugees, with noncamp suffering more than camp residents where the international effort mitigated at least some of these effects, IDPs and impacted communities alike. The combination of these factors has stretched the health sector response capacity further, in some areas beyond coping capacity. As a result, the provision of health care has suffered from shortages, such as human resources, interruptions in supply chains and limited funds to maintain and expand health facilities.

There are differences in diseases patterns and frequency between camp and community-based populations. In the recent MSNA 24 per cent of refugees in camp reported having a sick family member in the last two weeks as compared to 8 per cent of refugees living in host communities. Most common acute diseases were upper and lower respiratory tract infections, watery diarrhea and urinary tract infections. One in five refugee households reported a family member suffering from chronic diseases.

The Ministry of Health (MoH)/ Directorates of Health (DoH) have assumed their responsibilities to be in charge of health activities and work in close coordination with the health sector working group. In all refugee camps, comprehensive primary health care services are provided jointly by the DoHs and humanitarian actors ensuring access to curative, preventive and promotional services including maternal and child health care. The comprehensive package includes the provision of primary health care, immunization, reproductive health, nutrition and mental health services in all camps. Health services outside the camps are provided by the DoH and refugees have access to primary, secondary and tertiary health care for a nominal fee. Support to survivors of SGBV is available in public health facilities through trained specialists.

Before the recent IDP crisis, an estimated 20 per cent of the noncamp population and 24 per cent of the refugees living in camps were already encountering difficulties in accessing health services. Key obstacles include costs for health services and medicines as well as perceived availability of relevant services for all population groups. The recent influx of IDPs has further constrained the capacity of health services with additional consequences for refugees. Meanwhile this deterioration of access to

health for the Syrian refugee has not always been addressed by the humanitarian community which had often to prioritize and answer to the acute needs of IDPs to the detriment of refugee health. Health facilities in highly impacted communities have since seen an initial increase in daily consultations by up to ten times.

As per Directorate General of Health in Duhok (DOH-Duhok) data, in the last year (August 2014 to August 2015) a total of 1,249,073 IDPs sought medical consultation at hospitals and health facilities within the host community. In addition, 30,132 IDPs were admitted to the hospitals, 6,554 IDPs underwent surgeries, 10,039 IDP children were delivered in the host health facilities during the aforementioned period.

With the current ongoing humanitarian situation in Duhok Governorate with almost one million IDPs and refugees living in Duhok, the load on health care services has increased by almost 60% at all level including Hospitals providing emergency and critical care services; this negatively affects the quality of provided services and increase demand for services.

Moreover limited financial resources due to the ongoing budget shortfall caused by drop in oil prices, ongoing fighting with ISIS and standoff between Baghdad and Erbil, further restrained local health authorities capacity to cope with the additional work load (62%); the daily challenges are to sustain the current emergency and critical care services, increasing the capacity to serve the host community, IDPs and refugees.

For Turkey, health services are easier to access for Syrian refugees residing in camps (almost 90% used the existing medical facilities) compared to those living out of camp (60% used facilities). Refugees in the community receive free primary and inpatient health services. Language barriers, lack of information, cost of transportation to facilities are constraints to access. An increasing number of non-registered refugees can access emergency care, after which they need to register to obtain further care. Policlinics and hospitals report an additional patient load of 30 to 40 per cent. Local hospitals have been enlarged and equipped to cover the current and most acute needs. Due to the increasing pressure on state health facilities and the language barrier, Syrian refugees turn to ad hoc informal and registered clinics.

A large proportion of children refugees, particularly those residing outside the camps (over 40%) do not have polio or measles vaccinations. The health profiles and the disease spectrum of the host population and the Syrian refugees are very similar, with a high prevalence of non-communicable diseases. The reproductive-age women constitute 25 per cent and pregnant/ delivering women four per cent of the total population. Fifteen per cent of deliveries require high-risk emergency interventions. There are life-threatening reproductive health risks in the humanitarian crisis environment: several forms of gender-based violence may have fatal consequences; maternal and new born morbidity and mortality may increase due to lack of appropriate care; unwanted pregnancies due to lack of contraception may end up with maternal and child health complications; unprevented or not treated HIV and sexually transmitted diseases may cause fatal or disabling epidemics for large populations. Syrian refugees, especially those living in local communities are increasingly exposed to vaccine-preventable diseases, such as measles and pertussis. Malnutrition is expected to become a challenge among newly arriving refugees. Major concerns result from the increasing mental health and psychological problems of Syrian refugees. Surgical trauma and intensive care of the large number of severely injured patients, from the conflict areas, and their long term post-operative rehabilitation require enormous inputs of human and financial resources and equipment. As of October 2014, about 250.000 Syrian refugees received inpatient care; more than 200.000 patients were operated; 39.000 deliveries occurred and over 6 million consultations took place.

As a direct effect of living in a war-torn environment, vast numbers of Syrian refugees are suffering from psychological distress. A recent report showed that nearly 49% of Syrian refugees show at least one sign of either frequent or permanent psychological distress, while older Syrian refugees demonstrated even higher levels of psychological distress at a rate of 69%. Moreover, the lack of opportunities to interact with host community peers and limited access to recreational opportunities has had a significant impact upon Syrian refugee children's psychosocial well-being, as well as that of their caregivers. Psychological distress manifests itself in many ways, including behavioural, cognitive, emotional, and interpersonal difficulties. These forms of distress can manifest by loss of daily routine, feelings of a loss of status, inability to provide for oneself and family, and poor quality

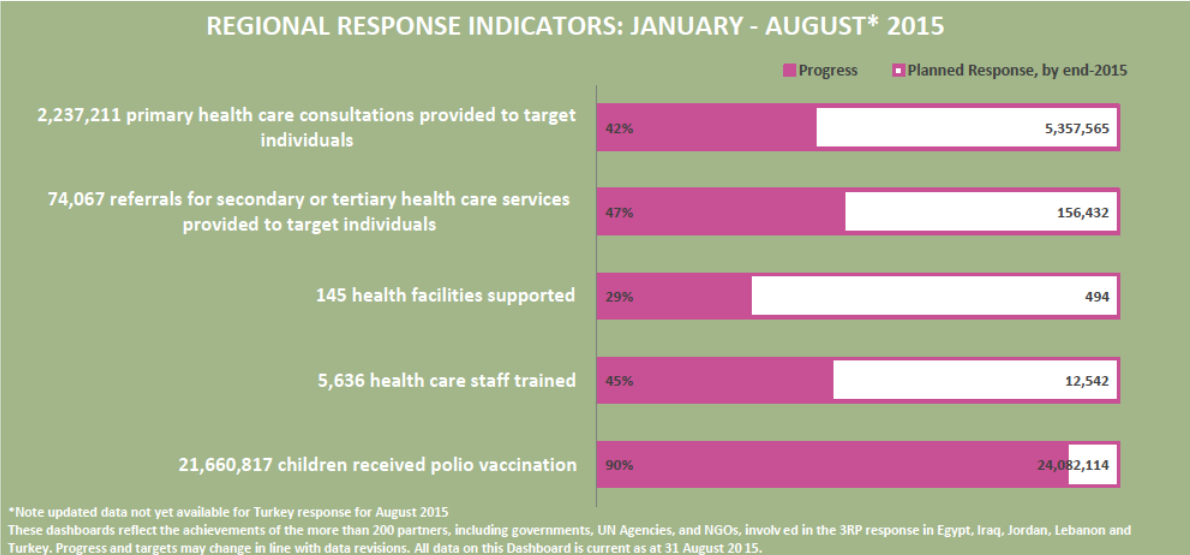
of life. In order to properly manage individuals suffering from trauma-related conditions, these multiple determinants need to be addressed in order to properly support individuals. However, due to the sensitivity of mental health issues in Syrian culture, in Turkey this issue has been largely unaddressed despite the high prevalence in the Syrian refugee population. The sensitivity of this issue is confounded by the language barrier. In order to adapt effectively to their new locations and develop a healthy and stable life in Turkish host communities, it is critical that Syrian refugees receive psychological support within a positive and encouraging environment.

Overall in the region, as of August 2015, and except for the polio vaccination campaign that reached 90% of its target, the regional response to Health needs still is only between 29% - 47% of response targets, which indicates a funding priority also for this sector of the 3RP:

3RP REGIONAL REFUGEE & RESILIENCE PLAN 2015-2016 IN RESPONSE TO THE SYRIA CRISIS

REGIONAL MONTHLY UPDATE: 3RP ACHIEVEMENTS - AUGUST* 2015

These dashboards reflect the humanitarian and resilience responses of more than 200 partners, including governments, UN Agencies, and NGOs, involved in the 3RP response in Egypt, Iraq, Jordan, Lebanon and Turkey. Achievements are cumulative from the start of 2015, while targets are based on full funding of the 3RP and an expected 4.27 million refugees by end-2015.



Source: <http://www.3rpsyriacrisis.org/wp-content/uploads/2015/11/3RP-Regional-Dashboards-August-2015.pdf>

2.3. Lessons learnt

A very important lesson learned is to distinguish the features of working with urban refugees, as opposed to camp based refugees. Different targeting strategies are required, with: a stronger focus on information campaigns and outreach work; service provision in multiple locations as well as service provision to host and refugee populations; and the development of partnerships with local organisations.

Although having a smaller absorption capacity than UN agencies, both international and national CSOs have shown proactivity and ability to implement significant projects at a local scale.

All responses to the crisis, including previous responses through the European Neighbourhood Instrument (ENI), have shown that the situation on the ground develops fast and often beyond projections made. For that reason, a large degree of flexibility will be required for any intervention addressing medium to long term needs in order to allow for an effective response to the evolving needs of the beneficiary populations.

Free access to health care services at primary, secondary and tertiary health care facilities level with limited funding and lack of financial resources require tremendous support from all donors and partners as shows the example of the Department of Health in Duhok (Iraq). After three years of the ongoing Syrian crisis and one year of mass IDPs influx into Duhok Governorate, the health infrastructure cannot accommodate more load and need expansion and development.

To make all the efforts sustainable and cost-effective they must be incorporated into existing processes of institutional strengthening so that health facilities, such as in DOH-Duhok can actively assume ownership and leadership of maternal, newborn and child health strategies.

Furthermore, prioritization on prevention and response efforts, empowering victims of severe trauma, providing comprehensive assistance to shift the stigma of shame from the victims should be ensured.

2.4. Complementary actions

Both in Jordan and Lebanon, funding from previous FPI and ENI special measures for health projects and from ECHO for humanitarian health interventions in most affected host communities has already placed the EU as an important donor in this sector.

In line with the ECHO-NEAR Joint Humanitarian Development Frameworks for Jordan and Lebanon, this action aims at building on these previous projects, and to continue and widen the initial humanitarian funding towards a more sustainable resilience-based response in the sector.

For Turkey, the proposed interventions will complement a IPA 2010 project totalling € 9.9 million implemented by UNHCR. The overall objective of the project is to improve the living conditions of out-of-the-camp Syrian refugees in Turkey, The health related issues cover the supply of ambulances, mobile health clinics, cold chain vehicles for vaccination campaigns, hygiene kits, etc..

Under the Instrument contributing to Stability and Peace (IcSP), IOM is implementing a € 6.7 million project for enhancing access to services, strengthening resilience of host communities, and facilitating integration of refugees. The aim is to set-up two Community Centres (CC) for assistance to out-of-camps Syrian refugees and host communities in Antakya and Istanbul. Services to be provided by the CCs are expected to enhance refugees' access to primary health care, psychosocial support, legal assistance, education and vocational trainings and alleviate the pressure on local authorities in terms of service delivery to refugees.

2.5. Donor co-ordination

At a broader level the EU is actively contributing to overall donor co-ordination under the auspices of the United Nations in the framework of the 3RP that integrates humanitarian, development and macro-fiscal interventions to increase coherence between humanitarian and development and national and regional priorities.

The European Commission also hosts regular meetings of the Core donor group on Syria, which unite the key institutional and bilateral donors to the Syrian crisis in the field of resilience and recovery funding.

In country, the relevant EU Delegations are leading coordination with EU Member States and are also important partners in the coordination platforms now established for the various National Response Plans to the refugee crisis.

The Madad Trust Fund Management is in the lead in order to ensure coordination with MS contributing to the fund. Moreover, the Fund Management will also coordinate with its selected implementing partners or other stakeholders on regional level or cross border issues.

On country level, all donors operate within the regulatory boundaries of the countries and in agreement with the relevant authorities. Thus, there is coordination with the national authorities,²

² However, in higher education there is very little coordination and different donors might deal directly with the Ministry responsible for higher education or with other ministries (e.g. Planning and International Cooperation or Labour).

usually through specific working groups.³ The lead in this coordination will be entrusted into the EU Delegation/EUTF field staff.

3. DETAILED DESCRIPTION

3.1. Objectives

The **Overall Objective** of the programme is to mitigate the destabilising effects of the refugee crisis in Lebanon, Jordan, Iraq and Turkey.

The Regional **Specific Objectives** are:

- Refugees from Syria and host communities in Turkey, Lebanon, Jordan, Egypt and Iraq have improved health care, including mental health.
- RCRC Societies in the region have strengthened their capacity and enhanced their ability to reach out to most vulnerable groups within the refugee and host communities
- Increased access and strengthened local capacity to deliver general primary and secondary, as well as psychosocial and reproductive health (RH) services to those affected by SGBV and/or conflict.

The country specific objectives are

Iraq

- Enhance equitable access, quality, use & coverage to essential health care to Syrian refugees and internal displaced persons in camp and community settings while ensuring sustained coverage of promotional, preventive, & curative interventions, including psychosocial support to SGBV victims of IS violence at all three levels of health care,
- Ensure – where necessary the rehabilitation of selected health facilities in the region
- Improve coverage of comprehensive health services for Syrian refugees and impacted communities through integrated community level interventions
- Support the capacity of the national health care system to provide services to Syrian refugees and members of impacted communities in the most affected governorates

Turkey:

- The provision of continued and strengthened support to national institutions to provide targeted assistance and support to the most vulnerable refugees and host communities, including psychosocial support;

Jordan:

- Ensure that the short term critical needs of refugees are met, through support for primary, secondary and tertiary health services both in and out of camps
- Reinforce the capacity of the national health system through targeted interventions to cope with the increased workload

Lebanon

³ For example the Jordan Response Platform to the Syrian Crisis is a partnership mechanism between the Government of Jordan, donors, and UN agencies to address the Syrian refugee crisis, operating through several thematic working groups (e.g. on health and education).

- Continuing to ensure access for life-saving primary, secondary and tertiary health care, mainly for the populations displaced from Syria.

3.2. Expected results and main activities

The **expected regional results** are:

- Increased access to inclusive and quality health care services for vulnerable refugees from Syria, internal displaced Persons and host communities.
- Improved psychosocial well-being and mental health of targeted beneficiaries.
- Conflict-affected women of child bearing age have increased access to essential RH services at facility and community level.
- The involved RCRC have sustainable institutional and organizational capacity and are collaborating on various levels (local, regional, national) with relevant authorities and communities
- Refugee and host community have improved access to safe and non-stigmatising trauma support services (psychosocial, legal, medical and mental health).
- Refugee and host community WGMB have increased awareness of the psychological effects of SGBV and conflict and the psychosocial and medical support services available.
- Conflict-affected women of child bearing age have increased access to essential RH services at facility and community level.

The expected country specific results are

Iraq:

- Equitable access, quality, use & coverage to essential health care to Syrian refugees in camp and community settings are ensured and the rehabilitation of selected health care facilities in the region have been rehabilitated/upgraded
- Comprehensive psychosocial support to SGBV victims of IS violence at all three levels of health care is been provided,
- The capacity of the national health care system to provide services to Syrian refugees and members of impacted communities in the most affected governorates has been strengthened

Turkey:

- The capacity of the national health care system at primary level to provide targeted health care assistance and support to the most vulnerable among refugees and the host community has been strengthened;

Jordan:

- Short term critical health care for refugees is provided, through support for primary, secondary and tertiary health services both in an out of camps
- The capacity of the national health system through targeted interventions to cope with the increased workload has been increased

Lebanon

- Access for life-saving primary, secondary and tertiary health care, mainly for the populations displaced from Syria has been ensured.

Principal **activities** will be specified during the inception phase of the programme at country level, and may include:

- First Aid training and establishment and training of community emergency response teams (Lebanon only)
- Provide mobile basic health care outreach services for most isolated refugee and host communities and establish referral systems for secondary health care
- Community health workers and social workers to strengthen community based health care and referral systems to secondary health care
- Organize health education activities through home visits, community meetings and health awareness campaigns
- Support emergency medical services
- Training of community volunteers, CHWs and social workers in community based psychosocial support
- Develop and implement agreed referral system; Train community health volunteers; Community-based workshops; Distribute Women's Dignity Kits; Counselling and follow-up through the established referral mechanism; Women's Support Groups; Safe spaces for women and girls.
- Train community health volunteers; Develop and print information, education and communication (IEC) materials; Conduct awareness raising within communities for WGMB, including at household level, in schools and other public venues.
- Provide induction and regular refresher training for medical staff from partner NGOs, supported and identified clinics and government ministries as appropriate; Develop and implement a subsidised referral system for RH; Support and supervise the delivery of general RH services including SGBV detection and referral in targeted clinics in Lebanon; Awareness raising sessions in targeted communities.

Provide SGBV and Child Protection specialist training and capacity building to local actors, CBOs and health staff at supported clinics; Design and implement a reliable monitoring and evaluation system; Data collection via Open Data Kit (ODK) and data sharing with key stakeholders; Baseline and endline focus group discussions with WGMB.

3.3. Risks and assumptions

The main risks are:

- Spill over of the Syrian conflict into the area of operations as well as political instability leading into changing policies and planning insecurity.
- Deterioration of the overall economic situation in the targeted countries in general and competition at local level with other service providers/donors (faith-based or other) in particular.
- Tensions created where different health services provision regimens are provided to different communities (refugees and residents)
- Rejection of activities by target beneficiaries.
- Mismatch between activities proposed and economic needs, mismatch between skill trainings proposed and practical skills required in a refugee/ future post-conflict environment.

- Sudden outbreaks of epidemics (i.e. cholera, watery diseases, meningitis, etc)

The assumptions for the success of the project and its implementation include:

- Willingness of host communities to engage in the project.
- Alignment of health services provision (for refugees) with host countries'
- Approval of the Programme by local and national authorities.
- Continuing hardship, need and tensions in host communities with very strong presence of Syrian refugees.
- Programme activities in the selected countries are in line with the national health strategies of the country concerned with the strategic objectives of the Regional Refugee & Resilience Plan 2015-2016 as defined for each of the participating countries
- Selected health institutions will collaborate in planning and implementing the activities
- Appropriate staff identified and appointed
- Medical equipment, consumables and construction materials are available in the local market or can be imported (no deterioration at the border crossings).

Mitigating measures have been considered, including:

- Very close coordination with local and national authorities at all stages of the planning and implementation; close coordination with local community leaders.
- Mapping of needs (also in forms of survey) to make sure there is a buy-in from target beneficiaries for the activities proposed.
- Adaptation of the activities proposed to the country-/community-specific contexts. Excellent knowledge of respective political context in the host countries.
- Develop a contingency plan for emergencies
- Pre-selection, based on previous experience in the country and in the Region, of trustworthy local contractors and companies with strong, reliable and long lasting work relations with international companies

3.4. Cross-cutting issues

The effective taking into account of cross-cutting issues into the Programme design will be verified via field visits and by analysis of reporting on the Programme. Projects funded under this programme will integrate a Rights-Based Approach in each step of the project cycle from identification, formulation, implementation, monitoring to evaluation.

Gender equality: is an integral part of the project's design, implementation, monitoring and evaluation since gender equality is acknowledged as a critical and essential component for achieving MDG targets. The shared and adopted approach is practically oriented and context-specific, addressing factors that might translate into risk factors.

Projects funded under this programme will integrate a Rights-Based Approach in each step of the project cycle from identification, formulation, implementation, monitoring to evaluation.

Key actions:

- Increasing accessibility/availability of health services for all victims; in particular women and girls (incl. SRH services);

- Gathering and spreading useful disaggregated data and information;
- Enhancing GBV policies, network of services and referral mechanism;
- Building the expertise and awareness of health staff on gender issues;
- Engaging other stakeholders in a networking and multidisciplinary strategy aiming at empowering women and raising awareness at community and institutional level.

Disability: disability has been taken into account during the project's design to enforce a mainstreaming and human rights-based approach, integral part of a comprehensive mother and child care program in terms of prevention, early detection and services delivery.

Key actions:

- Enhancing accessibility and availability of services
- Building the expertise and awareness of health staff on disability;
- Enhancing data collection and analysis
- Engaging other stakeholders in a networking and multidisciplinary strategy aiming at empowering persons with disabilities and raising awareness at community and institutional level.

3.5. Stakeholders

The main stakeholders of the project are local host and refugee communities as such, their leaders, local and national authorities of respective target countries, local and national CSOs as well as other forms of local community or business/economic associations.

All stakeholders need to be continuously consulted.

4. IMPLEMENTATION ISSUES

4.1. Financing agreement, if relevant

In order to implement this action, it is not foreseen to conclude a financing agreement with the partner country, referred to in Article 184(2)(b) of Regulation (EU, Euratom) No 966/2012.

4.2. Indicative operational implementation period

The indicative operational implementation period of this action, during which the activities described in section 3.2 will be carried out is 48 months from adoption of this Action Document by the Operational Board.

Extension of the implementation period may be agreed by the Manager. This will be immediately communicated to the Operational Board.

4.3. Implementation components and modules

a) Grant: direct award (direct management)

In order to be able to respond to immediate needs for interventions in the context of the Syrian crisis in favour of Health provisions of targeted population the direct award of grants is foreseen.

The Fund has been established under Article 187 of the Financial Regulation as 'emergency' trust fund, and is therefore covered with flexible procedures applicable to crisis situations. Moreover, the crisis situation applicable to all programmes implemented in the whole of Syria and activities related to the Syrian crisis which will have to take place outside Syria has been extended until 30/06/2016.

b) Eligibility conditions

The lead applicant needs to be a legal entity, be non-profit making and non-governmental organisation. Specialised European or International non-profit operators and CSOs will be envisaged partners.

c) Essential selection and award criteria

Essential selection criteria are the financial and operational capacity of the applicant. The essential award criteria are relevance of the proposed action to the objectives of the Action Document; design, effectiveness, feasibility, sustainability and cost-effectiveness of the action

Presence and experience in the region, immediate intervention capacity, and the ability to work in multi-actor approaches and inclusive partnerships aimed at recognising the value of different stakeholders' contributions and synergies will be part of the evaluation criteria.

d) Maximum rate of co-financing

The maximum possible rate of co-financing for the grants is 80% of the total eligible costs of the action.

If full financing is essential for the action to be carried out, the maximum possible rate of co-financing may be increased up to 100%. If full funding is essential, the applicant has to provide adequate justification and accepted by Manager, in respect of the principles of equal treatment and sound financial management.

f) Indicative trimester to conclude the grant agreements is 1st trimester of 2016.

4.3.1. *Management structure*

The management structure of the overall programme will depend on the implementation bodies that will be chosen. The Madad Fund liaison officers in the relevant EU Delegations shall ensure coordination between different partners and with the Delegation, and that activities are in line with host governments guidelines and national plans.

4.4. **Indicative budget**

Component	Amount in EUR
Grants (direct management)	59,000,000
TOTAL	59,000,000

* The costs of Evaluation and audit and Communication and visibility will be included in the projects' budgets

4.5. **Performance monitoring**

Monitoring shall be ensured primarily through EU Delegations in-country and in particular with the assistance of specific Trust Fund field & liaison officers posted within the EU Delegations. In addition, the EU Trust Fund will launch an independent M&E exercise to accompany all Fund programmes and ensure that targets are met and lessons learnt can be incorporated into other EUTF actions.

The purpose of the Madad EUTF Monitoring and Evaluation Framework is to assess, across various levels, the degree to which the Overall Objective of the Trust Fund has been achieved, ie: to assess whether the Madad EUTF provides "a coherent and reinforced aid response to the Syrian crisis on a regional scale, responding primarily and in the first instance to the needs of refugees from Syrians in

neighbouring countries, as well as of the communities hosting the refugees and their administrations, in particular as regards to resilience and early recovery".

The Madad Trust Fund M&E Framework will assess the effective delivery of programmes, contribute to improved project design, and develop a knowledge base of 'what works' to allow for continuous improvement of aid delivery. Above all and in the spirit of the Agenda for Change, the Madad Trust Fund M&E Framework aims to ensure upward and downward accountability and transparency of EU support towards the Madad Trust Fund Board and end beneficiaries, respectively.

The Trust Fund and actions financed by it are subject to the monitoring and evaluation rules applicable to EU external programmes, in order to ensure the respect of the principles of economy, efficiency and effectiveness, as per Article 13 of the Agreement Establishing the Madad Trust Fund.

4.6. Evaluation and audit

If necessary, ad hoc audits or expenditure verification assignments could be contracted by the European Commission for one or several contracts or agreements.

Audits and expenditure verification assignments will be carried out in conformity with the risk analysis in the frame of the yearly Audit Plan exercise conducted by the European Commission. The amount dedicated in the budget for external *Evaluation and Audit* purposes is EUR 300,000. Evaluation and audit assignments will be implemented through service contracts, making use of one of the Commission's dedicated framework contracts or alternatively through the competitive negotiated procedure or the single tender procedure.

4.7. Communication and visibility

While communication and visibility of the EU is a legal obligation for all external actions funded by the EU, to date the visibility of the EU's support to the Syrian crisis, in particular in neighbouring countries affected by the crisis, has been insufficient. The public perception is that the EU is not addressing the Syrian crisis, when in fact it is the largest donor. The lack of visibility to the EU's actions weakens the EU's political traction in the region and its standing in Europe.

Therefore, communication and visibility is an important part of all Madad Fund programmes factored into the implementation in order to underline its importance at all stages of the planning and implementation of the Programme.

All visibility actions by Madad Fund implementing partners outside areas of conflict should be stepped up. Each implementer will have to draw up a comprehensive visibility and communication plan for their respective target country/community and submit a copy for approval to the Madad Fund and relevant EU Delegation. The related costs will be covered by the budgets of the contract as part of the project.

The measures shall be implemented by the implementing consortium, its contractors and/or its grant beneficiaries. Appropriate contractual obligations shall be included in the grant contract(s).

The Communication and Visibility Manual for European Union External Action together with specific requirements to highlight the Madad Fund shall be used to establish the Communication and Visibility Plan of the Action and the appropriate contractual obligations.