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External Monitoring and Evaluation for the European Union Regional Trust Fund in response to the Syrian Crisis, the 'Madad Fund'

Evaluation of Madad-funded Programmes/ Projects for Health

Evaluation Report

Final report – May 2020

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ANNEXES

1. GLOSSARY OF ACRONYMS

Acronym	Full Title
3RP	Regional Refugee & Resilience Plan
AD	Action document
AFD	Agence Francaise de Developpement
AISPO	Associazione Italiana per la Solidarietà tra i Popoli
C&V	Communication and visibility
CBHFA	Community based health & first aid
CBO	community-based organisation
CRP	Country Response Plans
DG	Directorate General
DoA	Description of Action
DoH	General Directorate for Health of Duhok Governorate
DRC	Danish Red Cross
EQ	Evaluation Question
EUD	European Union Delegation
EUTF Syria	EU Regional Trust Fund in Response to the Syrian Crisis
FFM	Flat-fee model
GAC	Global Affairs Canada
GoJ	Government of Jordan
HPF	Health Development Partners' Forum
HRS	Health referral system
IC	Italian Cooperation
IDP	Internally Displaced Persons
IFRC	International Federation of Red Cross/Crescent Societies
IMC	International Medical Corps
IP	Implementing Partner
IRCS	Iraq Red Crescent Society

JORISS	Jordan Response Information System for the Syria Crisis
JRC	Jordanian Red Crescent Society
KRG	Kurdistan Regional Government
KRI	Kurdistan Region of Iraq
LRC	Lebanese Red Cross
MDA	Multi-Donor Account
MERA	Mobile Expanded Programme for Immunization Registry Application
MHPSS	Mental health and psychosocial support
MoH	Ministry of Health
MoPH	Ministry of Public Health
MoPIC	Ministry of Planning and International Cooperation
MoSA	Ministry of Social Affairs
MoSD	Ministry for Social Development
MoU	Memorandum of understanding
NCD	Non-Communicable Disease
NCE	Non-cost extension
NGO	Non-Governmental Organisation
NRC	Netherlands Red Cross
OO	Overall objective
PAGoDA	Pillar Assessed Grant or Delegation Agreement
PHC	Primary healthcare Centre
PUI	Premiere Urgence International
PwD	People with Disabilities
QIN	Quarterly information note
RCC	Red Cross & Red Crescent (Societies)
REBAHS	Reducing Economic Barriers to Accessing Health Services
RF	Results Framework
ROM	Results Oriented Monitoring
SO	Specific objective

STC	Health Steering Committee
ToR	Terms of Reference
UNHCR	United Nations High Commissioner for Refugees
UNOPS	United Nations Office for Project Services
WHO	World Health Organisation

2. EXECUTIVE SUMMARY

Background

The Syrian conflict has had a devastating impact on Syria and many of the neighbouring countries across the region. The large presence of Syrian refugees has an impact on the already fragile support systems in their host countries, including health care. Syrian refugees often have complex medical problems including physical injuries/disabilities and psychological trauma which are exacerbated by the poor conditions that refugees and host communities face. They often face poor housing and sanitary environments, difficult labour conditions, inadequate nutrition, and often unaffordable medical care. Aside from addressing immediate health needs long-term sustainable solutions are also required, as refugees are unlikely to return to Syria in the short term: this transition from humanitarian towards the strengthening and development of host healthcare systems is critical in the long-term. Finally, these health challenges are set against a backdrop of a difficult economic and political climate for all the countries covered.

In July 2019, the EU Regional Trust Fund in Response to the Syrian Crisis (hereafter EUTF Syria) commissioned an evaluation of its health portfolio. The evaluation formally started on 5th September 2019. Missions to Jordan, Lebanon and Iraq (Kurdistan Region of Iraq) were conducted by the four-man evaluation team in the period October – December 2019 as well as desk reviews of EUTF Syria health interventions in Egypt and Turkey. The evaluation reflects the situation in the portfolio as of 3rd December 2019, the cut –off date for this report.

The analysis and preparation of this evaluation report predates the COVID-19 pandemic. The possible structural and essential effects of this pandemic in the individual partner countries are therefore not included in the given analysis.

Purpose

The evaluation's purpose is to analyse the current EUTF Syria health portfolio in view of relevance, effectiveness, efficiency, coherence and EU value-added and; to provide conclusions and recommendations for future EUTF Syria support. An assessment of the communications and visibility of the portfolio and the effectiveness of measures addressing gender and special needs was also done.

Evaluation Sample

The evaluation examined a portfolio of 14 EUTF Syria -financed health interventions, which are listed below

No.	Intervention	Country
1	T04.30 Livelihood support, risk management, health and psychosocial support to refugee and host communities affected by the Syria crisis	Iraq, Jordan, Lebanon, Egypt
2	T04.31 Improving the well-being and resilience of Syrian refugees and host communities affected by conflict and sexual and gender-based violence	Jordan, Lebanon
3	T04.50 Resilience and Social Cohesion Programme	Lebanon, Jordan, Iraq
4	T04.47 Providing essential lifesaving care to refugees in Lebanon	Lebanon
5	T04.54 Reducing Economic Barriers to Accessing Health Services in Lebanon	Lebanon

6	T04.74 Strengthening the health care system resilience and provision of chronic medications at primary health care centres	Lebanon
7	T04.96 Securing access to essential medical commodities	Lebanon
8	T04.147 Improving Access to Quality Health Care for Persons with Disabilities	Lebanon
9	T04.18 Supporting Emergency/Critical Care Services and Maternal and Child Health care	Iraq
10	T04.181 Maternal and Infant health care	Iraq
11	T04.183 Strengthening quality and access to mental health services in Iraq	Iraq
12	T04.105 Expanding and Equipping Ministry of Health facilities impacted by the Syrian crisis	Jordan
13	T04.58 Improved access to health services for Syrian refugees in Turkey	Turkey
14	Third Party Monitoring of the Lebanon Health Programme	Lebanon

Summary of Key findings and Conclusions

Relevance

All EUTF Syria health projects and programmes in the sample are strategically aligned with the EUTF Syria's guiding principles and approaches and all the objectives are coherent with the current EUTF Syria Results Framework. Also, EUTF Syria health interventions are broadly in line with Syria Country Response Plans and, in general terms their designs reflect specific country needs. The original designs of the three EUTF Syria regional/ multi-country interventions containing health components initially met health needs in each country in rather general terms. These have however been successfully adjusted to meet actual needs on the ground. Nationally programmed EUTF Syria health interventions more closely reflect specific country needs; as a consequence, they benefit from stronger local ownership. Some regional interventions enjoy less ownership among national institutional counterparts.

EUTF Syria health Interventions cover different areas of need, originally without providing a clear focus in any specific area. This has not reduced their relevance as all these needs are valid, although it potentially reduces the scale of impact, they are likely to have. The constantly changing situation on the ground and the move towards a development paradigm challenged the EUTF Syria to meet this 'nexus' in its current and future actions. However, the latest Lebanon health action document has been designed to reflect on this issue to some extent. This also confirms the fact that national ownership of the refugee response has increased over time.

Effectiveness and Impact Prospects

EUTF Syria effectiveness in terms of delivery of outputs is good. EUTF Syria health interventions have made good progress in delivering planned outputs across all countries. Despite some weaknesses in definition and reporting, outcomes are largely on track and are already evident in terms of better care for Syrian refugees, vulnerable host populations and IDPs. Overall, the EUTF Syria health interventions will change the lives of their target groups for the better. Positive factors for effectiveness include sufficient time and resources for delivery of outputs, good implementing partner performance and good ownership of results among national partners for outcomes. Factors negatively influencing effectiveness were found to be mainly

external to the interventions such as unstable programme environments and some design shortcomings. However, the heterogeneity of the given portfolio makes it difficult to identify deeper effects and to report them clearly.

Assessing the real impact of the EUTF Syria Health portfolio will only be possible over a longer period of time after the current interventions are over. A case can be made for the support having a positive impact via its contribution to EUTF Syria results framework strategic health outcomes, but quantifying impact is far less easy. Much depends on how the contexts in each target country (as well as in Syria) play out over the next 5 years or so. Tracking actual effectiveness and impact once the EUTF Syria interventions are over is likely to prove difficult due to the lack of a post-project outcome monitoring mechanism to do this.

Efficiency

Overall efficiency is mixed. Regional/ multi-country interventions have been hampered by their implementation arrangements that have led to delays which were countered with project extensions. These extensions have ensured that planned outputs can be delivered and the implementing partners have done a good job overall in adjusting to the challenges posed by their own project set-ups and putting in place results.

At the beginning of the EUTF in 2015, the strategic decision was made to give priority to large regional programmes/ projects for the time being, in order to quickly launch massive support packages and give a strong political message of support to the affected countries and people, so that the EU could demonstratively provide large contributions to the Syrian crisis. However, this decision has subsequently often made efficient and rapid implementation on the ground difficult. Feedback from a wide range of stakeholders confirmed that the regional/ multi-country modality had no obvious practical advantages for delivering EUTF Syria health interventions. Nationally programmed interventions appear to be more efficient overall, as they are not characterised by rather costly contractual/ implementation arrangements that potentially weigh down regionals.

All the interventions are within budgets and follow the relevant procurement procedures. The extent to which budgets are clearly laid out in the programme documentation varies from project to project. Financial reporting often lacks a clear linkage between expenditures and delivery of project results. This weakens project transparency and represents an unnecessary barrier for assessing financial (and overall) performance. In the case of PAGoDA agreements with IPs, these are granted a larger scope of freedom in their reporting work. A situation beyond the control of the EUTF.

Coherence

Coordination mechanisms for health interventions exist in all the target countries. However, the effectiveness of these forums varies across countries. Some examples of synergies were noted in Jordan and Lebanon, although for the most part these seem to have occurred without prior planning. The latest Action Document for Lebanon suggests some progress in this respect. The lack of a longer-term planning and implementation perspective is seen as a limitation for

effective coordination & planning on the ground. There seems a case for the creation of a more strategic approach during the remaining lifetime of the EUTF Syria to better address issues of thematic focus, improve coordination, complementarity and communication as well as any possible future orientation of the support given to the sector.

Sustainability

In general sustainability of EUTF Syria health results are fragile, especially those linked to capacity development and service provision. Infrastructure investments represent the best examples of sustainability. Sustainability plans for intervention results are conspicuous by their absence. This can be partly attributed to the originally based and planned emergency response approach. Therefore, there is often no clear vision at project or portfolio level of the sustainability of the project results or the healthcare models that it has fostered. The absence of a coherent political will to take these results forward in the partner countries is another inhibiting factor.

EU Added Value

The effectiveness of EUTF Syria health interventions means they provide benefits to Syrian refugees and vulnerable host populations which confirms an appropriate use of resources compared to the initial aims of the EUTF. These benefits would not have been available to them without EUTF Syria support. Therefore, it is obvious that EUTF Syria support has clear added value. EUTF Syria added value would probably be most evident if it could address the core challenge in the health sector – affordability of care. Thus far, it has done so only in a handful of cases and this will remain a challenge for the future.

Communication and Visibility

The communication and visibility plans of the health interventions are being implemented as required. However, Target groups/final beneficiaries had mixed levels of awareness of EUTF Syria health support and this suggests that these measures have not been fully effective. Also, some uncertainty was noted among IPs and national stakeholders on how best to communicate EUTF Syria health actions in light of local sensitivities held towards providing support to Syrian refugees.

Gender issues

Programming documentation for all interventions make references to gender in their designs, but specific measures within programmes/ projects are relatively few. Nevertheless, evidence suggests that all implementing partners are sensitive to gender issues and look to integrate them into projects wherever possible. Gender-disaggregated data presented in QINs is widespread but without baselines and targets in the logframes, they are of little value in assessing performance. Thus, the actual effectiveness of interventions in terms of gender is impossible to gauge.

Measures for People with Disabilities in the EUTF Syria Health Portfolio

The evaluation found few measures for people with disabilities or special needs in the EUTF Syria Health portfolio with the exception of Lebanon. This represents a basic programming weakness. The new ADs for Jordan and Lebanon show divergent approaches to programming support for people with disabilities – some of the latest interventions place them as one of its key target groups. A more coherent EUTF Syria approach would still be welcome to addressing their needs.

Key Recommendations (full details are given in the main report)

- The EUTF Syria should deploy the regional/ multi-country implementation modality for delivery of assistance to the health sector only where there is a clearly beneficial case for its deployment. The recently approved health ADs point in the right direction in this respect.
- EUTF Syria Health support should be underpinned by a more strategic approach that outlines the aims of EUTF Syria in the sector. It should outline how the EUTF Syria will address the humanitarian development nexus in the health sector, stipulate the types of modalities to be used and also outline the basis of the EUTF Syria's possible planned phasing out.
- The EUTF Syria to put in place measures to ensure monitoring of EUTF Syria health outcomes and impacts takes place after implementation is over.
- Where contracting arrangements permit, the EUTF Syria should encourage implementing partners to provide clear financial reporting linked to delivery of deliverables/outputs.
- The EUTF Syria should request all implementing partners, as part of the preparation of the latest tranche of health programmes/ projects, to conduct a comprehensive mapping of potential synergies between their interventions and other health projects and integrate these into the project designs.
- The implementing partners of all EUTF Syria health interventions, both ongoing and those under preparation, should develop sustainability plans that realistically lay out measures for ensuring EUTF Syria results survive after the current tranche of EUTF Syria financing is over.
- Where country priorities allow, programmers should ensure that disability concerns are further integrated into the EUTF Syria health programming documents currently under preparation.
- Indicators for ongoing EUTF Syria health interventions with gender dimensions to them should be given baseline and target values and should be requested for future interventions. This implies that data are available in sufficient quantity and quality in the immediate area of intervention.

3. MAIN REPORT

3.1 INTRODUCTION

Background

The Syrian conflict has since its emergence in March 2011 had a devastating and lasting impact on Syria, the neighbouring countries and across the region. This situation has led to the EU to mobilise significant additional efforts and financial means to elevate the plight of Syrian refugees. One of the vehicles to achieve this is the EU Regional Trust Fund in Response to the Syrian Crisis (hereafter referred to in this report as 'EUTF Syria). The EUTF Syria was set up in 2014 with an initial duration of 5 years. This has been extended by the EU to 2020. One of the sectors covered by EUTF Syria funding is that of health – this is in recognition of the multiple health challenges posed by the crisis (see section 3.2 for more on this). Its first tranche of funding in the health sector was in 2015, with the approval of the Action Document financing three multi-country interventions. Thereafter a number of further interventions were approved specifically to address health challenges in selected countries (Lebanon, Iraq, Turkey and Jordan). EUTF Syria has financed a range of projects that target many of the health challenges facing Syrian refugees, their host communities and also other affected groups, such as internally displaced people in Iraq. This evaluation explores the extent to which this EUTF Syria support has been successful in its objectives and the factors behind it.

The evaluation[1]

In July 2019, the EUTF Syria Team commissioned an evaluation of its health portfolio. The evaluation formally started on 5th September 2019 with the kick-off meeting held in Brussels attended by the members of the evaluation team and Particip's EUTF Syria external Monitoring & Evaluation contract, EUTF Syria Team at headquarters, and representatives of EU Delegations (EUD).

The evaluation team presented the inception report (including a revised evaluation sample, evaluation questions, methodology for the delivery of the evaluation and a timeline for its implementation) to DG NEAR B1/ Middle East for approval, which was granted on 6th November 2019. Parallel to the approval process, the evaluation team prepared the field phase, with missions to Jordan, Lebanon and Iraq (Kurdistan Region of Iraq) taking place in the period October – December 2019. The Drafting of the evaluation matrix and answers to the evaluation questions for each country visited was carried out in December 2019 – to January 2020, with the draft final report submitted to the EUTF Syria on 31st January 2020. The evaluation has followed the methodology laid out in the inception report and approved by the EU on 6th November 2019. It is attached in annex A6.

1 This evaluation was conducted by Steven O'Connor (Team Leader) and key experts Dr Andrew Mathieson and Dr Mohammed Albittar. They were supported by junior evaluation experts Malik Al-Khawaja and Dr Chiara Amato.

3.1.1 Overall objective of the evaluation

The Terms of Reference (ToRs) state the overall objective as being "*To assess the performance of the current generation of EUTF Syria Health support (primary and secondary health care, community-based health and first aid, psycho-social support, etc.), considering both regional and bilateral actions. The evaluation is aimed at improving the effectiveness and impact of the EUTF Syria, strengthening stakeholders' involvement, ensuring a successful communication and reinforcing the EUTF Syria capacity to bring a change in the cooperation area in full respect of its natural environment*."

3.1.2 Purposes of the evaluation

The ToRs state three purposes of the evaluation:

1. Analyse the current EUTF Syria Health portfolio in view of relevance, effectiveness, efficiency and coherence;
2. Identify the added value, or comparative advantage, of EUTF Syria funding. 'Added value' is defined as the degree to which EUTF Syria funding makes a difference, positively or negatively, beyond the volume of aid.
3. Provide conclusions and recommendations for future EUTF Syria support.

3.1.3 Type of Evaluation

As noted in the ToRs and inception report, this is an evaluation of the EUTF Syria Health Sector Portfolio and as such it primarily analyses relevance, performance and sustainability issues at the level of sector, rather than just individual EUTF Syria interventions.[2] The evaluation sample has been used as the vehicle to explore sector-level trends and issues that can be identified within selected programmes/ projects and then synthesised up to portfolio level. Where the evaluator has found a project-specific issue worthy of further investigation (for the purposes of highlighting a particular challenge or example of best practice) then the project will be analysed in more depth and presented in the evaluation report. Project level assessments of performance are covered by either project evaluations that are commissioned by the EUTF Syria IP responsible for the intervention in question or by external Results Oriented Monitoring (ROM) missions. This is not the purpose of this evaluation.

Also, it is important to emphasise that the evaluation findings reach across the whole geographical scope of the portfolio – the evaluation is not a country-specific evaluation. Whilst the evaluators have developed country-level evaluation matrices to answer the Evaluation Questions (EQs), these have been synthesised to give an overall analysis of portfolio level

2 The term 'intervention' is used in this evaluation to cover the concept of project or individual action that is financed through a distinct financing agreement such as a Description of Action (DoA). On occasion the term 'project' will be used inter-changeably.

performance. As with project-specific issues, the evaluators have made references to country specifics primarily to highlight or illustrate issues of wider relevance to the portfolio.

3.1.4 Scope of the evaluation

The scope of the evaluation is outlined in the ToRs. In terms of its geographical scope, it focuses on three countries i.e. Lebanon, Jordan & Iraq. Two projects under implementation in Egypt and Turkey were also taken into account. In terms of the individual EUTF Syria health interventions included in the evaluation, the ToRs listed 9 projects to be covered. This list was expanded at the request of the EUTF Syria in the inception phase, to cover all interventions that include a health component. The evaluation finally took in 14 EUTF Syria projects (as confirmed in the inception report) which are laid out in Annex A1. As noted in the inception report, two of the projects in the sample have been the subject of a desk review (T04.30 – Egypt component; T04.58 Turkey) and one (Third Party Monitoring of the Lebanon Health Programme) has been included as a source of additional evidence and means of triangulation of preliminary findings).

In the course of the evaluation it became evident that in both Lebanon and Jordan, a further tranche of EUTF Syria funding had been earmarked for financing health interventions. Feedback from the missions established that in Jordan two new interventions were planned and in Lebanon a new action document encompassing three new interventions had been prepared for the consideration of the EUTF Syria Board at their meeting in December. The evaluators established that these interventions were in various stages of maturity but that none had yet to start. Although these interventions were not included in the evaluation sample (as no project documentation had been formally approved and thus only drafts could be provided), the evaluators nevertheless took these interventions into account in the field phase to understand how the EUTF Syria programme is evolving in terms of its responsiveness and relevance to strategic priorities and needs on the ground, as well as how mechanisms for coordination, complementarity and synergy function in practice.

3.1.5 Target Groups of the Evaluation

The inception report confirmed that the primary target groups of the evaluation are EUTF Syria decision makers and operational staff, the EUDs; the management staff of Implementing Partners (IP) of the selected interventions and; the national partners of the EUTF Syria in the health sector as well as health stakeholders in general. The final beneficiaries of any changes in the EUTF Syria health portfolio as a result of this evaluation are the aforementioned refugees, internally displaced persons (IDP) and host communities mentioned in the ToRs.

3.1.6 Cut-off date

The evaluation reflects the state of play as of ***3rd December 2019*** i.e. the last day of the field missions. This is the evaluation cut-off date. The evaluators are not able to take into account any further developments in the sector after this date. The EUTF Syria Health action document for Lebanon that was approved by the EUTF Syria Board on 4th December 2019 was reviewed by the evaluators after the cut-off date only to verify findings that were elicited in the field phase.

It should be stressed that the analysis and preparation of this evaluation report predates the COVID-19 pandemic. The possible structural and essential effects of this pandemic in the individual partner countries are therefore not included in the given analysis.

3.1.7 Limitations of the evaluation

As is the case in all evaluations, the evaluators had to content with a series of challenges that to varying degrees hindered their ability to conduct the evaluation fully in line with initial expectations (and laid out in the evaluation risks and assumptions). These are outlined in Annex A2.

3.2 REGIONAL CONTEXT AND COUNTRY HEALTH PROFILES

3.2.1 Regional Background

As noted in the ToRs, the Syrian conflict has had a devastating impact on Syria and many of the neighbouring countries across the region. The large presence of Syrian refugees has had an impact the already fragile support systems in their host countries, including health care. Syrian refugees often have complex medical problems including physical injuries/disabilities and psychological trauma which are exacerbated by the poor conditions that refugees and host communities face. This in turn leads to a significant increase in mental health needs. In host countries they often face poor housing and sanitary environments, difficult labour conditions, inadequate nutrition, and often unaffordable medical care. Aside from trauma-related mental, disability issues and psychiatric disorders, the most prevalent ailments are skin, digestive system, and respiratory diseases. In addition, coming from a lower-middle-income country with a stable middle class, many Syrians have chronic health conditions including hypertension, diabetes, and cancer. Negative coping mechanisms such as child labour, child marriages, etc. add to the burdens facing refugees and these heighten the risk of intergenerational transmission of vulnerabilities.

Experience shows that a return of refugees is often a long process even after a crisis ends; long-term sustainable solutions are needed where also the EUTF Syria plays a role – this move towards the strengthening and development of host healthcare systems is critical to addressing these health challenges long-term.

Finally, these health challenges are set against a backdrop of a difficult economic and political climate for all three of the main countries covered by this evaluation, with national health budgets under significant strain and healthcare systems increasingly unable to meet the complex needs of refugees and vulnerable host populations alike. Political and economic crises in both Lebanon and Iraq, ongoing at the time when this evaluation was conducted, further complicate the situation and increase the vulnerability of Syrian refugees, host populations and, in the case of Iraq, internally displaced persons (IDPs).

3.2.2 Specific Country Contexts

This evaluation focuses on three of the territories affected by the crisis i.e. Lebanon, Jordan and the Kurdistan Region of Iraq (KRI). The following section provides an overview of the main issues facing each of these countries in regard to health for both Syrian refugees and other vulnerable sections of the population. A more detailed analysis, including key health indicators, is provided in Annex A7.

Lebanon has higher number of refugees per capita than any other country in the world. The large number of Syrian refugees that have arrived in the country since 2012 has created additional pressure on Lebanon's already fragile infrastructure, institutions and economy. Lebanon continues to face a range of interrelated political, economic, and social challenges, including ensuring basic service provision and stimulating economic opportunity. Public services have been stretched, including health and education services, while poverty and unemployment have risen among already vulnerable segments of the society. While the levels of social tension between refugees and host communities have remained relatively stable on a macro level, the combined effects of these socio-economic conditions can lead to increased fatigue among host communities. The unfolding economic and political crisis that burst onto the streets of Lebanon in the second half of 2019 has added further uncertainty and instability to the situation in the country.

Key Figures (*sources in italics*)

- **Lebanon's population:** 6.9 Million (*Source: World population review.com*)
- 1.5 million **Syrian refugees** (*UNHCR, 2019*)
- **Total Fertility rate (TFR) Lebanese**: 2.097 (*World Bank*, 2017)
- **Total Fertility rate (TFR) Syrians (2017)**: 5.2 (*WHO* 2017)
- **Neonatal mortality rate (2018):** 4.3 per 1000 live births (*World Data Atlas, 2018*)
- **Maternal mortality ratio (2017)**: 29 per 100,000 live births (*WHO, 2017*)
- **Under-5 child mortality (2018)**: 7.4per 1,000 live births (*UNICEF, 2018*)
- 47% prevalence of **cardiovascular diseases** (*WHO 2017*)
- 16% - **Cancer** mortality rate (*WHO 2017*)
- **Life expectancy at birth (2016)**: 78.8 (*World Bank, 2018*)
- **Total TB incidence rate (2018)**: 11 per 100,000 (*WHO, 2018*)
- 76% of *Syrian refugees live below poverty line* (USD 3.84 per day) (*UNHCR, 2018*)
- 1.5 million **vulnerable Lebanese in need** (*UNHCR, 2019*)

Health services are characterised by a dominant private sector. The primary health care system is mainly operated by the NGO sector and based on user fees. Due to an absence of universal health coverage in Lebanon, all inhabitants have 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.

Given the current dynamics it is anticipated that the registered Syrian refugee population in Lebanon will remain high, in line with current figures. This will mean that the primary burden for the situation will continue to fall primarily on Lebanese institutions and host communities. This evaluation will consider eight health-related EUTF Syria programmes/ projects (3 regional/

multi-country + 5 Lebanon specific) that have been implemented in Lebanon, as well as a framework contract for 3rd party monitoring of the sector.

Jordan has by regional standards a modern health care system that includes the public sector, private sector and non-profit organisations. The Syria crisis has placed significant pressure on the national health system and hampered its ability to respond to the needs of both Syrians and Jordanians. Problems noted include deficiencies in the supply and availability of medication, medical equipment shortages, over-utilisation of health facilities and an overloaded health workforce. All of these factors negatively impact the quality of service provided. Jordan has made significant efforts to provide for the needs of the large number of refugees, while at the same time maintaining service standards for Jordanians. Nevertheless, the health burden has become an economic, political and social crisis for the Jordanian government and its people.

Key Figures (*Sources in italics*)

- **Jordan's population**: 9.5 million, including 2.9 million non- Jordanians (*Population and Family health survey, Dept of Statistics/USAID/UNICEF/UNFPA, 2017)*
- **Total Fertility rate (TFR)**: 2.7 Live Births per Jordanian Women (*Department of Statistics, 2019*); 4.7 for Syrian women in Jordan (*Population and Family health survey (PFHS) 12017)*
- **Modern contraceptive prevalence** rate: 42% (a rate of 75% is needed for replacement fertility) (*PFHS*, 2017)
- Average household size: 5.1 (*PFHS, 2017*)
- **Maternal mortality**: GOJ reports 19 per 100,000 live births; however, UN and World Bank figures differ (*PFHS, 2017*)
- **Infant and under-5 child mortality**: 17 and 21 per 1,000 live births (*PFHS, 2017*)
- **More than half** of all Jordanians rely on public-sector healthcare services (*PFHS, 2017*)
- **Non-communicable diseases** are the leading cause of death in Jordan (*PFHS, 2017*)
- **Anemia**: 32% (children under 5); 34% of women age 15-49 are anemic (*PFHS, 2017*)
- 86% are living **below the Jordanian poverty line** with heavy demands on health and other social services *(PFHS, 2017*)
- **1.4 million Syrian refugees** (*The National Strategy for the Health Sector in Jordan, 2016 – 2020*)

Syrian Refugees face financial barriers to accessing health care. Although refugees in the camps have free access to health care services subsidised by international agencies and access to vaccination provided by the government, those living outside camps are treated like non-insured Jordanians. Both groups reportedly experience financial problems: The cost of transportation is one of the highest expenses for refugees seeking health services from health centres outside the refugee camps due to their isolated locations. A survey conducted in 2016 cited affordability as the main reason Syrians would not access healthcare. Furthermore, in February 2018, the Jordanian government lowered the level of access for Syrians to 80 per cent of foreigner rate when they use all types of health services provided by the Ministry of Health (MoH).[3] This significantly increased the cost of public health services for all Syrian refugees, with fees increasing two- to five-fold for many services. However, in early 2019 this policy was reversed, allowing Syrians again to access health care as before. Accessing medicines (and their affordability) and other structural barriers such as a lack of specialist doctors at some health centres further exacerbate the problems encountered by Syrian refugees and host communities alike in this sector. This evaluation will consider four EUTF Syria health

3 Vulnerability Assessment Framework Population Study 2019 - Jordan, p.61.

interventions that have been implemented in Jordan (1 national and three regional/ multi-country).

In addition to these four under implementation, two projects are under preparation – a 30M€ intervention with the WHO focussing on vaccinations and a 22M€ with the Spanish Agency for International Development Cooperation (AECID) on non-communicable diseases (NCDs)). Neither project had signed contracts with the EUTF Syria at the time of the evaluation (the latter intervention was still in its design phase). For this reason, they were not proposed for inclusion into the evaluation sample by the EUTF Syria and this was confirmed in the inception phase. Nevertheless, the evaluators took both these interventions into account in the field phase to understand how the EUTF Syria programme is evolving in terms of its responsiveness and relevance to strategic priorities and needs on the ground, as well as how mechanisms for coordination, complementarity and synergy function in practice.

The Kurdistan Region of **Iraq's** (KRI) current health care system is primarily based on the public budget. All Iraqis are covered under the system, and a wide range of primary, hospital, and other medical care is offered in the public facilities, where most health care is provided. Some services are provided by private hospitals and physicians in private practice. Since the start of the crisis, the same health services have been provided for the Syrians in the KRI, as for the citizens. Despite the financial constraints in Iraq and particularly in the KRI, access to health care services has been ensured due to combined efforts of the Kurdistan Regional Government (KRG) and partners. Syrian refugees in Iraq have been given free access to primary health care services whether through camp-based primary health care centres for refugees living in camps or public health facilities specified for those living with the host communities. And this includes all levels of health services. The main challenge now is the huge number of Iraqi internally displaced persons (3.3 million), in addition to the Syrian refugees.

Key Figures (*sources in italics*)

- **KRI population**: 5,122,747 (*Source: International Organization for Migration (IOM), 2018*)
- **Iraqi IDPs (2016)**: 1,334,211 (Not including IDPs in disputed territories) (*Joint Crisis Coordination Centre - KRG, n.d.*)
- **Syrian Refugees (2020)**: 247,568 (*Data2.unhcr.org, 2020*)
- **Poverty rate (2014)**: 8.1% (*World Bank Group, 2015*)
- **Physicians (2014)**: 13 per 10,000 (*Shukor, Klazinga and Kringos, 2017*)
- **Neonatal mortality rate:** 9 per 1000 live births (*Moore et al., 2014*)
- **Infant mortality rate**: 28 per 100,000 live births (*Moore et al., 2014*)
- **Under-5 child mortality**: 40.83 per 1,000 live births (*Moore et al., 2014*)
- **Immunization coverage, children 12-23 months (Measles and DPT3 respectively):** 90% and 81% (*Moore et al., 2014*)
- **Cholera outbreaks**: 2007, 2012 and 2015 (contained) (*Islamic-relief.org, n.d.*)
- **Total TB incidence rate (2014)**: 43 per 100,000 (*Balaky, Mawlood and Shabila, 2019*)
- **Cancer:** 61.7/100,000 Sulaimani Governorate (*Khoshnaw, Mohammed and Abdullah, 2016*)

The large presence of refugees has had an impact on the local economy and host communities, and on public services. Prices and unemployment have increased while wages have tumbled and economic growth in the KRI has slowed. Also, the large number of IDPs represents a significant extra community inside and outside of camps in KRI in need of access to health services. Finally, in the aftermath of the Daesh occupation and destruction, Iraqis (including

non-refugees and non-IDPs) come to KRI from the liberated areas of northern Iraq to seek healthcare as infrastructure has not yet been rehabilitated in their areas.

All of these factors lead to suffering of the overstretched health system, from shortages in human resources, interruption in supply chains, and limited funds to maintain and expand health facilities. There are several EUTF Syria programmes/ projects with a health dimension working in Iraq whose overall objectives are to help the Syrian refugees, the local communities and government to meet the emergency needs and recovery and resilience building.

3.3 RESPONSE TO EVALUATION QUESTIONS

3.3.1 Relevance[4]

Alignment of Health Portfolio objectives with EUTF Syria Priorities

The EUTF Syria was established under Article 187 of the Financial Regulation (EU, Euratom No 966/2012) as an emergency and potentially also a post-emergency tool in response to the Syrian Crisis. Its underlying guiding principles are laid out in "Constitutive Agreement" and the "Strategic Orientation Document" of December 2014. These state "*The overall objective of the Trust Fund is to provide a coherent and reinforced aid response to the Syrian crisis on a regional scale, responding primarily in the first instance to the needs of refugees from Syria in neighbouring countries, as well as of the communities hosting the refugees and their administrations, in particular as regards resilience and early recovery. The Trust Fund will thus focus on current priority needs and may also be adapted to reconstruction needs in a future post-conflict scenario*." Together with the EUTF Syria Overarching Strategic Framework this represents the Instrument-level strategic statement for the EUTF Syria. The interventions in this evaluation sample provide assistance that falls within the broad definition of support to both Syrian refugees and host populations of the abovementioned document.

The EUTF Syria Overarching Strategic Framework refers to "*better health for Syrian refugees, IDPs and host communities*". The EUTF Syria Results Framework (RF) provides a more specific set of strategic objectives for the Fund, laid out sector-by-sector. For the Health sector, the overall result statement is "EUTF Syria target groups[5] have better health". This is supported by three strategic outcomes, which are:

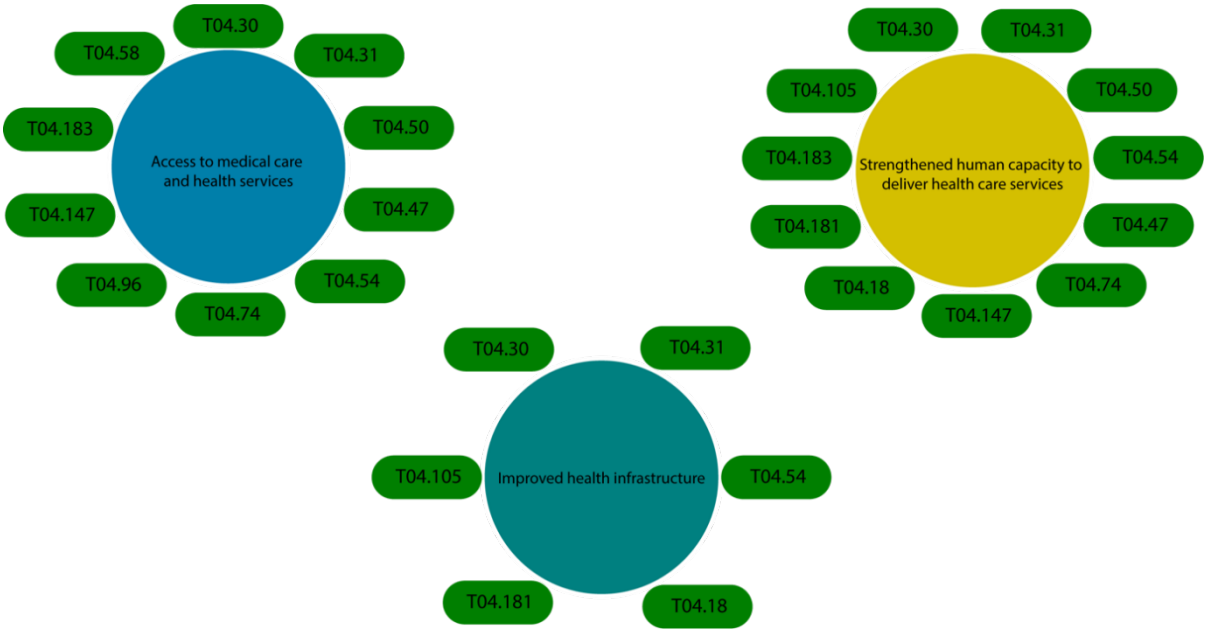
- Improved access to medical care and health services;
- Strengthened human capacity to deliver primary and secondary health care services;
- Improved health infrastructure.

For the purposes of this evaluation, these are considered to be the most relevant 'high-level' objectives against which all the EUTF Syria interventions in the evaluation should align and to which their results ultimately contribute. The evaluators reviewed the design documentation of all the interventions in the sample to assess the coherence of their expected results with these three EUTF Syria strategic outcomes. Diagram 1 below shows that every one of the interventions contains planned results link directly to at least one of these EUTF Syria outcomes. Indeed, three of the interventions (two regional/ multi-country and one national – T04.54) link to all three of these outcomes, whilst only two link to just a single outcome. This is perhaps not unsurprising given that the EUTF Syria RF emerged in December 2016, after many of these interventions were actually already programmed (in particular the regional

4 This evaluation criterion encompasses the following evaluation questions: EQ 1: Is programming of Health programmes/projects strategically aligned with the EUTF Syria's underlying guiding principles and approaches? EQ 2: How effectively are specific country needs, contexts, and barriers to health care services (HCS) taken into account in the programming of country-based EUTF Syria-funded Health programmes/ projects? EQ 3: How has the Health portfolio developed since the beginning of the EUTF Syria with regard to relevance, targeting and responsiveness? Has experience from previous actions been used successfully to improve the quality of later programmes/ projects?
5 These are stated as being Syrian Refugees, IDPs and Host communities.

interventions from 2015). **Nevertheless, it confirms that the basic pre-requisite of any programme that the individual interventions' results are coherent with those of its own.**

Diagram 1 – Alignment of EUTF Syria health interventions with EUTF Syria RF strategic outcomes (green cells indicate an alignment)



Alignment with Country Priorities

The overarching framework for assistance to all the countries affected by the Syrian crisis is the Regional Refugee & Resilience Plan (3RP) and the country response plans that link to it. **All the interventions, irrespective of whether they are programmed under regional/ multi-country or national action documents (see below) are in line with the health sector objectives of the 3RP.**

Beyond the 3RP, the Country Response Plans (CRP) for all the countries - (covering 2016-18, 2017-19, and 2018-20) - lay out country-specific needs related to the Syria Crisis. The Health Sector Response Strategy in each CRP outlines sector specific needs, which reflect national priorities for donor support in the area of health. A mapping of the EUTF Syria health interventions found that they all addressed health needs laid out in the respective CRPs. Thus, there is a high level of coherence between EUTF Syria objectives and 3RP health needs.

The EUTF Syria interventions also link to a range of national and sub-national plans and strategies in each of the countries covered by this evaluation. The strength of the linkages varies from country to country, but the evaluators found a relatively strong level of coherence in the key areas of EUTF Syria activity. For example, in KRI, the assistance is in line with the general objectives of "*The Future of Health Care in the Kurdistan Region—Iraq*", and the "*2020 Development Vision of the Kurdistan Region–Iraq*", which as regards health is focused on

delivering quality and accessible health and social services that meet the needs of the population, *inter alia* through the necessary physical infrastructure. In Jordan and Lebanon, support to mental health and psychosocial support (MHPSS) issues complements these governments' National Mental Health and Substance Use Strategies for 2018-2021 and 2015-20 respectively. Not all countries were found to have national strategies to which EUTF Syria interventions linked, but this is not considered a weakness given the context in which the projects were programmed and the sometimes-weak state of governance in the countries concerned.

Design of Multi-Country (Regional) Interventions

The three 'regional' (or perhaps more accurately 'multi-country')[6] interventions are included in the Health action document (AD), approved in December 2015. The specific objectives of the AD are:

- Red Cross & Red Crescent (RCC) 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
- 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.
- Increased access and strengthened local capacity to deliver general primary and secondary health, and reproductive health and psychosocial services especially to those affected by Sexual Gender Based Violence and/or conflict.

Each of these three specific objectives was translated into a separate project implemented by a consortium of national or international entities i.e. Red Cross/Crescent Societies – T04.30; International Development Agencies of EU Member States (Agence Francaise de Developpement/ Italian Cooperation) – T04.50 and; international NGOs (MEDAIR/ Tearfund UK) – T04.31). The expected results in these interventions' Descriptions of Action (DoA) reflect both their genesis and nature i.e. they express in fairly general terms what the interventions aim to achieve country by country. Their programming represented the earliest response of the EUTF Syria to the crisis and as such they contain some elements that have subsequently proven to be problematic. This is to some extent inevitable given the circumstances: i.e. consortia of selected implementing partners (IPs) were attempting to design multi-component interventions in a rapidly emerging programme environment across several countries, each with radically different contexts. Also, the original project ideas emerged in 2014, some 3 years before they reached implementation. In the meantime, the situation on the ground had inevitably changed, so that the original designs had to be revised to varying degrees.

6 The terms "Regional" and "Multi-Country" are used interchangeably in this report. The term 'Regional' is used more frequently to reflect the fact that the AD from which several interventions stem is called "Regional Health programme for displaced populations and host communities in neighbouring countries affected by the Syrian crisis".

Each of these interventions has therefore experienced some measure of re-design, which in each case was caused by circumstances on the ground differing significantly from those outlined in the programming documents.

For example, T04.30 has experienced changes in the lead IP in Jordan and a re-orientation away from community level MHPSS (envisaged initially by the international lead IPs) to a volunteer-led community based first aid model implemented directly by the Jordanian Red Crescent Society (JRC). In Lebanon, the design experienced several reiterations till it settled on its explicit focus of capacity development, emergency services and blood supply.[7] T04.50 has a joint livelihoods/health focus, with service provision and capacity development in the charge of AFD[8] infrastructure support under the aegis of the Italian Cooperation IP – the latter no longer having a health focus despite it being expected in the DoA. T04.31, implemented by MEDAIR in Jordan encountered significant resistance from Jordanian government institutions due to its failure to take into account local sensitivities and had to be cancelled in the country, with funds being relocated to Lebanon for activities there (see Box 1).

Box 1: Regional Interventions – Jordan

Regional interventions were found to be only loosely aligned with Jordanian priorities. Feedback from Jordanian stakeholders confirmed that they had not been engaged in the design of regional programmes/ projects prior to their approval. As a result, all had been subject to re-design after approval but before implementation started. This has had a negative consequence for both efficiency (as it delayed start-up whilst the projects were negotiated with the Government and registered on the JORISS system) and also ownership of results (as the Jordanian partners were not involved in the original creation of the interventions). Discussions with key National Institutions such as the Ministries of Planning & International Cooperation and Health confirmed that regional projects generally lacked a clear institutional partner on the Jordanian side.

The IPs charged with delivering these interventions in Jordan also noted that meeting national needs via a regional project was problematic both in terms of the need to redesign their activities once funding had been approved by the EUTF Syria and then gaining approval via the JORISS system. Indeed, the issue of gaining registration via the JORISS system has been a significant challenge for the regional projects and hindered their prompt start-up.

Also, evidence suggests that national stakeholders appear to have little or no inputs into the initial designs of the regional/ multi-country interventions. This reflects the then prevailing view of many partner governments that the Syrian crisis was first and foremost an international affair where the response would be covered by the international community. Some countries lacked any national institutional counterpart such as the ministry of health to work with or through to facilitate implementation and take forward project results.[9] This stands in clear contrast to those EUTF Syria Health interventions that were programmed at a national level (via separate ADs) and financed from country-specific funding allocations.

A final observation on the design of the regional/ multi-country interventions is the notable lack of any planned results of a specifically regional nature e.g. common regional outcomes related

7 Discussions with the Netherlands RC and Lebanese Red Cross during the evaluation mission gave an insight into the approach taken to refining the regional design to adapt it specific national priorities both directly (training and community activities) and indirectly (blood supply, refurbishment of ambulance control centre) See also Evaluation matrix p. 83 for Lebanon for more.

8 AFD in reality sub-granted the implementation of its component to 3 international NGOs i.e. Terre des hommes, ACTED and ACF. AFD's role has been primarily administrative.

9 Although not involved in the design phase, in the case of Lebanon, the Ministry of Public Health has been involved in the coordination of these regional interventions via the EUTF Syria Health Steering Committee.

to enhanced cooperation or learning among volunteers, national partner institutions etc from the target countries. Although many of these first programmes/ projects were titled "regional", on closer inspection they turn out to be multi-country interventions. With the exception of a few activities carried out involving MHPSS staff from different countries in T04.50, no other cross-country actions were noted. Discussions with stakeholders in all countries indicated that such opportunities would have been welcome and have given added value to the regional EUTF Syria model, which otherwise was perceived as very complex and administratively challenging (See also Efficiency).

Design of National Interventions

In addition to the three regional interventions, each country has its 'own' EUTF Syria health interventions that have been programmed specifically to address national needs. Each of these is covered by an AD. Of the main countries covered, only Lebanon has an AD that covers more than one individual intervention which is under implementation and outlines the programmatic basis for three individual health interventions in the country. [10] Other national interventions in Jordan (1 project) and KRI (3 projects) have their individual ADs, which are de-facto the same as project DoAs. As might be expected, these ADs more closely reflect the situation on the ground in each country than the regional AD does. Also, stakeholders in-country (such as ministries/departments of health) confirmed that they had been consulted in the process of preparing the national ADs and especially the subsequent DoAs for the individual projects. As a result, the interventions emerging from these documents had stronger relevance to national needs, generally benefited from having clear national counterparts who as a result exhibited stronger ownership of the projects (and thus improved sustainability prospects – see 3.3.5 for more). Also, unlike the regional/ multi-country interventions, they did not require any major re-design prior to or during implementation.

The country AD for Lebanon has the benefit of giving focus to the EUTF Syria health support beyond the project level. It captures the challenges facing the sector and the EUTF Syria programme responses to them in a way that has been absent in other EUTF Syria target countries.

Responsiveness of EUTF Syria support to Programme Contexts

The extent to which the EUTF Syria health interventions have been able to integrate experiences from previous actions is affected by when they started. In all but a couple of cases, these represent so-called 'first generation EUTF Syria projects' (first round of projects approved by the EUTF Syria board in 2015-17). As such, they have not benefitted from previous EUTF

10 The Action Document "EUTF Syria Jordan health programme for Syrian refugees and vulnerable Jordanians" (adopted in December 2018) also represents an example of a country-level AD with multiple interventions (2) planned within it. However, at the time of the evaluation, neither of these interventions had been approved for funding and their designs were still under development. As such neither of these interventions have been included in the evaluation sample. As with the 'new' AD for health in Lebanon, the evaluators have referred to this Jordan AD where appropriate to illustrate wider points emerging from the evaluation sample proper.

Syria interventions that have 'tested the water' and from which lessons could be learned directly. They therefore represent the first attempts at support to the health sector in the EUTF Syria countries. This explains both their diverse focus (see above) and also the differing approaches taken to programming (regional/ multi-country vs. national). Any evidence of evolution in terms of programmatic focus or responsiveness to emerging challenges (such as the transition towards a developmental paradigm) would therefore be evident only in those interventions programmed in later (i.e. in the period from 2018 onwards, when projects had finally entered implementation).

Evidence from those 'new' health ADs that the evaluators have seen (Lebanon, Jordan) indicate that the health portfolio is indeed evolving in several key respects i.e. it builds on the successes of previous interventions; takes into account lessons learned from the first tranche of projects; concentrates support in a small number of areas where the development opportunities are greatest.

Any experiences or lessons learned from which the portfolio of programmes/ projects could benefit stem primarily from the implementing partners' previous work in the country, sector or region. Project documentation makes general references to these but in many cases this experience was not sufficiently taken into account in the design of the interventions. The evaluation found several good examples of the IPs using their experience and standing within the countries to effectively deliver assistance. In Jordan, the United Nations Office for Project Services - UNOPS - (T04.015) and the JRC (T04.30) both used their standing and experience to (in the former case) effectively plan and execute its project, or (in the latter case) successfully adjust its design to local needs and implement it efficiently and effectively. T04.18 in KRI also highlights the importance of having an experienced IP to successfully deliver EUTF Syria results, especially in the challenging programme environment characterised by Iraq (See also case study 1 in the Effectiveness chapter). Finally, the work of International Medical Corps (IMC) and Premiere Urgence International (PUI) in Lebanon (T04.54) is also evidence of the IPs successfully delivering a 'risky' project thanks at least in part to their previous experiences of implementing projects of this type.

Current and Future strategic focus of EUTF Syria Health support

EUTF Syria health interventions provide support across a wide range of fields. The text box gives a general overview of the themes that are addressed by the interventions in the sample. As noted in previous paragraphs, all these areas are relevant as regards the health needs of Syrian refugees, IDPs and vulnerable host communities. Also, their broad spread thematically is warranted given the context in which they were programmed i.e. as essentially an emergency response to a multifaceted crisis, however with a certain manoeuvring space and therefore flexibility. As much of this assistance was programmed in the first round of EUTF Syria support, there was little in the way of an evidence base around which the interventions could be more narrowly focused.

Nevertheless, it does mean that, with the possible exception of MHPSS, there is little in terms of concentration of EUTF Syria health assistance around a core of thematic priorities. The three strategic outcomes for the RF relate to largely general aspects - access, capacity, infrastructure. Several stakeholders observed during interviews that the EUTF Syria could spend all of its funds in just one of these thematic areas – due to the overwhelming needs on the ground - and that it was unclear what the focus of the EUTF Syria actually was. Given the scale of the healthcare needs in the region both for Syrian refugees and vulnerable host communities (as starkly outlined in consecutive CRPs), spreading EUTF Syria funding relatively thinly across a wide thematic and geographical scope is unlikely to generate any substantial impact (although effectiveness is expected to be good – see next chapter). Also, with the move towards the humanitarian development nexus, EUTF Syria health assistance will probably need to follow this direction and look to concentrate its funds in those areas judged to be offering the best development opportunities and prospects for greater impact. The recent health AD for Lebanon shows the way in this respect and can be considered a blueprint for other EUTF Syria country programmes.

As noted above, the situation in the EUTF Syria countries has experienced significant evolution since the first health interventions were conceived in 2014/15. **The emergency response that the EUTF Syria was originally conceived to be is largely no longer relevant to the situations in the countries at the moment.** Instead of experiencing an influx of refugees or IDPs, the countries are now faced with a large refugee/IDP population that is unlikely to be leaving any time soon and which will place significant additional demands on existing healthcare services. Thus the variated response in enshrined in the original EUTF Syria health programming documents (some humanitarian-type interventions such as T04.47, piloting of healthcare models such as T04.54, reconstruction of essential; healthcare infrastructure in T04.105 and T04.18) has been supplanted by the need to provide support to the systems and institutions which provide healthcare i.e. a system-strengthening/ developmental/ resilience approach. This approach figures prominently in more recent 3RP/CRPs and to some extent in draft ADs for Lebanon and interventions in Jordan.

Thus the existing EUTF Syria health portfolio, whilst not outdated, represents a strategic approach that, especially in its earlier approaches, doesn't fully reflect the current thinking on how to address the Syria crisis in the area of health. Issues such as the nature of the support (e.g. institution building and capacity development or continued supplementing of dysfunctional health systems) and the objectives of EUTF Syria health in the region (e.g. a selected number of key areas) need to be considered by EUTF Syria programmers to ensure that the EUTF Syria health programmes remain relevant and deliver long-term sustainable results (see also the chapter on Coherence for more on this).

Quality of EUTF Syria logframes and result statements

The quality of EUTF Syria project logframes and intervention logics was assessed by the evaluators. **For the most part, the logframes of all interventions define outputs and output**

indicators reasonably well - thus it is possible to assess with some certainty what activities have actually delivered in terms of people treated, staff volunteers trained, equipment purchased and buildings reconstructed. The definition of outcomes and their indicators has evidently proved a challenge for IP programmers, with numerous examples of weaknesses found in the programming documentation, especially among 'first generation' interventions. In particular, during the basic project development phase, many IPs did not want to commit themselves beyond the general commitment to service delivery due to the many and not always easy to assess challenges at the ground. This led to a certain delay in setting detailed intervention targets. Some weaknesses are evident, especially among those 'first generation' of EUTF Syria health interventions, in the definition of results statements and indicators. However, it was also observed that the EUTF Syria team has been making a concerted effort over the last three years or so to address these issues. These efforts are evident in the improved quality of the 'second generation' intervention designs, particularly in their logframes.

The issue has improved for the second generation of EUTF Syria health interventions. Since the EUTF Syria Operation Board of Dec 2018, all ADs have a logframe with key performance indicators included, aligned to the EUTF Syria Results Framework and relevant sustainable development goal (SDG) indicator[11]. During negotiations between the EUTF Syria and the IPs the logframe is then revised during several rounds under the lead of the operational managers in charge, and with the support of the respective technical assistance.

Whilst in earlier times the weaknesses in these designs have prevented the EUTF Syria from reporting objectively on the performance of the interventions, the innovations instigated since 2018 have made a tangible improvement in assessing overall EUTF Syria performance against RF outcomes (see chapter 3.3.7 on impact).

Nevertheless, challenges still remain to be addressed. The quality of reporting results in the Quarterly Information Notes (QINs) was noted by the evaluators as still being uneven, but this appears to be caused mainly by inherent weaknesses in first generation logframes, as well as reporting methods of the IPs, rather than any flaw in the EUTF Syria reporting templates themselves. This situation applies to all EUTF priority sectors and does not indicate a sector-specific weakness. Improvements can be seen over time. These are not only based on the steadily increasing experience of the IPs with the required reporting requirements but also on an intensified support and guidance provided by the EUTF Syria.

The absence of the reported progress towards outcomes as provided by IPs in some of the QINs gives the impression that the EUTF Syria health portfolio has achieved little when in fact, it merely reflects the shortcomings of the logframes and IP reporting approaches (see also section on Effectiveness). It is expected that, thanks to the efforts being devoted to this issue by the EUTF Syria team and the wider support offered to improving programme design by DG NEAR and other DGs within the Commission, the quality of both programming documentation, results chains, indicators on the one hand and reporting by IPs will continue to improve. In the

11 ADs before this date often had a multi-country character and, moreover, no binding logframe and corresponding indicators were required. Project specific logframes were always mandatory and were also commented by the EUTF with regard to quality requirements.

case of Lebanon, the Third-Party Monitoring (TPM) contract there has the potential to work with IPs to improve the quality of ILs and indicators as part of its remit for ongoing and ex-post monitoring of outcomes.

3.3.2 Effectiveness and Impact Prospects[12]

Outcomes of EUTF Syria support

The most important result of any intervention are its outcomes i.e. the effects (expressed in changes in the behaviour or state of the project target groups) that are the direct result of the intervention's outputs. These are the changes that the EUTF Syria hopes to bring about to the health status of Syrian refugees and their vulnerable host populations, as well as IDPs. The evaluators conducted a detailed analysis of each EUTF Syria health intervention to understand i) whether the planned outputs mentioned above are likely to result in planned outcomes and ii) whether any unplanned outcomes had emerged. Diagram 2 below lays out in summary format the evaluators' assessment of actual or likely achievement of outcomes by each EUTF Syria health intervention. A more detailed analysis of EUTF Syria outcomes can be found in Annex A3. Finally, the evidence base for this assessment of effectiveness is found in the full evaluation matrix under EQ4 (found in Annex B).

Of the 27 outcomes stated in the project documentation, 21 are sufficiently advanced to be assessed, based on QINs and data collected during field interviews. The evaluators assess that 14 of these outcomes are likely to be achieved or have already been achieved. 4 outcomes are likely to be partly achieved, whilst 3 outcomes are unlikely to be achieved, based on progress to date and external factors. The planned outcomes for T04.31 in Jordan will not occur due to the cancellation of the project in that country.

In summary, the evaluators can state that there is extensive evidence from the field visits and (to a lesser extent) documentation that 85% of outcomes are likely to be either fully or partially achieved (as defined by the project documentation or as understood by the implementers and target groups). The factors behind this generally positive performance are discussed in the following section. One stand-out example of effectiveness from KRI is presented below in Case Study 1 to illustrate how EUTF Syria support can make a real difference to the health of its target groups.

12 This evaluation criterion incorporates responses to the following EQs: EQ 4: To what extent have EUTF Syria-funded Health programmes/ projects been effective in achieving their results?; EQ 5: What factors (positive and negative) have had the greatest influence on the achievement of results?: EQ6: To what extent have EUTF Syria-funded Health programmes been able to contribute to longer term effects (impacts)? To what extent are ongoing Health programmes likely to produce impact prospects?; EQ 7: What are the specific advantages/disadvantages of the various implementing partners (national, regional/multi-country) in terms of effectiveness?; EQ 8: Is the level of partnership with the national/ country-specific governmental partners appropriate to support the effective achievement of the EUTF Syria Health objectives?; EQ 9: Are Health referral systems (HRS) in the host countries working effectively? Do final beneficiaries receive reasonable medical care in the event of referrals to the secondary and tertiary medical system?

Diagram 2: Summary of EUTF Syria Health Interventions Effectiveness (*achievement of outcomes*)

Outputs of EUTF Syria Health interventions

Project documentation in the form of narrative reports and quarterly information notes (QIN) reliably report on the activities carried out by the IPs and the outputs put in place by them. The plethora of outputs delivered by the interventions are analysed in detail in the respective country evaluation matrices that are annexed to this report.

In general, delivery of outputs has progressed satisfactorily. Many of the interventions are still under implementation so their outputs still being put in place – this applies to, for example, the hospital facilities under construction in T04.105, the capacity of CBHFA volunteers under T04.30, the MHPSS services being developed under T04.50 etc. However, evidence both from project reporting and also field missions indicate that overall, these outputs are expected to be put in place by the end of their implementation periods. Those interventions (mainly regional/ multi-country) facing difficulties stemming from delays in implementation have been granted non-cost extensions which should ensure sufficient time is available to deliver all their planned outputs. Only two interventions will not deliver their planned outputs in the areas of healthcare i.e. T04.31 in Jordan, due to its cancellation there, and T04.50 in the area of health infrastructure, due to no health programmes/ projects being included in the infrastructure grant scheme component.

Table 1 below summarises the numerous outputs delivered, their type and other observations.

Intervention	Type of output	Observation/Status (as at cut-off date)
T04.105	Health infrastructure	Under implementation. Outputs not yet in place
T04.18	Health infrastructure	Project has fully achieved all planned outputs
	Institutional capacity for government institutions	
	Healthcare Personnel Capacity	
T04.30	NGO/Volunteer Healthcare Personnel Capacity	Project under implementation - capacity building outputs with CBHFA volunteers have been established;
	- New/extended services in selected health areas - Institutional capacity for government institutions	Project under implementation - overall progress towards achieving project outputs on track; The capacity support for the JRC has already over-achieved the original targets; LRC Blood Transfusion Service functional/ EMS ambulance service functional
	Awareness among target groups on health issues	Project under implementation - overall progress towards achieving project outputs on track
T04.31	Awareness among target groups on health issues NGO/Volunteer Healthcare Personnel Capacity New/enhanced RH & PSS services created	Jordan component cancelled Overall progress towards achieving project outputs satisfactory - Discussions with beneficiaries confirmed that the community awareness, education packages and midwife service were both effective and relevant to beneficiaries
	Institutional capacity for health care providers	Good progress towards achieving project outputs
T04.47	Secondary healthcare provision	Project complete; Outputs delivered on schedule

T04.50	Healthcare Personnel Capacity	Output is in place. PSS volunteers are trained and actively providing services
	Institutional capacity for local government institutions	Project under implementation - Overall progress towards achieving project outputs and outcomes.
	Health Infrastructure - Not delivered	Not included in IC grant schemes
	Awareness among target groups on health issues	Project under implementation - adequate progress towards achieving project outputs
	NGO/Volunteer Healthcare Personnel Capacity	
	New/enhanced RH & PSS services created	
T04.54	Healthcare Personnel Capacity	Project on schedule to deliver its outputs
	Primary healthcare provision	
T04.58	Healthcare Personnel Capacity Awareness among target groups on health issues	Documentation indicates that progress towards delivery of outputs has been satisfactory overall
	Primary healthcare (MHPSS) provision	
T04.74	Procured medicines and vaccines	Progress towards output achievement on track as of December 2019
	Supply chain management	
	Healthcare Personnel Capacity	
	Policy/Institutional capacity for government institutions)	
	Health infrastructure	
T04.147	Health infrastructure	Under implementation - Outputs being put in place.
	Healthcare Personnel Capacity New/enhanced PwD services created	
	Awareness among target groups on health issues (Advisory support for people with disabilities)	
	Policy guidance/institutional capacity increased	
T04.96	Procured medicines and vaccines	Project has delivered its outputs largely to plan
T04.181	Health infrastructure	This is a new project, and as a result it is too early to assess any progress towards achievement of project outputs
	Healthcare Personnel Capacity	
	Institutional capacity for government institutions	
T04.183	Healthcare Personnel Capacity New/enhanced MHPSS services created	This is a new project, which started on 1st October 2019, and as a result it is too early to assess any progress towards achievement of project outputs.

Unplanned results of the EUTF Syria support

The evaluation found two examples of unplanned results being put in place by the EUTF Syria support in Jordan (see boxes 1 & 2). These are unlikely to be a full list of cases where these occurred but serve as interesting illustrations of how programming and reporting (via QINs) often fail to capture or identify valuable effects stemming from the EUTF Syria interventions.

> ***Box 1 - Unplanned Results (i)***
> The Ministry of Health (MoH) staff working with EUTF Syria programmes stated that its close involvement in the programming process of the three national projects (T04.105 UNOPS and the two national projects currently under preparation) had increased their own knowledge and skills of programming interventions. Prior to the EUTF Syria, they had tended to be a passive partner in the design process (usually limited to commenting on and approving projects that had been conceived or designed by IPs or donors). The MoH staff observed that the EUTF Syria programming approach, whilst more demanding of their time and capacities, gave them a stronger appreciation of how to programme and the critical success factors in programme design. More importantly, its involvement in the programming process-built ownership of the project (unlike regional EUTF Syria and other donor interventions).

As a general observation, understanding the full breadth of the likely outcomes of these interventions (some of which have multiple components and operate in highly dynamic programme environments) would probably only be captured using an 'outcome mapping/outcome harvesting' approach to assessing intervention effectiveness. The Mid-Term Review of T04.30 to some extent took this approach and was able to establish some valuable insights (such as the fact that the main challenge to improved health for target groups in many countries was affordability, not health awareness) that a more formalistic assessment of performance might not have exposed.

Positive factors for effectiveness of EUTF Syria health assistance

For the successful delivery of outputs, a number of critical factors were observed. Firstly, the **project budgets were for the most part considered to be sufficient** to ensure that the planned outputs could be delivered to the expected quality and quantity. Where programmes/ projects faced the risk of being unable to deliver outputs due to delays in implementation, non-cost extensions (NCE) have been granted to ensure that sufficient time remains for their production. This has been a critical factor in enabling regional/ multi-country interventions to complete their implementation and have sufficient time to put functional outputs in place.

> ***Box 2 - Unplanned Results (ii)***
> In Jordan, as part of project T04.30, the training run by the JRC for CBHFA volunteers has developed their capacity. However, in addition to the improved CBHFA service that had been established by the project, it was also evident from the field visits that the project had had a strong transformational effect on the volunteers themselves. Thus the outcome of the support is twofold – one planned (improved health of target groups) and one unplanned (improved careers, social integration, and improved life prospects for the CBHFA volunteers directly benefitting from the training and opportunities stemming from it).

Secondly, the **good capacity of the IPs to implement their projects** was found to be key. Whilst the efficiency of the individual IPs sometimes varied, overall their performances in terms of delivering planned results was found to be positive. This included having sufficient staff of good quality and appropriate expertise to successfully manage implementation. The case studies from

Jordan and KRI illustrate examples of how IPs were able to deliver planned project results efficiently and effectively (See below). From an overall portfolio perspective, IP capacity was found to be a positive influence on effectiveness, rather than a negative one.

A third success factor has been the **design of the interventions, which in terms of their appropriateness to needs, has generally been sound** (in the case of Regionals, this has had to be adjusted in some cases to strengthen its relevance). This, in combination with the other factors mentioned above, has ensured the EUTF Syria support has met actual needs on the ground, whether they be related to health infrastructure, health service provision or procurement of medicines.

A clear positive factor on both efficiency and effectiveness was **the role played by the EU Delegation**. Where the EUD has a prominent and proactive role in facilitating the preparation and implementation of the EUTF Syria health programme, the benefits are obvious in terms of clearer programmatic focus, stronger engagement of national partners and other donors, improved lines of communication between stakeholders and stronger programme coordination. The EUD in Beirut is the obvious example of best practice in this regard, with stakeholder feedback highly positive in terms of the quality of the Delegation's expertise and engagement. The recent health AD for Lebanon (with its emphasis on concentration of funding in core areas and integrating lessons learned) is a further illustration of the benefits of a proactive EUD.

Finally, and importantly for project outcomes, a **strong relationship between the EUD, IPs and national partners** is central to any outputs being taken forward and put into practice (as it links directly to their ownership of results). This is particularly the case for those interventions that deliver outputs that link to existing or emerging national/regional health systems. For example, the construction of hospitals cannot be effective unless the beneficiaries are willing and able to utilise these outputs once they are in place. The evaluation found that, among nationally programmed, this level of ownership varied significantly. Many of the projects had, in themselves delivered good results, but that several of them had uncertain futures once project funding finished e.g. T04.54, T04.74 (see also Sustainability).

Negative factors influencing effectiveness

For the most part, the IPs coped very well with the **demanding environment** in which the programmes and projects have been delivered (see efficiency). Nevertheless, both Lebanon and KRI represent a challenge for outcomes to emerge. The unstable governmental landscape in Lebanon means there is constant uncertainty over whether the outputs delivered especially linked to existing healthcare structures or policy development issues are likely to result in any longer-term changes. Although design was noted as being a generally positive element for effectiveness, this was not universally the case. The inadequate design of T04.96, with its

limited remit to deliver supplies, weakens its effectiveness.[13] Likewise, the design of T04.74, while sound in principle, is in fact unlikely to deliver changes to the functioning of healthcare in Lebanon due to weak national institutions and a policy vacuum caused by the complex political environment in which the project operates and which it cannot fill on its own. This highlights the importance of strong ownership among national partners where such results are expected.

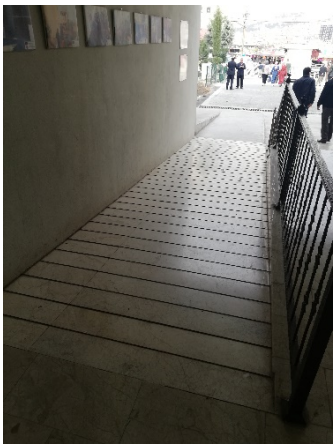
A final negative factor, linked more to impact, is the rather **heterogeneous nature of the portfolio and lack of dedicated strategic focus for EUTF Syria health interventions**. Although the reasons for this are recognised by the evaluators (see Relevance chapter) it does mean that the results of the interventions are required to deliver any deeper changes in selected target areas, or to have a wider impact, given the scale of the challenges in the areas targeted by EUTF Syria.

13 This shortcoming has been recognised by the EUTF Syria and reportedly addressed in the follow-up intervention covered in the Lebanon Health AD approved after the cut-off date of this report.

EUTF Syria Case Study 1 – A Successful Example of EUTF Syria Effectiveness in KRI: T04.18

Context

When one asks people in KRI about the EU they all say "*Yes, we know about MADAD, they did a really good job with the hospital in Duhok*". What have been the reasons why the project implemented by AISPO[14] been such a success? The secrets lie in the good choice of the target beneficiaries, a good implementing partner and a simple intervention with tangible and achievable goals.



Duhok is one of the four governorates in KRI but contains more than half of the displacement and refugee camps in the KRI (28 camps out of 44 in the KRI), these camps are allocated for IDPs, refugees and returnees. Duhok's population in 2016 was 1.26 million but due to the dual crises in Syria and Iraq since 2011, has as many as 750,000 IDPs and Syrian refugees living in its borders.

Duhok is a poor governorate, with very high mortality rate (neonatal and maternal), with a very weak health system, and a huge health needs. The Syria crisis and Daesh conflict have put massive pressure on this system. Health needs have increased fourfold, while resources have halved, if compared to the period between 2013 and 2016.

Results[15]

The EUTF Syria financed project, implemented by AISPO, an Italian NGO, has been able to provide support to the main hospital in Duhok, by rehabilitating hospital infrastructure, increasing capacity (including extra 50 beds in the paediatric facility), training staff and introducing modern equipment into its departments. It has also conducted capacity building with the General Directorate for Health (DoH) of Duhok Governorate. The new facilities and services are available to all i.e. host community members, IDPs and Syrian refugees. Whilst demand for services continues to outstrip the capacity of the hospital, the project has indisputably helped improve the health situation for the target groups in Duhok.

The Director General of Health at Duhok Hospital made his satisfaction plain when interviewed by the evaluators: "[*thanks to the EUTF Syria project], there is more capacity to receive patients and child mortality rate has decreased. Of course, this has a good impact on people*".[16]

14 AISPO - Associazione Italiana per la Solidarietà tra i Popoli - is the implementing partner of this intervention as well as T04.181.
15 A detailed analysis of the results of the intervention can be found in Annex 3 of this report and the Evaluation Matrix in Volume 2.
16 4th EUTF Syria Results Reporting; p. 35.

Ownership

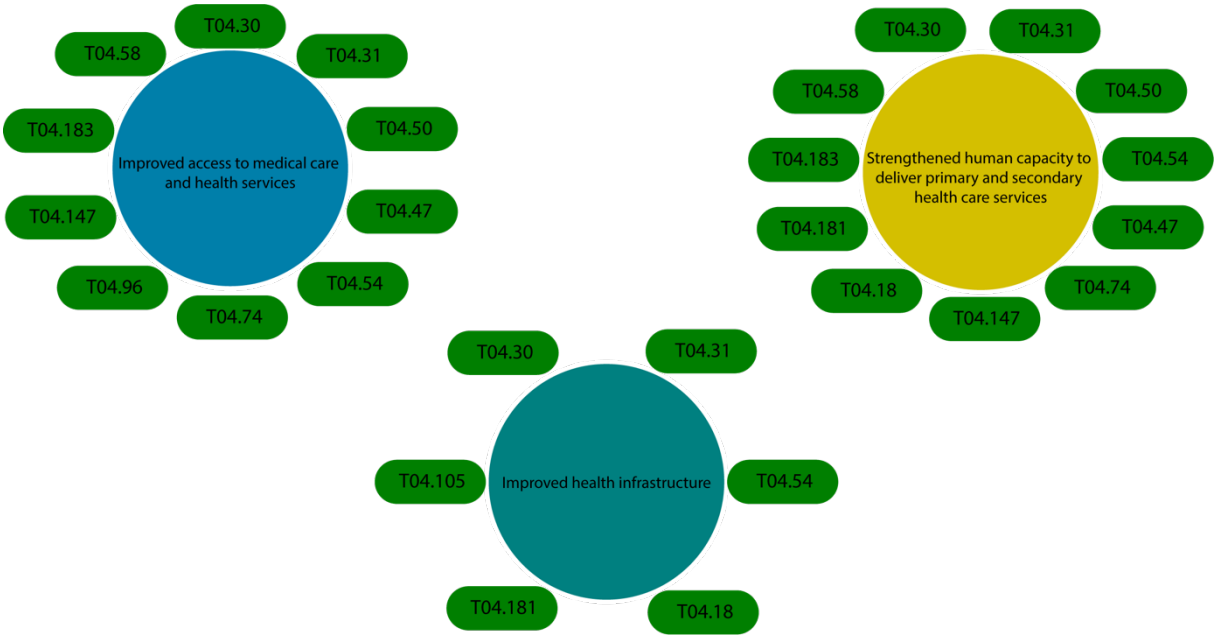
The field mission for this evaluation established that the project enjoys strong ownership from the main beneficiaries (DOH Duhok and the hospital management), with interviews confirming that "the project is belonging to Duhok DOH, and not only AISPO". Indeed, when in 2018 the security situation worsened in the governorate, AISPO staff stayed in the place, and everybody could see that AISPO were committed to Duhok and was not a just a transient guest. Hevi hospital has now become the "reference hospital in the country ", and the hospital (and all the other sites of interventions) no longer look like they were.

As noted by one respondent in the field mission "*whatever happens, the people in Duhok will not forget that EU MADAD (EUTF Syria) and AISPO changed their life for better, stayed when the others left, and stuck by them when the others gave up*".

Impact of the EUTF Syria Health portfolio

Assessment of impact is complicated by several factors. Firstly, the absence of a body of substantive project outcomes at this stage makes it difficult to assess their contribution to their overall objectives (OOs) – typically, impacts only emerge sometime after project completion and the majority of the EUTF Syria interventions have not yet finished their implementation (and those that have finished did so relatively recently). Secondly, the OOs of the projects are often so generally stated as to be of little use to understanding the impact that the individual interventions might bring about. Thirdly, impact of individual interventions is problematic to assess – typically, impact is measured at programme level and as observed in the Relevance chapter, the EUTF Syria health portfolio is essentially a diverse set of individual projects that loosely relate to overarching strategic objectives. In this regard the only health sector objectives against which impact could be assessed (albeit imperfectly) are the EUTF Syria RF strategic outcomes. Table 3 shows how the individual EUTF Syria interventions contribute, via their results, towards the achievement of EUTF Syria RF strategic outcomes:

Diagram 2: Contribution of EUTF Syria interventions to EUTF Syria Results Framework Health Outcomes



Based on the above, it is possible to assert that the EUTF Syria Health portfolio is likely to have impact across all three key priority areas of the Fund. **This positively answers the question: "*Is there (or likely to be) any impact*" with a "yes".**

Answering the question "*how much impact*?" is less easy. For each of the main countries visited, the evaluators conducted an analysis of the contributions made to EUTF Syria Strategic Outcomes based on data available from QINs and the 5th edition of the EUTF Syria Results

Reporting Document issued on 3rd December 2019. These are presented in Annex A4. The analysis provides a general impression of how the individual projects are contributing to wider programme impacts. Statistics suggest that they are contributing substantially to the first and second EUTF Syria strategic outcomes. As regards the third outcome of health infrastructure, the figure of 92 refurbished facilities and 25 with stock management systems seems to be unduly ambitious given the evidence from the projects (6 hospitals). Furthermore, the figures reported in the 5th RR document for health appear to not be fully coherent with the data presented in the QINs, while some project outcomes (such as the secondary health treatment provided to Syrian refugees by T04.47 in Lebanon) have no obvious RF indicator against which it can be associated (the indicator for EUTF Syria outcome 1 relates only to *number of primary health care consultations*).

Observations from the field phase provide a more subjective insight and indicate that the **humanitarian-type interventions have had impact inasmuch as they have helped their target groups** (especially T04.47 and to a lesser extent T04.54 Lebanon) but their future is fully dependent on further external funding as well as political will to take forward their results (which has been till now largely absent). More **developmental/ system strengthening support have not showed any impact yet** and these are likely to be influenced by external factors in future. These include security/stability; effective institutions; effective political will; the existence of future funds for beneficiaries/IPs and a clear strategy from the EUTF Syria on its future direction in the sector. Finally, as noted elsewhere, a more concentrated programme built around a smaller number of themes would provide deeper impact than the existing portfolio.

Effects of EUTF Syria Health interventions on indigenous health referral systems

At a system level, the evaluators found little evidence to suggest that health referral systems (HRS) are functioning more effectively at this stage thanks to EUTF Syria interventions. This is due to the fact that the projects are currently only in the process of delivering their outputs and any changes will be evident only once the outputs are in place and being properly utilised. Nevertheless, there is plenty of evidence that at project level the projects are helping e.g. T04.74, T04.30 in Lebanon, T04.105 Jordan and in KRI via T04.18. A particularly strong example of how EUTF Syria support is being effective not only in terms of delivering results but also laying the groundwork for potentially wider changes in healthcare is T04.54 in Lebanon (see case study 2 below).

Case Study 2 – T04.54 – Reducing Economic Barriers to Accessing Health Services in Lebanon (REBAHS Lebanon).

Background

IMC/PU-AMI ('the consortium') strategy is to enhance the capacity of a selected number of Primary Healthcare Centres (PHC) throughout Lebanon in locations with high concentrations of Syrian refugees as well as vulnerable Lebanese.[17] As of December 2019, the IMC consortium supports a network of 56 PHCs. Support includes a wide range of curative health services, preventive health care through routine physical examinations and paediatric check-ups, growth monitoring, immunizations, and reproductive health services, including maternal health and family planning. The project also provides MHPSS support via the PHCs. With regards to the mechanism of cooperation, the consortium established a flat-fee model (FFM) with patients paying a one-off charge (30 Lebanese pounds) to cover the full range of treatment provided for one case.

Positive effectiveness.....

The evaluators observed a range of positive elements to this intervention. Firstly, it has health benefits for the target groups, which are in line with its planned results i.e.

- The FFM is increasing access to health care and reduces overall household vulnerability among target groups.
- The current project integrates MHPSS care into the PHC system in line with the National Mental Health Strategy (hitherto largely absent).
- External monitoring (ROM) has highlighted the model is cost-effective and the resources are made available in a timely manner for the targeted needs.
- The FFM reduces the risk of health outbreaks and the need to access expensive secondary health care facilities.
- The FFM improves health outcomes of the population and reduces household expenditure on health, therefore increasing resilience to economic shock.
- It meets the expectations of the target groups: High patient satisfaction as evidenced by surveys of patients, who believe FFM is superior compared to the more expensive private health care system.

- The FFM ensures services are integrated into the existing PHC system and reduces tensions between the vulnerable Lebanese and Syrian refugee communities.

17 These locations were selected in agreement with the MoPH.

- FFM has increased access to health care by rebuilding the trust of local host communities and Syrian refugee populations in the Primary Health care sector.
- Improved ability to identify previously unseen problems (i.e. HIV in pregnant women) due to increased diagnostic testing.

... and potential to impact on wider HRS

In addition to the above, the project offers benefits from a system-wide perspective that is particularly relevant in Lebanon as it struggles to find the best approach to providing accessible and affordable PHC to the most vulnerable communities within its borders (over half the Lebanese population is not ensured in a system that it is highly privatised).

- The FFM provides a comprehensive and affordable primary health care benefit package at the PHC, whilst targeting services for key health needs (i.e. sexual and reproductive health).
- The FFM strengthens the referral pathways through patient tracking and follow-up visits by CHWs.
- It provides increased quality data on health trends, which feed into the national health database and thus help understand health needs of the populations. This again feeds into universal health coverage discussions in Lebanon for future policy making (supported under T04.74).

- It represents a pilot of a funding model (FFM) that is a viable alternative to the UHC model being tested by the Ministry of Public Health (MoPH) and WHO/World Bank. In this respect, evidence suggests that both these interventions are working together, sharing results and their lessons learned.

The EUTF Syria's ROM report of 2019 recommends that the FFM 'could be adopted by the MOPH, supported by other health donors and rolled out to all PHCs in Lebanon.' The evidence from this evaluation endorses this assessment.[18] It would significantly improve the MoPH's ability to provide universal health coverage to Lebanese vulnerable population regaining the ground lost by primary health care institutions to private and expensive medical providers.

18 From 2020 Canada (GAC) reportedly will adopt this model in 6 PHCCs and France (AFD) is studying the possibility of doing the same.

Effectiveness of Different Implementing Partners

As has been outlined in previous analysis, the bulk of EUTF Syria Health support is expected to deliver its planned results. Within this, there appears to be **no major fundamental difference between the effectiveness of different IPs**, irrespective of whether they are either implementing national or regional/ multi-country programmes/ projects.

There are some examples from the Regionals, which show reduced effectiveness. The most notable is T04.31 in Jordan, which will not deliver significant results. Also, the planned results for T04.30 have changed in some countries.

Perhaps the main weakness, already mentioned under Relevance, was the lack of systematically planned and overarching regional level results that the IPs could have delivered via their multi-country interventions. This constitutes 'missed effectiveness' rather than lessened effectiveness.

Effectiveness of Partnerships between EUTF Syria, its Implementing Partners and national counterparts

Formal partnerships between the EU and the Governments affected by the Syrian crisis are in essence enshrined in the respective CRPs and these underpin the assistance provided by the EUTF Syria. Also, other documents exist which express in more detail the nature of partnership between the two parties – for example the Jordan Partnership Paper presented at the Brussels II conference in April 2018 lays out future measures for the EUTF Syria there (with a small section on health). A similar document was also presented for Lebanon.

However, in terms of the EUTF Syria health interventions covered by this evaluation, few formal agreements are in place between the IPs and national government partners for the specific delivery of the interventions. T04.50 has reportedly signed memoranda of understanding (MoU) with their partner governorates in Jordan and in KRI (Directorate of Labour and Social affairs) on collaboration in project delivery. AISPO (IP for T04.18 & T04.181) has MoUs with the KRI government (Directorate of Health in Duhok), and MEDAIR in Lebanon has an MoU with the MoSA - but these are the exception to the general rule.

It was observed that most of the IPs working on national projects had established working relationships with their national interlocutors prior to the EUTF Syria interventions starting. In Jordan, UNOPS enjoys a strong, longstanding working partnership with its partners such as the EU Delegation and the MoH, and this has facilitated the smooth project delivery. In Lebanon, the IPs all have longstanding relationships with MOPH and Ministry of Social Affairs (MOSA) that facilitates dialogue, discussion and trust to enable the delivery of project results. In KRI, AISPO has a very strong relationship with and the local government (represented by the Directorate of Health), local community and other partners like WHO and other agencies.

The Red Cross/Crescent Societies implementing T04.30 enjoy a specific status in their countries and operate with the permission of the National governments and under the various

international conventions governing red cross/red crescent activities. Their partnership with national governments was typically neutral and this did not hamper their activities.

In all of the above cases, **the quality of the partnerships was found to be conducive to delivering the project results and therefore supported EUTF Syria effectiveness**. The regional/ multi-country programmes/ projects, however, did experience some problems due to their more 'distant' relationship between the IPs and the respective national authorities. This was mainly due to the fact that they had not been developed in consultation with these national partners (they had been programmed by the IPs alone) and once approved, the IPs then had to establish partnerships i.e. the reverse of how the national projects had been designed. In the case of Jordan, this seriously hampered their efficiency and in the case of T04.31, its effectiveness.

In Jordan, two examples highlighted the risk of looking to put in place a "pre-prepared" regional project without taking into account the local context or working through national counterparts. The main government interlocutor interviewed for this evaluation, the MoH, stated that it knew of only one EUTF Syria health project in detail – the nationally programmed T04.105 led by UNOPS. This limited awareness of the MoH had some influence on the difficulties two of the regional projects experienced in implementation (see below).

T04.50 was held up by some 8 months as because of difficulties experienced by the lead IP (AFD) in registering the two partner NGOs on JORISS. [19] This was due to concerns from the Ministry of Planning and International Cooperation (MoPIC) that the project had insufficient dialogue between these NGOs and Jordanian counterparts in the project's preparation. T04.31 experienced even bigger problems. The project lacked any form of agreement underpinning its delivery in Jordan between the IPs and the government. Despite negotiations lasting over a year, the IPs and the EUTF Syria could not gain the agreement of the GoJ for the project's registration on the JORISS system and as a result, the Jordan component was cancelled with the funds transferred to the Lebanon element of the project.

Monitoring Effectiveness and Impact post-project completion

Discussions with the IPs and EUDs revealed a **weakness in the reporting arrangements** for the health interventions. Once implementation is over, the IPs will no longer be obliged to report on progress towards results – or more specifically outcomes. However, it is only towards the end of an intervention and after its completion that outcomes start to emerge. Whilst some of the outcomes will be reported on in the IPs' final project reports, the outcomes and impact of the projects that appear in the period after implementation is over will not be tracked or fed back to EUTF Syria for analysis. This is understandable as the IP is responsible only for the implementation of the intervention, not what happens with the project results once it has ended.

19 JORISS is the Jordan Response Information system for the Syria Crisis. Any external donor intervention linked to the Syria crisis has to be registered on this system and this can only be done with the agreement of the MoPIC and a relevant Jordanian counterpart ministry. The JRC and ICRC are exempted from registering on JORISS.

This nevertheless represents **a paradox – the assistance's true effectiveness and impact can only be assessed after the interventions are over**; yet currently there are no arrangements at portfolio level to record and report these effects. In Lebanon the existence of the Third-Party Monitoring contract offers an opportunity to redress this Achilles heel for the interventions delivered there, although with the project only in its inception phase at the time of the evaluation, it was unclear to the evaluators whether such a task would be assigned to it. Elsewhere, no such facility exists so it can be assumed that there will be an evidence gap on programme effectiveness and impact for the rest of the portfolio.

3.3.3 Efficiency[20]

This chapter of the report discusses how well the EUTF Syria resources have been deployed to deliver their planned outputs. This encompasses the modality used to deliver the support, how well EUTF Syria funds have been managed and how the partners involved in the delivery of EUTF Syria assistance have performed. A case study is also presented to illustrate an example of good efficiency, the factors behind it and how it affects likely delivery of planned results.

Overall efficiency

Delays in the start of regional/ multi-country programmes/ projects have hampered their implementation but the use of non-cost extensions has meant there have not been direct budget implications for the EUTF Syria. These delays have not been evident among national projects, and their relatively smooth delivery suggests that they offer the most efficient modality for delivering EUTF Syria health support. The capacity of the main partners (IPs, EUDs and national/regional institutions/NGOs) has proven to be adequate. There are no significant issues of concern regarding budget allocations, with no budget over-runs noted. There is some concern over the quality of reporting, however, with financial reporting a particular area of concern.

Efficiency of implementation modalities - Regional vs. National

The principal defining element of efficiency of interventions in this portfolio is found in the division between 'regional' EUTF Syria projects and their national counterparts.

At the beginning of the EUTF in 2015, the strategic decision was made to give priority to large regional projects for the time being, in order to quickly launch massive support packages and give a strong political message of support to the affected countries and people, so that the EU could demonstratively provide large contributions to the Syrian crisis. However, this decision has subsequently often made efficient and rapid implementation difficult.

The evaluation found that **regional/ multi-country interventions were characterised by quite complex contractual and implementation arrangements** that has delayed implementation and hampered their efficient delivery of outputs. All the projects are being delivered by multiple partner consortia, each with a different contractual set-up. T04.30 is implemented by a consortium of 15 red cross/crescent societies in five countries led by the Danish Red Cross (DRC). The DoA states that "the European National Societies and the International Federation of Red Cross/Crescent Societies (IFRC) as co-applicants are responsible for support and technical input to the results and activities at country level." and these are paired with RCC National Societies who responsible for the "operational planning, implementation, monitoring,

20 This evaluation criterion incorporates responses to the following evaluation questions: EQ 10: What is the currently most efficient aid modality to support the effective provision of Health?: EQ 11: To what extent have resources been allocated and utilized in an efficient manner and achieve value-for-money?; EQ12: To what extent do the various stakeholders have the necessary capacity (technical, institutional and financial) to promote and implement EUTF Syria-funded Health programmes?

financial management and dissemination of Action outcomes and cooperation with the key stakeholders at national level with support from the designated Country lead and the DRC". T04.50, although covered by one AD and sharing a common DoA, is for various reasons and to all intents and purposes two separate projects operating with different implementation modalities (and with two separate Delegation Agreements). The first component is implemented directly by Italian Cooperation and operates independently of the second component managed by AFD. This second component is in fact subcontracted out to four international NGOs that were selected in 2015 via a call for proposals launched by AFD. It has a large number of implementation timelines (6) due to this complex implementation structure. It is implemented across three target countries. Each project has been handicapped by these structures in different ways.

In T04.30, the 'pairing model' has encountered multiple efficiency problems: changes in the IPs have led to delays in implementation; Also, there have been changes of project focus (see relevance); finally, uncertainties over reporting and administration arrangements were noted among stakeholders. For example, the Jordan component was delayed in its start-up phase, with two of the original IPs (French Red Cross and Danish Red Cross) leaving the project. The project endured 8 months of uncertainty with project activities largely on hold until the revised implementation structure was agreed, with just two IPs delivering the assistance (the IFRC and Jordanian Red Crescent Society). As with other regional projects, this intervention was granted a 12-month NCE, taking its completion date to December 2020. This gave the IPs enough time to deliver project outputs but delayed their delivery by a year (given the fact that projects were conceived in 2015, the AD approved in 2016, and the contracts signed in 2017, this constitutes a 5 year time span to achieve the successful delivery of activities, which in the context of the Syria crisis and the speed at which it has progressed, has to be considered slow – see also below for more).

Issues linked to procurement were noted as being a major efficiency issue – host RCC societies were unsure which rules to follow when procuring items for the EUTF Syria interventions. In Lebanon, requests from the Lebanese and Palestine RCS for clarification over this issue took some 12 months to be sorted out via the European RC partner. In the meantime, the local partners had reportedly procured the items using their own rules as project needs took priority over administrative rules.[21]

All host RCCs felt the requirement to collaborate with a European partner society was an unnecessary burden given the fact that host societies did most of the actual implementation and also a significant level of administration as well. In Jordan, where the original implementation structure was adjusted, the project partners noted that this new simplified arrangement (the IFRC and JRC which benefitted from a very clear national mandate) was superior to the original arrangements inherited from the regional project design.

21 This issue was highlighted during discussions between the LRC and the evaluators. It was also noted as an issue in the ROM report for T04.30 from October 2018.

T04.31 was operated in Jordan and Lebanon and has two international NGOs as partner IPs and two 'local' NGOs from Jordan. The selection of the local NGOs for this intervention was not initially consulted with the Jordanian authorities. As noted elsewhere, there was lengthy and intensive interaction between the IPs and the GoJ to resolve this issue, but to no avail. Interviews indicate that a significant amount of time was invested into this effort over the period of a year or so. This represents a highly inefficient and ineffective use of resources. An NCE until Dec 2020 was granted to manage the re-allocation of Jordan funds to Lebanon for its use in applying the REBAHS model by MEDAIR Lebanon.[22] Paradoxically, this was to Lebanon's benefit, with the IP (MEDAIR) being able to utilise the funds for the Lebanon component and, thanks to the NCE, delivering some tangible benefits.

The AFD-led component of T04.50 overall had an original duration of 30 months and formally started in July 2017, implying an original completion date of January 2020. However, due to delays in the project start up, this component has been awarded a NCE that now extends to January 2021 i.e. a 12 month extension. These delays are linked to the registration process of these NGOs in JORISS and also setting the complex internal contractual arrangements for the AFD-led component. The component led by Italian Cooperation also experienced delays prior to start up due reportedly to its internal reorganisation back in Italy as well as and the JORISS registration process. To compensate for these difficulties, an NCE was granted in December 2018 that extended the duration of the action from 30 to 42 months and it now has a completion date of June 2021.

A further point worthy of consideration when assessing efficiency of regional/ multi-country interventions is the length of time taken to turn these project concepts into action on the ground. Both T04.30 and T04.50 can trace their origins back to 2015, when the original project ideas emerged.[23] However it took some 3 years to translate both the proposals into start-up of implementation. The main reasons for this were reportedly linked to establishing the contractual and implementation arrangements and then agreeing the scope of work to be done by the various partners in each country. This implies that the approach taken for this project to deliver its results is inefficient and has held back the delivery of planned outputs far more than is stated in project reporting. This stands in contrast to the generally better efficiency of nationally planned actions (see below).

Efficiency of Nationally Programmed Interventions

Those interventions programmed nationally benefitted from simpler, less elaborate implementation arrangements (invariably one or two IPs working on delivery) – these ensured that the preparatory phases (finalising designs and putting in place contractual arrangements) were typically no longer than 12 months before projects entered implementation. This had a

22 Reducing Economic Barriers to Accessing Health Services.
23 This fact was confirmed to the evaluators by the IPs during the field missions i.e. that the original ideas for these interventions came from discussions between the international partners, their local interlocutors (such as LRC and JRC) and the EUTF Syria. These took place in the course of 2015. The AD was approved in 2016, contracts signed in 2017 and implementation commenced in the period between then and 2018/9.

knock-on effect in terms of the need for project extensions – no significant NCEs were noted in any of the national projects. The two health infrastructure projects in KRI and Jordan illustrate the benefits of the national approach, with the latter a particularly good example of efficient planning and implementation (see case study below).

Discussions with a wide range of partners in the field provided almost uniform feedback regarding the regional/ multi-country implementation modality i.e.: the potential benefit of the regional approach that was noted was linked to the ability to programme funds centrally (EUTF Syria and IPs located in Brussels), which represented a perceived efficiency gain in terms of allocating funds quickly to IPs to deliver actions on the ground. In reality, any efficiency gains have proved illusory as the projects became bogged down in their internal preparatory processes, approval with and redesigns due to the reasons mentioned throughout this report – also, project outputs from Regionals only began emerging 3 to 4 years after their approval, which stands in stark contrast to the efficiency of national EUTF Syria interventions (see case study 3 below).

Case Study 3 – Efficient Delivery of EUTF Syria Health Infrastructure in Jordan (T04.105 Expanding and Equipping Ministry of Health Facilities Impacted by the Syrian Crisis in Jordan)

Thanks to the EUTF Syria, Syrian refugees and Jordanians residing in Sahhab district, one of the most impoverished and under-served areas of Amman will have a better chance to access more improved primary and secondary health services in Jamil Tutunji Hospital (JTH). Around 500,000 people access the hospital, of which 70,000 are Syrian refugees. Jamil Tutunji Hospital is one of the main three hospitals nominated by the MoH to benefit from the project "*Expanding and Equipping Ministry of Health Facilities Impacted by the Syrian Crisis in Jordan*" implemented by UNOPS with financial support from the EUTF Syria programme. The hospital will receive from the EUTF Syria support a reconstructed and extended accident and emergency unit, new medical equipment for the facility and a new ambulance to serve emergency cases.

Strong Ownership Linked to Clear Strategic Priorities and Needs

The project embodies Jordan Crisis Response Plan health priorities of providing Syrian refugees and vulnerable host communities with improved health care services, as well as promoting inclusive and resilient health provision for the most vulnerable Jordanians and Syrians.

Of the projects financed in Jordan by the EUTF Syria programme, this particular project considered the first national one i.e. programming and implemented exclusively in Jordan. The direct engagement of the Ministry of Health (MoH) and management of beneficiary hospitals has built strong ownership of the project among its key institutional beneficiaries. The project was conceived and prepared throughout 2018 jointly by the MoH, UNOPS and the EUD. JORISS registration was quick and implementation started in March 2019.

Good Performance in Implementation

The project implementation has so far been efficient and UNOPS has demonstrated excellent planning. It has sequenced the procurement of medical equipment with the constructions works of to ensure that the former will be stored by the suppliers and delivered only once the works in the hospitals are completed. UNOPs expects to complete the construction phase and deliver the medical equipment within the set timeframe i.e. by the end of February 2020, less than 12 months after implementation commenced. This would allow the finalisation of the project by the end of March 2020. Coordination between MoH, UNOPS and the hospital's management has been good, as evidenced in the smooth workflow of the project. For example, to ensure continuation of service provision, MoH and UNOPS planned for a zoning approach in the hospital, with specific timeframe for each zone to be rehabilitated. The quality of the works was verified by the evaluators in the field as being of good quality and in line with the project documentation.

Cost-efficiency is also good - UNOPS reports to have managed to save 10% of the total budget in implementation and at the time of the field mission, discussions were to be held with the MoH and EU Delegation to agree on how best to use up these savings.

Sound Effectiveness and Sustainability

The project will deliver all of its planned outputs on time, and these in turn should result in clear direct benefits for the target groups in terms of better facilities and faster, better quality treatment of their emergency health needs. Also, sustainability is covered – project outputs will be handed over to the hospital management and will be maintained by MoH's technical and maintenance team in the future. This should ensure that project benefits remain available to target groups in the hospitals' catchment area.

Issues still to be addressed

Despite the excellent quality and timeliness of implementation evidenced by UNOPS, the current outcome indicator (which was defined in the initial programming document in 2017 and not subsequently updated) does not adequately capture the benefits to be brought by the project. The current outcome indicator is *"# hospital inpatient admissions per 1,000 population (disaggregated by host communities/ Syrian refugees)*" implying the project would aim to increase the number of people treated by the hospital. Discussions with UNOPS and the Jordanian beneficiaries showed that, in reality, the project does not aim to directly increase number of treated patients, but instead should lead to better quality of service for patients (i.e. a qualitative indicator) and reduced waiting times for treatment among patients (i.e. quantitative). This implies that the outcome indicator would benefit from a revision so that its outcomes could be better tracked for the purposes of EUTF Syria results reporting.

Performance of Implementing Partners

Evidence from the field suggests that in general, **both international organisations** (such as RCCs, UN agencies) **and international NGOs** (IMC, MEDAIR) **have experienced broadly the same levels of challenge (or not) in implementing EUTF Syria interventions efficiently.** There is no obvious correlation between the type of IP selected for implementation and the actual efficiency of the intervention.

The two infrastructure projects mentioned above illustrate this point: T04.105 in Jordan is implemented by UNOPS, an international organisation with a longstanding presence and experience in the country. AISPO (implementing T04.18/181) is an Italian health NGO with a presence in KRI since 2013. Both have been able to manage implementation well, irrespective of the type of organisation. This also applies to, for example, UNHCR in Lebanon (T04.47) and IMC in Lebanon (T04.54). Both have managed projects of a similar character efficiently, despite their different profile and resources available to them.

The key success factors evidently lie elsewhere i.e. in these organisation's expertise and experience in their respective countries, their relationships with national interlocutors, the quality of the project design etc. Of these, the main factor was noted as being the capacity of the selected implementing partner. The evaluation found overwhelming evidence to suggest that the selected IPs were up to the challenge of implementing their (often complex) projects. The importance of the capacity and experience of the UNOPS and AISPO in delivering their interventions has been discussed in the case studies. In Lebanon, project partners confirmed that the work done by the IMC/PUI (T04.54 and T04.147) was high quality and ensured the successful delivery of project results. Whilst problems have been noted in some aspects of T04.96, the IP (UNICEF) has successfully procured and delivered the vaccines and medicines requested of it – although its actual effectiveness remains open to question (see case study in Annex 5 for more).

The primary difficulty faced by the regional/ multi-country IPs (again discussed elsewhere) was the implementation structure that they had created for themselves, and which hindered project start-up and slowed down implementation. Despite these burdens, the evaluators found the IPs were able to overcome these difficulties thanks to a mixture of patience, pragmatism and expertise. In T04.30, the host RCCs in Lebanon, Iraq and Jordan have been able to deliver their planned activities in spite of the delayed start-up and disruption to the original project set-ups. Focus group discussions between evaluators and final beneficiaries confirmed the RCCs' high level of expertise and professionalism, as well as the high esteem in which the RCCs were held. In T04.50, the work of ACTED in conjunction with local community-based organisations (CBOs) to map local needs and then deliver valuable training courses on reproductive health was considered highly professional by local partners.

Adequacy of Budgets, Financial Performance, Adherence to Procedures

The evaluation was able to establish that some of the basic elements of programme efficiency had been met. Firstly, all of the EUTF Syria Health interventions had delivered their activities in line with approved budgets. **No budget increases were noted and where extensions were granted by the EUTF Syria for implementation, these were on a non-cost basis** (for the EUTF Syria). This has allowed the IPs to deliver their planned outputs without requiring any additional finances from the EUTF Syria. It was noted by a couple of regional IPs that the NCEs were not in fact totally cost-neutral: the IPs still had to find resources to cover staff costs and overheads for the period of time when the projects were not actually delivering activities, and in the case of the host RCCs in T04.30, these reportedly represented significant extra burdens that put these organisations under financial stress. Ultimately, there were no examples noted where this additional cost had significant implications for project performance, suggesting that the IPs were able to find internal solutions to these problems. Also, it confirms that the EUTF Syria budget allocations were adequate to ensure that activities and outputs were delivered in line with their planned costs i.e. that EUTF Syria support has been both cost-efficient and cost-effective.

Secondly, **all of the interventions appear to have been contracted in line with relevant standards and the IPs have followed all the relevant procedures** for procuring and contracting inputs. For the international organisations, this has been in line with their procedures (as per PAGoDA arrangements). For others, this has been either using EU PRAG procedures or in the case of T04.30, IFRC procedures harmonised in line with EU requirements. This was reportedly to be a somewhat unwieldy arrangement - both the JRC and IFRC in Jordan and the LRC, PRCS & Netherlands Red Cross (NRC) in Lebanon highlighted examples of difficulties in procurement linked to procedures that were in part due to this fusion of procedures and in part a by-product of the consortium set up. In Iraq, EUTF Syria resources were found to have been contracted and procured in line with prevailing procedures, with few exceptions or modifications (T04.18), where the project filed for an urgent request to seek an exception from PRAG rules (which was granted).

With one exception, the EUTF Syria Health interventions' resources have been made available and deployed in a timely and predictable manner. Funds have been at the disposal of the IPs from the EUTF Syria upon request and these have largely been allocated for the purposes intended as when needed. The only project experiencing difficulties with managing financial flows and budget planning is T04.96 in Lebanon, implemented by UNICEF. The procurement of medicines and vaccines is done based on a list drawn up by the MOPH in consultation with the necessary stakeholders (IPs). MOPH then estimates (on the basis of PHCCs requests) the needs/quantities of vaccines and acute medicines for procurement and delivery to MOPH central warehouse. UNICEF then places the order and managed delivery to the central warehouse. However, after discussions between the IP and MOPH, it was agreed to adjust the acute medicine list to include non-standardised items, although this resulted in delays in UNICEF procuring the necessary acute medicine and delivering it to the central MOPH

warehouse. The funds used for procurement have not always been in line with the demand for medicines and vaccines due to the lack of visibility of consumption.

The existing MOPH stock management system is noted by many stakeholders as having limited capability and is not able to systematically track the consumption of vaccines, vaccination consumables, and acute medicines beyond the central level warehouse. This lack of data/visibility for consumption data means it is always extremely difficult/near impossible to effectively monitor and manage inventory and obtain accurate procurement forecasts to assure proper stock management and availability. Thus, funds procure the bulk of the acute medicines at the start of a year. These are then depleted based on (previously unknown) demand which can lead to shortages of some medicines and over-stocking of others. Ideally the likely demand would be known in advance and procurement adjusted to meet it. This is not the case at present, although the future EUTF Syria intervention in this area aims to address this particular issue.

Reporting on Performance, Utilisation of Budgets

The evaluators sought to find a clear linkage between the activities/outputs planned in the project DoAs and the budgets allocated to their delivery in the accompanying annexes. Then they looked to track how the IPs reported the delivery of the aforementioned activities and use of financial resources for this purpose in the project reporting.

As regards the budgets and their linkage with planned activities/outputs, the picture was mixed. For the most part, they provided the basis for reporting on usage of resources for delivering project outputs. For the regional/ multi-country programmes/ projects, the DoA for T04.50 contains a detailed activity plan per result and outcome. In principle these should lend themselves to being translated into budget lines in the project budget. However, this was hampered by the lack of a clear costing of these activities in the DoA, and the budget itself is too brief to provide insight of whether the IPs have made a detailed costing of the action based on planned activities. This is also reflected in the project reporting (see below).

By contrast, T04.30 documentation gives a detailed assessment of planned activities. Their costs are laid out in the budget, which is sufficiently detailed to aid tracking of performance. The one weakness is that there are no explicit linkages between the costs laid out in the budget and the delivery of expected results (outputs). This complicates reporting (see below).

For the nationally programmed interventions, the picture is also mixed. In Jordan, T04.105 has a DoA that outlines the project activities in general terms and the project budget is detailed and clearly linked to the planned project activities and outputs. T04.96 and T04.74 in Lebanon also have budgets and activities that are well aligned. The project budget of T04.54 is detailed and contains a sound analysis of project costs linked to activities. This allows a clear tracking of activities against costs and a sound basis for project reporting. By contrast, the DoA of T04.58 in Turkey was found only to have a general budget description which lacked details about how project the budgets were arrived at.

The quality of financial reporting by the IPs was found to be generally sub-optimal. There is largely an absence of financial reports that explicitly link project expenditure to the delivery of project activities/results. Also, a wide variety of different formats of reporting was noted: some IPs provide lengthy and highly detailed financial reports while others provide little more than a basic summary of how much money was actually spent in the reporting period. The evaluators appreciate that each IP has its own reporting procedures and formats. In the case of those international organisations covered by Pillar Assessed Grant or Delegation Agreements[24] (PAGoDA 1, later replaced by PAGoDA 2), these are locked into the agreement between them and the EUTF Syria contractually. Nevertheless, the upshot of this state of affairs is that EUTF Syria programme managers and external assessors (such as ROM monitors and evaluators) face serious difficulties in understanding how EUTF Syria funds have been deployed by the IPs to deliver planned project results. These issues were noted among numerous projects across all countries and delivered by different IPs. The text box illustrates some examples found in the evaluation sample.

None of the analysis above is meant to imply that the IPs are intentionally aiming to hide how funds have been used failing of the IP – rather, it illustrates a wider trend among IPs of not fully appreciating the importance of providing clear and transparent financial reporting to external partners so that programme efficiency and effectiveness can be easily tracked.

Narrative reports submitted by the IPs to outline progress in the implementation of their EUTF Syria projects were found to be of generally good quality. The two regional interventions T04.30 and T04.50 faced the unenviable task of trying to capture all the various dimensions in their reporting. In the case of T04.30, the lead IP was able to do this. For T04.50, the narrative reporting is split between the two IPs (AFD and Italian Cooperation), each of which produce their own report. This approach merely reinforces the impression that this intervention is in fact two separate projects with no real linkage between them. Best practice for progress reporting can be found in T04.54 – in addition to concise, analytical progress reports (using the EUTF Syria template), the IP produced a 'dashboard' that captures the project design, the main activities and locations of the project and its achievements to date.

Role of EUTF Syria national counterparts

In **Jordan**, the main institutional partners at government level in the sector are the Ministry of Health (MoH) and the Ministry of Social Development (MoSD).[25] The former is the lead player in the sector The MoH has played a valuable role in facilitating the preparation and delivery of the only active EUTF Syria health intervention to date (T04.105). For T04.50, AFD and its partners have been working through governorates and local departments of MoH and MoSD

24 PAGoDA as a contractual model allows the signature of Delegation and Grant Agreements with organisations that have undergone a pillar assessment based on the conditions set by the EU Financial Regulation. In this regard, the Financial Regulation is laying down common rules and procedures for the implementation of the Union's instruments for financing external actions.

25 In addition to these two line ministries, there is also the High Health Council which plays an overall policy coordination role between the ministries and other key Jordanian institutional stakeholders. This is primarily a key interlocutor in coordinating donor assistance (see Chapter on Coordination and Synergies).

for the implementation of the project's MHPSS component. Evidence indicates that although these institutions' ownership is strong, capacity at local level among these partners (technical and personnel) are currently limited, with the IP reportedly now looking to address this capacity gap. Where the MoH (and also the MoPIC) have not been engaged directly in preparation of EUTF Syria interventions – i.e. regional/ multi-country programmes/ projects - primarily the mandatory but lengthy registration with JORISS has not really contributed to a quick project start (see Relevance and Effectiveness sections for more on this, particularly T04.31). As with Lebanon, the MoH has a key policy-making role. However, unlike the EUTF Syria there, the portfolio of interventions in Jordan has not yet looked to support the MoH in addressing policy issues. Of the two new interventions planned for Jordan, one (linked to NCDs) was originally designed to cover NCD strategy as well, but its design was later reportedly revised and the strategy component removed.

In **Lebanon** the MoPH and MoSA are the two key national institutions. Their capacities are reportedly weak in terms of staff numbers so their ability to actively participate in programming and implementation of the currently implemented projects has been limited. Also, the limited leadership and strategic steer provided by the MoPH was highlighted by multiple stakeholders as being a challenge in linking the developmental dimensions of EUTF Syria support (linked to reforms in critical areas such as primary and secondary healthcare) to national reform efforts. This is of critical importance for the sustainability of any EUTF Syria intervention that intersects with such reforms i.e. T04.47, T04.74 and most notably, the work with Primary Healthcare Centres (PHC) under T04.54. Finally, the ability/capacity of the MoPH to effectively manage the supply chain for vaccines and medicines that is critical for the effectiveness of T04.96 but has been found to be lacking (see Box 3).

Box 3: T04.96 – the importance of a functional Supply Chain

MOPH have the basic technical capacity to deal with the procurement and delivery of acute drugs/vaccines that is provided via T04.96. The Karentina MOPH warehouse in Beirut has storage facilities for vaccines and medicines. Problems occur when new orders of acute medicines arrive and the warehouse can be overloaded. The storage for vaccines is considered satisfactory and benefits from UNICEF's VIVA (Vaccine Visibility Platform) system. The absence of a comprehensive supply chain management system is the Achilles' heel in the set-up which occasionally compromises efficiency and effectiveness of the assistance.

Two IT systems exist in this area – The MoPH's PHENICS (health information system) and UNICEF's Mobile Expanded Programme for Immunization Registry Application (MERA) for real time monitoring of Immunization service at all epidemiology network facilities. Both of these in principle provide technical infrastructure that supports supply chain management but in reality their interoperability is not secured. The evaluators are of the view that the acute medicine and vaccine supply chain require a root and branch review and enhancement before it can be considered secure, sustainable and fit for purpose.

In **Iraq**, the engagement of the main national partners (the Ministry of Health and DoH of Dohuk Governorate) has been positive. Their capacities to facilitate the delivery of the EUTF Syria projects in KRI were found to be good. The DoH in particular has been proactive in working with donors to strengthen the health sector in its governorate. This has been particularly evident in its work with AISPO under projects T04.18 and T04.181. Nevertheless, capacities within these institutions are limited and in key areas addressed by EUTF Syria support, very much in need of strengthening. Under T04.183 for

example, according to DoH, the government's capacity to provide MHPSS for persons affected by the current crisis and those with chronic and severe mental disorders including IDPs, refugees and host communities, is very limited.

3.3.4 Coherence[26]

This chapter examines the interaction of the EUTF Syria health portfolio both internally and vis-a-vis other donor-led interventions. This coherence is looked at from multiple dimensions. The interaction between EUTF Syria health interventions and those projects financed from other donor mechanisms is assessed i.e. projects not financed by the EUTF Syria (external). Also, the evaluation will look at how well EUTF Syria interventions interact between one another (internal).

This interaction will be broken down into three dimensions i.e. **coordination** – based around communication between the programme stakeholders during project preparation and implementation on their respective activities; **complementarity** – whether EUTF Syria projects and other interventions are actively planned or carried out a related or consecutive manner[27] and; whether there is evidence of any **synergies** emerging from these interventions and the extent to which these synergies had been identified in the programming phase of the EUTF Syria health interventions.

Coordination mechanisms and complementarity with other donors/instruments

Each of the countries covered by the evaluation has a different donor landscape in the health sector. In Lebanon, the sector is dominated by EUTF Syria funding. In Jordan, the EUTF Syria is a relatively small player in a sector dominated by bilateral donors (especially the USA). KRI presents a mixed picture of EUTF Syria and other donors active in the sector, and particularly in the governorate of Dohuk. Both Turkey and Egypt also have other donors active in their health sectors. These contexts have influenced how EUTF Syria support has been coordinated with other donors, how its complementarity has been assured and whether synergies have emerged.

EUTF Syria programming documentation (ADs, DoAs) make extensive references to donor coordination arrangements, the forums in place and how the EUTF Syria intends to utilise these forums to ensure that programmes and projects are properly coordinated. In this respect, the mapping done is good and was found to correspond with the reality on the ground.

26 This evaluation criterion incorporates responses to the following evaluation questions: EQ 13: To what extent was the support provided by the EUTF Syria-Syria for Health programmes/ projects coherent, complementary and coordinated with other major funding mechanisms (EU including also ENI)?; EQ 14: What is the quality and extent of coordination/ complementarity/ synergies between national and regional/multi-country EUTF Syria Health programmes as well as ENI (and other EU) funded actions?

27 For a more detailed definition of complementarity, see, for example "How to effectively access and use the ESI Funds and exploit complementarities with other instruments of relevant Union policies" issued by DG Regional Policy" in 2014 https://ec.europa.eu/regional_policy/sources/informing/dialog/2014/3_guidance_beneficiaries.pdf.

Each country has its own set of donor coordination mechanisms. These include the health task force working groups for the country CRPs for each country. Various other forums also exist in these countries to manage donor-host country relations in the health sector. In Jordan there are two forums dealing with humanitarian and development assistance, with the latter – the Health Development Partners Forum (HPF) - the main mechanism for EUTF Syria coordination. In Lebanon, a high-level National Health Steering Committee exists for strategy and the other is a dedicated steering committee for EUTF Syria health interventions. In Iraq, the local authorities assume the role as coordinator amongst donors and implementing partners. Turkey has a complex network of coordination forums (e.g. the Health Information Working Group; Health Sector Coordination Meetings), while Egypt has a health working group that facilitate information sharing and complementarity between development partners based in Egypt with active presence of Ministries of International Cooperation and Foreign Affairs as key partners form the national side.

All of these forums in principle provide the space where coordination and complementarity between EUTF Syria and other donor assistance can take place. In reality, it was found that the picture was mixed. Evidence suggested that coordination between EUTF Syria and other donors worked well in Iraq thanks to the decentralised nature of the assistance there (largely centred in Duhok and strongly led by the Directorate for Health there). In Lebanon, the EUTF Syria Steering Committee acts as an effective forum to coordinate between EUTF Syria interventions but less so with other donor interventions (of which there are very few).

In Jordan the HPF is primarily an opportunity to exchange information on individual actions (including EUTF Syria ones) and also to discuss implementation issues relating to them. It has a useful coordination function, although it is less clear that it has strengthened complementarity between EUTF Syria and other interventions or for affecting the overall design of EUTF Syria programmes.

The desk review from both Turkey and Egypt found that coordination arrangements in those countries were also fit for purpose. Documentary evidence suggests that complementarity is taken into account in programming documentation to ensure these emerge.[28] ROM reports however were unable to identify cases of complementarity in practice.

Feedback from IPs, donors and national partners indicated that in many cases, issues of coordination and complementarity are discussed and, in some cases, addressed, but these often occur in informal settings, or through bilateral one-on-one meetings. In Lebanon, the EUTF Syria and Global Affairs Canada (GAC) have reportedly been in close bilateral discussions on how EUTF Syria and Canadian assistance into the health sector might complement one another (in specific terms for T04.31 there), and the EUD has been also exploring possible collaboration with France in the area of mental health; in Jordan, it emerged from discussions

28 In T04.30 for Egypt, the evaluation found that the DoA stated that RC/RC aimed to complement national efforts and existing community initiatives through support to individuals, organisational and institutional skills. According to DoA, through activity 2.1.3 (Provide mobile basic health care outreach services for most isolated refugee and host communities and establish referral systems for secondary health care) the action is synergic with an already ERCS PS programme of which provides medical convoys.

in the field mission that T04.50's work in the area of mental health is being looked by bilateral donors as an approach that they could also work with.

IPs noted that they were often communicating with their counterparts from other donor-funded activities to coordinate their interventions 'operationally' i.e. to ensure that that they did not duplicate each other's work, or to prevent events with similar target groups running in parallel. Such informal approaches appear to largely depend on the professionalism of the IPs to be effective. As noted under efficiency, IPs have for the most part such competences so it is reasonable to assume that this informal coordination adequately makes up for any shortcomings within the formal coordination mechanisms.

Complementarity and Coordination of ENI and EUTF Syria in the health sector

Despite some past interaction between the two[29], there is currently **no linkage between ENI and EUTF Syria** as they operate in different sectors and have until recently had different focuses (EUTF Syria more variated types of assistance, whilst, ENI more focused on system strengthening/ capacity development). In this regard, stakeholders noted numerous barriers to ENI and EUTF Syria being more harmonised to carry on the work done under EUTF Syria health interventions. As regards other EU-funding mechanisms, although dialogue is constant between ECHO and EUTF Syria, the two instruments do not currently link particularly well in programmatic terms. The need to improve this linkage was noted as an issue, particularly as both instruments need to address the prevailing development 'nexus' in the region.

Coordination and Complementarity within the EUTF Syria Health Portfolio

Ideally the EUTF Syria health portfolio would be coordinated as a coherent programme to ensure that each intervention complements its other counterparts in the sector, and that they are coordinated in such a way as maximise their efficiency and effectiveness. **In practice, the situation varies significantly from country to country**.[30]

Lebanon is unique among the countries in this evaluation inasmuch as it has its own dedicated EUTF Syria Health coordination forum - the EUTF Syria Health Steering Committee (STC). The evaluation found the STC to be functional and includes all ongoing EUTF Syria project partners and national agencies. Overall feedback indicates that the STC has ensured good coordination of the EUTF Syria interventions among one another. Stakeholders canvassed during the field mission observed its added value also in terms of being a forum for information exchange and a space for discussing health issues with representatives of the MoPH and MoSA. They noted that this forum remains primarily operational in character – it could in time ideally develop a more strategic focus for future EUTF Syria activities. Also, it was commented that in practice, even operational issues related to, for example, supply of medicines and failings in the supply

29 ENI emergency measures were launched in Lebanon in 2013 to address Syrian refugee humanitarian needs including health.
30 In Egypt and Turkey, the evaluators found no documentary evidence during the desk review to provide a detailed answer on this issue.

chain, could not always be adequately resolved at the STC (Although this was as much to do with the attitudes of the individual IPs as the functionality of the STC).[31]

In Jordan, the overall impression is that all the EUTF Syria projects are being implemented separately of one another, with few if any evident signs of complementarity between them. There are few references to other EUTF Syria interventions in the individual project designs. This could be explained by the programming approach taken at the time the projects' preparation, but in any case, it has meant that any sort of sector level appreciation of how EUTF Syria health interventions should complement one another is absent in the programming documents.

As regards implementation, the HPF evidently provides space for donors and GoJ representatives to discuss issues in the sector and coordinate at a programmatic level. However, there is no dedicated EUTF Syria sector support forum such as the one found in Lebanon that would bring IPs together along with their Jordanian counterparts under the aegis of the EUD. Discussions with IPs indicated that they were aware of each other's interventions and exchanged information on an ad-hoc basis. However, this did not constitute any sort of structured or formal process. The EUD appears not to play any proactive role in the steering of the EUTF Syria health portfolio interventions in Jordan. Overall, the evaluation found no examples where one EUTF Syria health intervention had influenced another to such an extent that it led to its redesign or implementation.

In Iraq-KRI, it is clear that EUTF Syria health interventions are effectively coordinated with other EUTF Syria health interventions to ensure their continuing complementarity with them -- this is done mainly through the Health cluster steering committee (led by Directorate of Health in each governorate). In Duhok governorate one can find the best level of coordination compared with other governorates, especially with the DoH there. Also, AISPO, ACTED and Norway RCC (T04.50) all reportedly coordinate bilaterally, which has led to the emergence of some synergies (see below).

Synergies

Programme documentation (ADs and DoAs) makes sporadic references to synergies between EUTF Syria health programmes/ projects and other interventions in the sector. The evaluation found that for the most part, these references were rather general in character and, with a few exceptions, failed to explicitly state how the EUTF Syria assistance, in combination with other funding interventions, generate enhanced project results. The evaluators were nevertheless **able to identify several examples of synergistic effects between EUTF Syria and other donor-led interventions**.

A clear, planned synergy was found in Lebanon, where the EUTF Syria funds used in T04.47 have a clear synergy with other funds provided to the UNHCR for the delivery of the project. These constitute some 10% of the total budget for the provision of secondary healthcare for

31 Ad hoc meetings are reportedly also organised by the EUD on specific topics according to the needs and only with relevant IPs.

Syrian refugees provided by the UNHCR. This pooling of resources ensured that a critical mass of Syrian refugees could access affordable hospital care in a way which the EUTF Syria itself alone would not be able to.

In KRI, synergies between EUTF Syria health interventions at all levels are identified and exploited to maximise their effectiveness. There are some examples of synergy that were created through the interventions, like the Hevi Paediatric Hospital (Partially funded by WHO), as an example of synergy and complementarity between T04.18 and GIZ-led projects (including equipment and training on how to manage and maintain them), and between T04.18 and WHO (the same thing is for T04.181 and WHO, where the project T04.181 covers some activities and WHO covers others).

In Jordan, project T04.105 exhibits some synergies with USAID and other donor investments into the hospitals benefiting from EUTF Syria support. Unlike the UNHCR example, however, this synergy was evidently not planned in the design stage – there is no explicit analysis in the DoA about how the project will look to take forward the investments of the other donors in these health facilities to improve their effectiveness and benefit Syrian refugees in their locations. Nevertheless, the fact that this has happened is a positive effect and demonstrates good additionality to the funds of both donors.

Box 7: Missed synergies in T04.50?
There have been no efforts on the part of the IPs to exploit potential synergies within the project, despite the obvious potential being there to do so. The infrastructure component led by AICS and the capacity building/service provision in the area of MHPSS led by the AFD appear to have a common area of interest i.e. it is recognised that facilities for MHPSS in Jordan (and the other two target countries) are minimal and what does exist is in need of upgrading. To meet these needs (and enhance the effectiveness of the AFD-led component) investments from the infrastructure grant schemes managed by AICS could have been used for this purpose. However, the grant scheme contains no specific focus on MHPSS and reportedly has no applications that are likely to be funded in the area of health.

In Turkey, T04.58 was noted to have some synergies with one German-financed initiative providing healthcare for Syrians under temporary protection (although this synergy is not noted in the project DoA).

Elsewhere, few synergies were noted. The regional/ multi-country intervention designs lacked any analysis of likely synergies and evidence from the field missions confirmed their absence. IPs appears to have been too pre-occupied with implementation to be looking for possible synergies with other interventions. No synergies have been reported in the project documentation or were evident during the evaluation mission of T04.30 (see Box 7).

The coordination mechanisms mentioned above appear to have not been used explicitly for the purposes of mapping or exploring potential or actual synergies. This is perhaps understandable given their more operational focus on coordination and communication among donors and recipient governments. Hence, the importance of identifying synergies in the preparatory phase. The fact that the current raft of EUTF Syria health projects lack in their DoAs a systematic mapping of possible synergies inevitably weakens the likelihood that such synergies will emerge in implementation, and where they do so, it is more likely to be by chance rather than design.

EUTF Syria future strategic approach

Donors and other external stakeholders observed that (with the exception of Lebanon) they had limited understanding of the EUTF Syria strategy for the health sector. This extended to the rationale behind the individual interventions funded by the EUTF Syria (most notably the case in Jordan). The evaluators were asked by stakeholders in the country what the longer-term intentions of the EUTF Syria are in this sector, as the prolonged crisis and the given needs would also require longer-term measures. This point raises the question whether, despite the limitations of the EUTF, a longer-term and more strategic approach would be desirable and what kind of benefits it would offer.

It was recognised that the EUTF Syria evolved rapidly in the period when the Syrian refugee crisis was at its peak and at that point a strategy would have been of little value. However, with the nature of the crisis having changed significantly, the utility of a more strategic perspective was seen as being much greater. The following areas were seen as being most worthy of consideration.

- Thematic concentration – as noted in the Relevance chapter, the wide array of themes covered to date by the EUTF Syria health portfolio lacks a clear focus in terms of priorities and related funding concentration. A strategy would help clarify the programme direction.
- Current and future programmatic orientation – the question of how EUTF Syria health interventions would address the humanitarian development nexus came up repeatedly. Given the circumstances that the EUTF Syria's target populations currently find themselves in (which is significantly changed from when the EUTF Syria started in 2015), a strategy spelling out the EUTF Syria's intentions would further strengthen the EUTF Syria's programming orientation and reflect the largely developmental nature of the challenges now in the sector.
- Linked to this issue is the future of the EUTF Syria itself. The EUTF Syria is in essence a temporary facility and it was evident that several stakeholders were uncertain of how long the Trust Fund would be active and if there was a vision or plan over how the EUTF Syria would exit the countries (and what would be the 'handover' arrangements). This fits in with the issue of linkages of the EUTF Syria with other programmes such as ENI, ECHO and other donor programmes (see also section above). At the time if this report the negotiations for the Multiannual Financial Framework 2021-2027 were still ongoing. The decisions still to be taken in this regard will also have a lasting effect on the future of the EUTF.
- Coordination & complementarity: Till now, EUTF Syria support has been built around individual programmes/ projects, which makes strategic coordination and complementarity difficult with other partners. The absence of a coherent EUTF Syria health 'programme' underpinned by a strategy was seen as being a weakness given the current circumstances.
- Linked to this, the importance of the EUTF Syria being able to clearly communicate its intentions to its partners (fellow donors, IPs and national partners) was noted.

Overall, it is recognised by the evaluators that given the temporary character of the EUTF Syria, a detailed strategy would have only limited utility. Nevertheless, based on such feedback it is evident that **capturing some key elements of EUTF Syria orientation and its future direction would offer benefits for both the EUTF Syria and its stakeholders**. In this context, the evaluators found that the 'new' ADs for Jordan and Lebanon go some way to addressing these issues.

3.3.5 Sustainability[32]

In this chapter the evaluators have considered the factors influencing the sustainability of the EUTF Syria-funded health interventions and how well their results are likely to be sustained once EUTF Syria assistance ends.[33]

Factors affecting sustainability

Any assessment of EUTF Syria sustainability has to take into account the basic character of the EUTF Syria. As noted in the previous chapter, the **EUTF Syria is a temporary funding facility and unlike many other development programmes, it is not in itself a sustainable source of funding.** Furthermore, health is not a priority in the cooperation between the EU and the partner countries given their middle-income status. In this context, it should be reiterated that the EUTF is in fact mainly concerned with providing direct assistance to Syrian refugees, rather than with providing a general regional and/or country-specific health sector reform strategy for Syria's neighbouring countries. Therefore, the EUTF Syria is by its very nature not a sustainable funding model in the health sector. For those interventions supported by the EUTF Syria and which are likely to require additional funding in future to sustain their results (such as the piloting of the FFM under T04.54) this represents a challenge, particularly where other donors in the sector are scarce on the ground, as is political will among host governments.

Table 4 below presents an overview of the factors identified by the evaluators as influencing the sustainability of the EUTF Syria health interventions in the sample. The paragraphs thereafter discuss these factors and their likely effect on the EUTF Syria health results.

Table 4 – Factors affecting sustainability of EUTF Syria health results

Common factors for all EUTF Syria interventions	Country-specific factors (Country)
Availability of follow-on funding (or lack thereof)	Institutional capacities of beneficiaries (Jordan)
Ownership of project results	Unstable political/institutional environment (Lebanon)
Alignment of project results with national structures/priorities	Affordability of services provided (Lebanon, Jordan)
Existence (absence) of sustainability plans	

32 This criterion covers EQ 15: What are the main factors for sustainability of the EUTF Syria-funded Health programmes/ projects and to which extent are these factors currently ensured?
33 EUTF Syria health support in Egypt and Turkey was not covered for this criteria as neither country was included in the field phase and sustainability factors could therefore not be verified on the ground.

As a general observation, those nationally programmed EUTF Syria health interventions appear to benefit from better ownership among their national institutional partners (whether these be ministries, directorates of health, or hospital/ PHCC management teams) than that enjoyed by regional/ multi-country interventions. This is directly linked to the process of preparation and design of these interventions, which has been more inclusive, has enabled the active involvement of these partners in the design process and has also involved them more directly in implementation (see also Relevance, p13). The most notable examples of this phenomenon are T04.18 in KRI, T04.54 in Lebanon and T04.105 in Jordan. This strong ownership also augurs well for the sustainability of these interventions, as outlined in the paragraphs below. By contrast, regional interventions generally lacked ownership beyond their IPs and direct beneficiaries, meaning that their lifespan is tied directly to the existence of EUTF Syria or other donor funding.

In Jordan, the main factors affecting sustainability of EUTF Syria health results are affordability of EUTF Syria results for the final beneficiaries, institutional capacities of beneficiaries, ownership of results by final beneficiaries, availability of national funds, and quality of alignment with national priorities in the sector.

The situation on the ground for the individual projects shows that benefits of EUTF Syria health interventions are already evident but that only one intervention (T04.105) has a clear pathway towards ensuring their sustainability.

As regards the regional interventions, there are mixed sustainability prospects. There is little evidence of EUTF Syria project results being integrated into national or other GoJ structures. Discussions with the main national partner (MoH) suggested that it has minimal awareness of the regional programmes'/ projects' results. Therefore, it is unlikely at this stage that these will in some way be integrated into national strategies or practices or benefit from whatever national funding is available for such services. Regional/district institutional partners reportedly lack resources to finance the continuation of these services after EUTF Syria funds are over and are not in a position to integrate them into their own work.

The results to be delivered by T04.30 and T04.50 to their target communities (Syrian refugees and vulnerable Jordanians) will need additional resources once EUTF Syria funding ends if they are to be sustainable over time. In most cases these resources are not currently evident. For example, the Syrian refuges and vulnerable Jordanians are unlike to be able to afford the health services provided by the projects, given the financial difficulties these groups are in. Alternatively, national or local funding would be needed. JRC and IFRC funds are reportedly insufficient to finance the continued work of volunteers working in the main project area (community-based health & first aid - CBHFA), which puts their future activities at direct risk. The future financing of the MHPSS work done by the AFD-led consortium would also require external funding. Interviews in the field phase indicated that bilateral funding from AFD is one possible direction that could ensure the benefits remain in place once the EUTF Syria funding is over.

By contrast, T04.105 – the nationally programmed intervention - has a realistic set of measures to ensure sustainability via the integration of its results (hospital facilities and equipment) into national arrangements (via the national network or public hospitals). Also, the tangible ownership of the final beneficiaries here is directly linked to their engagement in the project preparatory phase (see Relevance for more). This was also noted in KRI (T04.18 & 181).

The designs of all the interventions (both regional/ multi-country and national) explicitly state these factors in their programming documents and there is also evidence that some of the IPs (IFRC/JRC) are already considering sustainability of results. However, the evaluators did not encounter any sustainability plans specifically for this purpose (see below).

In Lebanon, although the benefits of EUTF Syria support are already evident, there is little prospect of these continuing once EUTF Syria funding ends. This is linked directly to beneficiaries not being able to access affordable health care. The lack of national funds, weak institutions, alternative donors and civil unrest means that the health sector projects are unlikely to continue once EUTF Syria funding is over. The limited institutional capacity and leadership within the sector from government institutions further mitigates against sustainability of those projects, as they depend on integration into a national system of financing that currently does not exist. The ongoing political and economic crisis has effectively paralysed decision-making in government and it is unclear when the situation is likely to improve. The designs of all the interventions explicitly state and consider factors influencing the likely sustainability of their results.

Discussions with the main national partners (MOPH and MOSA) confirmed that they have minimal awareness of the regional/ multi-country interventions' results. Other than T04.30 (which will be taken forward by LRC and its IPs), it is unlikely at this stage that any other health project will be integrated into national strategies or receive any national funding. Regional/district institutional partners reportedly lack resources to finance the continuation of these services after EUTF Syria funds are over and are not in a position to integrate them into their own work.

The subsidised primary and secondary healthcare provided by T04.54 and T04.47 respectively is intrinsically unsustainable without continued donor support. Subsidised hospital treatment of Syrian refugees under T04.47 will remain a long-term element of the health programme of the IP (UNHCR). The decision of the EUTF Syria to refrain from providing further funds to the programme is not, however, decisive for its continuation as it constitutes only some 16% of its total funding (the rest coming from bilateral and other multilateral donors).

The long-term sustainability of the flat-fee model (FFM) implemented by T04.54 is secured in the short-medium term as its funding will continue under the 'new' EUTF Syria health AD financing envelope. However, the long –term sustainability of FFM ultimately depends on how the Lebanese government decides to proceed with its plans for universal health coverage. This discussion (into which one of the results of T04.74 should feed) is ongoing and unlikely reach a conclusion for some time, given the current political turmoil in the country and paucity of national budgets. This principle also applies to T04.96, where the EUTF Syria will continue to

fund the purchase of vaccines and drugs for Lebanon under the new AD and also aim to fix the 'broken' supply chain for the MoPH – which at some point will need to take over the responsibility for both running and financing this system (see case study in Annex 5). Without a political decision from the Lebanese government on these issues, the sustainability of all these interventions is at risk.

In Iraq, factors influencing EUTF Syria health intervention sustainability are generally known and managed adequately – in particular, some of them are adequately addressed while others are not as they are outside of the scope and control of the programme stakeholders. The main factors that affect sustainability of results are:

- capacity building (technical and managerial skills)
- ownership of projects objectives by the final beneficiaries
- infrastructure (expansion, renovation and maintenance)

The benefits of EUTF Syria health interventions are evident, in most of the projects especially at the level of hospitals (T04.18), where the benefits are very prominent. 'Benefits' are likely to be identical to project outputs/ outcomes at community, country, and regional levels. For the new projects, it is too early to talk about project benefits.

The results and approaches of EUTF Syria health interventions are generally integrated into the national structures, policies and budgets. T04.18 stands out in this sense, as all the activities are integrated into hospital operations. In addition, all activities and related objectives reflect well real needs of the community and were developed jointly with the local staff of DoH.

This applies also to project T04.30, whereby all the activities and objectives were defined jointly between the MoH in Erbil, the Dohuk DoH and the Iraq Red Crescent (IRCS) High cooperation and synergy was achieved also for those activities related to the joint management and delivery of Ambulances, which are owned by IRCS, while the equipment is provided by the Norwegian Red Cross, the salary of the driver comes from the government and training is provided by the Norwegian Red Cross.

Sustainability plans for EUTF Syria health results

ADs and DoAs provide extensive coverage of the issue of sustainability of results and measures to be taken by the IPs to address risks to it. In practice, the impression from the field missions is that IPs have managed risks operationally – there were few examples (none) found of systematic management of risks (such as risk registers), and this extends to the approach taken by the IPs to sustainability of project results i.e. they are all aware of them, some have considered which steps would be needed to address them, but thus far none of them had actually prepared any sort of strategy or plan on how to ensure that the results would be sustainable once the intervention was concluded. As with the issue of tracking emergence of project outcomes, this occurs after project completion and IPs have little incentive to think beyond the end of implementation (as implied by their title). Nevertheless, the absence of such

plans (which could be relatively simple documents outlining practical steps to be taken to strengthen sustainability) weakens the overall sustainability prospects for the whole EUTF Syria health portfolio.

3.3.6 EU Added Value and Visibility[34]

This chapter examines what sort of added value the EUTF Syria health portfolio provides from its interventions. The concept of value added is understood here to be whether the EUTF Syria support provides its target groups with benefits above and beyond what would be available to them otherwise (i.e. if the EUTF Syria support was not available). Also, the evaluation here looks at how well EUTF Syria Health interventions are communicated and visible to their target audiences.[35]

EU Added Value[36]

As a general observation, the evaluators found that **the vast majority of EUTF Syria interventions have given significant added value in terms of improved quality of health care for the target groups**. The lack of healthcare coverage and the often very limited capacities of the healthcare providers in the host countries mean that the presence of Syrian refugees has exponentially reduced their effectiveness. As such, refurbished hospitals serving the communities most affected by the crisis are already providing quality of service in KRI and are on track to do the same in Jordan. The work of health volunteers trained under several interventions has evidently provided their clients with much needed advice and care that they would have been otherwise not received. The UNHCR and IMC-led interventions in Lebanon have ensured that Syrian refugees and poor Lebanese have received primary and secondary treatment that they would not otherwise have been able to access (or afford).

The paucity of MHPSS services in all the EUTF Syria countries for Syrian refugees and vulnerable host populations means that the work done by T04.50 in all three countries in this area has clear added value. T04.54 and T04.31 in Lebanon and T04.183 in KRI also contribute to covering this much-needed area. In Iraq, T04.50 was also found highly relevant to the context and made tremendous progress towards closing existing gaps through multiple activities (e.g. supply of ambulances, trained volunteers, supporting the referral pathway from camps to hospitals), in addition to improving the overall quality of care of the services provided by MoH, and building the capacity of health workers of MoH, particularly nurses and ambulance drivers.

34 This criterion covers EQ 16: What EU added value is resulting from the EUTF Syria-funded Health programmes/ projects? and EQ 17: To what extent are communication and visibility actions of EUTF Syria Health interventions proving conducive for achieving their desired effects.
35 EUTF Syria health support in Egypt and Turkey was not covered for this criteria as neither country was included in the field phase and sustainability factors could therefore not be verified on the ground.
36 The EC Better Regulation, Tool #47. EVALUATION CRITERIA AND QUESTIONS. defines EU-added value as "the changes which it can reasonably be argued are due to the EU intervention, over and above what could reasonably have been expected from national actions...." (p. 353). In the context of this evaluation, this is understood to mean that EU Added Value is represented by the results that would only have been achieved thanks to the intervention of the EUTF Syria.

T04.30 provides an interesting example of what actually constitutes added value: In Jordan, due to removal of the original European RCC societies, the planned results were changed and realigned away from the originally-planned MHPSS towards JRC's traditional 'core services' (CBHFA). Evidence suggests that this realignment has enhanced the work done by the project in Jordan for refugees and vulnerable Jordanians. Whether the EUTF Syria funding merely allows the JRC to do more of what it was already doing (and therefore does not in fact add much extra value) to the JRC's work is, however, a moot point. This observation also applies to the work of the LRC in Lebanon; for example, several the activities financed by the EUTF Syria there (particularly blood drives, emergency response) were part of the LRC's work prior to EUTF Syria funding being provided.

In this respect, the IPs stated (with justification) that the EUTF Syria funding allows them to enhance and extend their existing services and make them available to a greater number of beneficiaries. Also, focus group discussions with direct and final beneficiaries confirmed that services they were receiving were of high quality and much needed. Thus, it is clear that T04.30 provides 'even more' good support needed by its target groups.

A wider consideration is how the EUTF Syria addresses the generally accepted number one challenge for Syrian refugees and vulnerable host populations in the area of health i.e. access to affordable healthcare services. Whilst the work done under EUTF Syria health interventions has undoubtedly helped these groups address some of their health needs, this key issue remains to a significant degree unaddressed. The mid-term evaluation of T04.30 recognises this paradox in its own design "*there appears to be little indication that the health promotion activities [that constitute one of the main pillars of the health component] are resulting in increased access to health services, as lack of health information does not appear to constitute a central barrier to access. In Lebanon, Jordan, Iraq and Egypt, the key barrier to accessing health services is cost*"[37]

In Lebanon, two interventions have tried to directly address this problem (T04.47 and T04.54) and while they have been effective, their sustainability is a fundamental weakness. For these and other projects to provide added value long term, a sustainable model for healthcare remains critical in the country. As noted under sustainability, this is not likely to emerge any time soon. Also, without future EUTF Syria funding in future (which T04.54 has reportedly secured) and the absence of other donors in the health sector, these pilot approaches are at risk long term. Finally, the dominant private healthcare sector in the country is likely to remain the main healthcare provider in the country for the time being (although the economic and political crisis will inevitably have a knock-on effect on the private systems as well and reduce its effectiveness).

In Jordan, the establishment in 2018 of the Multi-Donor Account (MDA) by USAID along with Canada, Qatar and Denmark was a direct attempt by these donors to ensure affordability of services for the most vulnerable groups in response to legal changes by the GoJ relating to

37 Danish Red Cross "Addressing Vulnerabilities of Refugees and Host Communities in Five Countries Affected by the Syria Crisis" Regional Midterm Review", p.7.

health payments by Syrian refugees. The MDA has been instrumental in ensuring basic healthcare is affordable to refugees and has undoubtedly provided significant added value. As the EU is currently not participating in the MDA, EUTF activities are handled through the classic project mechanism.

Effectiveness of EUTF Syria health communication and visibility (C&V) plans

The EUTF Syria health interventions contain C&V plans which outline in varying levels of detail how the IPs will promote their projects. These extend from the very brief (e.g. T04.31, T04.50, T04.54 which have just 1 paragraph in their DoA) to more extensive examples (e.g. T04.74 in Lebanon, T04.58 in Turkey). The evaluators verified that the IPs were aware of and were using the latest guidelines for C&V of EU External Actions. **Also, field visits during the country missions confirmed the use of EUTF Syria logos on buildings, equipment, posters, banners and medication.** Project publications reviewed by the evaluators all conformed to EU requirements. In this regard, there has been little sign of inadequacies.

Field missions ascertained that awareness of the EUTF Syria among the final beneficiaries – Syrian refugees, IDPs and vulnerable host population - tended to be focused directly on the people delivering the assistance to them i.e. the IPs. In **Lebanon**, it was often difficult for beneficiaries to understand that the services they were receiving were a direct result of EUTF Syria funding. When questioned, beneficiaries often thought the IP was the funding body. This is despite evidence that some of the IPs have been trying to distinguish that the projects were EUTF Syria funded and they were 'only' the IP (e.g. IMC in T04.54). Often however, this distinction was lost on the beneficiary. In the case of T04.96, there was minimal visibility of EU support in terms of posters, leaflets and at the point of dispensing of medicines and vaccines directly procured using EUTF Syria funds.

In **Iraq**, the evaluation team asked the stakeholders and other actors if they are familiar with EUTF Syria or MADAD, and most of them claimed that they had not heard about it before. However, when the evaluation team asked questions about individual projects, the respondents were generally familiar with the projects and were aware that the EU was connected with them.

Discussions with stakeholders in **Jordan** highlighted an interesting split as regards the effectiveness of the C&V of regional/ multi-country vis-a-vis national interventions. All the main institutional stakeholders (both Jordanian, other donors and IOs) were aware of the one national EUTF Syria project (T04.105 led by UNOPS). This appears to be thanks to a combination of the UNOPS' profile and its promotion of the project among its interlocutors. By contrast, the regional programmes and projects had a very limited profile among the stakeholders not directly involved in their implementation. Government representatives (with the exception of Ministry of Municipal Affairs in T04.50, IC component) expressed minimal knowledge of the projects. This tended to suggest that even if the project is working well with local actors (AFD in T04.50); the projects are not effectively communicating their activities with these key target

groups. The implementation of some C&V plans would deserve to be further improved, with particular attention to the achievement of effects.

Challenges of communicating EUTF Syria health benefits to host populations

Across the region, IPs, EUDs and national stakeholders noted one important issue that they had to consider when preparing and implementing their C&V actions i.e. the sensitivities in the host countries surrounding the perception that EUTF Syria are helping Syrian refugees at the expense of host populations. Several IPs expressed uncertainty as to how approach this issue. All the IPs are aware of this issue and have been careful to tailor project designs to ensure that, where possible, all target communities benefit from EUTF Syria-funding services. Secondly, they are generally cautious about explicitly promoting their projects from a Syrian refugee angle, preferring instead to either emphasise their inclusive nature or making no specific references to Syrian refugees in their materials.

This is a rational response to the challenge. However, some IPs mentioned that this approach might not be fully aligned with what would be expected from EU Member States co-funding the EUTF Syria. In Lebanon, for example, the LRC in T04.30 had devised a two-pronged approach to dealing with this issue i.e. make no explicit mention of supporting Syrians in their materials circulated within Lebanon and featuring them prominently in those materials detailed for use outside the country (especially for the EC and EU Member States).

3.3.7 Gender and Special Needs[38]

This chapter considers how well EUTF Syria health interventions have integrated gender and special needs issues into their designs and how these are being addressed in implementation. In the case of special needs, the evaluation focused on the target group of people with disabilities.

Gender issues in programming documentation and implementation

Gender issues feature as a theme in all DoAs. In many cases, though, references tended to be general in character and only a handful contained gender specific results. There was a lack of evidence that programming documents had been analysed through a gender focus i.e. all project activities and results had been scrutinised for their potential gender dimension and adjusted accordingly. Thus, designs seldom explicitly lay out how gender considerations will be integrated into the intervention. Only T04.31 of the regional/ multi-country interventions and T04.18/181 have explicit gender focuses on their designs.

38 This evaluation criterion includes EQ 18: To what extent have gender issues been taken into consideration in design and implementation and what are the effects; and EQ 19: To what extent have accessibility and inclusiveness of persons with disabilities (Syrian refugees, IDPs and host community members) been taken into consideration in design and implementation and what are the effects?

However, evidence gathered in the field missions suggests that **gender considerations have in fact been integrated into the design of the projects, but that these are not explicitly stated in their documentation.** Each noted that they had their own internal expertise that ensured gender considerations were adequately addressed in their projects. For example, the AD/DoA for T04.105 in Jordan mentions gender issues but does not lay out what the specific challenges related to gender are for hospitals and emergency services, or how the project will address these challenges. Obvious issues such as specific areas in hospitals for treatment of males and females are not stated. However, in the field mission the IP and beneficiaries credibly cited numerous ways in which gender issues had been taken into consideration and how they would be addressed in the final outputs of the project. In T04.30, gender sensitive approaches of the RCCs in all the countries were evident, with evidence from Lebanon, Jordan, Iraq and also Egypt (via the desk review). This is despite their lack of prominence in the programme documentation. In Iraq, gender specific effects are evident in EUTF Syria health intervention in several aspects, most notably the focus of T04.18 & 181 on maternity/paediatric hospitals, which are de-facto gender specific towards woman.

Gender disaggregated data for EUTF Syria indicators

Most programmes/ projects provide gender disaggregated data for output indicators, which are presented in the respective QINs. The output indicators show females benefitting strongly from the project activities, which on first inspection can be considered positive. However, no health project has gender disaggregated baselines or targets for these indicators, not least because the necessary information is not available in the immediate intervention area. Without these in the DoA (or its logframe matrix) to compare against, gender disaggregated data in QINs provide limited value for assessing performance.

For example, several interviewees noted that services targeting MHPSS tend to attract more females than males. Therefore, the high representation of women in T04.50 outputs could in fact mean the project has failed to adequately include males into the MHPSS component. In Iraq, the evaluators noticed the scarce presence (sometimes lack) of gender disaggregated indicators. One of the reasons for this is linked to the methodology used in the national health system statistics (which does not differentiate data by gender), in addition to the weaknesses of the statistic section in Ministry of Health (it should be noted that health conditions in the country quickly deteriorated after the beginning of the war). Adopting gender mainstreaming principles as a strategy to promote gender equality and combating discrimination in different ways is necessary. The programme included also specific actions for raising awareness on violence against women, improving health care (physical and mental) disseminating gender equality principles, training female health professionals and managers.

Measures for People with Disabilities in the EUTF Syria Health Portfolio

Specific provisions for People with Disabilities (PwD) in the EUTF Syria health interventions are limited so far. The one exception to this situation is T04.147 in Lebanon, which is dedicated exclusively to this issue. References to PwD and the importance of supporting them are found in some EUTF Syria programming documents, but for the most part, these are little more than general statements or declarations of intent. For example, the Regional AD claims that *disability has been taken into account during the project's design to enforce a mainstreaming and human rights-based approach* and outlines "key actions" to deliver this. In practice, the programming documents do not follow up on this commitment: T04.50 makes one minor reference to PwD in its DoA, while neither T04.30 nor T04.31 contains any reference of note.

The evaluators found virtually no references to persons with disabilities in most of the other AD or DoAs of the projects in Jordan. In Lebanon, the DoAs for projects T04.47; T04.74; T04.96 lack any reference to PwD. The DoA of T04.54 makes a few minor references to people with disabilities. No other references or attempts to integrate them into the design of the action are evident.

More positively, in Iraq PwD issues feature more prominently in DoAs. Although T04.18 makes no reference to them, accessibility and inclusiveness aspects are adequately described and integrated in the project documentation of T04.181, while T04.183 – uniquely among the projects in the portfolio - provides a detailed outline of how PwD concerns will be integrated into the wider project delivery. Also, the DoA of T04.58 in Turkey outlines some measures to address disability needs. T04.147 is the only dedicated project for PwD in the portfolio and emerged due to a recognition of the EUD and the selected IP (IMC) of the importance of the issue and need to try and address it as best possible. It is currently under implementation (See Effectiveness section for information on its results).

As regards implementation and benefits of EUTF Syria, with the exception of T04.147, project reporting and ROM reports make scant reference to how PwDs are benefiting from EUTF Syria support. During the field mission, IPs were questioned on this issue, with the general response being that people with disabilities benefit from services as anyone else from the target groups. In the case of the infrastructure interventions in KRI and Jordan, the IPs stated that PwD considerations were addressed in the works design of the facilities e.g. access points to the hospitals reconstructed under T04.105 and T04.18 and equipment purchased specifically for PwD. As T04.183 is early in its implementation phase, evaluators were unable to assess its benefits for PwD so far.

Effectively integrating measures for PwD into programming documents was noted by several stakeholders as being a challenge. It was commented that such 'mainstreaming' of PwD needs had to be done at very start of the programming – i.e. building in PwD considerations into every element of the design (if there is no obvious PwD dimension to a project). Any intervention has to be assessed through the PwD prism to establish whether there is a PwD angle to the action and if so, how best to integrate it into its design (as is increasingly the case with gender issues). IPs observed that the current tranche of actions were evidently not programmed in this way

and therefore the PwD element lacks the prominence it might actually deserve. It was also observed by stakeholders that such programming approaches require expertise among programmers on the part of IP, national partners and EUTF Syria/EUD.

As a final observation, the new ADs from Lebanon and Jordan present contrasting impressions of how programmers are now looking to address PwD issues. The AD for Lebanon explicitly targets healthcare provision for PwD under its Specific Objective 2, implying that PwD are likely to be beneficiaries of assistance under the so-called REBAHS II intervention. By contrast, the new AD for Jordan contains few references to disabilities issues which also reflects country-specific sector priorities.

3.4 CONCLUSIONS & LESSONS LEARNED

This chapter presents a series of conclusions and lessons learned broken down by both evaluation criteria and thematic issue covered by the evaluation findings. They succinctly provide a summary analysis from the evaluators and also form the basis for the recommendations contained in the following section.

3.4.1 Relevance

Alignment with EUTF Syria objectives and Country Priorities

1. All EUTF Syria health projects and programmes in the sample are strategically aligned with the EUTF Syria's guiding principles and approaches and all the objectives are coherent with the current EUTF Syria Results Framework. Also, EUTF Syria Health interventions are broadly in line with Syria CRPs and, in general terms their designs reflect specific country needs.

Design of Regional/ Multi-country Interventions and National Interventions

2. The original designs of EUTF Syria Regional interventions containing health components corresponded generally to health needs in each country and where needed have been adjusted to meet actual needs on the ground. Nationally programmed EUTF Syria health interventions more closely reflect specific country needs and strategies; as a consequence, they benefit from stronger local ownership.

Responsiveness of EUTF Syria support

3. The evolution of the EUTF Syria support to the sector is based largely on the experience of the IPs under other funding mechanisms, as the bulk of the EUTF Syria health interventions had not benefitted from previous EUTF Syria support in the sector. Evidence suggests that the design of the latest tranche of EUTF Syria health interventions takes into account the experience of their predecessors and suggests that the EUTF Syria is proving responsive to the external environment.

Current and Future strategic focus of EUTF Syria Health support

4. EUTF Syria Health Interventions cover a wide range of areas of need, rightly bearing the title 'portfolio' as it lacks the structure of a health 'programme'. Relevance is ensured as all these needs are valid, although it will reduce the scale of impact, they are likely to have. However, the changing situation on the ground and the move to development paradigm (as reflected in the most recent CRPs and latest Lebanon Health AD) raises the question of how the EUTF Syria aims to meet this 'nexus' challenge in its current and future actions. Only the latest

Lebanon health AD reflects on this issue to any extent – otherwise it is a weak spot in the portfolio design.

Quality of EUTF Syria project design

5. The design of the EUTF Syria interventions is sometimes characterised by weak intervention logics and indicators. This is particularly evident for outcomes/specific objectives and complicates any objective assessment of project/programme performance. This complicates reporting on performance and results and weakens their utility for understanding the extent to which EUTF Syria support has been a success. EUTF Syria management has made significant efforts to improve this situation, but the evaluators believe this effort should be continued.

3.4.2 Effectiveness and Impact Prospects

Outputs of EUTF Syria Health interventions

6. EUTF Syria effectiveness in terms of delivery of outputs is good. EUTF Syria Health interventions have made good progress in delivering planned outputs across all countries. These are evident in the services provided, capacity developed, facilities that have been reconstructed or are under reconstruction and the medical equipment/supplies procured.

Outcomes of EUTF Syria support

7. Outcomes are largely on track to emerge. In those completed EUTF Syria interventions, outcomes are already evident in terms of better care for Syrian refugees, vulnerable host populations and IDPs. This is especially evident in several interventions (T04.54, T04.30) in Lebanon. The evaluators also noted some 'unplanned results' from Jordan which highlight additional benefits of the EUTF Syria support. Overall, the EUTF Syria health interventions will change the lives of their target groups for the better.

Positive and negative factors for effectiveness of EUTF Syria health assistance

8. A range of positive factors were noted that contributed to the effectiveness of the assistance, including sufficient time and resources for delivery of outputs, good IP performance and good ownership of results among national partners for outcomes. Factors negatively influencing effectiveness were found to be mainly external to the interventions such as unstable programme environments (for example in Lebanon) and the design failings in one regional programme leading to the loss of its Jordan component. The heterogeneous nature of the portfolio reduces the likelihood of deeper effects emerging.

Impact of EUTF Syria support

9. Impact of the EUTF Syria Health portfolio is difficult to gauge at present. This will only be possible over a longer period of time after the current interventions are over. A case can be made for the support having a positive impact via its contribution to EUTF Syria results framework strategic health outcomes, but quantifying impact is far less easy. Much depends on how the contexts in each target country (as well as in Syria) play out over coming years.

Effect of EUTF Syria Health interventions on indigenous health referral systems

10. All the active EUTF Syria-funded interventions should deliver results which interface with the health referral systems in the target countries. However, at this stage these effects are not evident at a system level – as with impact, these wider benefits for the health systems of host countries will only become evident over time.

Effectiveness of Different Implementing Partners

11. Although efficiency of working via regional/ multi-country interventions with multiple IPs posed a problem for project design and efficiency, these factors have not hindered the effectiveness of these interventions. Both nationally programmed and regional interventions are largely comparable in successfully delivering planned (or revised) results.

Effectiveness of Partnerships between EUTF Syria, its IPs and national counterparts

12. Formal partnerships between EUTF Syria and government partners are in place, but the relationships between IPs and national counterparts are usually not underpinned by written agreements. In most cases, the IPs have well established relationships with their governmental interlocutors which facilitate effective performance. These were most evident among those nationally programmed interventions, whilst Regional/ multi-country interventions often lacked clearly defined relationships with their national interlocutors – this has sometimes proven to be a problem for them, especially in Jordan, and raises the question as to why IP programmers did not take this more seriously into account in the preparation phase.

Monitoring Effectiveness and Impact post-project completion

13. In combination with the sometimes-weak intervention logics and indicators noted in Relevance, tracking the actual effectiveness and impact of EUTF Syria health interventions once projects are over is likely to prove difficult due to the lack of a post-project outcome monitoring mechanism to do this. The 3rd party monitoring could be used for this purpose in Lebanon, but elsewhere this is missing.

3.4.3 Efficiency

Efficiency of various implementation mechanisms

14. Overall efficiency is mixed. Regional/ multi-country interventions have experienced delays due to their implementation arrangements and thus required project extensions. These extensions have ensured that planned outputs can be delivered and the IPs have done a good job overall in adjusting to the challenges posed by their own project set-ups and putting in place results. The regional modality had little obvious practical advantages over national projects for delivering EUTF Syria health interventions. Nationally programmed interventions appear to be more efficient overall, as they are not challenged by the complex contractual/ implementation arrangements that weigh down Regionals.

Performance of Implementing Partners

15. There is no obvious difference in the performance between type of IP, irrespective of whether it is an international NGO, a UN agency or EU Member Aid Agency – Efficiency of EUTF Syria interventions lies in other factors such as the IP's experience, its expertise and the strength of its relationships with its project partners. For the most part, the selection of IP was appropriate – their capacities to successfully implement their interventions have been generally sound, and there are many good examples of this.

Role of National Counterparts

16. The evaluation found that EUTF Syria national counterparts are generally supportive in facilitating implementation, especially in those cases where they have been engaged in the preparation of interventions (via national ADs). In the case of regional/ multi-country interventions in Jordan, however, the lack of clear government interlocutors has proved a complication.

Financial Performance, Adherence to Procedures, Reporting

17. All the interventions are within budgets and follow the relevant procurement procedures. Their availability and deployment has been largely satisfactory. The extent to which budgets are clearly laid out in the programme documentation varies from project to project. This applies also to the financial reporting, which often lacks a clear linkage between expenditures and delivery of project results. This weakens project transparency and represents an unnecessary barrier for programme managers and other external parties trying to assess them for performance purposes.

3.4.4 Coherence

Coordination mechanisms and complementarity with other donors/instruments and within EUTF Syria portfolio

18. Coordination mechanisms for health interventions exist in all the partner countries. However, evidence of complementarities emerging from interactions in these forums is limited. Coordination and planning between EUTF Syria and other donors takes place in less structured settings. Overall the conclusion is that the existing arrangements are not that conducive to promoting complementarities. Within the EUTF Syria health portfolio, coordination and complementarity among EUTF Syria health interventions varied from country to country. Overall this is judged as adequate.

Synergies

19. Some examples of synergies were noted in Jordan and Lebanon, although for the most part these seem to have occurred without prior planning. In Iraq, synergies were more evident. However, there is no coherent approach among programmers to identify synergies in the preparation of EUTF Syria health interventions, or to actively seek them out during implementation. At least, synergies should be defined in the project identification phase and integrated into designs.

Strategic focus

20. The lack of a more strategic approach is seen as a limitation on effective coordination planning between the EUTF Syria and other donors. Issues of thematic focus, future orientation of the programme in the sector, coordination, complementarity and communication would merit further consideration. Despite the EUTF's special features and characteristics in terms of mandate and time frame, a stronger strategic direction for the remaining time is desirable, which could also point the way forward in some of the partner countries after the formal termination of the EUTF. The recent country ADs for Lebanon and Jordan partly address this issue.

3.4.5 Sustainability

21. In general sustainability of EUTF Syria health results are fragile, especially those linked to capacity development and service provision. Infrastructure investments represent the best examples of sustainability. Sustainability plans for project results are conspicuous by their absence, despite IPs recognising their potential value. Therefore, there is no clear vision at project or portfolio level of the sustainability of the project results or the healthcare models (such as FFM) that it has fostered.

3.4.6 EU Added Value

22. The effectiveness of EUTF Syria health interventions means they provide benefits to Syrian refugees and vulnerable host populations. These benefits would not have been available to them without EUTF Syria support. Therefore, it is obvious that EUTF Syria support has clear added value. Whilst it is debatable that some of the projects are providing 'new' support (rather than just enhancing already existing services) this in itself does not undermine their intrinsic value.

23. EUTF Syria added value would probably be most evident if it could address the core challenge in the health sector – affordability of care. Thus far, it has done so only in a handful of cases and this will remain a challenge for the future. At some point it would make sense for the EUTF Syria to tackle this issue more strategically.

3.4.7 Communication and Visibility

24. Evidence is that all projects have communication and visibility (C&V) plans that conform to EU requirements. These are being implemented as required. However, Target groups/final beneficiaries had mixed levels of awareness of EUTF Syria health support and this suggests that the C&V measures have not been fully effective so far. IPs and national stakeholders are often still looking for ways in which the EUTF Syria's health interventions can best be communicated, given local sensitivities to support Syrian refugees.

3.4.8 Gender issues

25. Programming documentation for all interventions make references to gender in their designs, but specific measures within projects are relatively few. However, evidence suggests that all IPs are sensitive to gender issues and look to integrate them into projects wherever possible. The evaluators conclude that gender issues are adequately addressed in the portfolio but could be better reflected in the programming documentation and gender considerations fully mainstreamed into the programming process.

26. Gender-disaggregated data presented in QINs is widespread but without baselines and targets in the logframes, they are of little value in assessing performance. Thus, the actual effectiveness of interventions in terms of gender is impossible to gauge. Their structure deserves a re-think to get the most out of the valuable data being gathered by the IPs in implementation.

3.4.9 Measures for People with Disabilities in the Portfolio

27. Apart from one stand-alone intervention in Lebanon, the evaluation found few measures for people with disabilities (PwD) or special needs in the EUTF Syria Health portfolio with the partial exception of projects in Iraq and Turkey. To a large extent this due to the

different partner country priorities. The new ADs for Jordan and Lebanon take a more intensive approach in this respect whilst showing divergent approaches to programming support for PwD. Greater consideration of PwD as a target group in the various EUTF Syria project activities would still be welcome.

3.5 RECOMMENDATIONS

The 10 recommendations offered in this chapter correspond directly to the conclusions and main findings presented in the previous sectors of this report. Consistent with the nature of the evaluation, all the recommendations are portfolio-level in nature. There are no country-specific recommendations, although many of the recommendations directly address issues identified in the target countries during the evaluation.

Each recommendation states the action to undertaken, an addressee (or addressees), and a timeframe for its implementation by the addressee(s). For ease of reading, the recommendation is explicitly linked to its associated conclusion(s).

Recommendation 1

The EUTF Syria should deploy the regional/ multi-country implementation modality (as set out in the regional AD for health and implemented under T04.30, T04.31 and T04.50) for delivery of assistance to the health sector only in very specific circumstances, where there is a clearly beneficial case for its deployment. This should include: a clear context analysis for each country involved; a design that closely reflects the country context and which has been developed closely with national partners in each country; has a straightforward and efficient implementation set-up and; contains a clear regional dimension in its results to address cross-regional health challenges (such as MHPSS); promote learning etc.

Addressees	EUTF Syria
Timeframe for implementation	Immediate
Related conclusions	2, 8, 12, 14

Recommendation 2

In recognition of the changing nature of the health challenges facing Syrian refugees and their host populations, EUTF Syria Health support should be underpinned by a more strategic approach that better outlines the aims of EUTF Syria in the health sector. The main priorities in the sector (ideally limiting to ensure thematic concentration) based on each country context as well as the EUTF Syria's priorities in the region should be better identified. In this regard also the humanitarian development nexus in the health sector should be more clearly explored. Due to the limited lifetime of the EUTF, transition aspects should be analysed more thoroughly and integrated into the detailed planning. All ADs in the health field should align with these strategic considerations. Actual implementation of this recommendation depends largely on the operational future of the EUTF Syria.

Addressees	EUTF Syria, EU Delegations
Timeframe for implementation	Immediate
Related conclusions	4, 9, 20, 24

Recommendation 3

Whilst it is recognised that the EUTF Syria management has made significant efforts to strengthen the quality of intervention logics and indicators in health interventions, the evaluators would underline the need to continue this work, particularly at outcome level. The EUTF Syria should thus continue to make use of available resources within DG NEAR (including the existing internal M&E network and its training possibilities) to review these elements of existing ADs and DoA and assess their adequacy for management purposes i.e. reporting on progress towards planned results, making corrective actions in implementation, identifying scale of achievement of planned results after interventions are complete. Defining outcome statements and formulating outcome indicators should in particular be prioritised.

As with ongoing programmes/ projects, the EUTF Syria should continue to utilise resources available to it (both internal and external) to ensure that these standards are met.

Addressees	**EUTF Syria, Implementing Partners**
Timeframe for implementation	**Immediate**
Related conclusions	**5, 7**

Recommendation 4

Indicators for ongoing EUTF Syria health interventions with gender dimensions to them should - where data are available in sufficient quantity and quality in the immediate area of intervention - be given baseline and target values to give meaning to the gender-disaggregated data reported in QINs. This is also linked to the issue of improving the quality of indicators in Recommendation 3.

Addressee	**Implementing Partners**
Timeframe for implementation	**Immediate**
Related conclusions	**25, 26**

Recommendation 5

The EUTF Syria to put in place measures to ensure monitoring of EUTF Syria health outcomes and impacts takes place after implementation is over. In Lebanon, this should be incorporated into the tasks of the 3rd party monitoring team there. In other countries with health interventions, the most appropriate way to do this should be discussed with the EUDs, IPs and, where feasible, national partners.

Addressees	**EUTF Syria/ EU Delegations/Implementing Partners**
Timeframe for implementation	**Immediate**
Related conclusion	**13**

Recommendation 6

Where contracting arrangements permit, the EUTF Syria should encourage IPs to provide clear financial reporting linked to delivery of deliverables/outputs. The basis for this reporting should be a codex of minimum reporting standards linked to a template. This should be developed in consultation with the IPs, EUDs and, if necessary, be done using external facilitators.

Addressees	EUTF Syria/ EU Delegations/Implementing Partners
Timeframe for implementation	To be in place by September 2020
Related conclusion	17

Recommendation 7

The EUTF Syria should request all IPs, as part of the preparation of the latest tranche of health DoAs, to conduct a comprehensive mapping of potential synergies between their interventions and other health projects (both EUTF Syria- and other donor-funded). These potential synergies should be clearly laid out in the DoA, as well as the approach to be taken by the IP to ensuring that these synergies are achieved in implementation.

For those health interventions already under implementation, the IPs should report on synergies between their projects and other ongoing interventions. The IPs should also outline measures on how they will enhance those synergies that have yet to be exploited.

Addressees	EUTF Syria, Implementing Partners
Timeframe for implementation	Immediate and ongoing for all new interventions
Related conclusion	19

Recommendation 8

The IPs of all EUTF Syria health interventions, both ongoing and those under preparation, should develop sustainability plans that realistically lay out measures for ensuring EUTF Syria results survive after the current tranche of EUTF Syria financing is over. Such a plan should identify the project results, the risks to their sustainability and measures to be taken to address these risks. The plan should in particular pinpoint follow-up financing sources (should they be needed). This recommendation particularly applies to those projects that are piloting innovative approaches to healthcare (i.e. T04.54 in Lebanon) whose long term sustainability is judged to be especially fragile and in need of support beyond the project level (i.e. as part of policy dialogue between the EU and government institutions in the health sector).

Addressees	EUTF Syria, Implementing Partners
Timeframe for implementation	As soon as possible
Related conclusion	21

Recommendation 9

EUTF Syria programmers (EUTF Syria staff, EUD staff and IPs) should ensure that People with Disabilities considerations are mainstreamed into all EUTF Syria health programming documents currently under preparation in future i.e. action documents, DoAs.

This approach should start with all the expected results being assessed from the angle of how they would potentially affect or benefit People with Disabilities. Based on this preliminary assessment, the programmers should then outline measures that will integrate People with Disabilities considerations into the design of planned activities and outputs. They should also explicitly state how the outcomes will benefit People with Disabilities and provide PwD-specific disaggregated indicators (with baselines and targets).

As a first step, the EUTF Syria should formulate guidance on how to do this (drawing on internal support from Centres of Thematic Expertise within DG NEAR, or if necessary, external consultancy support). This should then be auctioned by the EUDs and IPs directly via their programming exercise.

Addressees	EUTF Syria, EU Delegations, Implementing Partners
Timeframe for implementation	Immediate
Related conclusion	27

ANNEXES

Annex A1 – Full Evaluation Sample

No.	Intervention	Country
1	T04.30 Danish Red Cross Livelihood support, risk management, health and psychosocial support to refugee and host communities affected by the Syria crisis	Iraq, Jordan, Lebanon, Egypt
2	T04.31 Medair Improving the well-being and resilience of Syrian refugees and host community women, girls, men and boys affected by conflict and sexual and gender based violence	Jordan, Lebanon
3	T04.50 AFD Resilience and Social Cohesion Programme	Lebanon, Jordan, Iraq
4	T04.47 UNHCR Providing essential lifesaving care to refugees in Lebanon	Lebanon
5	T04.54 IMC Reducing Economic Barriers to Accessing Health Services in Lebanon	Lebanon
6	T04.74 Strengthening the health care system resilience and provision of chronic medications at primary health care centres	Lebanon
7	T04.96 UNICEF Securing access to essential medical commodities for most vulnerable population in Lebanon	Lebanon
8	T04.147 IMC Improving Access to Quality Health Care for Persons with Disabilities in Lebanon	Lebanon
9	T04.18 Supporting Emergency/Critical Care Services and Maternal and Child Health care	Iraq
10	T04.181 Maternal and Infant health care	Iraq
11	T04.183 ACF Strengthening quality and access to mental health services in Iraq	Iraq
12	T04.105 UNOPS Expanding and Equipping Ministry of Health facilities impacted by the Syrian crisis in Jordan	Jordan
13	T04.58 Improved access to health services for Syrian refugees in Turkey (see comment below)	Turkey
14	Third Party Monitoring of the Lebanon Health Programme for Syrian refugees and vulnerable Lebanese population[39]	Lebanon

39 The performance of this project was not assessed, as it was in its inception phase at the time of the evaluation – it is specific orientation was still evolving and it had yet to generate any results. It was however considered from the perspective of how it helps the main stakeholders understand EUTF Syria health sector performance and also how its role can be aligned with EUTF Syria sectoral goals (primarily in terms of tracking, measuring and understanding project and programme outcomes.

Annex A2 – Limitations

The evaluators encountered several limitations that to various degrees hindered their ability to conduct the evaluation as laid out in the ToRs and evaluation inception report. These are described below.

Access to key stakeholders

In the field phase, the evaluators had some difficulties meeting with representatives of central and regional government institutions responsible for health issues in Lebanon and KRI. In the case of Lebanon, this was due to the ongoing government crisis there, which seriously hampered communication with the Ministries of Public Health and Social Affairs in the planning of the mission. Aside from the logistical challenges posed by the crisis (see below) the high-level officials that the evaluators wished to meet at these institutions were not available during the mission. Thanks to the efforts of the EU Delegation staff, one of the evaluation team was able to meet with middle-ranking officials from both ministries, albeit rather briefly.

In KRI, identifying the correct interlocutors was problematic due to the absence of an EUTF Syria/EUD staff member on the ground there. The evaluators expended significant efforts to track down relevant KRG officials, but this proved only partly successful. Interviews with representatives of governorates were conducted which partially redressed this shortcoming.

Meeting these national/regional government stakeholders was crucial for the evaluators to answer EQs related to relevance, effectiveness, sustainability, coordination, synergies and added value. It is recognised that in both the two countries mentioned, the evaluators had to rely on feedback from other stakeholders based in-country as well as available project documentation – which does not wholly cover this gap. In Jordan, no such problems were encountered.

Quality of IP Reporting

The evaluators conducted a preliminary analysis of relevance, effectiveness and efficiency across a selection of EQs in the inception phase, with the responses presented in the inception report. The principal documentary source for the assessment of performance by project was the Quarterly Information Notes (QIN) provided by the project implementing partners. During this preliminary analysis it was already evident to the evaluators that the QINs had significant limitations in terms of their completeness and reliability of data they presented. The main challenge for the evaluators was trying to objectively assess progress towards and achievement of planned outcomes – primarily because the QINs provided little or no information on this. Thus, when providing responses to EQs related to effectiveness the evaluators had to rely on project narrative reports (which provided evidence in a variety of formats and levels of

completeness) and feedback from discussions with stakeholders and (where time allowed) with final beneficiaries of EUTF Syria assistance. The allegorical nature of the feedback from the field missions, whilst valuable for adding detail and context to the available data, could not make up for the lack of comprehensive data on progress towards targets in the QINs that was largely absent.

The variable quality and formatting of financial reporting from IPs posed a challenge for the evaluators when answering the EQs related to efficiency and value for money. Thus, the analysis found in this section rely on whatever evidence was available – from detailed budgets and financial reporting from some IPs to summary tables and superficial reports from others.

Disruption to the planning of the missions and changes to the evaluation team composition for field missions

A series of unforeseen events forced the evaluation team to adjust its planned deployment in the field missions.

Key Expert 3 was due to participate in the Jordan mission to provide health insights into the programme there. The GoJ declined to issue him with security clearance to enter the country for the mission due to him being a Syrian national.[40] As a result the mission was conducted by the Team Leader with the support of the junior expert 4.

The whole evaluation team was due to participate in the field mission to Lebanon, as it represents the largest portion of projects in the evaluation sample. Due to the anti-government protests that began in October 2019, the evaluation team was recommended to postpone the planned mission till the situation on the ground stabilised sufficiently to allow them to meet with relevant stakeholders. The two-week long postponement was effective inasmuch as it allowed the field mission to go ahead and for key stakeholders to be interviewed. However, it disrupted the sequencing of the other mission in Iraq (KRI), which ended up overlapping with the rescheduled Lebanon mission. These changes are laid out in the table below.

Country	Original dates	Original team composition	Actual dates	Actual team composition
Jordan	27-30/10	O'Connor (lead) Albittar Al-Khawaja	27-31/10	O'Connor Al-Khawaja
Lebanon	10-19/11	Mathieson (lead) O'Connor Albittar Al-Khawaja	25/11 – 03/12	Mathieson O'Connor
KRI	20-25/11/2019	Albittar (lead) Mathieson Al-Khawaja	19/11 – 28/11	Albittar Al-Khawaja

40 Dr Albittar was also refused a Schengen visa to participate in the evaluation kick off meeting and the debriefing of the field phase findings in Brussels.

The evaluation team do not believe that these changes fundamentally weakened the quality of breath of the evidence gathered during these missions. For Jordan, the actual issues related to the relevance of existing assistance were clarified by stakeholders and therefore the absence of the health expert in the evaluation team did not prove to be a handicap to the analysis.

Annex A3 – Assessment of Likely or Actual Achievement of EUTF Syria Project-Level Health Outcomes

Key
Green: Outcome achieved or very likely to be achieved
Yellow: Outcome partially achieved or likely to be partially achieved
Red: Outcome not achieved or unlikely to be achieved
No colour (white): Project not sufficiently advanced to be

Project	Health-related Outcome	Assessment/Status
T04.30	Refugees from Syria and host communities have improved health and psychosocial well-being	• The achievement of the health element of the will in part be achieved by the CBHFA outputs and the medical service provision. • The MHPSS outputs will improve the PS wellbeing of the target groups • The effectiveness of the awareness campaigns is not proven. • The principal barrier to improved health in the target groups in several countries is affordability, which is not addressed by the project • QINs provide no data on progress to outcomes
	RC/RC Host National Societies in the region have strengthened their capacity and enhanced their ability to reach out to most vulnerable groups within the refugees and host communities	• This is an output – the host national societies' capacities have been strengthened. • The host national societies are now better able to assist vulnerable groups. No direct evidence of this happening but it is assumed that the EUTF Syria support will ultimately ensure the Host National Societies are more effective in their work.

T04.31	1) WGMB in target communities have improved understanding, increased awareness of, and individual capacity to cope with trauma and access available RH and PSS services and support. 2) Improved capacity of community leaders, community-based organisations, and local organisations to support WGMB to access RH and PSS services and support. 3) Quality, safe, and non-stigmatising RH and PSS services in Ministry of Social Affairs (MOSA) and Ministry of Health (MOH) health facilities are available for conflicted-affected WGMB.	No outcome for Jordan expected as component cancelled • Progress towards all three outcomes in Lebanon is satisfactory. A shifting population and dynamic base line and target data make such psychosocial projects (with maternal health coverage) difficult to assess in terms of progress towards planned outcomes • Funds transferred across from Jordan have been deployed to support Lebanon activities – and expect to increase effectiveness of this component • QINs provide limited information on achievement of outcomes
T04.50	To provide national and local authorities with effective instruments to perform early recovery and resilience activities	No health projects supported – no outcome expected
	Health and education services of the most affected host communities are strengthened	• Project expected to contribute to the achievement of both planned health outcomes across all countries. • QIN reporting at outcome level confirm progress towards targets
	strengthen and sustain the role of the civil society (local NGOs and CSOs, grassroots organisations) and of the service providers in the resilience and stabilisation processes	The scale of the challenge in the areas tackled by the project (primarily oriented to MHPSS) is such that the project is likely to make only a modest contribution to meeting the needs of the target groups in all the target countries.

T04.18	Reinforced mother and child health services in selected health centres and in two tertiary hospitals of Duhok Governorate in KRI (Maternity and Hevi Paediatric Hospital) Reinforced Medical emergency response in one secondary level (Akre Hospital) and one tertiary level (Emergency and Trauma Hospital) in Duhok Governorate)	• The Project interventions have fully achieved their planned outcomes • All the outputs have been delivered to the required standard. • The hospital facilities are functional and providing care to the target populations
T04.105	Increased equitable access, uptake and quality of secondary and tertiary healthcare for Jordanian and Syrian women, girls, boys and men in impacted areas	• Project has not achieved its planned outcomes as the hospitals and equipment are not yet operational. • Prospects for this happening are, however, positive. • Progress towards the delivery of the planned outputs is very good. • QIN fails to report on performance towards outcomes • Result statement and Outcome indicator does not reflect actual project outcome • Actual outcomes are better expressed in the project 'results' in the LFM
T04.47	To provide essential lifesaving care to refugees in Lebanon	• Outcome has been clearly achieved even if at the moment it is not quantifiable as the related indicator (Maternal mortality ratio less than 15 deaths per 100,000 deliveries) had not been measured at time of evaluation. • Result statement is inadequate as it is in fact an activity • Actual outcome is directly related to the health of Syrian refugees seeking hospital care

T04.54	1. Improved access to quality health services for Syrian refugees and other vulnerable populations in Lebanon 2. Improved well-being for Syrian refugees and vulnerable Lebanese population participating in mental health and psychosocial support activities	• Evidence suggests both the outcomes have already been achieved • Data for some Indicators for outcome 1 are not available (to be measured post-completion) • Data for outcome 2 suggests overachievement of outcome
T04.58	support national health care services by increasing the capacity of Syrian health staff; provide quality health related services to refugees and impacted host communities in Turkey	• QINs and documentary evidence suggest that both these outcomes have been achieved. • Outcome indicators had been overachieved by June 2019 • This suggests that the indicators are not fully responsive to the result
T04.74	Outcome 1: 92,100 vulnerable Syrian and Lebanese patients benefit from continued access to NCD care at 420 Primary Health Care (PHC) facilities every year for 3 years	• QIN and field evidence suggests this outcome has been achieved i.e. improving access to chronic medicine • This outcome is in fact a mixture of a results statement, indicator, and target value
	Outcome 2: Resilience of structures and mechanisms for governing and regulating the health sector improved Outcome 3: Primary care service delivery structures and processes better aligned with the requirements of universal coverage with high quality, people-centred primary care	• Both these outcomes unlikely to be achieved. Outputs need to be taken forward by MoPH/MoSA and measures stemming from them (such as recommendations related to implementation of universal health coverage) implemented. Currently there is little prospect of any decision being made on this due to political and economic uncertainties in the country. • These are likely to provide evidence for further policy dialogue between the EU, the Gov of Lebanon and other donors on healthcare reform

T04.96	By the end of 2020, to continue guaranteeing essential acute medicines and vaccine pipelines, through the provision of needed supplies to the Ministry of Public Health (MOPH) and the Primary Health Care Centres (PHCCs).	• Project effectiveness not fully evident • Outputs (acute medicines, vaccines) have been procured and delivered • The outcome of the project should actually be a better stocked MoPH warehouse. This has been achieved, albeit with problems related to reliability of stocks • The stated outcome is an activity. • The indicators and associated values in the QIN are irrelevant in measuring the project outcomes (as well as many of its indicators). • This is recognised by the IP, although no attempt has been made to revise these to make them more meaningful.
T04.147	improve accessibility and coverage of health services for people with disabilities	• No outcomes have been reported as yet • Discussions with IP and stakeholders indicated good progress on delivery of outputs. • Latest QINs contain no data on progress towards outcomes
T04.181	reinforce Mother and Child Health services in three Hospitals of Duhok Governorate	• No outcomes yet evident • Intervention started in late 2019
	reinforce critical care at the Emergency and Trauma Hospital of Duhok and at the district General Hospital of Amedy	
	support intergovernmental dialogue between Duhok and Ninewa Governorates, in order to reinforce a referral path for serious patients from Ninewa to Duhok	

T04.183	Ministry of Health in the Iraqi federal government and the Kurdistan region of Iraq have increased resources and capacity building that will contribute to building sustainable systems and enhance the quality of mental health and psychosocial support (MHPSS) service provision)	• The project just started and it is too early to assess the delivery of outcomes. • Clear linkage between planned outputs and the project outcomes in the DoA • The definition of some of the outcomes is poor (use of 'that', 'in order to').
	Access to inclusive, comprehensive and integrated quality MHPSS services	
	Support the mental health authorities in Iraq in order to improve the access to and quality of services as well as increase community resilience	

Annex A4 – Analysis of Potential Impact of EUTF Syria interventions

The following tables show how the EUTF Syria health interventions contribute towards EUTF Syria strategic outcomes via their indicators. The project figures are derived from QINs and the PF figures from the latest version of the EUTF Syria Results Reporting Document (December 2019).

Jordan

EUTF Syria Outcome (as stated in the EUTF Syria Results Framework for Health) and associated indicator(s)		EUTF Syria Health Interventions			
		T04.30	T04.31	T04.50	T04.105
Outcome: Improved access to medical care and health services					
Number of primary health care consultations conducted with refugees and host communities	**Total in 5th RR**	**2,259,556**			
	Latest available QIN value	0	0	6134	0
Number of people reached through health education activities	**Total in 5th RR**	**320,477**			
	Latest available QIN value	95, 447	0	1,398	0
Outcome: Strengthened human capacity to deliver primary and secondary health care services					
Number of professional staff trained in primary, secondary and tertiary health care services	**Total in 5th RR**	**5,530**			
	Latest available QIN value	204	0	204	0
Outcome: Improved health infrastructure					
Number of health infrastructure upgraded/ refurbished/ constructed	**Total in 5th RR**	**92**			
	Latest available QIN value	N/A	0	0 (target 2)	0 (Target 3)
Number of health facilities using the upgraded stock management system	**Total in 5th RR**	**25**			
	Latest available QIN value	N/A	N/A	N/A	N/A

Lebanon

EUTF Syria Outcome		T04.30	T04.31	T04.47	T04.50	T04.54	T04.74	T04.96	T04.147
Number of primary health care consultations conducted with refugees and host communities	**Total in 5th RR**	**Current: 2,259,556 Target: 2,472,589 Progress: 91%**							
	Latest available QIN value	n/a	n/a	n/a	n/a	1,360,619	n/a	n/a	n/a
Number of people reached through health education	**Total in 5th RR**	**Current: 320,477 Target: 264,738 Progress: 121%**							
	Latest available QIN value	n/a	n/a	n/a	n/a	136,760	n/a	n/a	n/a
Number of professional staff trained in primary, secondary and tertiary health care services	**Total in 5th RR**	**Current: 5,530 Target: 7,059 Progress: 78%**							
	Latest available QIN value	n/a	n/a	n/a	n/a	545	n/a	n/a	n/a
Number of health infrastructure upgraded/ refurbished/ constructed	**Total in 5th RR**	**Current: 92 Target: 135 Progress: 68%**							
	Latest available QIN value	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Number of health facilities using the upgraded stock management system	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a

Iraq

EUTF Syria Outcome indicators (as stated in the EUTF Syria Results Framework for Health)		T04.18	T04.181	T04.50	T04.30	T04.183
Number of primary health care consultations conducted with refugees and host communities	**Total in 5th RR 2019**	**2,259,556**				
	Latest available QIN value	0	N/A	1000	NA	N/A
Number of people reached through health education	**Total in 5th RR**	**320,477**				
	Subtotal	**2,580,033**				
	Latest available QIN value	0	N/A	5100	23,400	N/A
Number of professional staff trained in primary, secondary and tertiary health care services	**Total in 5th RR**	**5,530**				
	Latest available QIN value	1550 (45%F)	N/A	40	150	N/A
Number of health infrastructure upgraded/ refurbished/ constructed	**Total in 5th RR**	**92**				
	Latest available QIN value	30	N/A	10*	0	N/A

* *Unlikely to be health facilities as the infrastructure component of project does not support health sector actions*

Methodological note

- Figures taken from 5th RR (December 2019) and the latest available QINs
- Some project outcomes are not captured in the RF e.g. T04.96 ensures medicines and vaccinations are procured and delivered to Lebanese MoPH warehouse. This is not covered by any RF result or indicators (although it loosely corresponds to "*Number of health facilities using the upgraded stock management system*" – paradoxically, this indicator is explicitly what UNICEF does NOT commit to in its DoA)
- Disaggregated data (gender; Syrian/host population) only available for some indicators.
- Not all reported indicator values in the QINs clearly correspond with the RF indicators (project results therefore may not actually link to the reported results in the RF).
- Denominators for indicators not always expressed in numbers (e.g. %)
- Reporting methodology used by IPs appear vary and is not consistent across the board.

Annex A5 - Case Study of T04.96 from Lebanon

"Securing access to essential medical commodities for most vulnerable population in Lebanon"

Background

UNICEF was contracted by EUTF Syria under T04.96 to support the MoPH in the procurement of quality acute medications and quality vaccines.

UNICEF identified from the outset that this project was vulnerable to external influences. UNICEF were also clear in the DoA that they would not be able to put into effect any of the recommendation from the "EUROPEAID: Review of the distribution supply chain of essential acute medicines and vaccines, chronic disease medications to the Ministry of Public Health and the Primary Health Care Centres in Lebanon". In essence UNICER would procure and deliver vaccines and acute medicine to the MoPH Karantina warehouse and support/monitor vaccine distribution and usage through other tools at its disposal.

After the project had been signed, NGOs and IPs worked with MoPH and MoPH approved an adjusted list of items, several of which were not available on the UNICEF standard list. UNICEF had previously explained that non-standard items could be supplied but as Copenhagen would have to initiate individual supply contracts this would take an additional 4-8 months to procure. It should be noted that 'Standard' items were available under existing UNICEF contracts via Copenhagen which meant that the requests could be processed and dispatched with minimal delay. This 'standard' list of medications was subject to rigorous contractual caveats including quality, consistency and potency. Setting up new contracts for the non-standard items process took Copenhagen some time, however Copenhagen did this as quickly as they could and UNICEF was on track to deliver all standard and non-standard items that had been procured at that time by the end of December 2019.

Strengths identified

1 Vaccines are being procured, supplied to the warehouse and distributed in a managed and maintained cold chain to international standards.

2 Acute medicine is being procured and delivered to the warehouse.

3 MoPH staff collect consumption data at PHCCs, collate vaccine and acute medicine requests at the cadre and consolidate at central MoPH.

4 The degree of functionality observed is due to the professionalism and good will of exceptional staff within MoPH, Karatina and UNICEF.

Challenges identified (acute medicines)

1 MoPH via EUTF Syria provided UNICEF with an acute medicine and vaccine list at the start of the year set against a defined budget. This resulted in an inflexible procurement plan.

2 NGOs and IPs persuaded MoPH to adjust the procurement list (against UNICEF specific condition in the DoA). This introduced a 4-8-month delay for the delivery of those additional non-standard items.

3 MoPH relied on a paper-based, stock control system that excluded Karentina.

4 Karentina did not issue stock availability/picking lists or short/stock out lists. This led to clinics requesting stock that was often not available.

5 UNICEF placed bulk orders to minimize freight costs. In doing so they placed additional storage burden on the warehouse resulting in stock sitting in the aisles between storage racks, stock getting damaged and ineffective stock control.

6 PHCC pharmacies looked well stocked so doctors over prescribed (in time of plenty prescribe) resulting in over dispensing increasing demand of some essential medicines.

Challenges identified (vaccines)

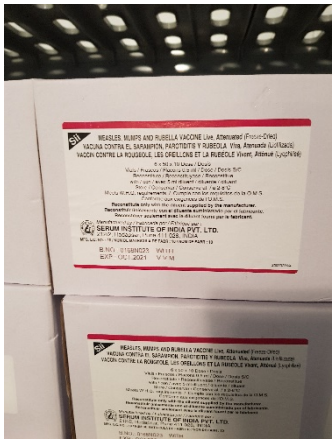
1 As funding for vaccines ran out remaining funding for acute medicine was shifted to bridge the funding gap thus ensuring the continuity of vaccine supplies. This was done with reference to EUD. Some acute medicines have run out at a time when numbers of upper respiratory infections and diarrheal disease are increasing.[41]

2 Pre conflict vaccination levels in Syria were reported to be high. However, as most refugees did not have health records when they fled the conflict, UNICEF decided to vaccinate. This led to over consumption due to repeat vaccination at border posts, PHCCs and UNHCR reception centres.

3 UNICEF introduced MERA (Mobile Expanded Programme for Immunization Registry Application) in order to track vaccine consumption data to try and better manage the vaccination supply chain. MERA is a 'closed source' third party product that offers limited added value as it stands, as it does not interface with other health products (i.e. Phenics) thus does not offer sustainability in the current form.

41 An emergency procurement has reportedly done by WHO/UNHCR in November 2019 to ensure adequate number of acute medications waiting for the new WHO EUTF Syria support to be signed (under the new health AD).

Challenges identified (institutional)



1 Beneficiaries commented they were being offered first generation medicine through the PHCCs whilst the clinic GPs were offering the more expensive second and third generation CE 'branded' medicine through private clinics.

2 MoPH staff collect consumption data at PHCCs, collate vaccine and acute medicine requests at the cadre and consolidate at central MoPH. However, this raw data is not shared with Karentina thus the supply chain 'loop' is open.

3 Karentina does not issue picking/availability/stock out lists. This produces an inefficient and ineffective system that is only functional to a degree due to the few dedicated staff that operate within the system.

4 Copenhagen supply acute medicine from 'approved' companies in distant countries (Bangladesh, Hungary), when beneficiaries see the country of origin labels leads to them questioning quality and safety of the items.

Issues to be addressed

The UNICEF contract was poorly designed. The supply chain is critically flawed. Future contracts need to be designed with a sustainable 'whole of supply chain' solution.[42] Prescription data should be monitored to manage over prescription and stop prescription of second or third-generation medicine where first generation is sufficient. Visibility of EU grants needs to be improved in terms of posters, leaflets and at the point of dispensing.

EUTF Syria should ensure the separation of competing needs. i.e. separate contracts for vaccines, acute and chronic medicine.[43] A whole of supply chain review to 'close the loop', should include effective patient record systems to reduce over vaccination, management of prescriptions to monitor GPs and dispensaries. This must be in an effective and sustainable manner allowing for future growth in PHCCs and linking into Phenics in an open source platform.

42 This is reportedly to be addressed as part of a new intervention financed under the Health AD approved for Lebanon after the evaluation report's cut-off date.
43 Ditto.

Annex A6 – Evaluation Methodology

4.1. Type of Evaluation – Health Sector Portfolio

As noted in the ToRs, this is an evaluation of the EUTF Syria Health Sector Portfolio and as such it primarily analyses relevance, performance and sustainability issues at the level of sector, rather than just individual EUTF Syria interventions. The evaluation sample, which is composed of the projects listed in section 2, will be used as the vehicle to explore sector-level trends and issues that can be identified within selected projects and then synthesised up to portfolio level. Where the evaluator finds a project-specific issue worthy of further investigation (for the purposes of highlighting a particular challenge or example of best practice) then the project will be analysed in more depth and presented in the evaluation report. Project level assessments of performance are covered by either project evaluations that are commissioned by the EUTF Syria IP responsible for the intervention in question or by external Results Oriented Monitoring (ROM) missions. This is not the purpose of this evaluation.

4.2. Data collection and analysis

Data Collection

The evaluation team will collect data from both primary and secondary sources and this will form the evidence base for the evaluation. This will be done using a variety of data collection techniques. Each evaluator is responsible for the collection and analysis of data for one country in the scope. This will ultimately generate a detailed evaluation matrix at country level, providing evaluation question (EQ) answers that will then be analysed and presented as findings in the final evaluation report at sector/portfolio level.

The main primary sources for the evaluation will be individuals who have been involved in the preparation and implementation of the interventions covered by the EUTF Syria health portfolio. These will be drawn from the stakeholders that are outlined in the ToRs and identified in the stakeholder analysis in Annex 4 of this report. The main stakeholders to be consulted are:

- EU services (EUTF Syria Staff; EUD staff)
- UN organisations
- Staff of IPs delivering health interventions
- Staff of counterpart national/regional/local authorities (including ministries, regional administrations, municipalities)
- management of beneficiary institutions (health centres, hospitals etc)
- Other direct beneficiaries (health workers)
- Other donors and international organisations (if not IPs) active in the health sector

- Final beneficiaries (refugees, IDPs and representatives of host communities that ultimately benefit from EUTF Syria assistance)

Given the strategic nature of the evaluation and the limited timeframes available for the country missions, priority will be given to those stakeholders able to give sector level insights i.e. EU Services, national/regional partners, UN organisations and IPs. These will be consulted whenever possible via face-to-face semi-structured interviews (or if not available in person, then via Skype or telephone). Site visits to projects will be conducted only where there is clear justification for this. In such cases, direct beneficiaries will be consulted via group interviews or focus groups.

Secondary sources are *de-facto* the documentation that the evaluation team will use as part of the data analysis. The main secondary sources that the evaluators should consult in their assessment of the EUTF Syria health portfolio are listed below:

- EUTF Syria Programming documents (including EUTF Syria strategic orientation document; action documents; descriptions of action/logframes/budgets)
- EUTF Syria project documents (QINs; narrative/interim/annual reports)
- Other EUTF Syria documentation
- ROM reports for individual EUTF Syria interventions[44]
- Project evaluations for individual EUTF Syria interventions (if available)
- Reports and analyses from other international organisations (including 3RP Syria reports, Vulnerability Assessments)
- Reports from national authorities (e.g. Jordan Response Plans)
- National policy documents (e.g. National Health Strategies)

The evaluators already have a substantial amount of documentation available from the Particip internal database. These have been used as the basis for the preliminary assessment of selected EQs presented in section 6 and Annex 5 of this report. Remaining documents will be gathered prior to and during the field phase.

Data Analysis

Analysis of data will be based around **two tools**. The first is the evaluation matrix (EM) in its two formats (the abridged version used for the preliminary analysis in the inception phase and the full matrix used in the reporting/synthesis phase). The second is the QINs analysis template used to provide the assessment of project performance for the evaluation sample in the inception phase. The **approach** to be taken when analysing the data collected is as follows:

44 ROM reports are available for the following projects: T04.18 AISPO, T04.47. UNHCR, T04.54 IMC, T04.96 UNICEF

Each evaluator will use the EM to assess performance of each intervention in the sample at indicator and JC level. The evaluator will firstly analyse each project against the indicators in the matrix, providing a written assessment for each indicator. The basis for this assessment will be the data collected from primary and secondary sources listed above, including the QINs analysis conducted in the inception phase. A simple scoring system for internal use will be used for each indicator to assess how well the intervention meets the indicator (3-strong/2-medium/1-weak). This will guide the evaluator when compiling the assessment for judgement criteria (JC). For those EQs related to performance issues (linked to effectiveness, efficiency and impact) the completed QIN analysis template will be used.

Once the indicators have been completed, the evaluator then creates a synthesis of the indicators per JC and provides an answer for each JC. The evaluator does this for each project in the sample, until all the indicators and JCs are complete for all projects. The evaluator will then answer each EQ in turn – again, synthesising the findings in the individual JCs as the basis for the analysis.

Finally, after the EM for each country is ready, it can be integrated into the final analysis at portfolio level. This will be done by the evaluation team leader during the reporting phase.

Triangulation

Evaluators will triangulate all findings to ensure that they are objectively balanced and methodologically robust. In practice this means that every key finding should be checked from at least two separate sources and documented accordingly e.g. from one or two primary sources such as interviews with EUTF Syria staff, focus group with final beneficiaries, and from at least one secondary source e.g. programming document or project progress report.

The robustness of findings will be further strengthened by the composition of the evaluation teams in the field missions. All the main findings will be discussed between the evaluators during the missions they attend. Also, the country findings in the reporting phase will be drafted by the Country Lead Evaluator but will be shared with the other senior expert evaluator who accompanied him on the mission for feedback and quality control (see below).

Composition of evaluation teams

A key element in the evaluation methodology is the composition of the evaluation teams in the field phase. The resources outlined in the ToRs for the field phase allow for two senior evaluation experts to participate in two field missions – one being the 'Country Lead Evaluator'. It is also proposed that they would be accompanied by the junior evaluation expert (see section 4.4 for more on this).

The rationale behind this is clear: Firstly, during intensive field missions, it is critical that the evaluator has the chance to reflect on the evidence he uncovers as soon as possible, consider its validity and veracity, and put this into the context of the main evaluation questions under

consideration. The presence of a colleague (or colleagues) with complementary knowledge of the themes under evaluation allows for immediate assessment and reflection, and acts as an immediate 'triangulator' of the facts. Secondly, it may prove to be the case that during a field mission (4-7 days) there will be a need for the evaluator to be in two places at once (due to the limited availability of key stakeholders). In such instances, the evaluators can divide their labour and each participate in separate meetings, site visits etc. At the end of each work day during the mission the evaluation team will be expected to convene to discuss their findings and note these down as part of the country mission report (composed by the junior Evaluation expert). Thirdly, in the reporting phase, the country lead evaluator will share his draft analysis of the EQs with his colleague who accompanied him on the field mission for feedback, further insights etc. Aside from further strengthening the analysis, this approach also ensures an informal first stage 'quality control'.

The evaluation team believe that this represents an efficient and effective methodological approach for data collection and analysis and will strengthen the overall quality of the evaluation findings.

QINs analysis

Aside from being part of the evidence base for the EQ answers by the evaluators, the QINs analysis will also be used in the synthesis phase to compare performance as reported in the project level indicators against the sector level indicators contained in the EUTF Syria Results Framework. This will fulfil the ToRs requirements in this respect.[45]

4.3. Evaluation questions, judgement criteria and indicators

Evaluation Criteria

The ToRs lay out the following evaluation criteria:

- Relevance
- Effectiveness and Impact
- Efficiency
- Coordination, Coherence, Complementarity and Synergies
- Sustainability
- EU Added Value and Visibility
- Gender and Special Needs
- Lessons Learned

45 ToRs p. 5 "Evaluation and subsequent analysis need to be based on a clear link to the EUTF Syria's identified objectives and the EUTF Syria Results Framework."

These evaluation criteria will be used to answer the evaluation questions listed in the following section, with the exception of the final point 'lessons learned'. This will be the subject of a separate section independent of the evaluation questions.

Evaluation Questions

Relevance

- EQ 1: Is programming of Health programmes/projects strategically aligned with the EUTF Syria's underlying guiding principles and approaches?
- EQ 2: How effectively do are specific country needs, contexts and barriers to health care services (HCS) taken into account in the programming of country-based EUTF Syria-funded Health programmes/ projects?
- EQ 3: How has the Health portfolio developed since the beginning of the EUTF Syria with regard to relevance, targeting and responsiveness? Has experience from previous actions been used successfully to improve the quality of later programmes/ projects?

Effectiveness and Impact

- EQ 4: To what extent have EUTF Syria-funded Health programmes/ projects been effective in achieving their results?
- EQ 5: What factors (positive and negative) have had the greatest influence on the achievement of results?
- EQ6: To what extent have EUTF Syria-funded Health programmes been able to contribute to longer term effects (impacts)? To what extent are ongoing Health programmes likely to produce impact prospects?
- EQ 7: What are the specific advantages/disadvantages of the various implementing partners (national, regional/multi-country) in terms of effectiveness?
- EQ 8: Is the level of partnership with the national/ country-specific governmental partners appropriate to support the effective achievement of the EUTF Syria Health objectives?
- EQ 9: Are Health referral systems in the host countries working effectively? Do final beneficiaries receive reasonable medical care in the event of referrals to the secondary and tertiary medical system?

Efficiency

- EQ 10: What is the currently most efficient aid modality to support the effective provision of Health services under the EUTF Syria-Syria in each of the countries of intervention?

- EQ 11: To what extent have resources been allocated and utilized in an efficient manner and achieve value-for-money?
- EQ12: To what extent do the various stakeholders have the necessary capacity (technical, institutional and financial) to promote and implement EUTF Syria-funded Health programmes?

Coordination, Coherence, Complementarity and Synergies

- EQ 13: To what extent was the support provided by the EUTF Syria-Syria for Health programmes/ projects coherent, complementary and coordinated with other major funding mechanisms (EU also including ENI)?
- EQ 14: What is the quality and extent of coordination/ complementarity/ synergies between national and regional/multi-country EUTF Syria Health programmes as well as ENI (and other EU) funded actions?

Sustainability

- EQ 15: What are the main factors for sustainability of the EUTF Syria-funded Health programmes/ projects and to which extent are these factors currently ensured?

EU Added Value and Visibility

- EQ 16: What EU added value is resulting from the EUTF Syria-funded Health programmes/ projects?
- EQ 17: To what extent are communication and visibility actions of EUTF Syria Health interventions proving conducive for achieving their desired effects

Gender and Special Needs

- EQ 18: To what extent have gender issues been taken into consideration in design and implementation and what are the effects?
- EQ 19: To what extent have accessibility and inclusiveness of persons with disabilities (Syrian refugees, IDPs and host community members) been taken into consideration in design and implementation and what are the effects?

Lessons learned

- Separate section linked to the ToR question "What lessons can be learned/ good practice can be identified/ from the implementation of the current generation of EUTF Syria-funded Health programmes/ projects?"

Judgement criteria and indicators

The proposed EM contains 36 JCs and 70 indicators. These are directly linked to the EQs listed above and these will ensure that all the relevant data is collected and analysed in a comprehensive and consistent manner by the evaluation team. The indicators are the starting point for collection of data from primary and secondary sources. The JCs analyse all their associated indicators and provide a composite finding for use in answering the EQ. The specific approach to be taken using this tool is described in more detail in the previous section. For the purposes of brevity, the JCs and associated indicators are presented in the evaluation matrix found in Annex B.

4.4. Timeline / workplan

The ToRs provide an indicative timeline for the delivery of the evaluation. Following the kick off meeting on 5th September, a revised timeline can now be proposed, which is found in the table below:

Event	Key milestones
Inception Phase	
Start of phase	05/09/2019
Submission of draft inception report	20/09/2019
Phase end	Upon approval of inception report
Field Phase	
Start of phase	27/10/2019
Jordan mission	27-30/10/2019
Lebanon mission	11-19/11/2019
Iraq mission	20-25/11/2019
Debriefing of field missions (Brussels)	Week of 02/12/2019
Phase end	06/12/2019
Reporting Phase	
Start of phase	09/12/2019
Submission of draft evaluation report	08/01/2020[46]
Submission of final evaluation report	14 days after submission of the consolidated comments by the EUTF Syria in Brussels and the European Union Delegations

46 The ToRs state that "The draft Evaluation report shall be submitted not later than 20 days after the end of the field phase (debriefing of field missions)." Based on the above timeline, this would fall on Saturday 29th December. Given that the drafting period falls over the festive holiday season, the evaluators believe it justified to set this deadline to the first working week of January 2020.

As with all timelines, these dates may be subject to some adjustments during the delivery of the evaluation. Nevertheless, the evaluators consider this timeframe and milestones within it to be a realistic assessment of the evaluation's expected duration. Any likely revisions to the above will be communicated in advance to the EUTF Syria team for their consideration and approval.

4.5. Evaluation report format

The evaluation report will follow this format (taking into account requirements in the ToRs).

1. Executive Summary (to be provided after the draft evaluation report is approved)
2. Introduction & country contexts
3. methodology used and limitations encountered
4. Key findings per EQ
    a. Synthetic answer for whole portfolio
    b. Country-Specific cases/examples to illustrate key findings
5. Lessons Learned & Conclusions
    a. at portfolio level
    b. country specifics (where applicable)
    c. assessment of the comparative advantage (if any) of the regional approach vs. bilateral programmes in health in the 3 countries under review
6. Recommendations
    a. at portfolio level
    b. country specifics (where applicable)
7. Annexes
    a. Completed evaluation matrix for each country
    b. List of interviewees
    c. Documents used

4.6. Quality control

The evaluation team sees internal quality supervision as critical to the success of this evaluation. The Evaluation Team Leader will review the quality of each report before passing it on to the M&E Team Leader who will ensure a final quality control before each report is sent to the Contracting Authority for approval. Overall quality assessment will consist of a thorough review of the report focusing on the following criteria.

- Meet information needs
- Appropriate design
- Reliable data
- Sound analysis
- Credible findings
- Valid and useful conclusions
- Realistic recommendations
- Clarity

The quality assessment will ensure that the evaluation report complies with the requirements of the Terms of Reference and meets adequate quality standards before sending it to the EUTF Syria. The team will use internal quality control to check and validate data sources and analysis. This is to ensure that findings reported are duly substantiated and fact-based, and that conclusions are supported by relevant judgement criteria. All limitations in the data sources and in the data analysis will be reported. Limitations on data reliability or related to the availability, quantity or quality of data which have implications for the findings, conclusions and recommendations will be articulated.

Annex A7 – Country Health Profiles

Lebanon

Since 2011, 1.5 million people have fled the conflict in Syria to seek refuge in Lebanon (997,905 million registered with UNHCR), including 34,000 Palestinian Refugees from Syria (PRS) and 35,000 Lebanese returnees in addition to a pre-existing population of more than 277,985 Palestinians Refugees residing in Lebanon (PRL). Consequently, the country's infrastructure, public services, labour market and healthcare have been drastically impacted as a result of hosting the biggest number of refugees per capita in the world. This has further exacerbated the pre-existing development constraints in the country with an estimated cost by the end of 2015 of 18.15 Billion USD.

Key Figures (sources in italics)

- **Lebanon's population:** 6.9 Million (*Source: World population review.com*)
- 1.5 million **Syrian refugees** (*UNHCR, 2019*)
- **Total Fertility rate (TFR) Lebanese**: 2.097 (*World Bank*, 2017)
- **Total Fertility rate (TFR) Syrians (2017)**: 5.2 (*WHO* 2017)
- **Neonatal mortality rate (2018):** 4.3 per 1000 live births (*World Data Atlas, 2018*)
- **Maternal mortality ratio (2017)**: 29 per 100,000 live births (*WHO, 2017*)
- **Under-5 child mortality (2018)**: 7.4per 1,000 live births (*UNICEF, 2018*)
- 47% prevalence of **cardiovascular diseases** (*WHO 2017*)
- 16% - **Cancer** mortality rate (*WHO 2017*)
- **Life expectancy at birth (2016)**: 78.8 (*World Bank, 2018*)
- **Total TB incidence rate (2018)**: 11 per 100,000 (*WHO, 2018*)
- 76% of *Syrian refugees live below poverty line* (USD 3.84 per day) (*UNHCR, 2018*)
- 1.5 million **vulnerable Lebanese in need** (*UNHCR, 2019*)

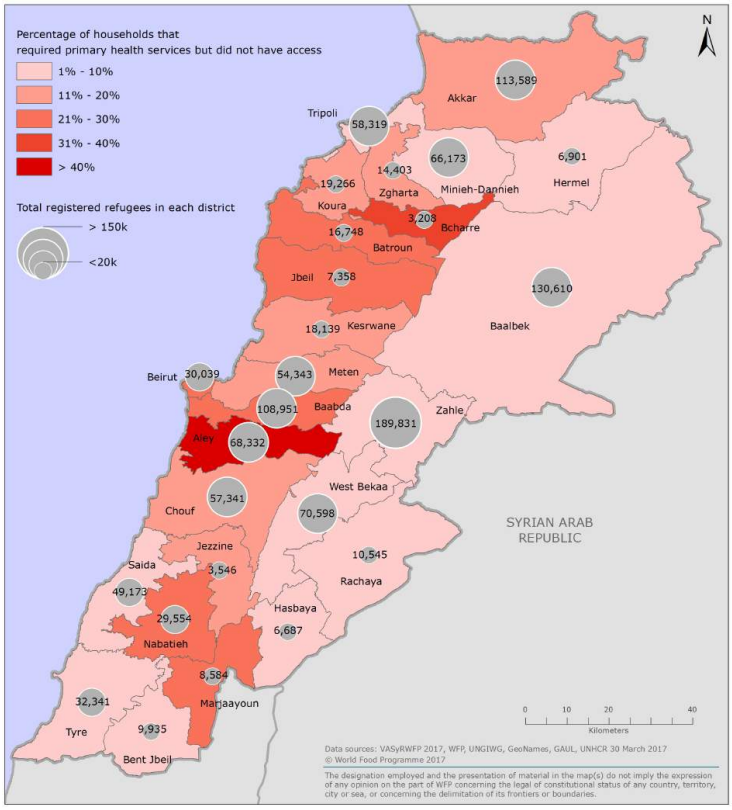
Healthcare structure in Lebanon is highly fragmented. Since the civil war in the 1970s and 1980s, the health sector has witnessed various waves of improvements and that was characterised by rapid growth in unregulated manner of the private sector and a weakened public sector. However, and despite progress made toward improving the health system performance and regaining the stewardship of the Ministry of Public Health (MoPH), health outcomes do not compare favourable to other countries with similar spending on health which indicates inefficiency of the system.[47]

Around 68% of the primary health care centres in the national network are owned by NGOs while 80% of hospitals belong to the private sector[48]. In the private sector, there are 165 hospitals with close to 13,000 beds in which they are located within larger cities while only 29 hospitals are operated by the MoPH. Likewise, the country has around 1219 primary health centres owned mainly by NGOs.

According to the World Health Organization (WHO), only 8% of the population benefit from government primary care, revealing a fundamental weakness in the primary healthcare

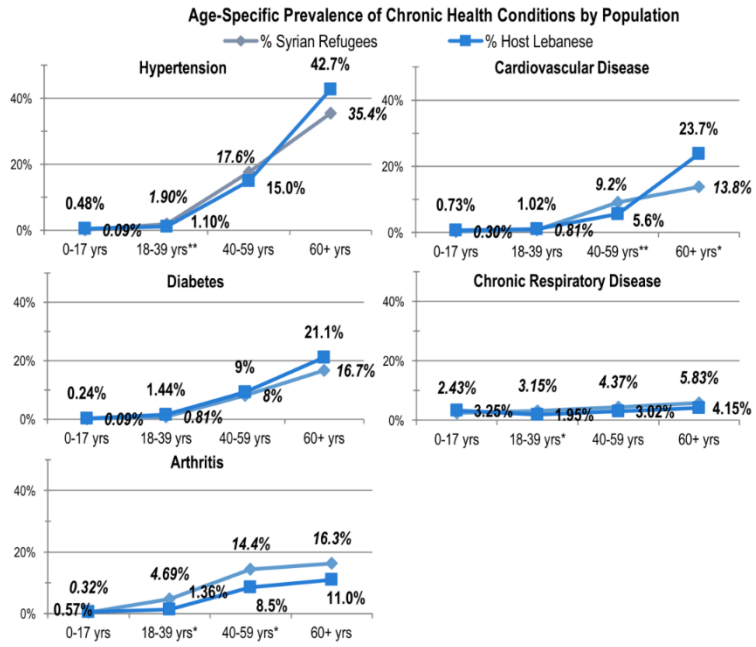
47 WHO, (2010), Country Cooperation Strategy for WHO and Lebanon: 2010-2015.
48 Ammar, W., Kdouh, O., Hammoud, R., Hamadeh, R., Harb, H., Ammar, Z., Atun, R., Christiani, D. and Zalloua, P. (2016). Health system resilience: Lebanon and the Syrian refugee crisis. Journal of Global Health, [online] 6(2). Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5234495/ [Accessed 12 Nov. 2019].

system[49]. Thus, the Increased levels of vulnerability among Syrian refugees (76% living below poverty line) and Lebanese (1.5 million vulnerable), lack of access, insufficient funds, ineffective governmental healthcare system, unequipped public health facilities and the heavily increasing demand on health services are the major challenges for Lebanon in addressing the negative impacts of the crisis. This is particularly acute in the regions of Akkar and Bekaa, as traditionally underserved areas, and hosting some 10% and 25% of Syrian refugees respectively.



Health profile of Syrian refugees:

Despite considerable progress made in terms of promoting access to healthcare services among Syrian refugees, access and affordability remain the biggest challenging barriers for Syrian refugees in Lebanon. Although there have been efforts made toward reducing the burden in providing subsidized healthcare services for refugees and for vulnerable Lebanese alike, particularly by the international community and the Government of Lebanon (GoL), Syrians are still required to finance the bulk of their health costs themselves. According to LCRP (2017), subsidized care is limited to obstetric and life-threatening conditions, which had been prioritized in light of available funding, and currently covers 75% of hospitalization fees and could be increased up to 90% for severely vulnerable households, but also for patients with acute burns and psychiatric conditions, as well as infants in need of neonatal and paediatric intensive care.[50]



49 BLOMINVEST BANK, (2018), The Lebanese Healthcare Sector: In Urgent Need of Reforms.
50 Lebanon Crisis Response Plan, (2017-2020).

In addition, the Lebanon Crisis Response Plan (LCRP) (2017) suggests that 76% of Syrian refugees are severely vulnerable and 27-30% of Lebanese are poor and require financial subsides to access timely and adequate healthcare. Evidently, and based on recent findings of the Vulnerability Assessment Framework (2017), 89% of refugees required primary healthcare were able to access it. However, affordability is considered the main barrier for the remaining 11% that were not able to access primary, secondary and mental healthcare due to the high treatment costs and doctor fees[51] [52]

In regards to non-communicable diseases (NCD), both Syrian refugees and host population suffer from the burden of NCDs which are often expensive and hard to manage and require continuity of assistance to mitigate the long-term complications.

Recent research indicates the prevalence of NCDs differs significantly between Syrians and Lebanese host community members. For example, rates of hypertension, cardiovascular diseases and diabetes are higher among Lebanese whereas rates of chronic respiratory diseases and arthritis are higher among Syrian refugees. Hypertension was the most prevalent of the included NCDs for Lebanese host community members (10.6%) and the second most prevalent, after arthritis, for refugees (7.6%).[53]

Governmental arrangements – Key institutions

The ability of Syrian refugees to access healthcare in Lebanon is not linked with their legal status.[54] According to Ammar, W et al. (2016), GoL had no clear policy in regards to the Syrian refugees hosted in Lebanon. Therefore, UNHCR and other international organisations created their own delivery system and financing mechanisms operated in parallel to the existing health system which whilst meeting the immediate health needs of the refugees, exacerbated that already fragmented situation in the sector and poor coordination among the main institutional players in responding to the refugee crisis. These shortfalls promoted the MoPH to call upon international agencies to consider more integrated approach of planning, financing and service delivery under a steering committee established and led by the MoPH where NGOs, UN agencies and other active players in the health sector have been holding regular meetings, setting up yearly plans and coordinating service delivery. [55]

In 2014, only 33% of the funding amount required was met by the international community[56]. However, from 2017, donors better realized their commitments towards responding to the crisis in Lebanon through various instruments such as Budget Support under the World Bank

51 UNHCR, Vulnerability Assessment Framework of Syrian Refuges in Lebanon, (VASYR) (2017).
52 Lebanon Crisis Response Plan, (2017-2020).
53 Doocy, S., Lyles, E., Hanquart, B. and Woodman, M. (2016). Prevalence, care-seeking, and health service utilization for non-communicable diseases among Syrian refugees and host communities in Lebanon. Conflict and Health, 10(1).
54 Thomas Schellen (2018), The impact of the refugee crisis on the Lebanese healthcare system. https://www.executive-magazine.com/special-report/the-impact-of-the-refugee-crisis-on-the-lebanese-healthcare-system.
55 Ammar, W., Kdouh, O., Hammoud, R., Hamadeh, R., Harb, H., Ammar, Z., Atun, R., Christiani, D. and Zalloua, P. (2016). Health system resilience: Lebanon and the Syrian refugee crisis. Journal of Global Health, [online] 6(2). Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5234495/ [Accessed 12 Nov. 2019].
56 United Nations. Syria Regional response plan – mid-year update 2014, Lebanon. 2014. Available: http://www.unhcr.org/syriarrp6/midyear/. Accessed: 9 September 2014. [Ref list].

Group's Global Concessional Financing Facility (GCFF)[57] and the Lebanon Humanitarian Fund (LHF). For example, under the LHF, International donor agencies channelled around USD 12.64 M in 2017, on top of USD 1.43 M carried over from 2016 (USD 1.13 M allocated for Health). The generous funding allowed LHF partners to continue supporting humanitarian activities in the country where in the Health sector, six projects were implemented by six partners across the country under the lead of WHO and UNHCR. Support included in these: Promoting access to hospital services, improving mental health and covering funding gaps.[58]

Consequently, the health response in Lebanon has been further characterised by an increasingly stable network of international and national organizations delivering support under the Lebanon Crisis Response Plan (LCRP)[59].

On the other hand, since 2014, EU has financed health projects in Lebanon with a total amount of 165M€[60] making it the leading donor to Lebanese Health sector. Under ENI, ECHO and EUTF Syria support, the EU has financed a range of responses both humanitarian and, increasingly, developmental in character.[61]

Kurdistan Region of Iraq

The Kurdistan Region of Iraq (KRI) has witnessed a multifaceted and complex crisis stemming firstly from the Syrian refugees' influx since 2012 and later on from IDPs in 2014. This has aggravated security, political, economic and social risks and undermined the population's wellbeing as well as the Government of Kurdistan Region of Iraq's (KRG) capacity to respond to the appealing humanitarian needs.

57 World Bank Blogs (2018). Financing health services for refugee populations: how to pay the bill?. [online] World Bank Blogs. Available at: https://blogs.worldbank.org/health/financing-health-services-refugee-populations-how-pay-bill [Accessed 12 Nov. 2019].
58 OCHA (2017), Lebanon Humanitarian Fund: Annual Report 2017.
59 Thomas Schellen, ditto.
60 A further 246 M EUR with the new AD was approved in Dec 2019.
61 EEAS - European External Action Service - European Commission. (2019). EU biggest donor to the Lebanese health sector. [online] Available at: https://eeas.europa.eu/delegations/lebanon/41772/eu-biggest-donor-lebanese-health-sector_en [Accessed 12 Nov. 2019].

The total number of IDPs and refugees KRI totalled 1.5 million in 2015 constituting 28% increase in KRI's population (this is now estimated at around 1.1.5 million). 60% of these reside in Duhok governorate, living among host communities and placing significant pressures on the government's ability to deliver health, education and social protection services.[62] This has left a substantial portion of the population, both Iraqi and Syrian in poverty of vulnerable to poverty.

Key Figures (sources in italics)

- **KRI population**: 5,122,747 (*Source: International Organization for Migration (IOM), 2018*)
- **Iraqi IDPs (2016)**: 1,334,211 (Not including IDPs in disputed territories) (*Joint Crisis Coordination Centre - KRG, n.d.*)
- **Syrian Refugees (2020)**: 247,568 (*Data2.unhcr.org, 2020*)
- **Poverty rate (2014)**: 8.1% (*World Bank Group, 2015*)
- **Physicians (2014)**: 13 per 10,000 (*Shukor, Klazinga and Kringos, 2017*)
- **Neonatal mortality rate:** 9 per 1000 live births (*Moore et al., 2014*)
- **Infant mortality rate**: 28 per 100,000 live births (*Moore et al., 2014*)
- **Under-5 child mortality**: 40.83 per 1,000 live births (*Moore et al., 2014*)
- **Immunization coverage, children 12-23 months (Measles and DPT3 respectively):** 90% and 81% (*Moore et al., 2014*)
- **Cholera outbreaks**: 2007, 2012 and 2015 (contained) (*Islamic-relief.org, n.d.*)
- **Total TB incidence rate (2014)**: 43 per 100,000 (*Balaky, Mawlood and Shabila, 2019*)
- **Cancer:** 61.7/100,000 Sulaimani Governorate (*Khoshnaw, Mohammed and Abdullah, 2016*)

The KRG continues to provide free access to primary healthcare services *de jure* for KRI citizens while refugees and IDPs residing within the region are treated as foreigners[63]. Primary care is almost exclusively provided through the public sector. However, the already scarce services are being inefficiently utilised due to overcrowding and a significant increase in demand linked to the refugees and IDPs. As such, health outcomes have been also negatively impacted, especially in the lights of the economic crisis as poverty had doubled from 3.5 % in 2012 to 8.1% in 2014[64] and to 12.5% in 2016 according to the KRG Ministry of Planning [65].

Similar to Lebanon, the private sector in KRI is characterised by an unregulated and rapid growth. This has been exacerbated by the weak and inadequately implemented regulations of MoH. This fragmented approach coupled with high service costs complicates access to health care by patients and increases their inability to afford medications. In a recent study conducted by (Cetorelli, V., Burnham, G. and Shabila, N. (2017), 85.4% of respondents were not able to take prescribed NCD medications due to its high price.[66]

Overall, challenges in the health sector are characterised in the lack of medications, understaffing in the health workforce, weak capacity among personnel, lack of effective health referral system and health information system.[67]

62 World Bank Group (2015). The Kurdistan Region Of Iraq: Assessing The Economic And Social Impact Of The Syrian Conflict And ISIS.
63 Shukor, A., Klazinga, N. and Kringos, D. (2017). Primary care in an unstable security, humanitarian, economic and political context: the Kurdistan Region of Iraq. BMC Health Services Research, 17(1).
64 World Bank Group (2015). Ditto.
65 Goran, B. (2016). Poverty rate rises to 12.5 percent in Kurdistan. [online] Kurdistan24. Available at: https://www.kurdistan24.net/en/news/49b098c8-62af-43d6-85cf-9588689bded4/Poverty-rate-rises-to-12-5-percent-in-Kurdistan- [Accessed 30 Nov. 2019].
66 Cetorelli, V., Burnham, G. and Shabila, N. (2017). Prevalence of non-communicable diseases and access to health care and medications among Yazidis and other minority groups displaced by ISIS into the Kurdistan Region of Iraq. Conflict and Health, 11(1).
67 RAND Health. (2014), The future of Health Care in the Kurdistan Region – Iraq: Toward an Effective, High-Quality System with *an Emphasis on Primary Care.*

Syrian and IDPs Health Profile

According to a RAND Health study from 2014 access to health care facilities in KRI is generally good as the catchment areas are only within 30 minutes for the vast majority[68]. However, more recent literature indicates that healthcare sustainability has been threatened due to the significant impact of the crisis and the imposing of additional barriers on refugees to access health. Notably, distance to facilities and therefore travel fees and the increased discretionary fees.[69]

Despite limited information and paucity of statistics as a result of the weak health information system in KRI, anecdotal evidence suggests that the burden of disease prevalence among Syrian refugees is higher than that of the host community in KRI[70]. For example, around 60-70% of Hevi Paediatric Hospital patients in Duhok are IDPs and Refugees[71]. According to a recent field study conducted by the World Bank Group (2015) in refugee camps in Duhok and Sulaymaniyah, it was evidenced that refugees were at higher risks of developing disease as a result of being prone to numerous environmental factors (Poor WASH)[72], In addition the challenging prevalence in epidemiology among refugees and IDPs has been reported (e.g. infectious diseases, chronic illnesses, gender-based violence, PTSD, maternal and child health problems). A 2017 study conducted in 13 IDPs camps found that the prevalence of NCDs was increasing among men and women. For example, Hypertension prevalence rose from 4.4% among those aged 30-44 to 23.9% and reached 32.1% among those aged 60 and above. Similarly, prevalence of musculoskeletal conditions increased among those aged 30-40 from 4.2% to 12.3%. In general, the prevalence of NCD multimorbidity was considerably high, with 38.5% of individuals having two or more conditions[73]

However, despite continuing to provide public health services free of charge, access remains a challenge due to the poor quality of services obtained and overcrowding which have magnified hospitals' inability to address the needs of Syrians and IDPs accordingly. For example, in Duhok, where the biggest chunk of IDPs and refugees reside, primary healthcare centres (PHCC) cover no more than 10,000 persons[74].

National Government health arrangements – Key institutions:

The Ministry of Health (MoH) of KRI oversees six Directorates of Health, which in turn are comprised of Districts and Sub-Districts. Health service delivery continues to be a mix of public-private participation and investment. In the public sector, services are administered by the Ministry of Health in Erbil, which manages a large network of primary and secondary health care facilities[75].

68 RAND Health. (2014). Ditto.
69 World Bank Group (2015). Ditto.
70 World Bank Group (2015). Ditto.
71Interview: Yehya, N. (2019). Evaluation of EUTF Syria -funded Programmes/ Projects Health.
72 World Bank Group (2015). Ditto.
73 Cetorelli, V., Burnham, G. and Shabila, N. (2017). Ditto.
74 Anthony, C., Constant, L., Culbertson, S., Glick, P., B. Kumar, K., C. Meili, R., Moore, M., Shatz, H. and Vernez, G. (2015). Health Sector Reform in the KRI. In: C. Anthony, L. Constant, S. Culbertson, P. Glick, K. B. Kumar, R. C. Meili, M. Moore, H. Shatz and G. Vernez, ed., Making an Impact in the Kurdistan Region—Iraq. [online] RAND. Available at: URL.
75 World Bank Group (2015). Ditto.

Despite the paucity in information published in relation to effects of the joint Syria and DAESH/ISIS crisis on primary health care governance structures, capacities and processes in either KRI or Iraq, it is clear that these health structures have been negatively impacted. The KRG thus continues to appeal the international community and humanitarian organisations to share the burden and mitigate the gaps in healthcare provision in whatever ways possible.[76]

Donor- and the EUTF Syria Response

The aforementioned situation has led to the introduction of many international actors involved in both humanitarian and development activities in the health. The most prominent are the WHO, leading the Humanitarian Response Plan (HRP) and UNHCR, leading the 3RP under which a large number of actors are gathered. However, funding requirements had not been optimally met. As of 2016, only 56% and 30% were financed of the appealed aid under the HRP and 3RP respectively leaving significant proportion of demands unfinanced.[77]

The EUTF Syria contribution has been recognised in KRI as being extremely beneficial, both inside and outside camps focusing on areas of strengthening the healthcare service provision in coherence with the needs and the objectives as identified jointly by the national authorities (e.g. DoH Duhok) and the implementing partners. Support has capacity building for doctors and nurses, rehabilitation and expansion of hospitals, equipping healthcare facilities with medical care units and ambulances.

76 Previous.cabinet.gov.krd. (n.d.). Impact of the Refugee Population on the Kurdistan Region of Iraq. [online] Available at: http://previous.cabinet.gov.krd/p/page.aspx?l=12&s=000000&r=401&p=484&h=1&t=407 [Accessed 27 Nov. 2019].
77 Shukor, A., Klazinga, N. and Kringos, D. (2017). Primary care in an unstable security, humanitarian, economic and political context: the Kurdistan Region of Iraq. BMC Health Services Research, 17(1).

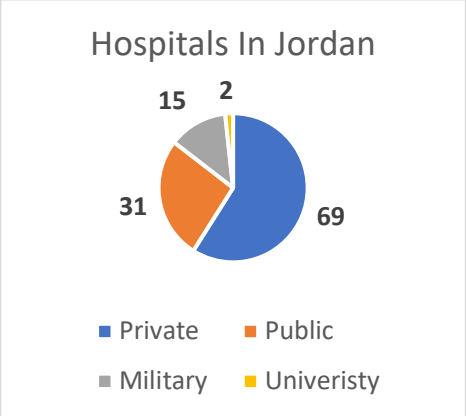
Jordan

Although Jordan is a lower middle-income country with scarce natural resources and high population growth rate, the health sector in Jordan is considered one of the best in the Middle East. Jordanian health sector has witnessed remarkable developments that positively affected the health status of Jordanians due to development plans which included health as a priority for sustainable development. According to the National Health Strategy for Health Sector in Jordan (2016 – 2020) positive trends were identified in several health indicators. Notably, GoJ has made a remarkable progress in the field of combating communicable diseases as result of number of policies and strategies like the institutionalization of the national vaccination programme. However, while the rates of communicable diseases have fallen down, mortality rate caused by NCDs have raised. It reaches 727 per hundred thousand population while the global mortality rate level from NCDs was 573 per hundred thousand people in 2008.

Key Figures (Sources in italics)

- **Jordan's population**: 9.5 million, including 2.9 million non- Jordanians (*USAID, 2017*)
- **Total Fertility rate (TFR)**: 2.7 Live Births per Women (*Department of Statistics, 2019*)
- **Modern contraceptive prevalence rate**: 42% (a rate of 75% is needed for replacement fertility) (*USAID, 2017*)
- Average household size: 5.1 (*USAID, 2017*)
- **Maternal mortality**: GOJ reports 19 per 100,000 live births; however, UN and World Bank figures differ (*USAID, 2017*)
- **Infant and under-5 child mortality**: 17 and 21 per 1,000 live births (*USAID, 2017*)
- **More than half** of all Jordanians rely on public-sector healthcare services (*USAID, 2017*)
- **Non-communicable diseases** are the leading cause of death in Jordan (*USAID, 2017*)
- **Anemia**: 32% (children under 5); 34% of women age 15-49 are anemic (*USAID, 2017*)
- 86% are living **below the Jordanian poverty line** with heavy demands on health and other social services *(USAID, 2017*)
- **1.4 million Syrian refugees** (*The National Strategy for the Health Sector in Jordan, 2016 – 2020*)

The country's heath system is fragmented and mainly divided between private and public institutions. In the public sector, MoH operates 1245 primary health care centres and 31 hospitals, covering 26% of all hospital beds in the country; the military's Royal Medical Services runs 15 hospitals across Jordan, accounting for 13% of all beds; the private sector provides 59% and operates 69 hospitals[78]. This capacity has been strained due to population growth and Syrian refugee influx.



The health sector has and still being prone to major challenges in terms of meeting the growing health demands and the rising health care costs in the lights of the deteriorating economic situation and addressing the negative impacts of hosting nearly 1.4 million Syrian refugees residing mainly in host communities and urban areas which put additional significant strains on health infrastructure and services provided.

78 Private Hospitals Association Jordan: https://phajordan.org/AR-article-3809-.

Lack of funding, limited number of health workers and the lack of sufficient facilities are considered major challenges in addressing the negative impacts of the Syria Refugee Crisis. Particularly, in Northern governorates, where the density of refugees is higher. For example, the burden of work in health centres has increased from 9% to 50% and the bed occupancy rate in each of Mafraq Public Hospital and Ramtha Public Hospital has reached 100%[79]. The Impact of refugee crisis on the health system according to Vulnerability Assessment (2015)[80] can be summarized as follow:

- +2,886 additional hospital beds needed;
- +22 comprehensive primary health centres;
- +1,022 physicians to meet population needs;
- Crowded health facilities;
- Essential services no longer affordable for most refugees;
- Reduction in consultation time;
- Shortages in medications and supplies;
- Overuse of equipment and infrastructure;
- Decline in performance on key health system indicators;
- Since the outbreak of the crisis, 34000 cases of communicable dieses had been reported among Syrian refugees; 95% of these cases were watery and bloody diarrhoea cases in addition to around 134 Tuberculosis (TB) cases among refugees with an estimated cost of over JOD 2M.

National government health arrangements – key institutions

Until 2014, all Syrians registered with UNHCR were eligible to access MoH facilities free of charge. Due to February 2018 regulatory changes, GoJ lowered the level of access for Syrians to 80% of foreigner rate upon using any health services provided by the MoH. Thus, imposing additional financial burden on Syrians' affordability to access health services and exacerbating their vulnerability. According to JRP (2018- 2020), current funding trends in the health sector suggests that only 40% of refugees living in host communities will be covered by health services[81].

As a result of the crisis, GoJ through JRP explicitly highlighted the need to further strengthen MoH's resilience through the provision of medical consumables, supplies, vaccines and equipment as well as building the capacity of MoH human resources in addition to constructions, maintenance, and rehabilitation of health-related infrastructures.

79 The National Strategy for the Health Sector in Jordan (2016 – 2020).
80 WHO (2018), Jordan: Migration and Health challenges. Dr Maria Crisitina Profili. Palermo.
81 JRP (2018): 36% of non-camp adult refugees were unable to access needed medicines or other health services primarily due to an inability to pay fees.

The international community and development agencies have been generous in addressing the aforementioned challenges and promote access to quality health care services since the outbreak of the crisis. Notably USAID, WHO and the EU through various aid instruments, like the Multi-donor Account (MDA), Jordan Partnership Paper, and the EUTF Syria programme, etc.

USAID is considered the largest donor to the Jordanian health sector and have contributed to the significant improvements in health outcomes by channelling USD 500M in the period of 2000 - 2017. USAID response to strengthening the health sector included; improving access and quality to an integrated health care services; expanding the community health network; establishing an effective system to maintain human resources for health; and upgrading hospitals[82].

The bulk of EUTF Syria health interventions in Jordan to date have been implemented under so-called 'regional' projects (implemented in more than one EUTF Syria country) aiming at strengthening and building the capacity of mental health and psychosocial support services; and promoting and increasing inclusive access to health services for refugees and host communities. One country-specific intervention has focused on rehabilitating and expanding state health infrastructures in locations with high numbers of Syrian refugees and vulnerable Jordanians.

In addition to the above, two projects are under preparation – a 30M€ intervention with the WHO focussing on vaccinations and a 22M€ with the Spanish Development Assistance Agency on NCDs. Neither project had an approved action document at the time of the evaluation so were not included in the evaluation sample. Nevertheless, the evaluators took both these interventions into account in the field phase to understand how the EUTF Syria programme is evolving in terms of its responsiveness and relevance to strategic priorities and needs on the ground, as well as how mechanisms for coordination, complementarity and synergy function in practice.

82 USAID (2017).

Annex A8 – List of interviews

Name	Organisation	Position
Sara Campinoti	EUD Lebanon	EUTF Syria Operational Manager Health
Sarah Bernard Spencer	EU Delegation Iraq	Operational Manager
Maria Rosa Vettoretto	EU Delegation Jordan	EUTF Syria Operational Manager Health
Emad Shanaah	MoPIC Jordan	Head Of EU cooperation Section
Huda Ababneh	MoH Jordan	Head Of Planning
Diya Nanda	UN WOMEN Jordan	Programme Management Specialist
Frederic Turlin	AFD	Programme Manager
Martino Costa	AICS	Programme Manager
Enrico Papitto	IFRC	MADAD Grant Manager
Mamdouh Al-Hadid	JRC	Head Of Programmes
Ibrahim Al-Ajlouni	JRC	National Centre for First Aid and Risk Reduction
Mayu Fujiwara	IFRC	CBHFA Delegate
Michie Mito	IFRC	Community Care Delegate
Dina Jalookh	IFRC	CBHFA Program Officer
Maria Cristina Profili	WHO	WHO Representative to Jordan
Muhammad Usman Akram	UNOPS	Director
Muna Al-Banna	UNOPS	Regional Infrastructure Advisor
Hatem Baara	UNOPS	Project Manager
Alex Fergusson	MEDAIR	Country Director
Margie Davis	MEDAIR	Deputy Country Director
Frances Villa Pala	AECID	Program Manager
Rasha Abdul Hafiz AlKurdi	IFRC and JRC	CBHFA Volunteer
Sameer M.Mmdoh ALAjami	IFRC and JRC	CBHFA Volunteer
Rula Basem Khader	IFRC and JRC	CBHFA Volunteer
Asmaa Khamis AlMohammad AlJabr	IFRC and JRC	CBHFA Volunteer
Nasrin Rakan Almeslmani	IFRC and JRC	CBHFA Volunteer
Rama Ayman AlNassar	IFRC and JRC	CBHFA Volunteer
Sara Jehad AbuJubara	IFRC and JRC	CBHFA Volunteer
Mahmoud Ahmad AlHassan	IFRC and JRC	CBHFA Volunteer
Ezz Aldeen Hmad AlHassan	IFRC and JRC	CBHFA Volunteer

Mansour Sameer Almasri	IFRC and JRC	CBHFA Volunteer
Eman Abedalaziz Thabet	IFRC and JRC	CBHFA Volunteer
Muhammed Juaidi	UNOPS: Construction Team	Engineer
Hashem Ramoni	UNOPS: Construction Team	Engineer
Asem Barakat	UNOPS: Construction Team	Engineer
Dr. Ameen Almayatah	Jamil Tutanji Hospital	Hospital Director
Dr. Mohammad Arman	Jamil Tutanji Hospital	Head Of Emergency Unit
Daniel Sinclair	USAID	Director: Population and Family Health Office
Jean-Marc Jouineau	ECHO	Technical Assistant
Branko Golubovic	ECHO	Technical Assistant – Jordan / Regional Sectoral Expert, DRR
Tanya Chapuisat	UNICEF	UNICEF Representative to Jordan
Areej Zuraigat	MoLA	Head of Department for International Projects
Abdalla Mkanna	Norwegian Red Cross	Former Project Coordinator of T04.30 in Erbil
Tarak Bach Baouab	ECHO Iraq	Technical Assistant
Dr Shakhawan Khailany	DoH Erbil	Head of IDPs and Refugees Dept.
Dr Arman Jalal	Iraqi Red Crescent	MADAD Project Officer
Hawri Ihsan	Iraqi Red Crescent	Head of Iraqi Red Crescent – Erbil Branch
Hoshang Mohamed	Joint Crisis Coordination Centre (JCC)	Director General
Tom Vincent	Group Meeting 1: ACF	ACF Country Director
Pius Mulonzya	Group Meeting 1: ACF	Consortium Coordinator
Blandine Bruyère	Group meeting 1: IMC	MHPSS Specialist
Megan Thompson	Group Meeting 1: IMC	Grants Coordinator
Dr Ali Khalid	Group Meeting 1: PUI	Deputy Medical Coordinator
Dr Dyar Ramadan	MoH	Rep. to JCC / Director of Health Services (Humanitarian aid Dept.)
Dr Idris Azabou	Norwegian Red Cross (NRC)	Health Delegate / MADAD Focal Point in Iraq
Dr Wael Hatahit	WHO Iraq	WHO Emergency Lead
Dr Abdullah Ibrahim	Duhok Emergency Teaching Hospital Management	Hospital Director
Dr Abdullah Ihsan	Duhok Emergency Teaching Hospital Management	Deputy Manager
Dr Zidan M. Abdullah	Group Meeting 2: Duhok Emergency Teaching	Emergency Medical Practitioner

	Hospital Doctors and Nurses	
Saad Younis Taha	Group Meeting 2: Duhok Emergency Teaching Hospital Doctors and Nurses	Nurse
Bahar Mohammed	Group Meeting 2: Duhok Emergency Teaching Hospital Doctors and Nurses	Nurse
Dr. Akram Ismail	Group Meeting 3: Maternity Hospital, Doctors, Nurses and Manager	Pediatric
Dr. Ali Ihsan	Group Meeting 3: Maternity Hospital, Doctors, Nurses and Manager	Pediatric
Zeinab Abdullah	Group Meeting 3: Maternity Hospital, Doctors, Nurses and Manager	Nurse
Nahida Hussein	Group Meeting 3: Maternity Hospital, Doctors, Nurses and Manager	Nurse
Hozan Jalal Majed	Group Meeting 3: Maternity Hospital, Doctors, Nurses and Manager	Midwife
Halima Sabri	Group Meeting 3: Maternity Hospital, Doctors, Nurses and Manager	Nurse
Layla And	Group Meeting 3: Maternity Hospital, Doctors, Nurses and Manager	Doctor
Zeelan Mohammed	Group Meeting 3: Maternity Hospital, Doctors, Nurses and Manager	Doctor
Ali	Group Meeting 3: Maternity Hospital, Doctors, Nurses and Manager	Doctor

Iman Mohammed	Group Meeting 3: Maternity Hospital, Doctors, Nurses and Manager	Doctor
Alessendra Rossi	AISPO	Health Coordinator – MADAD
Dr Omed Majid	DoH – Duhok	Head of MH Office / Public Relations Coordinator
Dr Farsat Saad	DoH – Duhok	Head of CPD Dept.
Martin Gallard	ACTED	CP Project Manager
Najem Kurdi	ACTED	Deputy Project Manager
Dr Blend Mizoory	WHO	National Emergency Medical Officer
Dr Gunnar Strote	GIZ	Head of Health Component: Support of Basic Services for Vulnerable Persons (ConNex)
Dr Nezar Tehya	Hevi Paediatric Teaching Hospital	Hospital Director
Dr Qadir M.Salih	Group meeting 4: Hevi Paediatric Teaching Hospital	Head of Pediatric Surgery Centre
Azad A.Haleem	Group meeting 4: Hevi Paediatric Teaching Hospital	Vice Manager
Hevan Adel Haji	Group meeting 4: Hevi Paediatric Teaching Hospital	Pediatric ICU Nurse
Bayar Haji Saleem	Group meeting 4: Hevi Paediatric Teaching Hospital	Pediatric ICU Nurse
Nora Suleeman	Group meeting 4: Hevi Paediatric Teaching Hospital	PICU and ER
Frank Paulin	3rd Party Monitor	EPOS Team Leader
Michele Asmar	3rd Party Monitor	EPOS PH Expert
Osmat Azzam	3rd Party Monitor	EPOS Economist
Jasone Amezqueta	Norway Red Cross	MADAD Grant Manager
Nabih Jabr	Lebanese Red Cross	Under-secretary General for Development and Support
Sabine Karout	Lebanese Red Cross	Assistant Director for Administration and Finance
Curt Tayler	MEDAIR	Country Director
Dr Iman Shankiti	WHO	Director
Dr Alissar Rady	WHO	National Advisor
Eduard Tschan	IMC	Country Director
Joseph Geal	IMC	Deputy Country Director
Adam Jacovou	IMC	MADAD Project Officer
Clare Shortall	PUI	Heath Coordinator

Jason Etheridge	FPS	Director of programmes - Mental Health Specialist
Patricia Khorshidian Houssein Sweid Rima Abo Darwich Rana Hassoun	IMC Field Visit – Kayan PHC	Senior Health Officer – BML – IMC Deputy Health Coordinator – IMC Al Kayan Manager Al Kayan Beirut PHCC Coordinator
Ama Guermes	FPS	Mental Health coordinator
Nadwa Rafeh	World Bank	Senior Health Specialist
Aicha Mouchref	Global Affairs Canada	Senior Development Officer
Shauna Flanigan	Global Affairs Canada	Senior Development Officer
Mme. Dima Chams	MOPH Lebanon	Responsible, Cold-chain and PHC medication
Mme. Maha Naous	MOPH Lebanon	Manager, MOPH Central Warehouse
Violet Warnery	UNICEF	Deputy Representative
Eleonora Genovese	UNICEF	OIC Chief of Health
Musonda Kasonde	UNICEF	Supply and Logistics Manager
Rabab Saffideen	UNICEF	Supply and Logistics Officer
Charly Feghali	UNICEF	Supply Intern
Jacob Arhem	UNHCR	Health specialist
Randa Hamdeh	MOPH	Head of PHC Department
Issam Bishara	YMCA	Chief Executive Officer
Cynthia Kheir	YMCA	Project Manager
Farah Asfahani	AFD	Regional project manager for Middle East Health & Social Protection
Hart Ford	ACTED	Country Director
Hajar Chamoun	ACTED	Protection Project Coordinator
Gelena Vougianovits	TdeH	Program Coordinator
Hoda Mouhana Adnan Nasruddin Abir Abdel Samad	MOSA Lebanon	Head of Social Development Department Head of Social Development Centers Affairs Department NGO coordinator
Curt Tyler Bouchra Doueihi Hiba Haj Omar Farah Darwiche Hussein Haraty Ghina Harb Reeda Chreif Khouloud Abbas Nouhad Younes	MEDAIR – Field Visit	Country Director Programme Funding Manager Communication Officer Health Project Manager Senior Health Officer Health officer Midwife PSS officer PSS officer
Jasone Garcia Amezqueta Sabine Karout	LRD/NRC/PRC/SRC – Field Visits (dispatch centre and PRC DG Health)	Response Preparedness Delegate Madad Grant Manager LRC_ Admin. Finances assistant. LRC dispatch centre supervisor.

Tharwat Halabi Dr. Samer Dr. Adel Sirine Abou Hatab Jim Bergenson		PRCS Lebanon branch director. PRCS Lebanon Branch Project director Madad project coordinator. Swedish RC delegate

Annex A9 - List of documents used

Strategic Documents	
Document	Source
EUTF Syria Strategic Orientation Document	EC
Jordan partnership paper 2018	Government of Jordan, EU, United Nations
Action Document Regional Health programme for displaced populations and host communities in neighbouring countries affected by the Syrian crisis	EC
Action Document Enhancing resilience in Iraq	EC
Action Document Expanding and Equipping Ministry of Health facilities impacted by the Syrian crisis in Jordan	EC
Action Document EUTF Syria Jordan health programme for Syrian refugees and vulnerable Jordanians.	EC
Action Document Lebanon Health Programme for Syrian refugees and vulnerable Lebanese population (including revision)	EC
Action Document EUTF Syria Programme in support of the Healthcare System for vulnerable population in Lebanon	EC
Regional Refugee and Resilience Plan 2018 Annual Report	3RP
Regional Refugee and Resilience Plan 2019 progress report	3RP
Regional Refugee and Resilience Plan strategic overview 2019-20, 2020-21	3RP
Jordan Vulnerability Assessment Jordan 2019	UNHCR/ACF/ILO
The Vulnerability Assessment of Syrian Refugees in Lebanon 2018	UNHCR et al
Health Sector Profile Jordan 2018	USAID
Jordan Response plan 2018-2020, 2016-18, 2017-2019,	Government of Jordan
EUTF Syria Results Report (4th and 5th editions)	Particip GmbH
Jordan Health Development Partners' Forum Minutes (2018, 2019)	EU Delegation

Jordan, Turkey, Egypt (plus Lebanon)

Project Documentation	
Document	Source
Quarterly Information notes to all interventions	EUTF Syria
All descriptions of action for all interventions	EUTF Syria/Implementing Partners
All Logframes to DoAs for all interventions	EUTF Syria/Implementing Partners
Project progress/narrative reports/workplans for all interventions	Implementing Partners
Financial reports/budget plans for all interventions	Implementing Partners
Communication and visibility plans for all interventions (where they exist)	Implementing Partners
Regional Mid-term Review of T04.30	Danish Red Cross
Regional Baseline Study of T04.30	Danish Red Cross
T04.50/T04.40 Call for proposals on local authorities: "Improving infrastructure and service delivery at municipal level"	Italian Cooperation
Minutes of Project Steering Committees (T04.31)	MEDAIR
Regional Baseline Study of T04.31	MEDAIR
REBAHS Quality Progress Dashboard 2019 for T04.54	IMC/PUI

Iraq – Strategic Documents

Strategic Documents	
Document	Source
Kurdistan Region of Iraq 2020 , A Vision for the Future	http://www.ekrg.org/files/pdf/KRG_2020_last_english.pdf
4_Presentation_NAZAR_MOUSA Kurdistan situation	ttp://www.senat.fr/fileadmin/Fichiers/Images/relations_internationales/Groupes_d_amitie/2019/4_Presentation_NAZAR_MOUSA.pdf
IRAQ-3RP-Regional-Refugee-Resilience-Plan-2017-2018	https://reliefweb.int/report/iraq/iraq-3rp-regional-refugee-resilience-plan-2017-2018-response-syria-crisis
AISPO Annual report 2017-2018	http://aispo.org/wp-content/uploads/2018/05/REP-17-18.pdf

AISPO Annual report 2018-2019	http://aispo.org/wp-content/uploads/2019/04/REP-18-19.pdf
Final Narrative Report of the Kurdistan Vision 20202 Facility	http://mptf.undp.org/document/download/18129
Regional Refugee & Resilience Plan (3RP) 2018-2019	http://www.3rpsyriacrisis.org/
IRAQ | Regional Refugee & Resilience Plan (3RP) 2018-2019	https://data2.unhcr.org/en/documents/details/63113
EU REGIONAL TRUST FUND IN RESPONSE TO THE SYRIAN CRISIS , 2nd RESULTS REPOR Jun2018	https://ec.europa.eu/neighbourhood-enlargement/sites/near/files/second_results_reporting_eutf_syria_-_vfinal_27_june_2018.pdf
EU REGIONAL TRUST FUND IN RESPONSE TO THE SYRIAN CRISIS , 4th RESULTS REPOR Jun2019	https://ec.europa.eu/trustfund-syria-region/sites/tfsr/files/4th_results_reporting_eutf_syria.pdf
EU REGIONAL TRUST FUND IN RESPONSE TO THE SYRIAN CRISIS ,5th RESULTS REPORT Dec-19	https://ec.europa.eu/trustfund-syria-region/sites/tfsr/files/5th_results_reporting_eutf_syria_2711_print_version.pdf
IRAQ | Regional Refugee & Resilience Plan (3RP) 2019-2020	https://reliefweb.int/report/lebanon/regional-refugee-and-resilience-plan-2019-2020-response-syria-crisis
Regional strategic overview (3RP) 2019-2020	https://www.nolostgeneration.org/sites/default/files/makhalid/3RPRS2019-2020.pdf
Health sector reform in Kurdistan region Iraq	www.rand.com
The Future of Health Care in the Kurdistan Region–Iraq,	www.rand.com
Health sector reform in the Kurdistan region –Iraq	www.rand.com
Prevalence of non-communicable diseases and access to health care and medications among Yazidis and other minority groups displaced by ISIS into the Kurdistan Region of Iraq	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5382370

Iraq Project documents

Project Documentation	
Document	Source
1. 2018-obblighi-di-transparenza-e-publicita	N/A
2. Aid coordination Agreements/protocols	N/A
3. AISPO Logical Framework	AISPO
4. AISPO Annex C_LF	AISPO
5. AISPO Annex VI_Final report_Feb 19	AISPO
6. AISPO DOA Madad Application for grants_AISPO	AISPO
7. AISPO final financial report Madad 1	AISPO
8. AISPO Financial interim report	AISPO
9. AISPO LOGFRAME Annex C	AISPO
10. AISPO LOGFRAME Annex C	AISPO
11. AISPO MOU	AISPO
12. AISPO T04.181 BUDGET	AISPO
13. AISPO T04.181 DOA	AISPO
14. AISPO T04.181 LOGFRAME	AISPO
15. AISPO T04.181 SIGNED MOU	AISPO
16. AISPO_ANNEX B budget_UE	AISPO
17. AISPO_TF-MADAD2016T04.18_Inception report	AISPO
18. Annex1 DoA	AISPO
19. DoA Budget	AISPO
20. DoA Madad Application for grants AISPO	AISPO
21. EUTF Syria programming documentation	EC
22. Expenditure verification report Madad_AISPO	AISPO
23. Logframe	-
24. Madad Action Document HEALTH FINAL Ref. Ares(2016)248814)	EC
25. Minutes of coordination meetings	-
26. Partnership agreements	-
27. Programme/project reports/QINs	AISPO
28. Project reports	AISPO
29. Project/programme reporting	AISPO
30. Projects Logframes	-
31. QIN 07072017_AISPO_dec 17	AISPO

32. QIN EUTF Syria MADAD - RSCP AFD_IC - Iraq - 31122018	AISPO
33. QIN/EUTF Syria MADAD TEMPLATE QIN	EC
34. QIN/EUTF Syria MADAD TEMPLATE QIN 07072017_AISPO_dec 17	AISPO
35. QINs	-
36. QINs and AFD Interim Progress Report comments	AFD
37. Quarterly Information Note – Resilience & Social Cohesion Programme (RSCP) – IRAQ ,7/21/2019	-
38. REP-17-18(Annual Report 2018-2019)	-
39. REP-18-19(Annual Report 2017-2018)	-
40. Signed Grant Agreement TF-MADAD-2017-T04.30	EC
41. STRATEGIC ORIENTATION DOCUMENT FOR THE EUROPEAN UNION REGION , TRUST FUND IN RESPONSE TO THE SYRIAN CRISIS, "THE MADAD FUND"	EC
42. T04 DoA_Madad_IC&AFD_06.2017	EC
43. T04.18 AISPO IRQ QINs Review sheet	AISPO
44. T04.18 ROM REPORT_30.04.2018	AISPO
45. T04.18_MQ_30.04.2018	Particip
46. T04.183 ACF_DOA	-
47. T04.183 BUDGET	-
48. T04.183 LOGFRAME	-
49. T04.30 2a - DRC revised interim report Y1 - 03-07-2018	DRC
50. T04.30 2b - DRC - narrative report year 2 - 28.02.2019	DRC
51. T04.30 5a - DRC_MADAD Regional Baseline Study _Final Report	DRC
52. T04.30 5c - Regional Midterm Review_final aide memoire 23.11.2018	DRC
53. T04.30 Amendment 02 - Cooperation Agreement - MADAD - signed by all[1269]	DRC
54. T04.30 Annex 1 Description of the Action FN	DRC

55. T04.30 Annex 1a Logframe of the Action FN FN_T04.30_DRC	DRC
56. T04.30 Annex 3 Budget to the Action FN FN_T04.30_DRC	DRC
57. T04.30 DRC IRQ–QINs analysis	DRC
58. T04.30 Iraq MQ_after EUTF Syria Stakeholder comments 26 11 18 (1)	DRC
59. T04.30 Madad_Action_Document HEALTH FINAL	DRC
60. T04.30 Regional Midterm Review_final aide memoire 17.12.2018	DRC
61. T04.50 10DFH_MoU_ACTED_DoLSA_signedbyboth	AFD
62. T04.50 AFD BUDGET stamped	AFD
63. T04.50 AFD CZZ 2144 02 Z _ ACTED_Iraq_QIN EUTF Syria MADAD - RSCP AFD_IC - Iraq_tosubmit	AFD
64. T04.50 AFD CZZ 2144 02 Z_ACTED_Iraq_Narrative information note_QIN6_tosubmit	AFD
65. T04.50 AFD DOA stamped	AFD
66. T04.50 AFD Interim Progress Report comments	AFD
67. T04.50 AFD Progress Implementation Report n°2, submitted on 01/03/2019	AFD
68. T04.50 Annex Ia_DoA_Madad_IC&AFD_06.2017	AFD
69. T04.50 Annex 1 Description of the Action FN	AFD
70. T04.50 Annex 3 Budget to the Action FN FN_T04.30_DRC	AFD
71. T04.50 Annex Ia_DoA_Madad_IC&AFD_06.2017	AFD
72. T04.50 Annex Ib_Logical Framework Madad IC AFD 26042017	AFD
73. T04.50 ANNEX III Budget of action AFD	AFD
74. T04.50 Annex VI Communication & Visibility Plan_Madad_IC&AFD__12.2016	AFD

75. T04.50 QIN EUTF Syria MADAD - RSCP AFD_IC - Iraq - 30062019	AFD

Lebanon Project Documents

Project Documentation	
Document	Source
Regional Docs (DoA, etc)	Particip/ EUTF Syria
T04.30 DoA	Particip/ EUTF Syria
T04.30 QIN	Particip/ EUTF Syria
T04.31 DoA	Particip/ EUTF Syria
T04.31 QIN	Particip/ EUTF Syria
T04.47 DoA	Particip/ EUTF Syria
T04.47 QIN	Particip/ EUTF Syria
T04.47 Interim Reports	Particip/ EUTF Syria
T04.50 DoA	Particip/ EUTF Syria
T04.50 QIN	Particip/ EUTF Syria
T04.50 Interim Reports	Particip/ EUTF Syria
T04.54 DoA	Particip/ EUTF Syria
T04.54 QIN	Particip/ EUTF Syria
T04.74 DoA	Particip/ EUTF Syria
T04.74 QIN	Particip/ EUTF Syria
T04.96 DoA	Particip/ EUTF Syria
T04.96 QIN	Particip/ EUTF Syria
T04.96 Interim Reports	Particip/ EUTF Syria
T04.147 DoA	Particip/ EUTF Syria
3RP Progress Report Jan-June2018	Particip/ EUTF Syria
3RP Regional Strategic Overview 2018-19	Particip/ EUTF Syria
Joint vulnerability assessment june 2018	Particip/ EUTF Syria
VASyR2018 vulnerability assessment of syrian refugees	Particip/ EUTF Syria
vulnerability assessment framework popn study 2019	Particip/ EUTF Syria
revised_5th_board_action_document_madad_health_lebanon	Particip/ EUTF Syria
Minutes SC 6052019 final	Particip/ EUTF Syria

Lebanon LCRP 2017-2020 2018 Update 1	Particip/ EUTF Syria
EUTF Syria Health steering com minutes	EUD
Review of the distribution supply chain of essential acute medicines and vaccines, chronic disease	EUD
medications to the Ministry of Public Health and the Primary Health Care Centres in Lebanon 2016	EUD
EU MADAD year 1 reporting- 2 July 2019- COMMENTS SC- WHO adjusted	DG Near
IMC PwD Update	DG Near
INTERIM REPORT FINANCIAL CONFORME AUX FAIT	DG Near
MADAD Secondary Health Care UNHCR - Interim Narrative Report	DG Near
PwD Project - MADAD	DG Near
2019 11 04 EU Lebanon IR FINAL	Third party monitor
Amended ToRs Lebanon Health Monitoring_FwC	Third party monitor
Emergency Primary Health Care Restoration Project towards Universal Health Coverage in Collaboration with World Bank	https://www.moph.gov.lb/en/Pages/6/779/universal-health-coverage-project-lebanon
ROM reports to EUTF Syria health interventions T04.54; T04.18; T04.30 (all countries); T04.47; T04.50 (KRI/Jordan); T04.96;	Particip/ EUTF Syria