HEALTH

The Trust Fund supports access to primary health care, which includes consultations, vaccinations, emergency services and health education for refugees, IDPs and host communities. Interventions are tailored around three areas:

1. **Improved access to medical care and health services;**
2. **Strengthened human capacity to deliver primary and secondary health care services and**
3. **Improved health infrastructure.**

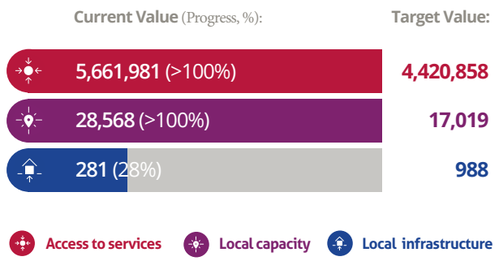
To date, **the Trust Fund has supported 29 actions and 18 implementing partners, mainly in Lebanon, Jordan, Iraq and, to a lesser extent, Türkiye, the Western Balkans, and Egypt**.

IMC, WHO, AISPO, YMCA, UNICEF, ACF, Lebanese Red Cross, UNOPS, and MEDAIR have been the main implementing partners of the EUTF health portfolio. Others, such as UNRWA or IOM, have also implemented specific components as part of wider actions. AECID and la Chaîne de l'Espoir are implementing the latest health actions approved by the Trust Fund in Jordan. It is also important to highlight that **many of these actions have been crucial in delivering the Trust Fund´s COVID-19 response**. Eight actions are still being implemented during this period.[13]

Progress continues to be satisfactory for health services regarding output delivery and has increased as compared to the previous reporting period. Targets have been increased for health consultations -specifically in Lebanon since the project is now able to reach more beneficiaries *(T04.74)*. The rest of the targets, on health education and training of health personnel, have stabilised. In all these KPIs, planned output achievement has been reached. Targets of health infrastructure improvements have considerably increased in Lebanon due to their revision in one project *(UNICEF: T04.296)*. Relative output performance is, therefore, still at 28%.

In terms of individual beneficiaries, **women are benefitting more from primary health consultations (35%**

HEALTH
PRIORITY SECTOR OUTPUTS



→ **16.** Ongoing actions are being implemented in: Lebanon (UNICEF: T04.96, T04.296; WHO: T04.74, T04.300), Jordan (AECID: T04.255), WHO: T04.202), and Iraq (Chaine de l´Espoir: T04.237, UN Habitat: T04.247).

vs. 25% in the case of men) and are being reached by health education activities in proportionately greater numbers than men (60% vs. 34%). Refugee communities are accessing more health care consultations (34%) and health education sessions (56%), compared to host communities (25% and 38%, respectively). There is still scope for improving health consultation data disaggregation by sex and community of origin. In terms of **health staff training**, men and women are accessing training to a similar extent (48% vs. 46%). **Health personnel in refugee communities are being trained to a larger extent compared to their peers among the host communities (50% vs. 38%)**.[14]

→ **17.** As previously stated, in some KPI, such the one on health consultations, disaggregation by sex and/or community of origin is not fully available.

COVID-19 SPECIFIC RESPONSE OF THE TRUST FUND

The number of cases of COVID-19 and related deaths reported in most countries of the region is declining, while vaccination continues.[15] Nevertheless, EUTF continues to deliver its support for the pandemic response in the partner countries. **As part of the COVID-19 response, to date, the Trust Fund has supported 29 actions** of which almost half are health and WASH interventions. Currently, 10 projects are still ongoing, but seven are specifically related to health and WASH. The comprehensive response of the Trust Fund encompasses access to services, such as consultations, psychosocial support, and medical supplies (e.g., COVID-19 vaccines, tests, and Personal Protective Equipment -PPE); *capacity building*, i.e., of training of health personnel, technical support to improve epidemiological surveillance, and *infrastructure refurbishment* -to help with isolation spaces, hospitalisations, and WASH services. In addition, the COVID-19 response included awareness campaigns, actions to support local schools, municipalities and/or MSME . A few actions included emergency cash assistance whilst others focused on protection measures. The WHO is one of the main implementing partners leading the COVID-19 response of the Trust Fund in Jordan. Other organisations such as UNICEF, IMC, YMCA, Lebanese Red Cross and UNRWA in Lebanon; ACF, AISPO, UNDP and UN-Habitat in Iraq; UNDP and WHO in Türkiye or EFI, UNICEF and AFD, in Jordan, are contributing to key functions.

During this reporting period, **COVID-19 specific results are stabilising across all sectors. Targets have been exceeded or almost achieved in access to services (100%), local capacity strengthening (95%) and local infrastructure improvements (100%). The areas where progress has increased during this period refer to emergency cash transfers and people treated in emergency services.** Targets for cash transfers have also increased to a similar extent. As in the previous reporting period, most services have been accessed as primary health care-consultations in Lebanon, which predominantly refer to people screened for COVID-19. Awareness campaigns on COVID-19 prevention, vaccination, hygiene, protection, and education have reached a substantial number of people in Lebanon, Jordan and Iraq. While PPE has been provided largely in Lebanon, Jordan and Türkiye, access to COVID-19 vaccines, support to the public health system and WASH-related interventions (mainly in schools) have benefitted Jordan mostly. Psychosocial support services have only been provided in Lebanon. **In terms of local capacities' strengthening, the emphasis has been on training health personnel on COVID-19 guidance**, mainly in Lebanon and Türkiye. **Local infrastructure improvements have been mainly delivered in Lebanon as part of isolation and quarantine spaces** for hospitals and in the community. From the disaggregated information available, **women have accessed COVID-19 related services more than men, while many more refugees have benefitted from them. Women have been also trained to a larger extent in COVID-19** related topics, while host community members have participated in training to a larger extent than refugee members of the community.

→ **18.** For detailed information, see: https://www.emro.who.int/pandemic-epidemic-diseases/covid-19/covid-19-situation-updates-for-week-18-30-april6-may-2023.html and https://covid19.who.int/region/euro/country/tr

HEALTH OUTCOMES IN LEBANON

The recent EUTF outcome evaluation highlights that improved access to quality primary health care services for Syrian refugees and vulnerable host communities is *"the most significant change obtained by the project "Reducing Economic Barriers to Accessing Health Services in Lebanon- REBAHS"*. Since fees have also been subsidised, affordability has also improved. While the three IMC-led actions had been testing models of subsidisation of primary health care centres (PHCCs) removing economic barriers to improve access to primary health care (PHC), other actions have improved access to acute and chronic medicines (YMCA/WHO), vaccine stocks (UNICEF), pre-hospital emergency care and blood transfusion services (LRC) or reproductive health and psychosocial services at community level (Medair). According to the same evaluation, there is moderate evidence that EUTF interventions have affected **changes in individual behaviour and perceptions** among the target groups. Syrian refugees' attitudes, perceptions, and behaviours *"have positively changed when it comes to seeking treatments in public primary health care"*. Syrian refugees and Lebanese host communities are increasingly using PHC services; they are more aware that services in PHCC are affordable, and that medication is free of charge; people are perceiving PHCCs as trustworthy, with qualified medical staff, and people are reporting improvements in their day-to-day lives, as well as improved knowledge of (mental) health topics.

Regarding **changes in local organisations and institutions**, there have been positive effects in the institutional framework of the sector and practices and capacities of local PHCCs. Overall, it is recognised that in addition to the improvement in quality of PHC services, PHCCs improved capacities and together this strengthened the PHC system. REBAHS I and II are considered *"the most important, learning-by-doing approach in Lebanese primary health care"* and therefore, the evaluation categorised it as a case study. The projects strengthened PHCCs' capacity to match well the identified health needs, ensuring at the same time access to subsidised primary health care services. An immediate response model, following the 2020 Beirut blast, had been developed. A long-term primary healthcare subsidisation protocol (LPSP), i.e., a comprehensive fee-based health services protocols package, is now applied in many PHCCs. It is noted that *"a strong link and trust with the Ministry of Public Health (MoPH) were established"* through the subsidisation model, *"being coherent and suitable for Lebanon in its current situation"*. Discussions are being held with MoPH about the model of funding primary care. The evaluation also highlights improved knowledge of health staff on how to manage mental health cases. Capacities of PHCC have been *"substantially increased to attend increased number of patients"*. UNICEF is strengthening 800 vaccination points, all with cold chain able to store and administer vaccines, across the entire Lebanese territory, while YMCA and WHO are supporting the MoPH in their ability to procure and store medications. Challenges with the supply chain and shortages of chronic diseases medications were being addressed at the time of the evaluation with transportation of blood units still being an issue. Currently LRC has become a proxy blood bank in the country– since there is no national institution assuming this task. Referral paths, which need to be strengthened in the country to lower pressures on the hospital system, are not yet fully effective however, according to the evaluation this aspect of the fragmented health system is being dealt with by the projects. There is also evidence that most projects are contributing to strengthened coordination among health institutions and organisations.

Regarding changes at **regulatory or national policy level**, REBAHS II has supported the subsidisation model, the LPSP, that was tested with and

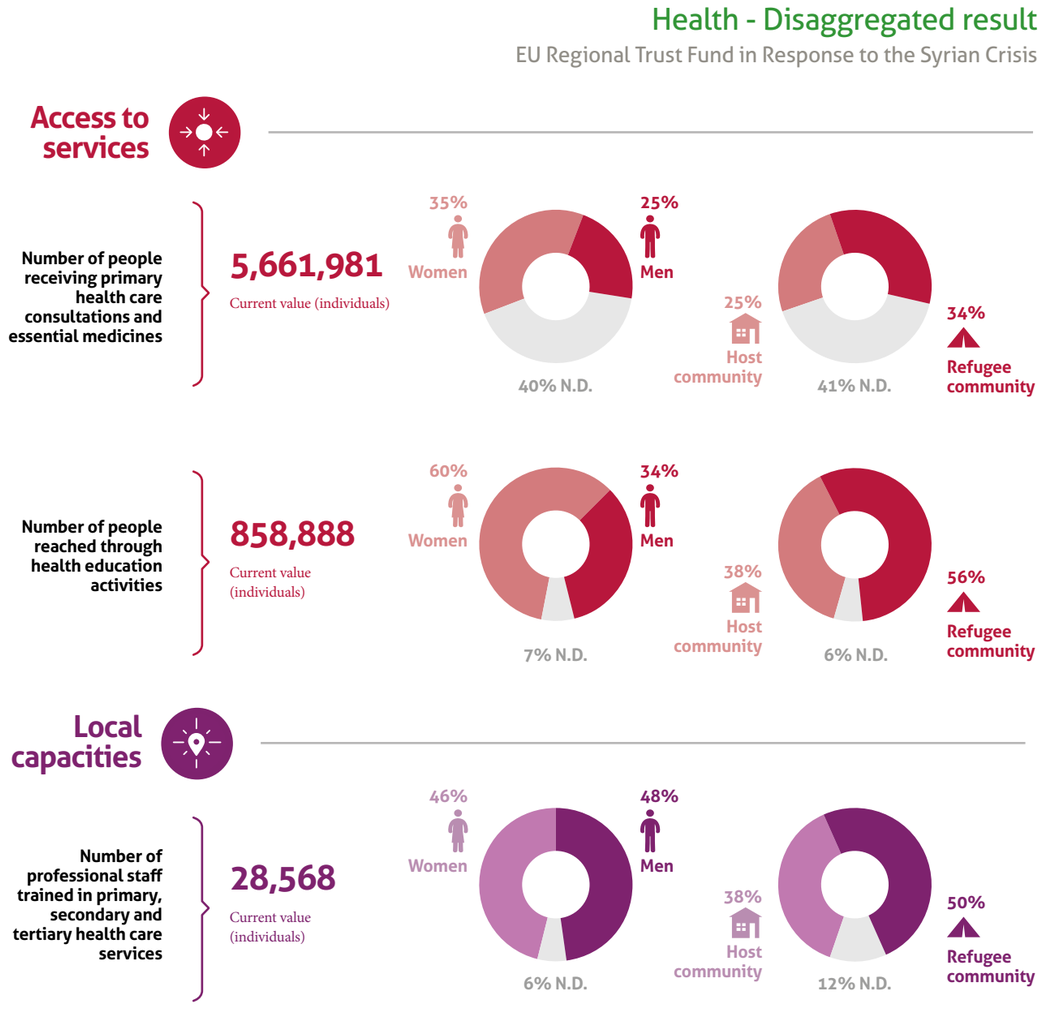


Figure 11: Trust Fund: Health results disaggregated by sex and community of origin (as of 31/03/2023).
*N.D.: Not disaggregated.

approved by MoPH and has expanded as a viable model of primary health care. Although ownership is high, due to the crisis in the country, the model is still dependent on donor funding and the sector is still dominated by large private health providers. The Minister has also realised an imbalance highlighted by the evaluation, between funding and actual service delivery: while 80% of the people use PHCCs, less than 3% of the health care budget is for primary health care. In a context with a renewed focus on primary health care, some of the projects assessed had a clear policy component to work on a health model towards universal health care, i.e., widening access to more beneficiaries and doing it more affordably. Other outcomes highlighted by the evaluation are the introduction of the indicator for disability to health sector policy, along with a switch from a medical model to a rights-based one, including the mental health integration in PHC. This model is now a reference for the future mental health integration in PHCCs. Community health is also introduced as a concept and a guidebook for PHCCs, approved by MoPH. WHO also contributed to the first draft of the Health Sector Strategy, which has been available since July 2022.

HEALTH OUTCOMES IN JORDAN

The **outcome** evaluation underlines that there was an improvement in access to primary healthcare of refugee families and vulnerable families in host communities. Additional capacity has been created in three hospitals and in primary health care centres with focus on the Vaccine Preventable Diseases and Immunisation (VPI) activities. National level outcomes can be identified in tertiary service delivery improvements. In terms of **changes of individual behaviours**, the recent evaluation highlights *"a slight increase in usage of primary health care services by the refugees"* (...), although *"the refugees are less aware of being entitled to access health services under the same conditions as uninsured Jordanians"*. As the report points out improved access and quality of secondary and tertiary healthcare services (UNOPS) were achieved *"by expanding and equipping emergency departments of three public hospitals, Jamil Tutunji, Ramtha and Ruwaished, and by procuring and delivering three ambulances to the Ministry of Health (MoH)"*. The WHO led action focused on vaccination availability to Syrian refugees and host communities, both in terms of COVID-19 protection and routine immunisation. The project has contributed significantly to strengthen Vaccine Preventable Diseases and Immunisation activities and disease

surveillance at the primary health care. The project promoted by AECID also included the aim of access to public PHC services in relation to non-communicable diseases (NCD), notably in the three target governorates of Mafraq, Tafilah and Ajlun. However, it is still in early stages to assess if access has increased.

Regarding changes in **local organisations and institutions**, these are visible for the completed infrastructure project (UNOPS) *"whose technical and medical design reflected well the given needs and priorities"*. The evaluation continues underlining that *"the hospitals, including refurbished and new emergency wards, are in full use and well maintained and their capacity is improved"*, not only in terms of new beds but also in terms of service types. The evaluators also report new higher standard protocols, e.g., for sterilisation, enabled by the EUTF funded project. The hospitals now provide new larger working areas, more beds and new equipment as well as better working conditions for medical staff. Although the vertical coordination in Jordanian health sector is weak, in general, the outcome evaluation sees *"signs of change in this area"* and an increase in the MoH's coordination capacity. The procurement of COVID-19 vaccines with WHO support has positively influenced the procurement of routine vaccines. The AECID led action aims at addressing NCD and mental health needs to strengthen MoH Management and PHC service provision capacities.[16] The improvement of protocols for NCDs (e.g., early detection of cancer), the training of health personnel and front-line medical workers (e.g. in HEARTS protocol, Mental health GAP protocol, Jordan Integrated Electronic Reporting System (JIERS) reporting and monitoring and/or trauma, stress-related disorders and Mental Health and Psychosocial Support -MHPSS- in emergency settings) and the procurement to strengthen capacities in the three target governorates is still incipient. The technical unit within the MoH has already started to work at different levels, e.g., a roadmap for designing a colon and cervical cancer screening protocol has been prepared and a National Committee for Birth-Defects Registry and other Hereditary Diseases Registry has been formed.

It is important to underline that PHC is now a new focus of the health strategy in Jordan. In this context, policy work towards universal health care is ongoing although a model of health finance with close collaboration with MoH is still in development. Changes at **the regulatory or national policy level** are emerging. For example, work on health governance is more recent and includes a health roadmap and health finance strategy *(WHO)*. The outcome evaluation highlights that Jordan is committed to the achievement of the goal of Universal Health Coverage (UHC), and the EU supports the UHC Partnership. However, the country still faces the challenge of a fragmented health system with multiple providers and parallel governance mechanisms, except for PHC where MoH is the main provider. The recent inclusion of the PHC focus with referrals between primary and secondary health care in the Plan for Reform of the Health Sector is partly based on a WHO study. The project has also contributed to policy dialogue with high-level stakeholders. The review regarding immunisation and the comprehensive assessment of primary health care has been used by the MoH, so that now both topics are prioritised in the sector agenda. The AECID-led project states that the absence of a National Strategy on NCDs affects the capacity of MoH, however no work at this level is currently planned.

→ **19.** Under this project, work to strengthen prevention and early detection capacities with decentralised organisations, such as the Jordan Breast Cancer Programme, the Institute for Family Health, Our Step Association and the Royal Health Awareness Society is planned.

HEALTH OUTCOMES IN IRAQ

In terms of **outcomes**, at **individual level**, according to various assessments *(ROM T04.18; EUTF portfolio health evaluation; final report T04.181)*, health interventions have improved access to quality secondary and tertiary healthcare services for refugee, IDP and host communities. This is particularly relevant for mother and child critical care in Duhok, Kurdistan Region of Iraq (KRI) and primary mental health services in selected governorates. More patients have accessed improved services – as measured in births, surgeries, and referrals - at the Duhok Maternity and Paediatric Teaching Hospital, the Duhok Emergency and Trauma Hospital and Akre Emergency Hospital of Duhok. Maternal and child health and mental health services improved after the intervention in the network of PHCCs. Health authorities had highlighted a reduction of morbidity after surgeries and reduction of neonatal mortality. Recent evidence highlights reduced new-born suffocation and improved detection, referrals, and treatment of disability in children. Regarding mental health, beneficiaries reported a change of attitude towards mental health and psychosocial services, feeling more comfortable accessing them, suggesting increased service quality, and improved mental health-related quality of life.

Regarding **changes in local institutions and organisations**, the Duhok Maternity Hospital; Duhok Hevi Pediatric Hospital; Akre Emergency and Maternity Hospital, the Emergency and Trauma Hospital of Duhok and the General Hospital of Amedy had shown improved quality of service provision to mothers and children. Skills of their staff had been strengthened in terms of management, collecting, and using data, treating infection, and detecting disability, teamwork, using new medical equipment, and communication with the patients. Nurses are now widely respected, according to reports, and awareness on prevention had been integrated. In relation to the pandemic, the capacities of Duhok governorate had been strengthened with trained staff, a PCR laboratory and reinforced tracing of cases. Regarding mental health (ACF), it has been reported that personnel of Ministry of Health and Directorate of health, as well as PHCCs improved their overall knowledge and skills *(QIN 03/22)* on mental health and psychosocial support (MHPSS). Community-based organisations were also trained to improve collaboration and integration of mental health services in PHCCs.

No **changes at the level of national policy**, strategy or regulation have been reported. The integration of mental health services in the primary health care system of the country requires sustained government support, additional resources, and comprehensive local adherence to policy, which were not given at the time of the finalisation of the mentioned project (ACF). An action plan resulting from it had been shared with the Ministry of Health and other key actors to inform the design and strengthening of existing policies and strategies across Iraq.