



International Federation
of Red Cross and Red Crescent Societies

End of Project Evaluation for Jordan National Red Crescent Society (JNRCS) Community Based Health and First Aid (CBHFA) and Psychosocial Support project in Jordan

EVALUATION REPORT

February – March 2017

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This evaluation was produced at the request of the International Federation of the Red Cross and Red Crescent Societies. Ofelia García, independent consultant, led the evaluation exercise and is the author of this report.

DISCLAIMER

The author's views expressed in this publication do not necessarily reflect the views of the International Federation of the Red Cross and Red Crescent Societies or the Jordan Red Crescent Society.

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LIST OF ACRONYMS

€	Euro
4Ws	Who Does What Where
ANC	Antenatal Care
AP	Annual Plan
Asylum Seeker Certificate	ASC
AUD	Australian Dollar
CBHFA	Community Based Health and First Aid
CFPSs	Child and Family Protective Spaces
CHTF	Community Health Task Force
CHVs	Community Health Volunteers
DRC	Danish Red Cross
ECHO	Directorate-General for European Civil Protection and Humanitarian Aid Operations
F	Female
GoJ	Government of Japan
GPB	British Pound
GRC	German Red Cross
HAUS	Health Access and Utilization Survey
HH	Household
HIP	Humanitarian Implementation Plan
HQ	Head Quarters
HR	Human Resources
ICRC	The International Committee of the Red Cross
IDPs	Internal Displaced Persons
IFRC	International Federation of Red Cross and Red Crescent
IHL	International Humanitarian Law
IHRC	International Human Rights Clinic - Harvard Law School
iNGO	International Non-Governmental Organization
IT	Information Technology
ITsS	Informal Tented Settlements
JHAS	Jordan Health Aid Society
JNRCS or JRCS	Jordan National Red Crescent Society
JOD	Jordanian Dinar

JORISS	Jordan Response Information System for the Syria Crisis
JRP	Jordan Response Plan
JRPSC	Jordan Response Platform for the Syria Crisis
KIIs	Key Informant Interviews
M	Male
M&E	Monitoring and Evaluation
MEB	Minimum Expenditure Basket
MENA	Middle East and North Africa
MoH	Ministry of Health
MoI	Ministry of Interior
MoPIC	Ministry of Planning & International Cooperation
MoU	Memorandum of Understanding
MSF	Médecins sans Frontières
N.A.	Not Available
NCD	Non-communicable diseases
Norwegian Refugee Council	NRC
PHC	Primary Health Care
PHC	Primary Health Care
PNC	Post Natal Care
PNSs	Partner National Societies
PRS	Palestinian Refugees from Syria
PSP	Psychosocial Support Programme
RC	Red Cross
SMEB	Survival Minimum expenditure Basket
ToT	Training of Trainers
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees
UNICEF	The United Nations Children's Fund
USD	US Dollars
UVE	Urban Verification Exercise
VAF	Vulnerability Assessment Framework
Water, Sanitation and Hygiene	WASH
WFP	World Food Programme
WHO	World Health Organization

1. EXECUTIVE SUMMARY

1.A EVALUATION PURPOSE AND SCOPE

This is an external evaluation commissioned by the Japanese Government through IFRC and has been guided by the Terms of Reference (ToR) attached as Annex I, and by the Inception report elaborated by the evaluator.

Specifically the Evaluation aims to better understand the overall added value of the CBHFA approach in the current context, providing the International Federation of the Red Cross and Red Crescent Societies (IFRC) and the Jordan Red Crescent Society (JNRCS) with guidance for future programmatic developments in Jordan.

1.B INTERVENTION'S BACKGROUND

Since February 2014, the Jordan National Red Crescent Society (JNRCS) with the support of IFRC has been implementing a holistic Community Based Health and First Aid (CBHFA) approach to meet the needs of the Syrian refugees and host communities (currently in six Jordan's Governorates).

The CBHFA approach seeks to create healthy and resilient communities worldwide, using an integrated approach, volunteers are trained and mobilised to carry out activities within their communities. Community activities planned in Jordan under this intervention included: the dissemination of health information at community events, and raising awareness / preventive approaches about different health related topics, establishment of referral pathways and its communication to beneficiaries to improve their access to health care and psychosocial support services, and building the capacity of communities to reduce the risks and impact of emergencies.

1.C METHODOLOGY – OVERALL ORIENTATION

The evaluation process was based on a mixed-methods approach, combining qualitative and quantitative methodologies, performing both quantitative and qualitative analysis.

During the field phase and in order to collect qualitative information, IFRC, JNRCS, ICRC and Partner National Societies (PNSs) staff, as well as a broad range of external stakeholders were interviewed:

- Thirty-eight (19 M / 19 F) key Informant Interviews (KIIs) with individuals from different institutions
- Five Group discussions with fifty-six CBHFA volunteers (15 M / 41 F) from five different JNRCS branches/governorates were carried out.

1.D CONCLUSIONS

Overall the rationale in early 2014 (when it was designed) to launch the CBHFA and the IFRC prioritisation of an intervention to respond to the community health and information needs of the Syrian refugees living out of camps was, from a needs-based perspective, highly relevant and fully justified. The relevance of responding to the most vulnerable refugees' health related needs, improving access to information at community level and effective referrals has increased over time. This is mostly due to: (#1) deteriorating access to the health system and worsening key health indicators (highly influenced by the November 2014 policy change from free public healthcare to requiring Syrian

refugees to pay for health services in the public sector), (#2) the acute decline in the Syrian refugees' economic situation in Jordan and their resorting to negative coping mechanisms, (#3) the rising protection vulnerabilities and (#4) diminishing funds and changing priorities, from addressing humanitarian needs to the resilience and development agenda.

In spite of its relevance, the CBHFA first design / formulation: did not sufficiently consider equity amongst different vulnerabilities/situations and was not sufficiently adapted to the targeting challenges in urban and peri-urban settings and the foreseeable deterioration of the protection environment associated with protracted displacement situations and more specifically to the specific protection challenges and needs of a non-camp refugee case load. The limitations of what the CBHFA implementer could achieve with a stand alone intervention (intangible) in terms of connecting populations in high distress with other levels of assistance (tangible) to be delivered by service providers / organisations was not sufficiently taken into consideration in successive formulations, especially after the November 2014 policy change.

Design choices and formulation weaknesses have enormously conditioned the interventions' possibility of being effective:

- Whilst it is widely recognized that the largest groups of concern are, since 2015, refugees who are ineligible to receive new MoI cards and refugees who are eligible, but have not yet obtained new MoI cards because they lack the documents necessary to receive a card through the normal issuance process, all IFRC interventions (not only CBHFA) in Jordan are addressed to registered Syrian refugees.
- The available information did not permit a clear picture on the intervention, as well as of the quality-outputs of the different components. Too many efforts have been exerted in increasing the project's governorates coverage (that is a clear humanitarian priority), as well as CBHFA volunteers' presence and training accordingly.

The geographic choice of Governorates made alongside the implementation period is considered inadequate; on the contrary, the historical and the information on communities/areas covered within each Governorate and their identification, as well as the total population per community, different population categories (registered refugees, non-registered refugees, host population), etc. is not available, that does not allow a validation of any of the interventions' total beneficiaries' cumulative figure.

Non intended positive project's effects have been identified in two main areas: (#1) the project contribution to "normalise" and reduce the gender gap at community level (and (#2) the decision to have both Jordanian and Syrian nationals in the same pairs and teams, showed cohesion and a positive model of coexistence, that in certain areas with high tensions between both communities, could have had a further positive impact as a positive model. This pairing of different nationals in the community work seems also to be quite unique for the project (if compared with the other Community Health Task Force (CHTF) organisations' reported working models).

The major factors negatively affecting the CBHFA implementation are related to: (#1) the JNRCS' internal management structure and organisational culture, (#2) the insufficiently detailed IFRC-JNRCS partnership and (#3) the insufficient or non-existent link with other initiatives within the Red Cross movement. There is also a partnership (IFRC-JNRCS) risk that is not sustainable and could start having negative effects for the image of IFRC in particular. That risk is generated primarily by the difference between the IFRC projection-humanitarian profile and the real JNRCS capacity to deliver a fully oriented humanitarian response according to minimum standards (that relies on the JNRCS willingness to change and follow a different way of management).

Efficiency gains were achieved through a new CBHFA Volunteers' selection and validation procedure that was put in place in 2016 but the overall Efficiency of this intervention is considered low, mostly due to the non- appropriateness and the non-adaptation of the chosen strategy to cope with the main health population needs and serious inefficiency at JNRCS management and decision-making level that in some cases, also raise ethical issues.

The alignment with country strategies and priorities is, in the current situation, the best approach to Connectedness. It is confirmed that the community health and information approach as well as the CBHFA approach, are fully aligned with the current national priorities. Conversely, JNRCS Interest in Institutional Capacity Building and the development of long-term Youth department/volunteers is not compatible with the need to maintain a project orientation of the CBHFA volunteers that would have to focus on being effective and efficient in the short term (project orientation).

1.E RECOMMENDATIONS

R1 CBHFA addressed to out-of camp Internal Displaced Persons (IDPs) or refugees in humanitarian settings, should consider, adaptability to the context/needs changes and a different approach than the work with host-fixed population in rural environments (traditional CBHFA scenario), where usually population needs are structural / linked to poverty. In the Middle East and North Africa (MENA) region evolving specific vulnerabilities and protection needs of the most vulnerable refugees, should ensure that the design and implementation of activities aims at reducing and mitigating those protection risks.

R2 In the 2017 Jordan context, a relevant CBHFA design requests high level of flexibility and some degree of "out of the box" thinking (that other CHTF organisations already implemented) for: (#1) setting up an effective referral system, either complementary or outside the initially available free of charge public health system (looking beyond the traditional community mapping, expanding the referrals to whatever reliable partner within the district, Governorate or even national level) and (#2) for adaptation to the specific health related and protection gaps at each Governorate and district level (different caseloads and offer of free services).

R3 The main focus of any humanitarian intervention in the current context, should be, from a principled humanitarian action perspective, on out of camp refugees. CBHFA should clearly refocus in the most vulnerable and consequently, following the "One refugee approach" recommendation (R4), prioritise for geographic intervention, the areas where the most vulnerable are living.

R4 Priority groups within target population for the next phase should be:

- Refugees of any nationality included in the UNHCR Populations of concern:
 - Having more problems for any household member's civil-legal and/or identity-recognition (renewal of asylum certificate, difficulties in obtaining all the legal documents for MoI new card), living in a unsafe environment, etc...
 - Family with a member with disabilities /estimated at a minimum of eight percent of refugees in Jordan having a significant injury of which 90% were conflict-related (Handicap International / Help Age International).
 - Families with out of school children at primary school age and/of families with young children: that cannot be enrolled / follow secondary education.
 - Female headed households with children,
 - Families with bed ridden and/or mental health disorders' members.
 - Households with children born from teenager couples and early marriage couples (a crime under Jordan law).
- Refugees of any nationality not included in the UNHCR registered Population of concern and/or not

eligible for MoI registration/renewal for different reasons (including lacking civil documentation, left the camps without Baillout, entered illegally, etc.). ECHO estimates a minimum figure of around 100,000 Syrians refugees in this situation.

R5 A feasibility cross-check needs to be carried out by the IFRC, related to the capacity and the willingness of JNRCS (IFRC partner) to commit to the needed institutional changes requested to be both: aligned with the humanitarian priorities of the most vulnerable refugees' population and effective in the new design.

R6 To Increase emphasis on targeting the most vulnerable and ease their access to key services, it will be needed to map vulnerability zones and groups and ease their access to key components, reconsidering the size of the project and the current number of CBHFA volunteers. It will also be needed to better plan, and assign means to follow and track coverage making use of Information Technology (IT) means, for a better Monitoring and Evaluation (M&E), follow up and georeferencing.

R7. CBHFA should be organised, having one Field Coordinator per Governorate (same as German Red Cross (GRC)-JNRCS in Irbid), reporting to one and unique CBHFA IFRC-JNRCS coordinator in Amman. Those profiles should be selected following the best practices achieved through a new CBHFA Volunteers' selection and validation procedure that was put in place in 2016 and to the extent possible, should be refugees. Each Field Coordinator per Governorate will be responsible for two different teams:

- Public health and information campaigning CBHFA teams to facilitate the entry point for the linking with health and civil documentation referrals with priority population (activity to be delivered by mixed Syrian and Jordanian CBHFA volunteers together: minimum of 20 hours a month per area of coverage, with incentives paid according to MEB or at least half of the minimum monthly salary). Group gatherings –campaigns for social cohesion In these areas: The First Aid GRC-JNRCS Irbid's model (training directly delivered to communities with first aid kits for enhancing behavior) and Behaviour change and raising awareness campaign/activities for key and basic health and legal/civil documentation topics.
- Outreach district referral teams for Identification of the most vulnerable refugees (activity to be delivered preferably only by refugees' CBHFA volunteers, organised by pairs, that would include home visits for identification of the most vulnerable households, referrals' needs and follow up, following/adapting the International Relief & Development (IRD) Community Health Volunteers (CHVs) model and performance targets. Incentives should be a minimum monthly salary or directly equivalent to those of IRD: higher than the minimum salary). This approach questions the strategy of one CBHFA attached only to their original area vs mobile teams for the district/subdistrict to reach more vulnerable subareas/population (rotating and moving to other areas when targets are reached).

R8. Good practices from other CHTF organisations could also be applied, such as: (#1) pretest and post test for volunteers and ToTs trainers before going to the field (they need to pass a minimum in the tests) and retest them on regular basis (performance grid), (#2) Avoiding CHVs related to each other in the same governorate, as a rule to reduce cheating, (#3) Use of portable devices with georeference for outreach referral teams and follow-up visits AND (c) CHVs goals defined per month for outreach referral teams related to the most vulnerable profiles: number of visits, number of referrals, number of follow up referrals, etc.

2. EVALUATION PURPOSE & EVALUATION QUESTIONS

2.A EVALUATION PURPOSE AND SCOPE

This is an external evaluation commissioned by the Japanese Government through IFRC and has been guided by the Terms of Reference (ToR) attached as Annex I, and by the Inception report elaborated by the evaluator.

Specifically the **Evaluation aims** to better understand the overall added value of the CBHFA approach in the current context, providing IFRC and JNRCS with guidance for future programmatic developments in Jordan. The analysis therefore focused on:

- Factors which determined the strategic choices, performance and results of the CBHFA intervention, including the management and working procedures of the CBHFA teams and the criteria, challenges and limitations of responding to the priority health needs of the Syrian refugees in the areas of intervention.
- The added value, strengths and weaknesses of the CBHFA model in Jordan and also in the Middle East context, and how both in a conflict setting and a protracted crisis, it can be contributing to a good showcase for the global CBHFA.
- A comparative element/benchmarking exercise, as far as possible, with other in country PNSs/ International Non-Governmental Organization (iNGOs) with outreach community health projects and other CBHFA programmes in the MENA region.
- The degree of collaboration and the results obtained in the IFRC-JNRCS partnership and with other actors: Ministry of Health (MoH), CHTF participants, etc.

Audience: the results of the evaluation will be used to report back to the Government of Japan on the achievements of the project, the evaluation will be used by JRCS, IFRC and Partner National Societies (PNS) in Jordan.

The evaluation covers the JNRCS CBHFA programme implementation supported through IFRC from February 2014¹ until January 2017 in 6 Governorates of Jordan, namely: Amman, Jerash, Ajloun, Mafraq, Balqa and Madaba.

2.B EVALUATION QUESTIONS

During the Inception phase, some of the questions of the initial ToR were reduced in number (from forty-one to eight) by reformulation, merged or others converted into Indicators in the Evaluation Matrix to better capture the agreed purpose and scope of this Evaluation.

These are the questions that the Evaluation will respond to (grouped by Criteria):

¹ Date of the first CBHFA project (a nine-month proposal to the Government of Japan - 15th February to 15th November 2014).

Relevance / Appropriateness²

- 1) Does the Project respond to the primary health care needs of the target population, local context (incl. MoH) and specific needs, such as referral system?
- 2) Should the direction of the project be changed to better reflect those needs and priorities by: a) scaling it up, b) by adapting it, and if yes, how?, c) or considering other more appropriate approaches and is it adapted to the reality of the urban displacement in Jordan?

Targeting / Coverage³

1. Is the Project reaching the right areas and the right people?

Effectiveness⁴

- 3) To what extent have the program objectives been achieved and what were the major factors influencing the achievement or non-achievement of these objectives and what other alternatives could be tried?
- 4) Has there been any unforeseen or indirect effects either positive or negative (on the communities, volunteers, National Society (JNRCS))?
- 5) Does the Project have an effective coordination linking with other interventions, including JNRCS programmes such as Cash Transfer Programme (CTP), Psychsocial Programme (PSP), Youth and Livelihoods. How can integration be improved in the future?

Efficiency⁵

- 6) In the current Jordan context, are there alternative models that could improve CBHFA planning or reduce costs?
- 7) Were there sufficient and appropriate resources and support from both (IFRC and the National Society) to implement the project?

Connectedness⁶

- 8) Do the lessons from the implementation of this project indicate any changes to its design in the future to ensure that an exit strategy establishes a community basis for the National Society, thus better enhancing connectedness / sustainability?

² Relevance is concerned with assessing whether the project is in accordance with local needs and priorities (as well as donor policy). Appropriateness is the tailoring of humanitarian activities to local needs. Targeting is considered a basic criterion and as such will be independently analysed under the criteria Targeting / Coverage.

Appropriateness is the tailoring of humanitarian activities to local needs.

³ The need to reach major population groups facing life-threatening suffering wherever they are.

⁴ Effectiveness measures the extent to which an activity achieves its purpose, or whether this can be expected to happen on the basis of the outputs. Implicit within the criterion of effectiveness is timeliness.

⁵ Measures the outputs – qualitative and quantitative – achieved as a result of inputs. This generally requires comparing alternative approaches to achieving an output, to see whether the most efficient approach has been used.

⁶ Connectedness refers to the need to ensure that activities of a short-term emergency nature are carried out in a context that takes longer-term and inter connected problems into account.

3. BACKGROUND

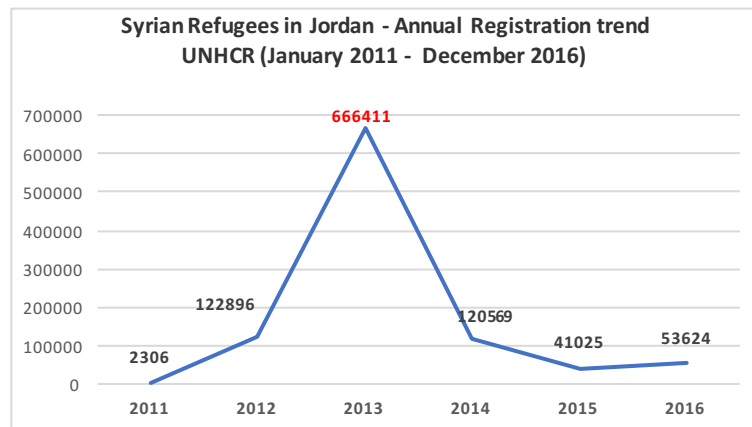
3.A CONTEXT

3.A.1 Introduction

Despite the worsening situation in Syria, Turkey, Lebanon and Jordan, which initially maintained ‘open-border’ policies to those fleeing Syria, have effectively closed their borders to the majority of refugees trying to reach safety.

The Syria crisis has impacted – both directly and indirectly – all aspects of life in Jordan, exacerbating the Kingdom’s socioeconomic vulnerabilities, security burdens and environmental challenges. The influx of Syrian refugees, that reached its peak in 2013, has placed ever increasing demands on the national health system, where one third of the Jordanian population does not have access to universal health insurance coverage.⁷

Figure 1: Annual UNHCR Registration trend of Syrian refugees in Jordan⁸ (January 2011 – December 2016)



Source: Evaluation compilation based on UNHCR data

With the Syrian crisis entering its seventh year, 6.6 million Jordanians⁹ host more than 1,2 million Syrians, of which 655,732¹⁰ are registered with UNHCR¹¹ (49.4% M / 50.6% F):

- 78.5% (514,669) are out of camp refugees (living outside refugee camps, in cities, towns, and rural areas) and 21.5% (141,063) are camp refugees.
- 50.9% of the registered refugees are children (less than 18 years).
- 86% of Syrian refugees in urban areas are living below the Jordanian poverty line and they face a continued lack of access to livelihoods and complicated registration procedures which restrict their access to services¹².

⁷ Jordan Response Plan (JRP) 2017-2019.

⁸ Including both: Camp and Out of Camp Refugees.

⁹ According to the 2015 Census, the total population of Jordan was estimated at around 9.5 million, including 6.6 million Jordanians.

¹⁰ A total of 728,955 people of concern were registered with UNHCR in Jordan as of January 2017, including 655,732 Syrians, 61,405 Iraqis and 11,818 other nationalities including, 6,360 Yemenis, 3,322 Sudanese, and 778 Somalis. (January 2017 - UNHCR information).

¹¹ In Jordan, UNHCR registers Syrians as refugees, giving them “*prima facie*” status without the need for a status determination process.

¹² Five Years into Exile. Care Report. June 2015.

Despite years of assistance, humanitarian needs in Jordan for refugees remain acute, and according to most of the consulted sources, are worsening for an important percentage of them, whilst, on the other hand *“funding constraints are becoming a major limiting factor as needs remain stable or multiply, and contributions by development actors are still insufficient to adequately complement humanitarian interventions or fully replace humanitarian aid budgets in certain sectors as appropriate. Populations’ needs largely outweigh and surpass the capacity of humanitarian actors to respond, both physically and financially”*.¹³

3.A.2 Refugees’ legal framework in Jordan and specificities of the Syrian refugees

While the Jordan Constitution provides protection against extradition (the principle of *“non-refoulement”*) for political asylum seekers¹⁴, Jordan has not enacted domestic legislation to deal with refugees (there is no national legislation governing the protection of asylum-seekers and refugees) and is not a party to the 1951 Convention on Refugees or its 1967 Protocol. The legal framework for the treatment of refugees is a 1998 Memorandum of Understanding signed between Jordan and the UNHCR.

Since July 30, 2012, all Syrians arriving at the Jordanian border without passports were brought to one of two refugee camps, either Zaatari, the vast expanse often described as the fourth-largest city in Jordan, or the newer site at Azraq. Technically, only those who could secure a sponsor from the surrounding Jordanian communities were allowed to leave, through a procedure called a *“bailout.”*

For all UNHCR registered Syrian refugees residing in the camps¹⁵, UNHCR issues a *“Proof of Registration”* document, which they hold while they remain in the camps¹⁶.

For Syrian refugees who live outside camps, in Jordanian cities, towns, and rural areas, and are registered with UNHCR, they get an asylum seeker certificate: a document that states that those listed on the certificate (usually a family, but in some cases just one person) are *“persons of concern”* to UNHCR. The asylum seeker certificate allows Syrians to access services and assistance provided outside the camps by UNHCR and its implementing partners.

Regardless of whether they have registered with UNHCR as refugees, all Syrians living in Jordan are required to register with the Jordanian Ministry of the Interior and receive an MoI Service Card (*“MoI card”*), which is valid only if the Syrian remains living in the district where the card was issued. If the refugee moves from the initial place of registration, they are required to re-register with the police in the new location and update their MoI service card.

3.A.3 Humanitarian setup

The Ministry of Interior is responsible for all refugee related issues in Jordan, including those related to PRS. The Minister of Planning and International Cooperation (MoPIC) approves humanitarian aid projects in coordination with the relevant line Ministries.

UNHCR is leading the inter agency coordination for the Syrian Refugee Response while UNRWA is in

¹³ Humanitarian Implementation Plan (HIP) ECHO 2016.

¹⁴ An asylum seeker is someone who says he or she is a refugee, but whose claim has not yet been definitively evaluated.

¹⁵ Which are jointly administered by the Government of Jordan and UNHCR.

¹⁶ All refugees living in camps have access to shelter, water, food and a cash for work scheme as set up by the UN, in addition to access to education and health care. Services in the camps are provided by the United Nations (UN) and national and international organisations. Source: Amnesty International – *“Living on the margins”*, April 2016.

charge of the coordination of assistance to Palestinian Refugees from Syria (PRS)¹⁷.

Sector coordination relies on working groups with Task Forces¹⁸ established for the following sectors: Education, Energy, Environment, Health, Justice, Livelihoods and Food Security, Local Governance and Municipal Services, Shelter, Social Protection, Transport and Water, Sanitation and Hygiene (WASH).

In late 2013, a Community Health Task Force (CHTF) was formed, to harmonise the approach to community health, including developing a Community Health strategy and reaching consensus on the definition and main tasks of Community Health Volunteers.¹⁹

3.A.4 Timeline of Key Events / Relevant dates (2014 - 2016)

July 2014

Pursuant to a government decision, any refugee who leaves the camps without bailout after this date (or previously left without bailout and never registered with UNHCR in a host community before this date) is ineligible to receive an asylum seeker certificate or MoI card:

- UNHCR stopped issuing Asylum Seeker Certificates²⁰ (ASCs) to Syrian refugees that have left the camps without proper “*Bail out*” documentation.
- The ASC is indispensable for obtaining Ministry of Interior (MoI) Service Card for refugee access to UNHCR implementing partners’ (IPs) services such as cash and food assistance, as well as to public health care and education services in host communities.

September 2014

With the creation of the Syrian Crisis Response Platform and the launch of the Jordan Response Plan (JRP)²¹, MoPIC requirements for project approvals become streamlined by utilising the same revision process for all projects.

- All projects to be implemented in the framework of the JRP will have to be uploaded onto the Jordan Response Information System for the Syria Crisis (JORISS), which centralises all financial and technical project information. Once uploaded onto JORISS, projects are reviewed and cleared electronically by MoPIC and then submitted to the Inter-Ministerial Coordination Committee for approval before going to the Cabinet for final approval.
- All implementation partners are requested to report back to MoPIC through JORISS on their project progress on a half yearly basis. The IFRC is not affected by this procedure.

November 2014

Jordanian authorities introduced fees for Syrian refugees accessing public health centres that

¹⁷ PRS are “persons whose normal place of residence was Palestine during the period 1 June 1946 to 14 May 1948, and who lost their homes and means of livelihood as a result of the 1948 conflict”.

¹⁸ Task forces are chaired by the line ministry responsible for that sector, and composed of representatives from the government, the UN system, the donor community, and a national and international NGO with significant involvement in that sector (Source: Jordan Response Plan for the Syria Crisis 2015).

¹⁹ In early 2014: 1) a Strategic Advisory Group was created to provide technical and strategic support to and increase ownership and joint accountability within the Health Sector. Currently, the Health Sector is comprised of a main working group and two sub-working groups (Nutrition and Reproductive Health); a third sub-working group, Mental Health and Psycho-Social Support, falls under both the Protection and Health Sectors. 2) A Non Communicable Disease (NCD) Task Force was also formed to support MoH in increasing the response capacity for NCDs, and for actors to share experiences and consolidate NCD interventions.

²⁰ The certificate provides Syrian refugees with proof of registration as a person of concern, as well as access to all UNHCR services in urban areas.

²¹ The implementation of the JRP Plans (currently 2017-2019) is guided by the JRPSC, under the leadership of the Government of Jordan. The Jordan Response Platform for the Syrian Crisis (JRPSC) Secretariat Works with MoPIC Humanitarian Relief Coordination Unit to facilitate the swift implementation and accurate monitoring of JRP projects.

previously since the beginning of the crisis, had been offered for free (as there was free healthcare services for all Syrian refugees) by the Jordan Ministry of Health:

- The fees are equal to those paid by non-insured Jordanians and Syrian refugees must present their Ministry of Interior Service Card in order to receive these subsidised rates. If a Syrian refugee seeking care at a Ministry of Health provider does not possess documentation through the Ministry of Interior, which verifies their refugee status, he or she must pay the “foreigners’ rate,” which is 60% higher than the non-insured Jordanian rate.

January 2015

The *bailout* process²² from the camps was suspended without an official announcement in January 2015.

February 2015

The Urban Verification Exercise (UVE) began in the north of Jordan:

- This is an ongoing process of status verification that requires all Syrians – not just registered refugees – to register with the nearest police station to obtain a Jordanian identity card. Without updated registration or a valid MoI card, refugees risk detention, forced encampment and even deportation.
- Although children have the right to register in school regardless of their legal status, in practice families without valid registration also struggle to access education, other basic services and even humanitarian aid. They also face challenges to register births, deaths and marriages. Children whose births have not been registered in Syria or Jordan are unable to receive new MoI cards through the normal UVE process.

November 2015

The fee for obtaining a health certificate (required documentation in the UVE) was reduced from JOD 30 (USD 42) to JOD 5 (USD 7) and the process of demonstrating proof of address was also made easier²³.

February 2016

The “Jordan Compact”, a new holistic approach between the Hashemite Kingdom of Jordan and the International Community to deal with the Syrian Refugee Crisis was presented at a London conference, setting out a series of major commitments aimed at improving the resilience of refugee and host communities, focusing mainly on livelihoods and education. However, the document did not include any specific commitments on protection, including on legal stay.

King Abdullah says Jordan has reached saturation point in its ability to take in more Syrian refugees.

June 2016

Despite the worsening situation, the countries of Syria, Turkey, Lebanon and Jordan, which initially maintained ‘open-border’ policies to those fleeing Syria, effectively closed their borders in June 2016 to the majority of refugees trying to reach safety. Jordan closed its borders with Syria and Iraq in the

²² Until January 2015, Jordanian authorities allowed Syrians to apply to leave the refugee camps and move to host communities through a “bailout” process involving a Jordanian sponsor. The sponsor had to be a Jordanian citizen with no criminal history who was aged over 35 years, married, and a relative of the refugee/s seeking bailout.

The sponsor was required to obtain security clearance, file an application with the local municipality, provide documents that showed a family relationship with the refugee/s seeking bailout, pay a fee of JOD 15 (USD 21) for each refugee seeking bailout, and finalise bailout at the relevant refugee card.

²³ Initially, refugees had to present a certified copy of their lease and a copy of their landlord’s identity document; later, two additional alternatives to prove address were established.

wake of a suicide attack²⁴ against a border post on June 14 in the Ruqban²⁵ border area. The area is home to a demilitarised zone that prevents people from crossing into Jordan but gives relief agencies a place to provide assistance to refugees.

- As a result, more than 75,000 Syrian refugees have spent more than six months stranded on the Syrian-Jordanian border, including in the Ruqban and Hadalat camps. The Jordanian government said no new refugee camps would be built and none would be expanded.

August 2016

As at the end of August 2016, out of the 515,000 refugees registered with UNHCR as living outside the camps, nearly 363,000 had obtained new MoI cards and the rest around about 152,000 had not. The Norwegian Refugee Council (NRC) estimates²⁶ that at least 17,000 additional refugees living in host communities²⁷ are ineligible to receive new MoI cards.

October – December 2016

There is satellite evidence²⁸ of rising numbers of Syrians stranded at the border in “no man’s land” just north of the “berm”, which is a raised barrier of sand marking the Jordanian limit of the Jordan-Syria border near the crossings of Rukban and Hadalat. The number of refugees arriving at the border has also increased, fleeing from conflict escalation but they have been denied access to Jordan by the authorities²⁹.

3.A.5 Health in Jordan (for Jordanians and Refugees)

Health is provided by both the public and private sectors with public services mainly funded by the Ministry of Health, which is the largest health care provider for Jordanian citizens.

The UNHCR approach towards refugees is as follows:

- UNHCR’s Public Health approach is based on the Primary Health Care (PHC) strategy whereby UNHCR’s role is to facilitate and advocate for access through existing services and to monitor access.
- Essential secondary and tertiary health services are available to eligible refugees who have been registered with UNHCR and offered through government hospitals and other hospitals supported by UNHCR’s referral partner, Jordan Health Aid Society (JHAS). See Annex II (JHAS / UNHCR Hospitals) for more details.

Between 2011 and November 2014, Syrians with MoI service cards could access health care in Ministry of Health facilities for free, and were treated in the same way as insured Jordanians. In the wake of the November 2014 change (when the government changed its policy and required Syrian refugees holding

²⁴ It took the Islamic State almost two weeks to claim responsibility for the attack. This was the first major attack against a Jordanian border post since the eruption of the Syrian conflict in 2011.

²⁵ A sprawling informal camp on the Syrian side of the border has grown to house tens of thousands of people who fled conflict in places like Aleppo, Homs and Palmyra.

²⁶ “Securing Status: Syrian refugees and the documentation of legal status, identity, and family relationships in Jordan”, NRC, November 2016.

²⁷ Those that left the camp without “bailout”, now living in host communities, but that remain officially registered in the refugee camp where they resided.

²⁸ Amnesty International and Human Rights Watch sources.

²⁹ With only one delivery of humanitarian aid allowed between June and August 2016, desperately needed aid deliveries resumed in October 2016. However, such deliveries remain under threat, as do the lives of the camps’ residents – the camp was reportedly struck by a car bombing in October and an improvised explosive device (IED), believed to have been planted by Islamic State group militants IED exploded in mid-December.

Mol cards to pay the same rates as uninsured Jordanians), UNHCR issued a new policy to mitigate its immediate effects: All cases involving Sexual Gender Based Violence (SGBV), mental health, malnutrition in children, neonatal complications and obstetric emergencies were given free healthcare support. In order to facilitate the referral process UNHCR has established two levels of authority with the implementing partner:

- If the estimated treatment cost is less than JODs 750 per person per year then the UNHCR partner will manage the referral directly,;
- If the referral cost is more than JODs 750 per person per year, the case has to be approved by the UNHCR health unit (for emergency cases) and/or the Exceptional Care Committee for non-emergency cases (before the referral takes place).

3.B INTERVENTION’S BACKGROUND

Since February 2014, the JNRCS³⁰ with the support of IFRC has been implementing a holistic community based health and first aid approach (CBHFA) to meet the needs of the Syrian refugees and host communities (currently in six Jordan’s Governorates).

Table1: IFRC – JNRCS geographic coverage timeframe

Governorate	Starting date
Irbid	2014 ³¹
Mafraq	2014
Jerash	2014
Ajloun	2014
Amman	2014
Madaba	2015
Balqa	2016

The CBHFA approach seeks to create healthy and resilient communities worldwide³², Using an integrated approach, volunteers are trained and mobilised to carry out activities within their communities.

Community activities planned in Jordan under this intervention included:

- The dissemination of health information at community events, in schools, during household visits and with established community groups and community based organisations through activities and printed materials.
- The promotion of healthy lifestyles and good nutrition to prevent Non-communicable diseases (NCDs).

³⁰ JNRCS was established on 1947 and admitted to the International Red Cross and Red Crescent Movement in 1950. JRCS is active in different sectors in Jordan including disaster risk reduction, community development, health care and psychosocial programmes. It has 10 branches spread all over 10 out of the 12 Governorates of Jordan and has an auxiliary role to public authorities in the humanitarian field.

³¹ In 2015, Irbid was handed over to one of the PNSs: GRC. Since then, the Irbid Project is managed independently from the IFRC intervention: JNRCS-GRC.

³² The Red Cross / Red Crescent National Societies have been addressing first aid and health promotion using the community-based first aid method (CBFA) since the 1990s. CBFA has since been revisited, and a community participation element to health promotion has been introduced. In 2009, the CBHFA approach was launched and disseminated around the world.

- Home visits to pre-natal and post-partum mothers to educate and support them achieve healthy pregnancies, exclusive breast feeding practices, to recognise the danger signs in a newborn and to promote immunisations.
- Promotion of routine immunisations and for targeted children to participate in National Immunisation Days.
- Dissemination of accident prevention messages and basic first aid skills in the community.
- Raising awareness within communities about the prevention of violence and enlisting the support of men and boys to promote a culture of non-violence and peace.
- Establishment of referral pathways and its communication to beneficiaries to improve their access to health care.
- Provision of psychosocial support services³³ at the JNRCS PS centres supported by the Danish Red Cross (DRC): initially in Amman and since 2015 also through the new centres in Jerash, Aqaba and Ajloun.
- Access to Child and Family Protective Spaces (CFPSs) for refugees' children and their families from Syria (for socialising, playing, learning and psychosocial support).
- Building the capacity of communities to reduce the risks and impact of emergencies through trained community health volunteers.

3.C INTERVENTION'S EVOLUTION

According to the different interviews held, **target population** in the initial 2014 were, in priority, Syrian refugees, although group activities would be applied to both Syrian refugees and Jordan host population (men, women, boys and girls). The search for a specific targeting prioritisation of Syrian refugees is diluted throughout the proposals:

Table 2: IFRC-JNRCS CBHFA Historical Intervention in Jordan:
Overall Objective, Target population, Proposal duration and Donor

Proposal 1	Proposal 2	Proposal 3	Proposal 4	Proposal 5
15 February 2014 – 15 November 2014	01 March³⁴ 2015 – December 2015	October 2015 – March 2016	31st March 2016 – December 2016	March 2016 – December 2016
Proposal to Government of Japan (GoJ): 9 months	Proposal to GoJ: 10 months	Proposal to Australia Red Cross: 6 months	Proposal to British Red Cross: 9 Months	Proposal to GoJ: 10 months
Objective: The adverse effects of the Syria crisis on the health of the affected population are reduced	Objective: To improve the well-being of the Syrian refugee and host community members	No Objective	No Objective	Objective: Improved wellbeing, resilience and peaceful co-existence among 32,000 (CBHFA: 22,000 and PSP: 10,000) vulnerable Syrian refugees and host communities in Jordan

³³ The JNRCS psychosocial support programme provides services through guided workshops and group meetings on various topics and themes addressing the different needs of the beneficiaries. These include good parenting skills, coping mechanisms, improvement of children's playfulness, tolerance, trust and life coping mechanisms, child protection, early marriage and Gender Based Violence (GBV). The PS centres also act as referral centres for the management of cases in need of specific, mental health and psychosocial support needs of specialised referrals / case management.

³⁴ Reflected as expected start date (proposal GoJ version 26th January 2015).

6,000 beneficiaries (CBHFA & PS)	33,000 beneficiaries: Syrian refugees and the host community	7,500 direct beneficiaries (65% female, 35% male; 50% Syrian, 50% Jordanian; 375 people with a disability: 5% of the total)	Targeted to JNRCS volunteers only (complementary trainings)	32,000 beneficiaries (CBHFA & PS) ³⁵
Outcome: 6,000 affected people in 20 Communities in the Governorates of Amman, Ajloun, Jerash, Mafraq and Irbid have improved their health and well-being through Community Health and Psychosocial support	Outcome: 33,000 beneficiaries within the Syrian refugee and the host communities in the Governorates of Amman, Ajloun, Jerash, Mafraq and Madaba have improved physical and psychological health related to disease and disaster risk reduction, with a special focus on women and girls	<i>7,500 direct beneficiaries:</i> Outcome 1: Increased health knowledge and skills among Syrian refugee and host community members in disease prevention and home and community safety Outcome 2: Increased capacity of JRCs staff and volunteers to conduct effective community health activities related to health and home and community safety	No Outcome	Outcome ³⁶ : Improved wellbeing, resilience and peaceful co-existence among 32,000 (CBHFA: 22,000 and PSP: 10,000) vulnerable Syrian refugees and from the host communities in Jordan

The CBHFA strategy was designed alongside three main components / outputs that have varied since 2014. In 2014, the Outputs' formulation was much more results and problem solving oriented (in terms of aiming at achieving a positive health and psychosocial support gain through improved access to assistance in a target population in distress) than in successive years, where it seems much more geared towards resilience and capacity building:

Table 3: IFRC-JNRCS CBHFA Historical Intervention in Jordan: Outputs evolution

Proposal 1	Proposal 2	Proposal 3	Proposal 4	Proposal 5
Output 1: 6,000 affected people in 20 Communities in the Governorates of Amman, Ajloun, Jerash, Mafraq and Irbid have improved their health and well-being through Community Health and Psychosocial support	Output 1: Increased knowledge, skills and positive coping mechanisms among 33,000 Syrian refugee and host community members in disease prevention, home and community safety and psychological well-being, contributing towards community resilience	No Output	Output 1: Increased health knowledge and skills among Syrian refugee and host community members in disease prevention and home and community safety	Output 1: ³⁷ Refugees from Syria and host communities are more self-reliant and resilient to diseases, disasters and local conflicts
Output 2: 2,000 refugee children and	Output 2: Increased capacity of JNRCS		Output 2: Increased capacity of JNRCS	Output 2: The protective

³⁵ (CBHFA 22,000 and PSP 10,000).

³⁶ Although in the proposal it was included as an Objective.

³⁷ This is the first proposal that includes the indicators per Output.

their families in three out of the five targeted Governorates have access to psychosocial health services for improved psychosocial well-being ³⁸	staff and volunteers to conduct effective community health activities related to health and home and community safety		staff and volunteers to conduct effective community health activities related to health and home and community safety	environment of the most vulnerable refugees from Syria and members of the host communities (adults and children) is enhanced and their psychological distress is minimized
Output 3: JNRCS/IFRC capacity in community awareness and on community-based health and first aid is strengthened ³⁹				Output 3: JNRCS have strengthened their capacity and enhanced their ability to reach out to the most vulnerable groups within the refugee and host communities

The overall, allocated **budget** planned for the CBHFA intervention (for the period February 2014 – March 2017) is **US\$ 1,804,580**⁴⁰.

2016 is the year with the highest budget, which is closely related to the increase in the number of Governorates covered and the number of trained CBHFA volunteers:

Table 4: CBHFA (IFRC – JNRCS) Budget evolution (2014 – 2017)

Budget period	Amount	Currency
February - November 2014	500,000	US\$
March – December 2015	400,000 ⁴¹	US\$
October 2015 – March 2016	169,994	AUD
March 2016 – March 2017 ⁴²	140,000 ⁴³	GPB
March 2016 – March 2017 ⁴⁴	607,580	US\$

³⁸ Refugee children and their families from Syria have access to Child and Family Protective Spaces (CFPSs) for socialising, playing, learning and psychosocial support.

³⁹ JNRCS benefit from a dedicated focal point experienced in community and public health that is able to facilitate and train and lead CBHFA methodology and its tools. The capacity building activities will be coordinated with other members of the Movement such as French, Danish, Italian, German, British Red Cross and ICRC. This will lead to build a stronger National Society at both branch and Head Quarter levels.

⁴⁰ Estimated amount with the conversion of AUD and GPB currency exchanges.

⁴¹ It included US\$ 48,000 for the Psychosocial programme managed by DRC.

⁴² Including a three-month no-cost extension.

⁴³ Complementary funds for additional trainings for volunteers.

⁴⁴ Including a three-month no-cost extension.

4. EVALUATION METHODS & LIMITATIONS

4.A TIMELINE – PHASES AND DELIVERABLES OF THE EVALUATION

Table 5: Evaluation timeline and deliverables

Activities	Dates (Year 2017)	Deliverables
Desk Review Phase (1):	30 January – 4 February	Desk review Plan and schedule; draft methodology; define data collection tools Inception report
Field Phase (2):	5 – 20 February	Complete visits, complementary data gathering and interviews with key informants (KIIs) Conduct validation session for feedback at end of field visit
Synthesis and Reporting Phase (3):	23 February – 6 March	Complementary information and data cross-check for analysis Submit draft version of evaluation report for IFRC-JNRCS revision
	14 March	Final version – evaluation report submission

4.B METHODOLOGY – OVERALL ORIENTATION

The evaluation process was based on a mixed-methods approach, combining qualitative and quantitative methodologies, performing both quantitative and qualitative analysis:

Table 6: Tools and techniques used in this evaluation

Tool/Technique	Targets and Actors involved	Comments
Compilation and analysis of available documents and quality of monitoring information	<ul style="list-style-type: none"> Analysis of documents (see Annex III: List of Consulted Documents - Bibliography) provided by the IFRC and those directly compiled by the evaluator (external reports-documents) prior to the field visit (Phase 1) Analysis of the complementary documents (considered relevant) that the evaluator was able to obtain from IFRC and/or other organisations/institutions during the visit to Jordan (Phase 2) and during Phase 3 of the evaluation (see Annex III: List of Consulted Documents - Bibliography) 	The quantitative data came from the reports and data already collected by IFRC and already reflected in the reports and other relevant documents pertaining to the projects
Semi-structured individual key informants' interviews (see figure with the breakdown below – figure 2)	<ul style="list-style-type: none"> Key Actors present in the area of intervention working with whom the projects had/have any type of coordination: other PNSs, iNGOs, Donors, etc. IFRC key staff (Regional and National level) JNRCS key staff (National and field level) 	The interviews with key informants served to collect information and views on key issues outlined in the inception report and indicators in the Evaluation matrix, as well as to identify causalities and bridging information gaps
Joint brainstorming-analysis sessions	<ul style="list-style-type: none"> Joint analysis sessions with IFRC and JRCS key staff 	For information triangulation and contribution to learning and identification of challenges and best practices

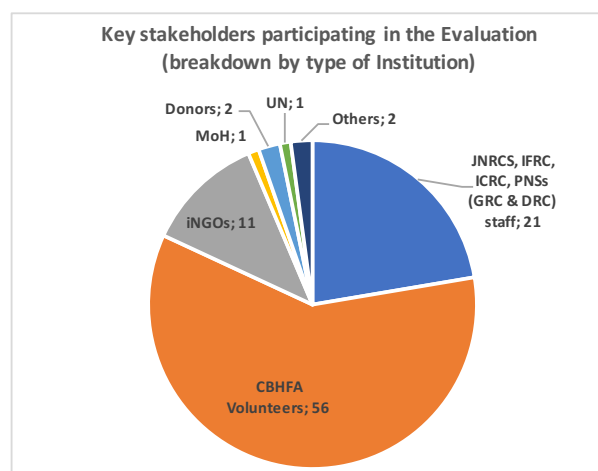
Group Discussions	<ul style="list-style-type: none"> Group discussions with CBHFA volunteers in five⁴⁵ out of the six governorates (JNRCS branches) where the project is implemented. 	The group interviews with CBHFA volunteers served to collect information and views on key issues outlined in the inception report and indicators in the Evaluation matrix, as well as to identify causalities and bridging information gaps. The evaluator counted upon translators support to facilitate the dynamics
Direct observation	<ul style="list-style-type: none"> Cross-check of databases and existing monitoring tools – including hardware copies 	For information analysis and reliability check of existing Monitoring and Evaluation (M&E) system

All the quantitative information was extracted from secondary sources (both internal and external to IFRC-JNRCS). Existing data sets, reports and studies were used, and where these were not reliable or available, qualitative approaches were followed to compensate. The data analysis enabled the evaluator to identify/map possible trends and hypotheses of this new programmatic approach to be tested during the field phase.

During the field phase and in order to collect qualitative information, IFRC, JNRCS, ICRC and PNSs staff, as well as a broad range of external stakeholders were interviewed:

- Thirty-eight (19 M / 19 F) key Informant Interviews (KIIs) with individuals from different institutions
- Five Group discussions with fifty-six CBHFA volunteers (15 M / 41 F) from five different JNRCS branches/governorates were carried out.

Figure 2: Key Stakeholders participating in the Evaluation



Source: Own elaboration based on evaluation data

The IFRC, JNRCS and PNSs interviews were reinforced through two Joint sessions (one for briefing purposes at the beginning of the evaluator's visit to Jordan and a second one at the end of the stay). The evaluator also attended the Community Health Task Force monthly meeting in Amman, that included 22 participants from 11 different institutions. The List of contacted Key Informants (KIs) is attached as Annex IV. On February 19th which was the last day of the field phase⁴⁶, the evaluator presented preliminary findings to the IFRC, CBHFA staff (JNRCS) and PNSs key staff.

⁴⁵ Only Madaba could not be included due to time constraints.

⁴⁶ February 19th.

4.C LIMITATIONS

- External (context related):
 - The enormous burden of external factors and the context (mostly political) needed a constant exercise to balance and analyse its burden to respond to each of the evaluation's questions.
 - Difficulties in obtaining reliable and updated statistics/figures on population and socio-medical data (validity, consistency and accuracy of secondary data that the evaluation has to rely on).
 - The difficulty to interview the intended CBHFA beneficiaries (Syrian refugees), led to focus the field phase on CBHFA volunteers, due to:
 - 1) Limitations related to the risk of limiting livelihood opportunities that are already extremely constrained (preventing them from going to work to participate in the evaluation).
 - 2) Refugees may be hesitant to meet.
 - 3) Refugees may have high expectations, or at least expect you to bring assistance.
 - 4) Some refugees can feel uncomfortable talking about protection risks and/or other personal issues, what lead the evaluator to rely as much as possible on existing internal information and to concentrate upon the field dynamics (group discussions) with CBHFA Volunteers.

- Internal:
 - The available CBHFA narratives do not include Assessments/Exploratory missions, that made the Relevance, Appropriateness, Targeting and Effectiveness' analysis of some components difficult. The evaluator then included qualitative tools/techniques and questions that would complement the initial research (such as communication with previous IFRC participating in the design of the intervention, revision of hardware copies and Monitoring tools, etc.).
 - Ideally and to answer some of the evaluation's main questions (related to Effectiveness), comparisons between initial base-lines and "comparison groups" should be made before and after the implementation of programmes. The CBHFA project has different base lines and intermediate measurements but with important methodological limitations, that does not allow the validation of their results. Some findings are thus expressed in terms of likelihood rather than proof.

The identified limitations have reinforced the importance of counting on information collected during interviews with key stakeholders. The detected limitations have been (in the opinion of the evaluator) partially alleviated, in large part by the qualitative analysis (interviews, research and cross-checking of information) made during the field and analysis phase of this evaluation, leading to a result that does not compromise the conclusions of the evaluation.

5. FINDINGS

The Findings' section is the most extensive part of the report. In these sections, the evaluation criteria are analysed in depth in response to different Questions, according to the Indicators, Sources and Methods outlined in the Methodology section and the Evaluation Matrix that were defined during the Inception phase.

The most comprehensive analysis in this Section is done for the sub sections 5.A (Relevance and Appropriateness) and 5.B (Targeting and Coverage), where there were an increased number of secondary and primary sources for review, and the Indicators, defined to respond to the questions, required further analysis. It was also found that design and formulation of the intervention have been determinants in the overall low Effectiveness and Efficiency of the intervention.

Given the unquestionable relevance and humanitarian value of a community based intervention a justification of the findings are needed for a future reorientation of the intervention.

5.A RELEVANCE AND APPROPRIATENESS

5.A.1 Does the Project respond to the primary health care needs of the target population, local context (incl. MoH) and specific needs, such as referral system?

5.A.1.a) Relevance at the start of the intervention (2013 – 2014)

The initial project decision to intervene in the health domain for out-of camp refugees was fully relevant if taking into consideration the gaps and the needs of the Syrian refugees in early 2014:

- In **2013**, the health sector response was primarily focused on the refugees living in camps, whilst the majority of the Syrian refugees were living out-of camps and the health response at community level was insufficient. The priority needs were changing with changes in demography and epidemiological profile, and the Jordanian health system was under huge pressure (refugee health care was provided for free through the Jordanian MoH structures, what was, in the mid-term, unsustainable).
- According to IFRC staff that participated in the first proposal's design, in **2014** the need for an IFRC health intervention at community level came through discussions with UNHCR⁴⁷ at interagency meetings, where UNHCR expressed concern at the insufficient refugee health response services directed outside of refugee camps. They proposed IFRC to intervene and also to set up and chair a Community Health Task Force .
- Although no written information could be found, it was mentioned that in early 2014, the ratio of one Community Health Volunteer (CHV) to population in non-camp areas was of 1 CHV/ 4000 refugees (1:4000), whilst the Sphere minimum standard is of 1 CHW / 1,000 (1:1000).

At that time, the Community health main gaps were in the following areas:

- **Preventive approach** to support the Jordan Health system (when the project was formulated, MoH was giving free access to refugees) to avoid its collapse due to refugee pressure.. The CBHFA

⁴⁷ UNHCR was at that time, the leading agency for health. The Health Sector is co-chaired by WHO and UNHCR. The secretariat of the sector is provided by UNHCR.

intervention was intended to contribute to a reduction in the financial burden on health services of Syrian refugees.

- **Access to Information** for refugees to improve their access to health care, given that the main barriers that had been identified at that time were related to bureaucratic-administrative hurdles and financial constraints:

“The top two Barriers to Care most mentioned in the Health Access Assessment focus groups were systematic issues with administrative documentation: (#1) was the residency stipulation on the MoI Security Card that limits the cardholder to medical facilities where he/she originally registered. (#2) was the rapid expiration of the UNHCR Refugee Registration Card and the lengthy and complex renewal procedure that, in the interim, leaves the refugee without access to free health coverage through the MoH.

Issues of physical access were the next most frequently discussed: long distances to health facilities (#4), lacking means of transportation (#6), and the cost of what little transportation is available (#3). Communication deficiencies also figured in the top-10 (including confusion about the referral process)⁴⁸. “

It is also worth mentioning that in 2013 JNRC was not associated with any particular and/or regular service⁴⁹ at community level and the CBHFA intervention implemented through different branches and CBHFA volunteers could help to integrate the JNRCs's branches into the communities.

5.A.1.b) Appropriateness of the Initial CBHFA intervention (2014)

The initial CBHFA design contemplated the CBHFA implementation through:

- comprehensive programme management
- strengthening community systems
- setting up of a referral system
- integration and partnerships
- behaviour change communication

Given the community health needs were identified at the **end of 2013 and early 2014**, the **CBHFA approach was appropriate** if considering it as an **entry point for connection** with the public health system (MoH) and different partnership complementarities⁵⁰ with a twofold purpose:

- I. to reduce the Syrian refugees' frequentation by reinforcing key behaviour change topics (preventive approach),
- II. facilitate enhanced coordination and referral mechanisms across health (MoH) and psychosocial sectors.

In spite of its initial relevance (needs based orientation) and the appropriateness as an entry point at community level mentioned in the previous paragraph, the CBHFA intervention was, in its design, partially appropriate.

- This was mostly due to: lacking adaption in its formulation to the non-camp refugee reality, what would have been needed considering that the intervention was going to be developed with a

⁴⁸ The #1 barrier to care cited in the focus group with a sizeable unregistered refugee representation was lack of knowledge about available health services, while lack of knowledge ranked last in the top-10 barriers most mentioned in primarily registered refugee focus groups. Source: "Population-Based Health Access Assessment for Syrian Refugees in Non-Camp Settings throughout Jordan", UNHCR, International Medical Corps, UNFPA survey. November 2013 – March 2014.

⁴⁹ Except of non-regular Non Food Items' (NFIs) distributions.

⁵⁰ Except of non-regular Non Food Items' (NFIs) distributions.

protracted refugee caseload, in a country that (as previously developed in the section 3 of this report), is not a party to the 1951 Convention on Refugees or its 1967 Protocol⁵¹.

- In areas with fixed population, it makes sense to concentrate on having a permanent CBHFA volunteer, but the peculiarities of the urban approach in a small size country with a high density of population, easy transportation and a large refugee case load (mobile), was not sufficiently recognised.

5.A.1.c) Evolution of Relevance (2014-2016)

Serious deterioration of the Syrian refugees' economic situation:

The last available Vulnerability Assessment Framework (VAF)⁵² data in Jordan (**2016**) reinforces the above mentioned data:

- The economic situation of Syrian refugee households living in Jordan is precarious. Many refugees have entered a cycle of asset depletion, with savings exhausted and levels of debt increasing.
- It found that 93% of refugees are now living below the Jordanian poverty line of 68 JOD per capita per month. Moreover, 80% of the refugees report engaging in 'crisis or emergency' negative coping strategies. These include reducing food intake and taking children out of school⁵³. This represents a deterioration from the previously available data (UNHCR source).

"In 2015, only 10% of Syrian refugees held a valid work permit and in November 2015, 62% of households had no economically active members. In 2015, the number of Syrian refugees involved in exploitative and high risk jobs increased by 29% on a year-on-year basis (WFP, 2015).

Most Syrian refugee families spend more than they earn to meet their needs.

In 2014, the average expenditure was 1.6 times greater than income (UNHCR, 2014c) and the gap between expenditure and income has been progressively worsening. Several studies find households amassing high levels of debt: over 67% of refugees borrow money (CARE, 2015) while as many as 86% of households took on debt in 2015, compared to 77% in 2014 (WFP, 2015). Therefore, refugee families are at an increased risk of taking up unsustainable levels of debt and falling into debt traps with no steady income streams to bail them out.

Since 2014, decreasing level of income pushed the share of rent and utilities in total expenditure to consistently increase over time. In addition, the average food share in total expenditure grew from 24% in 2014 (UNHCR, 2014c) to 40% in 2015 (UNHCR, 2015b), another indicator of increased economic hardship⁵⁴."

The Health situation evolution since the start of the intervention in 2014:

In the May **2015** "Health Sector Humanitarian Response Strategy for Jordan", it was reported that the main health concerns with regard to Syrian refugees were: non-communicable diseases⁵⁵, communicable diseases (such as measles, polio, tuberculosis and leishmaniasis), poor infant and young child feeding practices, anaemia and micronutrient deficiencies, deliveries in girls under the age of 18, a significant prevalence of disability among Syrian refugees; mental health problems, access to care and insufficient community outreach coverage with limited Syrian involvement⁵⁶.

⁵¹ More details on the specific points that would have been desirable to consider are given under 5.A.1.d) "Appropriateness of the successive CBHFA interventions".

⁵² A survey conducted by the United Nations High Commissioner on Refugees (UNHCR) and Humanitarian Partners that also provide insight into health utilisation and expenditure patterns amongst the Syrian registered refugees' households.

⁵³ ECHO Factsheet – Jordan: Syrian Crisis - January 2017.

⁵⁴ "Running on Empty", UNICEF, May 2016.

⁵⁵ The Syrian refugee health profile reflects a country in transition with a high burden of NCDs.

⁵⁶ Health Sector Humanitarian Response Strategy: Jordan 2014-2015. Health Sector Working Group. Updated May 2015.

In the UNHCR Health Access and Utilization Survey (HAUS)⁵⁷, it is mentioned that: *“the policy change from free to subsidised care was associated with a reported decrease in access to curative and preventative health care services among Syrian refugees living out of camps in Jordan. Households reported that the main barrier to seeking care when needed, was their inability to pay the requested fees”*.

According to the consulted sources, the 2015 health concerns were very similar to those in 2014, with increasing evidence that Syrian refugees had less access to health care⁵⁸:

The HAUS data for **2016** (still provisional) also confirms that expenditure on health has dramatically increased and some key access and health indicators show a deteriorating situation for the period 2015-2016.

The 2014-2016 UNHCR HAUS data comparison shows as a deterioration from 2014 to 2015 (policy change requiring refugee households to pay for health services obtained in the public sector).

It is also important to take into consideration that the HAUS is conducted among registered non-camp based Syrian refugees living in Jordan, with households that had a listed telephone number⁵⁹. It is reasonable however to assume that households with no phone access⁶⁰ (40 % in the 2016 HAUS) are likely to be more financially vulnerable and therefore at higher risk of not being able to access and utilize health services as needed.

It is also recognised by all actors interviewed that **the situation of non-registered refugees** (not surveyed in the HAUS) could be **worse**.

In the 2014-2016 HAUS data trend's comparison, the sample size of 2015 (n=411) and 2016 (n=400) is **not comparable** with the **sample size** of 2014 (more than triple than in 2015 and 2016: n= 1,550 HHs), thus the **methodology of 2015 and 2016** is insufficiently explained in the published reports, showing **serious pitfalls**, thus only allowing to compare a general trend.

Patients must present a valid UNHCR registration certificate and security card in order to receive services at subsidised prices. The **indicator** referring to the **proportion of households (HHs) that do have a Mol security card in 2015 and 2016 only refers to the respondent (not all the HH members) and does not allow to identify the most relevant information, which would be, the precise percentage of HH members that obtained the new security card (Mol card) after the UVE started in February 2015**⁶¹.

- The 2015 HAUS figure for that indicator (94%) does not correspond to the “new” cards due to the fact that the UVE process had only recently been initiated (February 2015) and the Survey was dated on May 2015.

⁵⁷ This type of survey is designed to characterise the care-seeking behaviour of Syrian refugees and to better understand issues related to health care access among the refugee population.

⁵⁸ These concerns and needs are generally still valid in 2017.

⁵⁹ As recognized already in the 2014 HAUS report, survey findings may not be generalizable to refugee households without registered telephone number, as they could not be interviewed for that survey. It is reasonable however to assume that households with no phone access are likely to be more financially vulnerable and therefore at higher risk of not being able to access and utilize health services as needed.

⁶⁰ It also includes invalid phone numbers or no longer reachable numbers.

⁶¹ As previously detailed in section 3.A.4 of this report, this is a process of status verification (UVE) that started in February 2015 and that requires all Syrians – not just registered refugees – to register with the nearest police station to obtain a Jordanian identity card that confirms residency in Jordan and affords the holder access to education and health care. Without both of these documents, displaced Syrians have no right to any of this help.

- At the end of August 2016, different INGO reports, citing UNHCR official information, showed that 70% of urban refugees registered with UNHCR were issued the new Mol cards, but that information and a more recent update on that figure could not be confirmed by the evaluator⁶².

Table 7: HAUS Jordan - Some Key Indicators with Negative Evolution (series 2014-2015 and 2016)

Indicator	2014	2015	2016
Proportion of households that did not obtain the new security card (Mol card)	Not Available (N.A.)	N.A. (The HAUS indicates that the 94% respondents have a Mol card, without indication of “new” cards out of the respondents and HHs members)	97% ((The HAUS indicates that the 94% respondents have a Mol card, without indication of “new” cards out of the respondents and HHs members)
Reasons for not obtaining the security card	N.A.	Lack of ID documents: 15% Changed area of residence Unable to find Jordanian bailer, lack of bail out document, cost of disease free certificate ⁶³ : 8% each	Lack of ID documents: 15% ⁶⁴ Changed area of residency: 15% Unable to find Jordanian bailer: 18 % Cost of disease free certificate: 8%
Percentage of households who know that refugees have subsidised access to government PHCs	96%	64%	70%
Health seeking behaviour in Adult household members (1 st facility)	Public sector (including hospitals): 53% Private sector : 33% (private hospitals and clinics: 31.3%, , Syrian doctors: 1.7% and shops/informal providers: 0.3%) Pharmacies: 5%	N.A.	Private hospital/clinic 38% (including JHAS clinics: 13%) Gov. Hospital: 28% Home: 2% Private Pharmacies: 14%
Household spending on health the month preceding the survey	57.0 JOD (consultation and diagnostic fees: 32.1 JODD and spending on medications: 24.9 JD)	N.A.	105 JOD (no breakdown available but according to the HAUS survey, it represents 45% of their total income)
Average cost of care paid in the first facility visited by the refugee	32 USD	46 USD	57.1 USD

Source: Evaluation compilation based on UNHCR HAUS data

The indicators that represent an improvement if comparing 2016 with 2015 are included in the following table, and seem to be closely related to either the knowledge about a service free of charge (immunisation for under-fives) or a partial exemption of antenatal care (ANC) and post natal care (PNC) that is free of charge to all refugees who hold UNHCR documentation as well as valid Mol card, since

⁶² The evaluator tried to reconfirm with UNHCR the validity of the percentage or a most updated figure but no response was obtained before finishing this report.

⁶³ As previously detailed in section 3.A.4 of this report, this is a process of status verification (UVE) that started in February 2015 and that requires all Syrians – not just registered refugees – to register with the nearest police station to obtain a Jordanian identity card that confirms residency in Jordan and affords the holder access to education and health care. Without both of these documents, displaced Syrians have no right to any of this help.

⁶⁴ This is also consistent with UNICEF 2016 information: “Expensive services and missing documents are also important factors driving refugee’s choice of seeking healthcare outside of governmental structures”. “Running on Empty”, UNICEF, May 2016.

April 2016:

Table 8: HAUS Jordan - Some Key Indicators with Positive Evolution (series 2014, 2015 and 2016)

Indicator	2014	2015	2016
Percentage of households that know that under-fives have free access to vaccines	92%	82% ⁶⁵	93%
Measles immunisation coverage in under fives	87%	82%	93% ⁶⁶
Percentage of pregnant women having difficulty accessing ANC services	4%	15%	9%
Percentage of household members with Chronic Health Conditions in adults that were unable to access medicines or other health services as needed	24%	58%	36% ⁶⁷

Source: Evaluation compilation based on UNHCR data

Other key indicators that were assessed in 2014 and that could also give a clear overview on the evolution of the situation (presumably negative), were not publically available in 2015 and 2016.

As the data collection tools-questionnaires are not included in any of the externally published reports, it is not possible to know if the information was obtained but not published or if it was simply not obtained:

Table 9: HAUS Jordan - Some Key Indicators That Are No Longer Publically Available for 2015 and 2016

Indicator	2014	2015	2016
Households that receive cash or vouchers from the UN-NGO in the month preceding the survey (an average value)	93.7% Average value: 201 JD	N.A.	N.A.
Percentage of births taking place in public hospital, private clinic or doctor and non-institutional	Public hospital (51,8%) Private clinic or doctor (30,4%) Non-institutional: 17,8%	N.A. but presumably also negative ⁶⁸	N.A.
Percentage of households that did not seek care the last time care was needed for an adult	4%	9% ⁶⁹	NA
Percentage of households that did not seek care the last time care was needed for a child and primary reason	9% Primary reason -cost: 68%	NA	NA

Source: Evaluation compilation based on UNHCR data

More recently, UNICEF published a report focusing in the situation of Syrian children in host communities in Jordan⁷⁰, where the deterioration of the Syrian refugees situation was clearly made evident, with some paragraphs (copied below), giving more information that could help to interpret the preliminary 2016 HAUS' information:

⁶⁵ Considering that only 76% of children under 5 reportedly had a vaccination card, measles coverage is likely to be even lower than that estimated above by self-report.

⁶⁶ This figure could be lower due to the same reason as the previous footnote. UNICEF information for 2016 also reports a low figure of vaccination rates (that include measles): "Syrian children appear to have slightly lower full vaccination rates (84.8%) when compared to Jordanian children (93.2%). Vaccination rates remain high in Jordan, yet pockets of children not holding valid documents or living in informal settlements may not be vaccinated". Source: "Running on Empty", UNICEF, May 2016.

⁶⁷ This information is contradictory with: 1) the information obtained through the different interviews carried out in the evaluation, where it was consistently reported that the accessibility to health care and treatment for chronic conditions has worsened due to its direct relation with financial barriers and 2) the same information collected in the HAUS 2015 and 2016, where the % of those who couldn't afford fees increased from 57% in 2015 to 75% in 2016.

⁶⁸ See information from UNICEF below (in the paragraph in quotation marks' last line), related to refugee women women having to pay for medically assisted childbirth in 2015 was nearly three times more than in 2014.

⁶⁹ It represents a deterioration/negative trend, interpreted as directly related to a financial barrier / cost of service.

⁷⁰ "Running on Empty", UNICEF, May 2016.

“Refugee families are shifting away from public healthcare and turning to NGOs or private service providers (CARE, 2015), (UNHCR, 2015b). Only 45% of families with a medical need in the last 6 months accessed the national healthcare system (UNICEF, 2016). Refugees are no longer choosing public clinics or hospitals mainly because of substandard quality of services; expensive services and missing documents are also important factors driving refugee’s choice of seeking healthcare outside of governmental structures (UNICEF, 2016). Costs connected with assisting childbirth have risen. The odds of refugee women having to pay for medically assisted childbirth in 2015 were nearly three times higher than in 2014 (UNICEF, 2016c)”.

The VAF 2016 data also shows that the majority of Syrian refugee families access health services at facilities operated by charitable institutions.

Relevance to intervene in **Community health:**

- The Community health gaps identified and that initially justified a community (CBHFA) intervention, changed after November 2014, thus:
 - ✓ Becoming more relevant to focus on: access to information for refugees to improve their access to health care and referrals / connection with different partnership complementarities (not only across health⁷¹ and psychosocial sectors, but also to cover other basic needs).
 - ✓ The Project focus on the preventive activities (that had been initially justified by the intention to contribute to a reduction in the financial burden on public health services for Syrian refugees) become less relevant after November 2014 (MoH was no longer giving free health care to Syrian refugees).

5.A.1.d) Appropriateness of the successive CBHFA interventions

Most of the out-of camp Syrian refugees were located outside CBHFA traditional “community environments⁷²” (in urban or peri-urban areas and to a lesser extent in rural areas). As mentioned before, the intervention was put in place in a country with high density of population in a small territory, that facilitates movement, and that compounded with the above concerns and the refugees’ search for assistance and livelihoods / socioeconomic opportunities, represents targeting an important percentage of non-fixed population (Syrian refugees). That approach would have required quite a flexible and vulnerability focused targeting and would also influence the ability to recruit, train and keep Syrian⁷³ CBHFA volunteers.

The initial formulation (as well as successive designs/proposals), did not take into consideration neither the specific protection vulnerabilities associated with the out-of camp refugee’s condition of the target population, nor the burden and influence that legal / policy factors-changes could have on them. More specifically in the non-registered refugees or in refugees either unable to register or renew UNHCR registration and obtain “asylum-seeker” certificates, obtain/renew an MoI card or lacking civil documents.

In the new proposal of 2015, the project design did not give enough importance to the **need for securing the health referral pathway in the absence of a free public health system for Syrian refugees** and in 2016, it was simply not considered (see more details in response to question 5.A.2).

⁷¹ “Including the provision of cash to refugees to offset the cost of accessing health services at Ministry of Health facilities and strengthen links with agencies providing cash assistance to support transport costs to access health services for vulnerable refugees”. Recommendations’ section of the 2015 “Health Access and Utilization Survey”.

⁷² According to certain sources, for the Syrian refugees, the traditional sense of community is replaced by nationality/origin ties.

⁷³ Defined to be at least 50% of the CBHFA volunteers (while the remaining percentage, should be Jordanians).

On the contrary, in 2016 there was a planned a non-justified increase in the number of CBHFA volunteers from 70 to 150, that represented a huge investment in recruitment, training and management reorganisation, diverting resources away from the needed focus in reaching and “doing more” for the population most in need, that has been determinant in the overall loss of relevance of the CBHFA intervention.

What can be considered positive in the whole series of projects (2014-2016) is that the DRC-JNRCS Psychosocial Support Programme (PSP) With PSP centres in: Ajloun, Amman and Jerash., which was partially financed by the CBHFA proposals and could have helped to facilitate certain referrals (psychosocial, violence, Sexual and Gender Based Violence, etc.) was kept inside the different proposals.

5.A.2 Should the direction of the project be changed to better reflect those needs and priorities by a) scaling it up, b) by adapting it , if yes, how?, c) or considering other more appropriate approaches and is it adapted to the reality of the urban displacement in Jordan?

Successive Proposals did not take sufficiently into consideration the Context changes (external factors detailed in section 3.4.A of this report: Timeline of Key Events / Relevant dates) that contributed, with a different degree of causality, to a serious deterioration in the ability of the most vulnerable refugees’ families to: (#1) have access to health care, (#2) to cope with other basic needs (that were detected in the 2014-2015 IFRC-JNRCS CBHFA evaluation⁷⁴) and (#3) the consequent protection challenges and severely negative coping mechanisms resorted and widely documented by different sources since 2015 and mentioned as well in the previous paragraph.

There has also been an over increased protection related risk for those refugees’ groups who are ineligible to receive new MoI cards and refugees who are eligible, but have not yet obtained new MoI cards because they lack the documents necessary to receive a card through the normal issuance process.

Whilst the largest groups of concern are refugees, IFRC interventions in Jordan are addressed to registered Syrian refugees and Jordanians, when the needs (from a Humanitarian principled approach) would request a shift in focus towards the most vulnerable populations, not based on legal or nationality status.

Those refugees’ categories that were and are exposed to a range of human rights related concerns stem from the lack of documentation, such as:

- gender-based risks for Syrian women and girls without documentation (including early marriage⁷⁵, sex trafficking, sexual and physical violence, social isolation, etc.),
- restrictions on movement and marginalisation
- restricted access to services (particularly health and education),
- exploitation in illegal, unsafe or risky work,

⁷⁴ This was widely documented in the evaluation report of the IFRC-JNRCS CBHFA project carried out in December 2015, which stated that even lacking a standard evaluation structure and a minimum quality, it could have been useful to identify main challenges and opportunities of the approach.

⁷⁵ In Jordan, girls need a judge’s approval to marry between the ages of 15 and 18 lunar years (the judge must also obtain the consent of the Chief Justice to the marriage). Syrian girls who married before 18 therefore struggle to obtain marriage certificates or marriage ratification certificates, and consequently the children of early marriages often remain unregistered. Data from the 2015 Jordanian national census indicates that more than half of Syrian women in Jordan married before the age of 18. Early marriage is used as a coping strategy for young girls in abusive home environments and poor living conditions. Families marry off their daughters with the idea that they are providing protection for young girls, continuing family traditions, alleviating poverty or helping daughters escape the environment. In general, girls under 18 are more likely to experience obstetric and neonatal complications and death associated with pregnancy and childbirth at a young age.

- violence,
- resort to other severely negative coping strategies, such as returning to Syria or taking on unsustainable debt,
- forced relocation to refugee camps, and possible “*refoulement*”⁷⁶,
- proving child’s identity and prevention of statelessness:

“One increased risk for unregistered Syrian children is statelessness. Every child has the right to acquire a nationality and although lack of birth registration does not always lead to statelessness, the Office of the United Nations High Commissioner for Human Rights (OHCHR) has explained that: birth registration is fundamental to the prevention of statelessness and essential to ensure the right of every child to acquire nationality. Under Syrian and Jordanian law, nationality is passed through the father; if a Syrian woman gives birth in Jordan but the couple cannot prove that they are lawfully married and so cannot obtain a birth certificate, the child may, in effect, become stateless. If parents cannot prove their child’s identity, nationality, or relationship to the family, a child’s lack of documentation could also affect a refugee family’s ability to travel together, imperiling family unity – a right protected under international law and an important principle of refugee protection”⁷⁷”

As mentioned in 5. A.1, in **2016** (when it was most needed and a previous evaluation showed the dire need to either complement with assistance or to secure referrals to other organisations⁷⁸), the formulation did not include **any referral activity**⁷⁹, that has been found as a **major factor hindering** the overall **effectiveness and efficiency** of the intervention:

- In light of the serious deterioration of the Syrian refugees’ situation, the appropriateness of the CBHFA approach was insufficiently focused in securing referrals, when Referral care is considered as an essential part of access to comprehensive health services and different UNHCR and other actors (including donors as ECHO) issued different related recommendations⁸⁰ and adapted their strategies to the evolving needs of individuals with specific needs and vulnerabilities, enhancing as well the possibilities to cover basic needs.
- The 2016 intervention focused in raising awareness (non-tangible focus) and increasing the number of CBHFA volunteers (by 100 percent), with the consequent effort and investment in training, diverting attention away from the priority needs of the most vulnerable populations.
- The need to prioritise the refugees’ access to complementary and “tangible” assistance was also widely documented in the evaluation report of the IFRC-JNRCS CBHFA project carried out in December 2015, a report that even lacking a standard evaluation structure, could have been useful to identify main challenges and opportunities of the approach and better define the last year of the intervention.

⁷⁶ Refoulement means the expulsion of persons who have the right to be recognised as refugees.

⁷⁷ Source: “Securing Status” Syrian refugees and the documentation of legal status, identity, and family relationships in Jordan, International Human Rights Clinic-Harvard Law School (IHRC) and NRC.

⁷⁸ 11 out of the 15 Beneficiaries’ priorities identified in that Evaluation report are directly related to the refugees’ need of obtaining complementary support (beyond awareness sessions), Literally: “*Material help-house rental fees, Medical aid (Medication), Cooperation between different programmes, More support for children and mothers, First aid bags, Aiding tools for disabled people, Clothes-blankets-baby milk, Health centres for Syrians, Legal services, Free medical days and Covering deliveries in JNRCS*”. Throughout that document, there are numerous references to the need of assistance and support.

⁷⁹ That decision seems to have been taken by a simple feasibility and activity oriented analysis, that will be further developed under Effectiveness.

⁸⁰ Recommendations were already included in the 2015 Health Access and Utilisation Survey (HAUS): “Pilot provision of cash to refugees to offset the cost of accessing health services at Ministry of Health facilities and strengthen links with agencies providing cash assistance to support transport costs to access health services for vulnerable refugees would help to address financial barriers for accessing the health system”.

The potential for the **use of social media** for communicating with the affected population and even with volunteers could have been considered, when according to the “Findings from Consultations within Syria and Among Syrian Refugees in Jordan”⁸¹:

“Most Syrian refugees in Jordan have access to cellphones — half (53%) have access to smart- phones and one third (37%) have access to feature phones. After television (92%), social media or messaging (51%) was the most common ways to learn about receiving aid and assistance. Particularly outside of refugee camps, more than one third (39%) of Syrian refugees use social media or messaging to find out about support and assistance, either citing Jordanian sources of information (29%), Syrian sources (48%), or sources from other countries (31%) as the most useful.

Facebook was the most commonly used form of social media or messaging (85%), with almost two thirds (60%) of respondents logging on a few times a week or more.

Whats App seems to be the predominant messaging service used by Syrian refugees in Jordan: two-thirds (64%) use WhatsApp every day, and one-fifth (20%) use it a few times a week. WhatsApp usage in general is more common in urban locations (88%) than rural (79%), and slightly more common among men (89%) than women (82%). WhatsApp is considered to be a low cost communication channel that is effective and widespread⁸²”.

Other key strategic elements, such as the training approach, IFRC management, partnerships, JNRCS branches’ role and participation and CBHFA volunteers’ selection are analysed under Effectiveness (section 5.C of this report).

The benchmarking of some CBHFA components with other similar interventions in Jordan⁸³ are analysed under sections 5.B. (Targeting and Coverage), 5.C (Effectiveness) and 5.D (Efficiency) and also in relation to the GRC-JNRCS CBHFA approach (implemented since 2015 in Irbid).

⁸¹ “Community Consultations on Humanitarian Aid, Findings from Consultations within Syrian and among Syrian refugees in Jordan”, World Humanitarian Summit Istanbul, May 2016.

⁸² Virtually no other platforms — Twitter, YouTube, Instagram, Skype — were reported to be used by Syrian refugees in Jordan.

⁸³ Although the benchmarking exercise was initially planed as well with the CBHFA approaches in the MENA region, the information collected did not allow to carry out that exercise.

5.B TARGETING AND COVERAGE

5.B.1 Is the Project reaching the right areas and the right people?

5.B.1.a) Geographic targeting

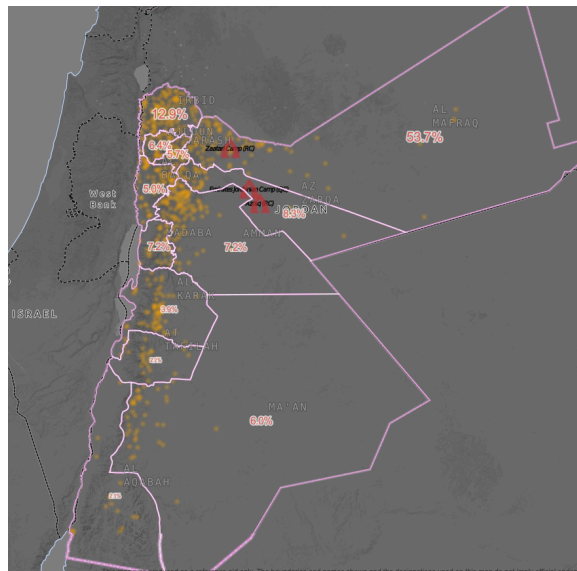
The deliberate choice to target out-of camp population is, from a protection and assistance gaps' perspective fully justified. At the time of starting the CBHFA intervention, it was a population underserved if compared to the assistance provided to the existing UNHCR camps.

The second step, the governorates' geographic targeting was also justified).

According to the different interviews held, the rationale for the choice of the governorates was (#1) the ratio of Syrian refugees out of Jordanian hosts, combined with (#2) the lowest ratio of CHW / registered refugees' population (benchmarking with the Sphere minimum standard, which is 1 CHW / 1,000 , 1:1000).

- Although it has not been possible to obtain the information for 2014, the available data for 2015 (the 4Ws⁸⁴ matrix of the CHTF), helps to confirm that the addition of one new governorate (Balqa⁸⁵) in the 2016 proposal, was clearly guided by the CHW ratio per registered Syrian refugees).
- There are references, as well in the 2015 proposal, that the new inclusion of Madaba was also guided by the non presence of community health actors.
- If analysing the current (2017) available information on registered Syrian refugees / Jordanians ratio per governorate:
 - ✓ The current governorates' choice is adequate.
 - ✓ Mafraq (included in the CBHFA intervention) is the governorate that would deserve, according to its ratio (53.7%) further investment⁸⁶:

Figure 3: Syrian – Jordanians Population Ratio per Governorate



Source: UNHCR. February 2017 screenshot from the web page <http://data.unhcr.org/jordan/situation-map/>

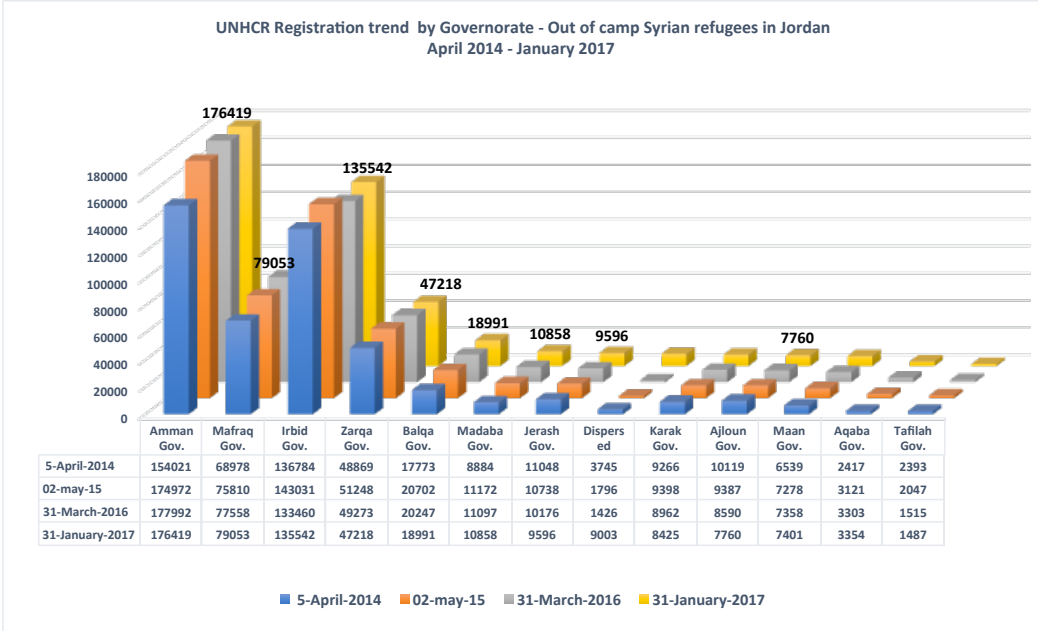
⁸⁴ Who is Working Where.

⁸⁵ Three Governorates had the lowest ratio: Zarqa, Balqa and Tafilah.

⁸⁶ See as well Table 9: CBHFA Volunteers distribution per Governorate (2016-2017 comparison) for further details.

To have an element of comparison with the registered refugees' case loads per governorate, the following figure shows the 2014⁸⁷-2017 comparison of out-of camp Syrian refugees' registration trend⁸⁸. The current total number of registered Syrian refugees in the Governorates where the CBHFA intervenes is highlighted in the label to better visualise the current (January 2017) figures⁸⁹.

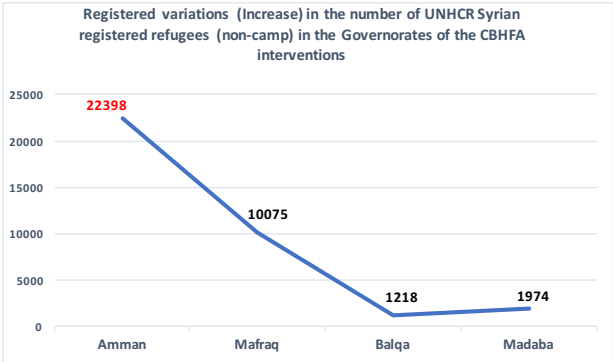
Figure 4: UNHCR Registration of Out of Camp Syrian Refugees by Governorate⁹⁰ (Evolution 2014 – 2017)



Source: Evaluation compilation based on UNHCR data

Four out of the Six governorates of the CBHFA registered an increase in the number of registered Syrian refugees for the period of intervention, what clearly backs up the geographic choice made alongside the implementation period. The only two governorates of the CBHFA that register a decrease in the Syrian refugees figures are Jerash (1,452) and Ajloun (2,359):

Figure 5: Registered Variations – Increase (2014-2017) of Registered Out of Camp Syrian refugees



Source: Evaluation compilation based on UNHCR data

⁸⁷ The initial figure is April 2014 (the closest date found to the start of the intervention).
⁸⁸ Administratively, Jordan's 12 governorates are divided into 52 districts, which vary in size and population.
⁸⁹ For the country (UNHCR registered Syrian refugees at 31 January 2017) Total Urban: 514, 669. Total Camps: 141,063.
⁹⁰ It is also worth mentioning that In Amman, UNHCR figures by 31st January 2017, there are also: 54,374 Iraqi refugees (88,5% of total registered case load).

5.B.2.b) Refugees vs host population and equity targeting

The purpose of targeting is to meet the needs of the most vulnerable. When a targeting system fails to reach all of the vulnerable people in need, individuals or groups can quickly develop critical needs. Targeting criteria must be then based on a thorough analysis of Vulnerability and Beneficiaries should be clearly identified (geographic location, Household, Individual profile, etc.).

“When they settle in a city, urban refugees are usually confronted with the same poverty problems as the local urban poor. Yet they also face additional challenges due to their refugee status: in most cases, they live with the constant fear of being arrested, detained and returned forcibly to their home country.

They are denied access to basic services such as education or health and are exposed to harassment, intimidation and discrimination. Because urban refugees tend to keep a low profile and are dispersed in the city, they often pass under the humanitarian radar.

Supporting and protecting refugees in cities is a new challenge to humanitarian organizations who are used to assist refugees in camps⁹¹”.

According to the information comparison on the economic situation of vulnerable Jordanian and Syrian refugees, the April 2016 CARE research⁹² is the most updated and methodologically reliable report that the evaluator could find. The main finding for Syrian refugees was that *“sources of income have drastically changed since 2015, with work and humanitarian assistance cited equally as respondents’ primary sources of income. Monthly income has decreased on average from 209 JOD in 2015 to 185 JOD in 2016. Accordingly, monthly expenditures have followed a downward trend since 2014, as Syrian refugees have less cash to cover their basic needs”*.

If comparing the monthly average income and expenditures of the sample of vulnerable Jordanians, the situation shows a higher monthly average income and expenditure for Jordanians: the monthly average income is 356 JOD⁹³ with a higher monthly expenditure of 411 JOD.

Although Jordanian host communities do not face the same challenges as refugees would (i.e. documentation status, access to employment, access to services etc.), they can experience different challenges instead, or a variation in scale in terms of need (around one quarter of the Jordanian population does not have access to universal health insurance coverage⁹⁴).

Vulnerable Jordanians benefit from various government-run social protection schemes depending on the type and extent of their vulnerability, but these programmes do not support refugees in need.

- The Ministry of Social Development also offers several protection programmes and has a mandate to support poor Jordanians.
- Refugees, however, are not eligible for any of the programmes it provides.

Another social protection programme is run by the Zakat Fund, administered by the Ministry of Awaqaf, Islamic Affairs and Holy Places. The Zakat Fund delivers cash and in-kind assistance only to HHs

⁹¹ Source: <http://urban-refugees.org>.

⁹² Riyada Consulting and Training was contracted to carry out CARE Jordan’s 2016 assessment, collecting qualitative and quantitative data on the needs, coping strategies, and perceptions of Syrian urban refugees and vulnerable Jordanian host communities residing in Amman, Irbid, Mafraq, and Zarqa. A stratified random sample of 2,079 persons was targeted, including 1,608 Syrian refugees and 471 Jordanian citizens. The confidence level was maintained at 95% and the margin of error is 2.4% for the Syrian refugee sample, and 4.5% for the Jordanian sample. Of those surveyed, 97.6% of Syrian refugee respondents were registered with CARE and had received assistance from the organisation (emergency cash assistance and psychosocial support).

⁹³ Almost double the monthly minimum salary of 190 JOD in 2016, which recently increased (February 2017 communication) to 220 JOD since March 2017. The minimum wage in Jordan is set by executive decree.

⁹⁴ Cited in the “Comprehensive Vulnerability Assessment”, Hashemite Kingdom of Jordan, Ministry of Planning and International Cooperation, published in 2016 with 2015 data.

who do not receive any other eligible benefits | Both Jordanians and foreigners are entitled to regular cash assistance – but a recent study found no evidence of refugees accessing transfers under this scheme⁹⁵.

On the contrary, the **support of refugees comes from international organisations, but this support has to be also directed to Jordanian residents** due to (as mentioned in the Context section), a specific requirement of the Jordanian Government that programming supports vulnerable Jordanians as well as refugees; it stipulates that either 30% or 50% of beneficiaries are Jordanian, depending on the type of support⁹⁶.

Even when it is good practice to include both populations (refugees and host) to enhance social cohesion and coexistence, the **mandatory inclusion of Jordanians** (government requirement) in all **refugees' assistance projects conflicts with the basic humanitarian principle of Impartiality and targeting by vulnerability** and not by status, nationality, etc. In that sense, it would be coherent, to be incoherent (not aligned) with the Government of Jordan's policies. **IFRC** (due to its different status and non-mandatory reporting to the MoPIC), **is in an unique position** (if compared with the rest of INGOs) **to implement a principled humanitarian targeting**.

According to reliable sources, the government also instructed humanitarian organisations (through the MoPIC⁹⁷) to serve only refugees with complete documentation, that makes it even more justified to try to reach and assist those categories, presumably that are more deprived and at a higher protection risk.

It is also important to highlight that the standard approval letter that NGOs receive for Refugee assistance projects' approval from the Ministry of Planning and International Cooperation (MoPIC)⁹⁸ for which the process was already long and not always clear⁹⁹, stated that the NGO in question is permitted to assist only refugees with new Mol cards.

Given the acuteness of the most vulnerable refugees' needs, diverting humanitarian resources from refugees in dire need to target Jordanian hosts affected by poverty/structural needs that have dedicated social programmes, would only make partial sense from a cohesion perspective and for a limited number of activities. In any case, the main focus of any humanitarian intervention in the current context, should be, from a principled humanitarian action perspective, on refugees.

5.b.1.c) Vulnerability targeting – priorities within the refugees' caseload

The **targeting of refugees** and especially those **without valid refugee documentation**, as the main

⁹⁵ A mapping of social protection and humanitarian assistance programmes in Jordan. What support are refugees eligible for? . ODI – Maastricht University, Working paper 501. January 2017.

⁹⁶ According to different reports (Danish Refugee Council, NRC) and even the HIP 2016 from ECHO, the condition for approval of any refugee project was in 2014, that at least 30% of the caseload had to be Jordanian, and it was changed to 40% or according to other sources, 50%. No directive or instruction on this request could be found in any of the publically available MoPIC documents.

⁹⁷ The process was “used by the Ministry to redirect the type of interventions according to the Government of Jordan's priorities, often in contrast with those of the Humanitarian Community and of the donors. For instance “hardware projects” are prioritised over protection/psycho-social assistance”. Source: “Strategic Programme Document”, Danish Refugee Council, 2014.

⁹⁸ Already before 2015, Refugee assistance projects need to receive the authorisation of the Ministry of Planning and International Cooperation (MoPIC) which was entitled to request modifications to the project design.

⁹⁹ The process was “used by the Ministry to redirect the type of interventions according to the Government of Jordan's priorities, often in contrast with those of the Humanitarian Community and of the donors. For instance “hardware projects” are prioritised over protection/psycho-social assistance”. Source: “Strategic Programme Document”, Danish Refugee Council, 2014.

focus of any intervention is, **in 2017, more relevant than in 2014**. This is mainly due to: (#1) the widely documented deterioration in the Syrian refugees' capacity to cope with the monthly survival expenses, (#2) the shortfalls in humanitarian assistance that meant that many Syrian refugees in urban areas have reduced access to public services and assistance, combined with (#3) the restrictions imposed by the Government and the hurdles of getting health and other priority assistance), and (#4) the increase in protection related risks and resorting to severely negative coping mechanisms.

Whilst the **largest groups of concern**¹⁰⁰ are **refugees** who are **ineligible to receive new Mol cards and refugees who are eligible**, but have not yet obtained new Mol cards because they **lack the documents** necessary to receive a card through the normal issuance process, all IFRC interventions (not only CBHFA) in Jordan are addressed to registered Syrian refugees. The CBHFA has been addressed to both: Syrian refugees and Jordanians.

At the same time, the **need to intervene** as well with other **non-Syrian refugees** clearly emerges. Some of those non-Syrian refugees, due to their reduced levels of assistance and access to subsidised services and even more bureaucratic hurdles encountered than Syrians, could be exposed to similar or even worst conditions than some of the Syrian refugees. As an example of the different hurdles, this is the comparison between the Syrian, Iraqi and Non-Iraqi / non-Syrian refugees health fees:

- Syrian refugees, with valid UNHCR registration and Mol card, can use government health services at all levels at the non-insured Jordanian rate.
- The Public Health Care Services are available to Iraqi refugees at Ministry of Health (MoH) facilities at the non-insured Jordanian rate while they must pay the foreigners' rate to access secondary and tertiary level services.
- Non-Iraqi/non-Syrian refugees are charged the foreigners' rate when utilising MoH services at all levels.

5.b.1.d) Coverage of the CBHFA intervention

CBHFA volunteers

The 2015 and 2016 volunteers' figure is neither proportionate to the refugees' case loads in the governorates nor to the Syrian/Jordanians ratio.

This is the distribution of volunteers as per the 2015 and 2016 proposals:

Table 10: *CBHFA Volunteers distribution per Governorate (2016-2017 comparison)*

Governorate	CBHFA volunteers (2015)	CBHFA volunteers (2016)
Amman	40	90
Jerash	6	10
Ajloun	4	10
Mafraq	10	10
Madaba	10	10
Balqa	-	20

Source: Evaluation compilation based

The 2016 structure was devised for 150 CBHFA volunteers. As per January 2017, there are 132 active volunteers:

- 79 Syrian, 52 Jordanian and one Iraqi (37 M / 95 F).

¹⁰⁰ Refugees without new Mol cards live in situations of legal uncertainty, without access to essential services and at risk of arrest, detention, forced relocation to refugee camps, and possible "refoulement" (forced return to a country where they may be subjected to persecution).

- The 2015 figures reached 50% M / F split when the incentives for transportation were the same as in 2014: double that of in 2016).

Comparative coverage with other organisations participating and reporting to the CHTF shows that IFRC-JNRCS-GRC account for more than 50% of the total number of reported CHVs:

Table 11: Reported National distribution of Community Health Volunteers per Governorate (non-camp mapping) – January 2017 figures

Governorates	UNHCR Registered Refugees (31-January-2017)	Ratio Registered refugees / CHVs as per figures confirmed through the CHTF (January 2017)	Total of reported CHVs	JNRCS (IFRC)	JNRCS (GRC)	Other Organizations
Amman	176419	1649	107	67		40
Mafrq	79053	1719	46	11		35
Irbid	135542	1936	70		25	45
Zarqa	47218	7870	6			18
Balqa	18991	826	23	18		5
Madaba	10858	679	16	10		6
Jerash	9596	600	16	10		6
Dispersed	9003	0	0			
Karak	8425	2106	4			4
Ajloun	7760	485	16	10		6
Maan	7401	1234	6			6
Aqaba	3354	1118	3			3
Tafilah	1487	0	0			0
			313	126	25	174

Source: CHTF January 2017 data

The available breakdown per governorate shows a certain degree of overlapping with other organisations (mainly in Amman), that would deserve further clarification.

District / Subdistrict / Communities covered

What is not clear is the precise intervention location within each of the Governorates per each of the years of intervention, the decision making behind the choices made, as well as the total population per community, different population categories (registered refugees, non-registered refugees, host population), etc. in each of the areas/ communities that were included in the different proposals.

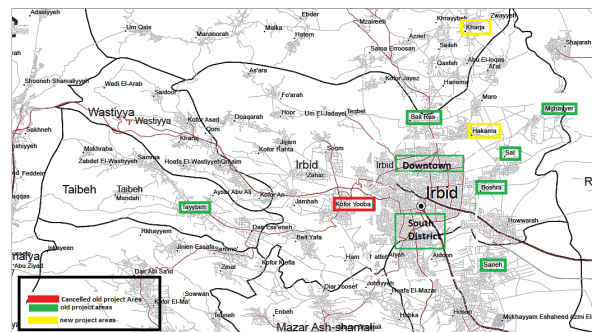
The need for getting that information is not only based on accountability purposes, but a priority when considering the evolution of the situation (negative) for many Syrian refugees, who have lost their savings and are indebted, and have been forced to move towards more precarious shelters (unfinished houses, substandard buildings, Informal Tented Settlements (ITs) and/or overcrowded shelters).

- According to the different interviews held with the CBHFA volunteers, many of them mentioned that some of the most vulnerable groups are located in more precarious and peripheral

neighbourhoods – including ITSs and many of them without valid refugee documentation are facing significant barriers in accessing basic services.

Both the historical and the current information on communities/areas covered and their identification on a map is missing and despite of several requests by the evaluator, that basic information could not be provided by the project. This contrasts with the clear identification and location of the GRC-JNRCS area of intervention in Irbid (tracking old and new project areas), that is identified as a good practice and should be replicated by the IFRC-JNRCS project:

Figure 6: GRC historical Geographic Coverage within the Irbid's Governorate (February 2017)



Source: Screen shot from the GRC office map

Number of direct Beneficiaries covered with the intervention

The above mentioned limitations do not allow us to validate the estimations of the number of beneficiaries reached by the project (which is a maximum cumulative figure of 78,500) – see Table 12 below.

- The numeric figures show an important level of activities, but the precise geographic coverage (district, sub-district, communities) is not tracked on regular basis and the estimated population for those areas was not collected. So the simple addition of the population to be targeted in each of the proposals to obtain a cumulative figure of beneficiaries reached could create a double or even a triple counting due to a partial or total overlapping over the years. That is the reason why the reported IFRC-JNRCS figure of beneficiaries cannot be validated in this evaluation.
- The available breakdowns per categories are quite generic and it is not possible to further refine them. What is available is a numeric counting of activities (very well structured and followed in some areas with a new tool that has not yet been used as a standard in all the governorates).

Table 12: Cumulative figure of targeted population / direct beneficiaries of the CBHFA intervention (2014 – 2016)

15 February 2014 – 15 November 2014	01 March 2015 – December 2015	October 2015 – March 2016	31 st March – December 2016 (with no-cost extension until the end of March 2017)	March – December 2016 (with no-cost extension until the end of March 2017)	Cumulative Figures reported for the period February 2014 – November 2016
6,000 beneficiaries (CBHFA & PS) – initially Syrian refugees	33,000 Syrian refugees and host community	7,500 beneficiaries – Syrian refugees and host community	JNRCS volunteers (complementary training)	32,000 beneficiaries (CBHFA & PS) – Syrian refugees and host communities	Unknown: up to a maximum of 78,500 (both categories: Syrian refugees and host population) Volunteers: 1,107

5.C EFFECTIVENESS

5.C.1 To what extent have the program objectives been achieved and what were the major factors influencing the achievement or non-achievement of these objectives and what other alternatives could be tried?

Outcome and Output level (effects in the target population)

The available information has not permitted us to have a clear picture on the intervention, as well as of the quality-outputs of the different components.

- None of the different formulations/proposals used the Logical Framework Approach methodology or format (IFRC programme – project planning guidance) and only the 2016 formulation included Output indicators¹⁰¹, that has made the project, too much Activity versus Output oriented. The same applies to the M&E System (not standardised for all CHVs-areas and full activity counting oriented)
- Just as an example, for the Outcome and its corresponding indicator: “Improved wellbeing, resilience and peaceful co-existence among 32,000 (CBHFA: 22,000 and PSP: 10,000) vulnerable Syrian refugee and host communities in Jordan”, the indicator defined was: % increase in health knowledge among Syrian refugees and host community members. That indicator shows a rising awareness or information visits’ immediate effect, and can be a first step (knowledge) towards a change in health seeking behaviour, etc. but by no means, measures the defined Output.

What can be confirmed from different focus groups carried out during the 2014 and 2015 base lines and evaluation is that beneficiaries acknowledged, with some variation, that they have been exposed to useful learning sessions concerning medical diseases and health matters, becoming more aware of a number of preventive measures that were promoted through home visits.

Reporting mechanisms are based on a general narrative report, purely activity based (that collects the information in hardware/paper¹⁰² copies) and it is not put in relation to vulnerable groups’ targeting, coverage and positive changes in the targeted groups.

As already mentioned in the Limitations section of this report (4.C): “the CBHFA project has different base lines and intermediate measurements but with important methodological limitations, that does not allow their results’ validation”.

The difficulties associated with short-term funding cycles (9-10 months), compounded with the delays in implementation and the insufficient technical preparation of the implementers, have contributed to the non-validity of the information obtained for the purposes initially verified.

- For short-term / emergency type activities, other type of techniques (like regular FGDs with representative groups, following a purposive sampling approach) could have been used.

Design factors affecting effectiveness

As mentioned in previous sections, design and formulation choices and weaknesses have enormously conditioned the interventions’ possibility of being effective.

¹⁰¹ The indicators included in that proposal, either (#1) don’t measure their correspondent Outcome or Output or (#2) are of process-type (not results oriented), as they should be to measure Outcome / Output level.

¹⁰² No use of portable devices and software has been made for reporting purposes (partially due to the IFRC difficulty to have a permanent Information Technology (IT) referent. 50 tablets are kept for the CBHFA project and only used once for a base line measurement that was not successful.

All the stakeholders interviewed that were involved in the first phases of the design and implementation of the CBHFA project responded that the 2014 focus was on Syrian refugees. Some of them also clarified that the main idea behind the first proposal was that Syrians were new in their communities, they had recently settled and they did not know about the services, they did not find their way around the public health system, etc. In that context, service information to facilitate their access to the MoH and other organisations and feel integrated were the main reasons behind the first design.

But when checking that rationale with the written proposal, the specific focus on Syrian refugees is not there nor in successive proposals. This is because the activities are addressed to both communities (Syrian and Jordanian).

- Equity amongst different vulnerabilities/situations is not sufficiently considered. It seems that the main reason behind the intervention (humanitarian purpose) is not sufficiently clear or at least not clearly verbalised.
- All target population's categories receive similar or the same type of activities, but the differences in profiles and situations are too important, as well as the needs of delivering specific support to those identified as most vulnerable (including persons living with disabilities, a high number within the Syrian refugees' caseload), from that has seriously affected the effectiveness of the intervention and its alignment with a key humanitarian principle: "Impartiality".

Some key strategic and practical project's aspects were not sufficiently considered or developed in the first proposal and were left "open" to implementation and interpretation, that has negatively affected the implementation and consequently, the overall Effectiveness' intervention. Some of those were as important as:

- How the selection process of the CBHFA volunteers was going to be carried out: through a community participation and validation process (that would allow to identify one Syrian and one Jordanian), through a fully decentralised JNRCS branch' process?, project oriented or with a long-term recruitment vision? with or without validation from the CBHFA programme?, etc.
- Would the volunteers be mobile or would they be attached to their communities¹⁰³?
- Considering the complexity of targeting in urban and peri urban settings, how the Project was going to be targeting priority areas of intervention (geographic targeting at district, sub-district and community level) within the prioritised governorates.
- How the Project would be monitored and outputs/outcomes measured. There was an absence of Indicators and external hypothesis/Assumptions for the intervention (no logical framework matrix was available to guide the Project).
- How performance's targets for CBHFA volunteers were going to be defined: purely quantitative-activity based?, in relation to target population per community or more linked to specific vulnerable / refugees' groups?,
- Which activities were going to be reinforced for community cohesion (Jordan host population and Syrian refugees) and which ones specifically addressed to the Syrian refugees?
- What type of needs and what could be done by CBHFA teams if non-registered Syrian refugees were found in the same communities of intervention?.
- How and who should be doing the mapping of services and its update if considering that the traditional "community mapping" of the CBHFA rural approaches was not adapted to the situation in the areas of the intervention, where sub-district, district, governorate and even national level mapping of services would be needed?

¹⁰³ Since 2014, the CBHFA project has been implemented following the same community approach than in rural areas and areas with fixed population, where it makes sense to concentrate on having a permanent Volunteer that can act as focal point per community.

- How the First Aid component of the CBHFA approach was going to be delivered to communities, taking into consideration that CBHFA volunteers in Jordan could not act as first aid referrals points¹⁰⁴ and that the ICRC was already having a First Aid training programme in collaboration with JNRCS focusing on Jordanian nationals and not refugees¹⁰⁵?

Factors hindering implementation - effectiveness

Management related factors

The **JNRCS' internal management structure** and **organisational culture** and the **insufficiently detailed IFRC-JNRCS partnership framework** seriously affected (and still affects), the CBHFA project implementation.

- JNRCS has out-of-date practices, that caused: (#1) serious delays in decision making and approvals for activities to take place (despite them being in the proposal and letter of agreement), (#2) delayed payments to CBHFA volunteers and staff (leading them to be frustrated and demotivated), (#3) delayed financial reporting, thus new transfers of funds and consequently resulted in delays in the implementation of activities.
- HR limitations. The limited JNRCS availability to discuss and resolve issues and to conduct sufficient monitoring of the activities continues, restricting the institution's ability to be able to provide adequate support to the CBHFA project officers (dependent from JNRCS):
 - ✓ In practice, only one focal person at the JNRCS holds CBHFA, First Aid, Disaster Management and Cash programmes with the IFRC, PNSs and ICRC, that makes impossible (although attempted), the requested time allocation to properly follow CBHFA, which is implemented with 2 different approaches (GRC – IFRC).
 - ✓ A Health Coordinator was recruited by JNRCS but left without achieving the expected results.

The working framework agreement between IFRC and JNRCS is more a generic partnership document (IFRC – National Societies¹⁰⁶) than a layout of detailed obligations and relationships with the Amman office and the different branches (including supervision) around a project implementation plan. That results in two speeds of ownership and implementation of the CBHFA project. IFRC influence is also difficult to guarantee with the current partnership agreement.

The lack of JNRCS experienced staff in health and/or humanitarian programmes meant that the IFRC support had to focus disproportionately on capacity building and direct involvement in bureaucratic and administrative processes with the JNRCS to follow the commitments with donors. That required a lot of time and energy and, taking away time from the CBHFA project development.

Accountability – Transparency related factors

The IFRC had a very timid role in terms of establishing responsibilities when serious allegations of JNRCS abusive/coercive power were reported.

- IFRC insufficient enforcement of the “Fraud and corruption prevention and control policy” with regards to serious allegations of (as the minimum) systematic abuse of power by the JNRCS towards different HR assigned to the project. This would have deserved and still deserves, an IFRC

¹⁰⁴ The Jordan legal framework allows First Aid practice to doctors, nurses and paramedical, but not to volunteers (except in accidents, when they would be acting as individuals).

¹⁰⁵ The First Aid approach is not really delivered at community level. Due to legal limitations, the volunteers cannot be a community first referral or have a first aid kit for the community. The IFRC-JNRCS strategy did not consider to directly train community members in first aid, that would be more appropriate and would also help to perceive the added value of the CBHFA volunteers at community level. This is something that GRC-JNRCS is on the contrary implementing, and according to them, with a lot of success at both (community level and iNGOs/NGOs in Irbid).

¹⁰⁶ Within the Red Cross and Red Crescent Movement, the host National Society is not usually considered as an implementing partner (although a back donor may look at it that way). Relationship is not between a donor and recipient but equal partners (at least, that is the expected spirit).

Geneva involvement and the follow up of the actions detailed in the mentioned policy.

- At a given moment, this lack of IFRC action seems to have demotivated staff and created a lack of trust in the IFRC's ability or willingness to investigate the reported wrongdoings and grant the comprehensive anonymity and protection for those reporting the allegations (to avoid all possible retaliatory actions).

5.C.2 Has there been any unforeseen or indirect effects, either positive or negative (on the communities, volunteers, National Society (JNRCS))?

What can be extracted from the different project documents and also from the CBHFA volunteers' group discussions as unforeseen or indirect effects are:

Positive effects

- The most positive effect of the decision to have both Jordanian and Syrian nationals in the same pairs and teams, shows cohesion and a positive model of coexistence, that in certain areas with high tensions, could have had further impact. This pairing of different nationals in the community work seems to be quite unique for the project (if compared with the other CHTF organisations' reported working model: with less Jordanian nationals' participation).
- A contribution to "normalise" and reduce the gender gap when the CBHFA home visits and activities are done in Male / Female pairs¹⁰⁷. In some cases, it was mentioned that it helped to change perceptions in certain areas that were very conservative and in others it was said that it put pressure on the CBHFA female volunteers, but in the majority of the cases, it was perceived as a positive element.
- In some communities, population feeling of being considered and not neglected.
- Increase in the technical capacity of the trained staff that could contribute in the future to the improvement of community work and health care in the country (even those that were trained and that are no longer collaborating with the intervention).
- Increase in the population awareness of key health and psychosocial topics and some key success stories in some Governates were shared during the evaluator's visit.
- Some of the Volunteers also pointed out that they gained trust, self esteem and social abilities that are already useful in their personal/family and professional life.

Negative effects

- The most regularly pointed out negative part of the CBHFA work was consistently reported in all the CBHFA group discussions carried out during the evaluation, and it is referred to the increasing difficulties to confront dire and acute needs of the refugees and not being able to do anything about it (no possibility to give assistance or support). That has created, in some cases, an impossibility to carry out home visits and an overall reduction in its total number throughout the years and a negative community perception that will possibly reduce institutional acceptance.
- Some sentences extracted from the discussions (volunteers explaining what some families told them) illustrate the challenging situation: *"If you cannot give me any assistance, go away", "Stop informing me about the NCDs; I need medication". "I need support and you come here to talk"...*

¹⁰⁷ Even if in the HH there were women alone and the male was not allowed to enter, it was still considered positive as a "model" of change.

5.C.3 Does the Project have an effective coordination linking with other interventions, including JNRCS programmes such as CTP, PSP, Youth and Livelihoods. How can integration be improved in the future?

The project has participated in different coordination forums (external and internal) and created spaces for bilateral and multilateral exchanges that have not been always fruitful. The missed opportunities are more evident in the PSP component, that could have been more optimised; a referral pathway and protocol was created and agreed between IFRC-JNRCS and DRC but it seems not to have been put in place. Other initiatives within the RC movement are not linked.

External participation

The IFRC is regularly attending the inter-sectorial coordination mechanism established throughout the Country as the Humanitarian Country Team (HCT), CASH Working Group, Country Health Sector. JNRCS has recently (2017) started to attend the Country Health Sector monthly meetings.

The IFRC/JNRCS was leading (until 2016), the Inter – agency Community Health Task Group (CHTG) at Country level in Jordan and still participating in the monthly meetings. The objectives for this group are:

- Increase health service accessibility and coverage by raising refugee and host community awareness of the available health services and by strengthening the referral mechanisms in place.
- Promote a sense of ownership and control of affected communities of their own health through community capacity building and increasing community participation.
- Some key tasks are the development of a standard job description amongst humanitarian agencies on the role and responsibilities of a community health worker/volunteers and a bank of resources of training and IEC (Information Education and Communication) materials.

Internal

RCRC health partners meeting In addition to the CHTG, the Movement coordinated until 2016, a health partners monthly meeting. The objective was to share who is doing what where, reduce duplication, share resources, share experiences/knowledge and promote a one RCRC approach.

With the German RC (the other country CBHFA implementer), a close working relationship was developed and it is still maintained throughout. This led to sharing of tools and resources and even joint training at times.

5.D EFFICIENCY

5.D.1 In the current Jordan context, are there alternative models that could improve CBHFA planning or reduce costs?

The overall Efficiency of this intervention is considered low, mostly due to the non- appropriateness and the non-adaptation of the chosen strategy to cope with the main health population needs.

An improvement in the above mentioned points, with a rationalisation of the training approach and CHBFA volunteers' time allocation and a better management and partnership's definition (see section 5.D.2), would contribute to a clear improvement in the overall CBHFA planning and efficiency of the intervention.

More detailed suggestions are given in the Recommendations' section of this report. Here, the focus is in training (which has been one of the main projects' activities).

Training approach

The training approach was fully **centralised** by JNRCS in Amman:

- 1 Training of Trainers CBHFA Master facilitator training was carried out in early 2014 by the Egyptian Red Crescent, but only two participants were ultimately linked to the project. No documented information on the JNRCS rationale for the participants' choice could be found and no other ToT were delivered.
- The rest of the training (modules to the CBHFA volunteers), have been delivered, in its majority by only one JNRCS trainer in Amman, losing the opportunity to: (#1) create a permanent network of trainers that could facilitate replication at Governorate level (for other volunteers and organisations), (#2) to improve the effectiveness of the training delivered if counting the reduced number of participants¹⁰⁸ that would allow more interaction or (#2) directed to the target population (as the GRC-JNRCS is doing in Irbid with two First Aid trainers).
- There are doubts about the quality and standardisation of some of the training delivered. The fact that many of the documents, training contents, etc. are not systematically translated into English, compounded with: (#1) the JNRCS adaptation and production of materials on topics and modules where both: ICRC and IFRC have a vast standardisation and manuals already available, (#2) No systematic pre and post test results are available or translated into English, (#3) the non-Arabic abilities of the IFRC delegates to monitor and supervise the overall content and delivery of modules, contribute to raise these doubts.

The **number of trainings** that **CBHFA volunteers** have gone through is totally disproportionate (too many topics to be effective), and more appropriate for a paramedical volunteer than for the Health and Service information purpose initially envisaged for that network.

- Training has accounted for a high percentage of the total activities and resources carried out since the start of the intervention.
- A demanding calendar for volunteers to be able to follow the whole yearly plan: in 2016, 20 training days in total for each of the CBHFA volunteers, that can hinder participation and commitment amongst volunteers. As an example: 132 CHVs were trained in 2016 (37 M / 95 F) but only 35% - 46 CHVs (14 Male and 32 Female) assisted at all training (9) delivered throughout the year.

¹⁰⁸ As the training was centralised, many times participants from different governorates gathered together and were higher in number than 40, that also conditioned the venue place, the cost of transportation, etc.

- Capacity building efforts to the volunteers have been made almost exclusively through training, when capacity building goes beyond training. Without a correct planning at Governorate level and continuous presence of qualified staff for supervision, even in the best case scenario of a successful and sustained training, pressures in the JNRCS branches and other types of difficulties would need to be monitored to obtain positive results at community level.

The number of trainings delivered is **not proportionate** with the regularity and type of **activities** to deliver on a monthly basis (lacking a comparative Effectiveness-Coverage and Efficiency analysis).

- If carrying out a basic **efficiency analysis**, considering the **2016 training budget**¹⁰⁹ (37,500JOD) in comparison with the maximum number of hours per month that the **current** number of **CBHFA volunteers (132)** can **work** due to the incentives reduction policy (a maximum of 8 hours/activities a month), the result is a maximum of 1,056 h. per month, that **could be done** by **26 CBHFAs volunteers if they worked 40 hours a month** (as it was done in 2015).
- If comparing the 2016 annual **training budget** with the number of training days delivered during the year 2016 (37,500 JOD - 20 days¹¹⁰), an increase in the **CBHFA volunteers' incentives budget** (33,525 JOD) to a minimum ethical standard, it could be immediately feasible to reduce the number of training days to 8-9 days a year and allocate a proper budget line that would make the intervention effective.
- Other organisations don't base their calculations on hours per month. They define more refined targets per month per volunteer. IRD for instance, in one of the governorates stipulates 34 home visits a month and 53 referrals + Follow up for the 53 referrals per volunteer (done through mobile devices with ODK software and Referral forms), with a monthly incentive of 260 – 280 JOD.

Out of the different **topics** in which the CBHFA volunteers were trained, volunteers appreciate a lot for its content (usefulness) and practical approach, the **First Aid training** (delivered in 2 days).

- There is an overwhelming preference for that module. 97% of all the CBHFA volunteers that participated in the different evaluation's group discussions manifested their preference for this training, identifying it as their favourite.
- It was frequently suggested to create an advanced module.
- After consulting the available training material, that module is the best structured and could be considered as the most distinctive topic of the Red Cross and Red Crescent movement that could definitely be more exploited at the community level.

Violence Prevention (new 2016 topic delivered in one day) had as well a great acceptance amongst the volunteers. According to them, violence is widespread and the basic skills acquired to identify cases and have a basic intervention and/or referral was found very useful for their activities.

Out of the 20 training days delivered in 2016, only one day was allocated to the activity that would have been key: Referrals and Coordination. Other topics that some of the CBHFA CHVs suggested to reinforce were Behavior Change and Communication skills.

5.D.2 Were there sufficient and appropriate resources and support from both (IFRC and the National Society) to implement the project?

Different models of supervision – management were tried for CBHFA management at Branch level, that included a full time HR allocation in 2014-2015 (one per governorate) that was replaced in 2016

¹⁰⁹ Training budget lines do not include any running cost, or HR permanent staff salaries, that if calculated, would increase the reflected figure.

¹¹⁰ Training centralised in Amman during the year 2016.

by volunteers' focal points (a decision that was not based in a cost-effectiveness and efficiency analysis).

- The fact that some of the initially appointed human resources at branches' level¹¹¹ were either not the right match to the position or were not given space to work by the branch managers, would have deserved IFRC and JNRCS to apply problem-solving alternatives (including considering the GRC-JRCS model in Irbid, request a replacement and new recruitment of HR, request a change of attitude in some branch managers, etc.), instead of replacing the structure by volunteers with much less dedication and responsibility obligations¹¹².

A similar dynamic happened with the **drastic JNRCS unilateral decision to cut**, from the 2016 project, **volunteers incentives** (that were entitled to cover transportation expenses) **by half**¹¹³, without any further analysis or discussion.

- The JNRCS Youth-Volunteer policy and the Youth-Volunteer specific department interests seem to have guided the decision-making behind that JNRCS instruction to drastically reduce the CHVs incentives' scheme that had been in place in 2014 and 2015¹¹⁴. According to the different stakeholders interviewed, monthly incentives were cut by half "*because youth incentives are 5 JOD /day*"¹¹⁵ and that department wants to standardise the policy".
- This had, according to all actors interviewed (including CBHFA volunteers), serious and very negative consequences on both: the implementation of activities (that had to define a ceiling of only 8 activities per month per volunteer¹¹⁶) and an important loss of volunteers (mostly males) that obliged to enter again into a full cycle of new training (instead of refreshments).
- The decision to review the incentives should have been based on ethical, effectiveness and efficiency considerations and the overall alignment with other organisations doing the same type of activities (CHTF). It is also surprising to see that whilst IFRC-JNRCS volunteers are paid a maximum of 5 JOD per day with a maximum of 40 JOD per month, GRC-JRNCs are paid double per day and the number of days per month is defined according to the activities' needs.
- The amount defined under the unilateral JNRCS decision is simply unethical if considering:
 - ✓ the minimum salary in Jordan (recently increased to 220 JOD/month),
 - ✓ what other organisations from CHTF pay to their volunteers (in some cases, higher than the minimum salary, and most of all, if comparing the monthly incentives with the Minimum Expenditure Basket (MEB)¹¹⁷ and the Survival Minimum Expenditure Basket (SMEB)¹¹⁸ in Jordan and the fact that many of the CBHFA volunteers are Syrian nationals, confronted to a dire economic situation who have hardly any other income:
- In 2016 (November figures) only 132 active volunteers out of the 1,107 trained since 2014 (cumulative figure) remain. There is always a high turnover, which is linked to the nature of any volunteer work, but according to the interviewed CBHFA staff and volunteers, the drastic and "out

¹¹¹ Field officer assistants (One per branch).

¹¹² More details about the initial structure are provided in Annex V: Organisation Chart for the CBHFA Roll out (13-March-2014), that also included the Health Coordinator position.

¹¹³ That were defined at a maximum of 10 JOD/day and were reduced to 5 JOD/day.

¹¹⁴ And that was also aligned with the GRC, the CHTF working group and the IFRC Cash Transfer Programme (CTP) volunteers.

¹¹⁵ In the 2014 GoJ proposal, volunteers were paid 10 JOD/day, the Volunteers' supervisors (15 JOD/day) and the Field Officer Assistants (350 JOD/month).

¹¹⁶ That minimises the possibility to optimise the training efforts and activities at community level.

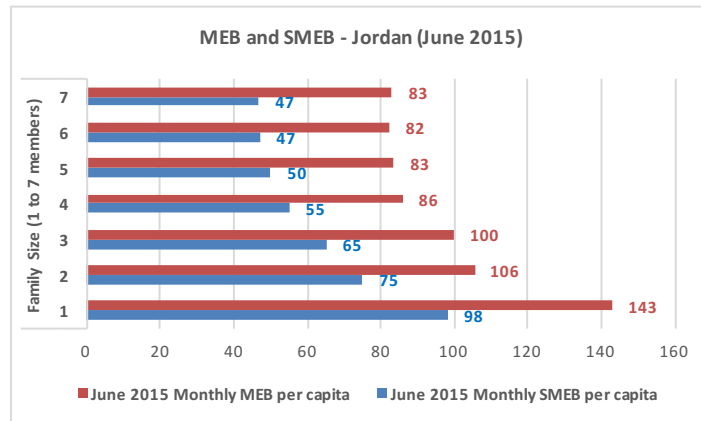
¹¹⁷ The Minimum Expenditure Basket (MEB) is a way of establishing poverty lines for refugee populations. It is emerging as the primary tool to develop a cost and market based expression of minimum needs of refugees in any given country. It broadly follows the notion of a "cost of basic needs approach". The MEB is the expression of the monthly cost per capita, which allows a Syrian refugee to live a dignified life outside the camps in Jordan. This implies the full access to all rights and represents the minimum needed to lead a dignified life outside the camps.

¹¹⁸ The SMEB is the expression of the monthly cost per capita which is the minimum needed for physical survival and implies the deprivation of a series of rights.

of the market” cut in the support for transportation-incentives has had a major impact in the **very low volunteers’ retention rate**: which is only **12%**.

The monthly incentive was 100 JOD in 2015, and it can be considered correct from a pure “volunteer” perspective. It was a little bit above the Jordanian SMEB for one individual alone and the equivalent to the average MEB for an individual in a HH of 3 members:

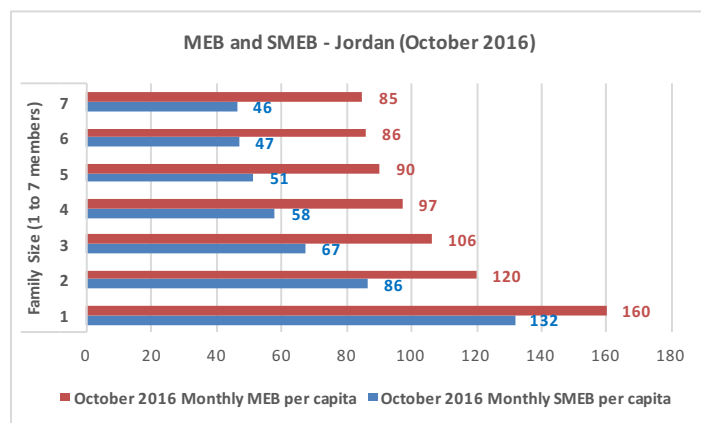
Figure 7: Minimum Expenditure Basket and Survival Minimum Expenditure Basket in Jordan (June 2015)



Source: Evaluation compilation based on MEB and SMEB data for Jordan

The monthly incentive was 40 JOD in 2016 and still the same in 2017 and it is simply unethical. It is equivalent to 30% of the Jordanian SMEB for one individual alone (132 JOD) and the equivalent of 38% of the average MEB for an individual in a HH of 3 members (106):

Figure 8: Minimum Expenditure Basket and Survival Minimum Expenditure Basket in Jordan (October 2016¹¹⁹)



Source: Evaluation compilation based on MEB and SMEB data for Jordan

Efficiency gains through a new CBHFA Volunteers’ selection and validation procedure

The 2016 new volunteers’ recruitment was, for the first time, also opened outside the previous JNRCS entourage¹²⁰ (through Facebook) to more applicants.

¹¹⁹ It was not possible to find the MEB and SMEB data for June 2016. The October 2016 data is the only information externally accessible for 2016.

The newly created selection and validation procedures defined by the CBHFA project officers, have undoubtedly been decisive in the successful profiles that were either recruited or validated in 2016.

- This shift was put in place to (#1) counteract previous weaknesses identified in some volunteers that had been directly recruited by JNRCS branches (were possibly and due to conflicting interests – family ties, their profiles did not match the minimum requirements to perform the tasks that were included for CBHFA volunteers in the years 2014 and 2015), and (#2) to improve the training’ level and effectiveness, as well as the activities’ reporting¹²¹.
- The current network of trained CBHFA volunteers have a huge potential and their level of commitment, willingness to do more and humanitarian vision mean they are a major asset for the institution and for the future project’s reorientation.

The **2016 new volunteers’ selection and validation process** that was set up by the JNRCS CBHFA staff team (represented in the following figure) is **good practice that could be replicated** not only in other JNRCS programmes with volunteers but also for the selection of CBHFA project’s staff.

Figure 9: 2016 CBHFA volunteers’ recruitment and selection process



Source: CBHFA Field Officer presentation

¹²⁰ Before the JNRCS Youth department had volunteers in their database. With the new volunteers’ selection process setup in 2016, the potential candidates go through a separate process (not with Youth department). Facebook has been key, having an average of 10 volunteers per day and collecting a total of 700 application whilst the recruitment was open.

¹²¹ That (according to the interviewed) was very challenging due to the different levels of education and capacities of the initial network of volunteers, that had made difficult the standard follow up of some parts of the modules, as well as the correct implementation of some monitoring and reporting mechanisms.

5.E CONNECTEDNESS

5.C.1 Do lessons from the implementation of this project indicate any changes to its design in the future to ensure an exit strategy establishes a community basis for the National Society, thus better enhancing connectedness / sustainability?

Concerning the choice of partnership connectedness, the IFRC decision to use local capacities (JNRCS), and using the existing JNRCS branches' infrastructure can have, in theory, a better contribution to connectedness than in the case where foreign capacities and resources had been utilised in a parallel-vertical set up, but this needs to be put into perspective.

The IFRC-JNRCS partnership, due to the long JNRCS presence in the country, could also contribute to Connectedness by its influential role if JNRCS is considered a reliable partner by the Government and international actors, thus affording a strong relationship and an influential voice with Authorities. That influential role could have been useful for the project purpose but at least in the relations with the MoH, the added value has not been found¹²².

- The JNRCS partnership with the MoH¹²³ for the setting up of an integrated health approach, linking communities with primary/secondary health has been acknowledged by different actors interviewed as quite a controversial issue inside JNRCS. The fact that there is a clear deficit and difficulties in the exchange-coordination between the JNRCS and the MoH and that JNRCS does not have a health department, even when the IFRC and some PNSs vision contributed to its set up¹²⁴, is a serious obstacle to connectedness and minimizes the potential lobby and advocacy role of the National Society.
- JNRCS Interest in Institutional Capacity Building and the development of long-term Youth department/volunteers is, in the current humanitarian situation not compatible with the need to maintain a project orientation of the CBHFA volunteers that would have to focus on being effective and efficient in the short term (project orientation).

What is also a fact is that there has been limited integration of the previous evaluation's Findings that had already identified, as a priority, the need for securing key referrals and looking for complementary assistance.

The alignment with country strategies and priorities is, in the current situation, the best approach to Connectedness. It is confirmed that the community health and information approach and by similarity the CBHFA approach, is (as reflected in the "Health Sector Humanitarian Response Strategy Jordan 2017-2018"), fully aligned with the current national priorities.

CHVs themselves, in that strategy, are entitled to be focal points for Information-Referrals, that opens as well the pathway for further investment in that area.

¹²² Different IFRC attempts to engage MoH with JNRCS at branch level were not successful, apparently due to JNRCS reluctance to the involvement.

¹²³ The fact that there is a clear deficit and difficulties in the exchange-coordination between the JNRCS and the MoH has been acknowledged by different actors interviewed as quite a controversial issue, also affecting the possibility of creating a more formal framework at national level.

¹²⁴ PNSs and the IFRC contributed for more than one year to a JNRCS health coordinator position but they refused to continue given the non-decision making capacity and weak position of the selected JNRCS profile.

6. CONCLUSIONS

Relevance-Appropriateness

Overall, the rationale in early 2014 (when it was designed) to launch the CBHFA and the IFRC prioritisation of an intervention to respond to the community health and information needs of the Syrian refugees living out of camps was, from a needs-based perspective, highly relevant and fully justified by:

- the possibility to reduce Syrian refugees' pressure and financial burden on the Jordan public health system (that when the project was formulated, was granting free access to Syrian refugees), by reinforcing key behaviour change topics (preventive approach);
- the possibility of reducing, through improved access to information, enhanced coordination and referral mechanisms, the main barriers limiting refugees' access to health care that had been at that time identified (more related to bureaucratic-administrative hurdles and lack of knowledge about the Jordanian health system and referral processes).

In spite of its initial relevance, the CBHFA first design / formulation:

- did not sufficiently consider equity amongst different vulnerabilities/situations. All target population's categories would receive similar or the same type of activities, but the differences in profiles and situations are too important, as well as the needs of delivering specific support to those identified as most vulnerable, that has seriously affected the effectiveness of the intervention and its alignment with a key humanitarian principle: "Impartiality";
- and was not sufficiently adapted to: (#1) the targeting challenges in urban and peri-urban settings, considering the relatively small size of country with high population density and easy transportation that would facilitate refugees' movements in search of livelihood opportunities and/or better access to services; (#2) the foreseeable deterioration of the protection environment associated with protracted displacement situations and more specifically to the specific protection challenges and needs of a non-camp refugee case load in a country that is not a party to the 1951 Convention on Refugees or its 1967 Protocol;

The relevance of responding to the most vulnerable refugees' health related needs, improving access to information at community level and effective referrals has increased over time. This is mostly due to: (#1) deteriorating access to the health system and worsening key health indicators (highly influenced by the November 2014 policy change from free public healthcare to requiring Syrian refugees to pay for health services in the public sector), (#2) the acute drop in the Syrian refugees' economic situation in Jordan and their resorting to negative coping mechanisms, (#3) the rising protection vulnerabilities in 2015 and 2016 (highly influenced by legal and policy changes happening in those years) and (#4) declining funds and changing priorities, from addressing humanitarian needs in benefit of the resilience and development agenda.

The limitations of what the CBHFA implementer can achieve with a stand alone intervention (intangible) in terms of connecting populations in high distress with other levels of assistance (tangible) to be delivered by service providers / organisations was not sufficiently taken into consideration in successive formulations (2015 and 2016), especially when: (#1) there is an insufficient offer and coverage (especially in the health sector and cash-based assistance) and (#2) there are external factors such as the legal status issues that limits what can be handled directly by the implementer.

Targeting and Coverage

Four out of the Six governorates of the CBHFA registered an increase in the number of registered Syrian refugees for the period of intervention, that clearly backs up the governorates' choice made alongside the implementation period.

- On the contrary, the historical and the current information on communities/areas covered within each Governorate and their identification on a map is not available for some periods of time, whilst the total population per community and different population categories' breakdowns (registered refugees, non-registered refugees, host population), are not available. This missing information is key to estimate the intervention's coverage and validate the estimations of the number of beneficiaries reached by the project (which, according to IFRC reports, reached a maximum of 78,500 Syrian refugees and Jordanian hosts - cumulative figure since the start of the 2014 intervention).
- In spite of the "right" Governorate targeting, the 2015 and 2016 CBHFA volunteers' figure is neither proportionate to the refugees' case loads nor to the Syrian/Jordanians ratio proportion by Governorate. Mafrqa is the Governorate that is clearly underserved by the CBHFA coverage.

Whilst the largest groups of concern are, since 2015, refugees who are ineligible to receive new MoI cards and refugees who are eligible, but have not yet obtained new MoI cards because they lack the documents necessary to receive a card through the normal issuance process, all IFRC interventions (not only CBHFA) in Jordan are addressed to registered Syrian refugees.

- The fact that the government also instructed humanitarian organisations (through the MoPIC) to serve only refugees with complete documentation (including "only" those with new MoI cards), makes it even more justified to try to reach and assist those categories, presumably that are already more deprived and at a higher protection risk or risking to fall into those.

Effectiveness

Design choices and formulation weaknesses have enormously conditioned the interventions' possibility of being effective. The available information did not permit a clear picture on the intervention, as well as of the quality-outputs of the different components. What can be confirmed is that too many efforts have been exerted in increasing the project's governorates coverage (that is a clear humanitarian priority), as well as CBHFA volunteers' presence and training accordingly. However, very little has been done to improve the quality (targeting and effectiveness), that makes an unbalanced coverage-effectiveness intervention, thus, highly inefficient.

Non intended positive project's effects have been identified in two main areas: (#1) the project contribution to "normalise" and reduce the gender gap at community level (when the CBHFA volunteers' home visits and activities are done in Male / Female pairs) and (#2) the decision to have both Jordanian and Syrian nationals in the same pairs and teams, showed cohesion and a positive model of coexistence, that in certain areas with high tensions between both communities, could have had a further positive impact as a positive model. This pairing of different nationals in the community work seems also to be quite unique for the project (if compared with the other CHTF organisations' reported working model: with less Jordanian nationals' participation).

The major identified factors negatively affecting the CBHFA implementation are related to: (#1) the JNRCS' internal management structure and organisational culture, (#2) the insufficiently detailed IFRC-JNRCS partnership and (#3) the insufficient or non-existent link with other initiatives within the RC movement:

- the JNRCS implementation structure does not rest easily with a structure internally organised to steer and implement the project's goals and a clear line of operational decision-making in

- accordance with the needs and volume of the CBHFA programme;
- to be successful, each partner should bring capacities and resources to an inter-dependent relationship and the added value of working together should be clear and recognised, creating a sense of joint investment and partnership. What seems to have happened is that the IFRC is pulling (active role) without having a clear management role, and JNRCS is just drifting (passive role)
- the coordination missed opportunities are more evident in the DRC PSP component, where a referral pathway and protocol was created and agreed between IFRC-JNRCS and DRC but it seems not to have been put in place. Other initiatives within the RC movement are not linked with the CBHFA intervention.

There is a partnership (IFRC-JNRCS) risk, that is not sustainable and could start having negative effects for the image of IFRC in particular, related with:

- the current visibility and external exposure of IFRC (including to donors), generated primarily by the difference between the IFRC projection-humanitarian profile and the real JNRCS capacity to deliver a fully oriented humanitarian response according to minimum standards (that relies on the JNRCS willingness to change and follow a different way of management);
- the poor CBHFA performance in responding to the acute needs of the most vulnerable populations in proportion to their needs;
- the IFRC insufficient willingness to follow and enforce the “Fraud and corruption prevention and control policy” when serious allegations of JNRCS abusive/coercive power were reported.

Efficiency

Efficiency in this type of programme is not just about minimising or reducing costs but in balancing relative costs with the needs of the people, equity targeting, coverage and effectiveness. The overall Efficiency of this intervention is considered low, mostly due to the non- appropriateness and the non- adaptation of the chosen strategy to cope with the main health population needs.

Efficiency gains were achieved through a new CBHFA Volunteers’ selection and validation procedure that was put in place in 2016:

- Volunteers’ recruitment was, for the first time, also opened outside the previous JNRCS entourage (through Facebook) to more applicants and the process was operated separately from the Youth Department (fully by CBHFA). The newly created selection and validation procedures defined by the CBHFA project officers, have undoubtedly been decisive in the successful profiles that were either recruited or validated in 2016.

On the contrary, three main issues were identified as key in lowering the overall intervention’s efficiency and some of them also raise ethical issues:

- Different models of supervision – management were introduced for CBHFA management at Branch level, that included a full time HR allocation in 2014-2015 (one per governorate) that was replaced in 2016 by volunteers’ focal points (a decision that was not based a cost-effectiveness and efficiency analysis).
- The drastic JNRCS unilateral decision to cut, from the 2016 project, volunteers incentives (that were entitled to cover transportation expenses) by half¹²⁵, without any further analysis or discussion. The amount defined under the unilateral JNRCS decision is simply unethical if considering: (#1) the minimum salary in Jordan, (#2) what other organisations from CHTF pay to their volunteers and most of all, (#3) if comparing the monthly incentives with the Minimum

¹²⁵ That were defined as a maximum of 10 JOD/day (maximum monthly allocation of 100 JOD per volunteer) and was reduced to 5 JOD/day (maximum monthly allocation of 40 JOD per volunteer).

Expenditure Basket (MEB)¹²⁶ and the Survival Minimum Expenditure Basket (SMEB) in Jordan and the fact that many of the CBHFA volunteers are Syrian nationals (subjected to a dire economic situation who have hardly any other income).

- The 2016 intervention focused in Raising awareness (Non-tangible focus) and increasing the number of CBHFA volunteers (by 100 percent), with the consequent effort and investment in training, diverting attention away from the priority needs of the most vulnerable populations.
- Capacity building efforts to the volunteers have been made almost exclusively through training that took a disproportionate effort and resources, when capacity building goes beyond training.

Connectedness

The alignment with country strategies and priorities is, in the current situation, the best approach to Connectedness.

- It is confirmed that the community health and information approach as well as the CBHFA approach, are (as reflected in the “Health Sector Humanitarian Response Strategy Jordan 2017-2018”), fully aligned with the current national priorities. CHVs themselves, in that strategy, are entitled to be focal points for Information-Referrals, that opens as well the pathway for further investment in that area.

Conversely:

- JNRCS Interest in Institutional Capacity Building and the development of long-term Youth department/volunteers is not compatible with the need to maintain a project orientation of the CBHFA volunteers that would have to focus on being effective and efficient in the short term (project orientation),
- The fact that there is a clear deficit and difficulties in the exchange-coordination between the JNRCS and the MoH and that JNRCS does not have a health department, are serious obstacles to connectedness.

¹²⁶ The Minimum Expenditure Basket (MEB) is a way of establishing poverty lines for refugee populations, following the notion of a “cost of basic needs approach”. It is the expression of the monthly cost per capita, which allows a Syrian refugee to live a dignified life outside the camps in Jordan, whilst the SMEB is the expression of the monthly cost per capita which is the minimum needed for physical survival and implies the deprivation of a series of rights.

7. RECOMMENDATIONS

CBHFA priorities and focus (Design-based)

R1 (*addressed to IFRC MENA–GLOBAL*). CBHFA addressed to out-of camp IPDs or refugees in humanitarian settings, should consider, in its design and throughout the whole implementation period, the following design-guiding elements:

- the possibility to vary strategies according to the context/needs changes (adaptability). The evolving specific vulnerabilities and protection needs of the most vulnerable refugees, in the MENA region (at least in Lebanon and Jordan) are highly dependent on the legal framework and the context evolution. In this context, CBHFA interventions should ensure that the design and implementation of activities aims at reducing and mitigating protection risks;
- that addressing out-of camp refugees or IDPs interventions (growing global trend) needs a different approach than the work with host-fixed population in rural environments (traditional CBHFA scenario), where usually their needs are structural/linked to poverty;
- the need to sign more detailed IFRC-National Society partnerships' agreements, clearly stating minimum commitments and milestones from the RC National Society to be accomplished.

R2 (*addressed to IFRC-JNRCS*). In the 2017 Jordan context, a relevant CBHFA design requires a high level of flexibility and some degree of “out of the box” thinking (that other CHTF organisations already implemented) for adaptation to:

- the specific health related and protection gaps of the most vulnerable non-camp refugees;
- the notorious Governorates and districts differences in refugees' caseloads and free services offer available for Syrian refugees (including health care).

That demands the setting up of an effective referral system, either complementary or outside the initially available free of charge public health system and looking beyond the traditional community mapping, expanding the referrals to whatever reliable partner within the district, Governorate or even national level.

R3 (*addressed to IFRC-JNRCS*). For the next phase, the main focus of any humanitarian intervention in the current Jordan context, should be, from a principled humanitarian action perspective, on out of camp refugees, out of which, the most vulnerable categories should be targeted in priority. CBHFA should clearly refocus on the most vulnerable and consequently, to follow the “One refugee approach” recommendation (R4) should prioritise, for geographic intervention, the areas where the most vulnerable are living:

- Given the acuteness of the most vulnerable refugees' needs, diverting humanitarian resources from refugees in dire need to target Jordanian hosts affected by poverty/structural needs (that have dedicated social programmes), would only make partial sense from a cohesion perspective and for a limited number of activities. In that sense, it would be coherent, to be incoherent (not aligned) with the Government of Jordan's policies, that places IFRC-JNRCS, due to its different status, in an unique position (if compared with the rest of iNGOs) to implement a principled humanitarian targeting.

R4 (*addressed to IFRC-JNRCS*). Priority groups within the target population for the next phase should be:

- Refugees of any nationality included in the UNHCR registered Populations of concern:
 - ✓ Having more problems for any household member's civil-legal and/or identity-recognition (renewal of asylum certificate, difficulties to have all the legal documents for MoI new card), living in a unsafe environment, etc.

- ✓ Family with a member with disabilities /estimated at a minimum of eight percent of refugees in Jordan having a significant injury of which 90% were conflict-related)¹²⁷.
 - ✓ Families with out of school children at primary school age and/of families with young children: that cannot be enrolled / follow secondary education.
 - ✓ Female headed households with children,
 - ✓ Families with bedridden and/or mental health disorders' members.
 - ✓ households with children born from teenager couples and early marriage (a crime under Jordan law).
- Refugees of any nationality not included in the UNHCR registered Population of concern and/or not eligible for MoI registration/renewal for different reasons (including lacking civil documentation, left the camps without Baillout, entered illegally, etc.)¹²⁸. Under this category, the need to intervene as well with other non-Syrian refugees clearly emerges, due to their reduced levels of assistance and access to subsidised services and even more bureaucratic hurdles encountered than Syrians and that could be exposed to similar or even worst conditions than some of the Syrian refugees.

The IFRC-JNRCS partnership

R5 (addressed to IFRC). Considering the foreseen evolution of the refugees' crisis in Jordan, the space for a principled humanitarian emergency-type response gains relevance but at the same time, a feasibility cross-check needs to be carried out by the IFRC. Not all relevant interventions are feasible (for either external or internal factors or a combination of both) and in this case, the main limiting feasibility factor to be cross-checked is the capacity and the willingness of the implementing partner (JNRCS) to commit to the needed institutional changes requested to be both: aligned with the humanitarian priorities of the most vulnerable refugees' population and effective in the new design's implementation.

- It is also important to clarify why IFRC wants to remain present in Jordan and what needs to be achieved (operational side) within a timeline, featuring clear milestones for the continuation of the mission, its downsize or termination. Otherwise, the inertia of the daily activities and the need to surmount administrative and bureaucratic JNRCS barriers enables CBHFA staff to not prioritise the basic in order to perform what's urgent.
- The clearest space to maximise the potential added value for a CBHFA IFRC-JNRCS intervention is the branches' theoretical outreach coverage potential, but as it is not feasible to carry out Organization Development activities and achieve minimum standards whilst delivering effective projects in a humanitarian crisis, a parallel IFRC setup (similar as the GRC-JNRCS in Irbid) should be considered for implementation at both: Governorates and Head Quarters' level (see R8 for more details). This setup could be in place at least until JNRCS' minimum conditions¹²⁹ to be considered a reliable humanitarian partner are met).

Implementation focus

R6 (addressed to IFRC-JNRCS). To Increase emphasis on targeting the most vulnerable and ease their access to key services, it will be needed to map vulnerability zones and groups and ease their access to key components, reconsidering the size of the project and the current number of CBHFA volunteers. It will also be needed to better plan, and assign means to follow and track coverage (including clear population's estimates and mapping, making use of IT means) for a better M&E, follow up and

¹²⁷ "Hidden victims of the Syrian crisis: disabled, injured and older refugees", HelpAge International and Handicap International, 2014.

¹²⁸ ECHO estimates a minimum figure of around 100,000 Syrians refugees in this situation.

¹²⁹ Including until the investigation on the abuse of power allegations' is satisfactorily closed.

georeferencing for CBHFA CHVs¹³⁰. It is also suggested to explore the possibilities of an agreement with IRD, that developed an impressive referrals' mapping system and adapted PDA tools.

R7. (*addressed to IFRC-JNRCS*). CBHFA should be organised, having one Field Coordinator per Governorate (same as GRC-JNRCS in Irbid), reporting to one and unique CBHFA IFRC-JNRCS coordinator in Amman. Those profiles should be selected following the best practices identified in the Efficiency conclusions (efficiency gains were achieved through a new CBHFA Volunteers' selection and validation procedure that was put in place in 2016) and to the extent possible, should be refugees. Each Field Coordinator per Governorate will be responsible for two different mobile teams for the district/subdistrict to reach more vulnerable subareas¹³¹/population (rotating and moving to other areas when targets are reached).

R7.I. Public health and information campaigning CBHFA teams to facilitate the entry point for the linking of health and civil documentation referrals with priority population (activity to be delivered by mixed Syrian and Jordanian CBHFA volunteers together¹³²: minimum of 30 hours a month per area of coverage, with incentives paid according to MEB or at least half of the minimum monthly salary).

- In group gatherings – campaigns, it is suggested to deliver:
 - ✓ The First Aid GRC-JNRCS Irbid's model after a revision of the module and content. ICRC could facilitate a new Training of Trainers (ToT) First Aid training that would allow to have at least 3 formed trainers at Governorates level. The objectives and population invited to assist should be the subject of further research, benchmarking with current GRC activities.
 - ✓ Behaviour change and raising awareness (Health and basic civil documentation messages) through interactive methodologies such as role playing, recreational activities, small quizzes and games...) about:
 - a very reduced number of health messages that should be adapted to the morbidity profile of under 5s to achieve impact and should be delivered through interactive demonstrations in public institutions (schools, mosques, health centres...) and also be delivered in public places where out of school refugees' children and youth could be gathering;
 - basic civil documentation messages, concentrating on Information about the importance of Birth and Marriage Certificates and direct referral for free Counselling and free legal representation (if necessary). See Annex VI, Diagrams of the Birth and Marriage certificates' process.

R7.II. Outreach district referral teams for Identification of the most vulnerable refugees (activity to be delivered preferably only by refugees¹³³, CBHFA volunteers, organised by pairs that would include home visits for identification of the most vulnerable households referrals' needs and follow up, following/adapting the IRD CHVs model and performance targets. Incentives should be of minimum monthly salary or directly equivalent to those of IRD¹³⁴). Priority will be to ensure short-term acute needs of refugees are met: equitable access, uptake and quality comprehensive health care of primary and secondary health care healthcare.

- Key referrals (health, disabilities assistance and legal) should be secured in bilateral partnerships with health, legal and organisations working with refugees' disabilities for free (regardless their status): such as MSF, NRC and Handicap International. Cash for health through the ECHO iNGO's consortium.

¹³⁰ All the CHVs that participated in the evaluation discussions have Whats App, the majority Facebook and suggested that they would rather prefer to use tablets than paper for reporting-M&E purposes.

¹³¹ That according to the CBHFA volunteers interviewed, can be sometimes located in the outskirts or their initially assigned neighborhoods.

¹³² To maximize the cohesion perception between both communities.

¹³³ If the outreach targeting are the most vulnerable refugees (mostly Syrians with difficulties to cope with legal requirements), it will be easier to get access and trust through refugees of the same nationality (common practice in this type of approaches).

¹³⁴ Higher than the minimum salary.

R8 (*addressed to IFRC-JNRCS*): Good practice from other CHTF organisations could be applied, such as:

- Pretest and post test for volunteers and ToTs trainers before going to the field (they need to pass a minimum in the tests) and retest them on regular basis (performance grid).
- Avoiding CHVs related to each other in the same governorate, as a rule to reduce cheating.
- Use of portable devices with georeference for outreach referral teams and follow-up visits.
- CHVs goals defined per month for outreach referral teams on precise targets per month per volunteer and related to the most vulnerable profiles: number of visits, number of referrals, number of follow up referrals, etc.

**Annexes to the End of Project
Evaluation for Jordan National Red
Crescent Society (JNRCS)
Community Based Health and First Aid
(CBHFA) and Psychosocial Support
project in Jordan**

ANNEX I: Terms of Reference



ANNEX I - Terms of reference

End of Project Evaluation for Jordan Red Crescent Society (JRCS) Community Based Health and First Aid and Psychosocial Support project in Jordan

Summary

Purpose: The purpose of this evaluation is to account for JRCS support provided to Syrian refugees living in host communities and to vulnerable Jordanians. This evaluation will be conducted to document the good practices, challenges and lessons learned that will be useful in the improvement of future project implementation.

As for CBHFA project in Jordan, this is the third year of implementation and it is important to review the past three years' activities. CBHFA in the Middle East context, both a conflict setting and a protracted crisis, can be contributing a good show case for the global CBHFA.

Audience: The results of the evaluation will be used to report back to the Government of Japan on the achievements of the project, the evaluation will be used by JRCS, IFRC, Partner National Societies (PNS) in Jordan

Commissioners: This will be an external evaluation commissioned by the Japanese Government through IFRC.

Duration of the evaluation: The whole evaluation process will take 4 weeks, including 1 day for briefing, 12 days of field work, 1 day for debriefing and 7 days for writing the report.

Time frame: February 2017

Location: Field visits will be carried out in the Governorates of Amman, Jerash, Ajloun, Mafraq, Balqa and Madaba.

1. Background

JRCS' CBHFA project was initiated in 2014 with support of the Japanese Government. The Project titled 'Enabling healthy and safe living in families affected by the Syrian crisis in Jordan' is implemented by Jordan Red Crescent Society (JRCS) with technical support from IFRC and funding support from the Government of Japanese. Between February and November, 2014, activities were implemented in the governorates of Irbid, Mafraq, Jerash, Ajloun and Amman and targeted 6,000 beneficiaries in 20 communities.

Since then, over 300 volunteers have been trained in various health topics including non-communicable diseases, first aid, common illnesses and violence prevention. Through their activities the volunteers, have reached over 102,000 beneficiaries with health information during the three years.

The overall **goal** of the project is "Improved wellbeing, resilience and peaceful co-existence among (22,000) vulnerable Syrian refugee and host communities in Jordan."

Federation's community health promotion approach, Community Health and First Aid in action (CBHFA) was introduced for the first time in Jordan Red Crescent. CBHFA approach seeks to create healthy, resilient communities worldwide. CBHFA comprises a comprehensive approach to primary health care, first-aid and health preparedness at community level. It mobilizes communities and volunteers to use simple tools, adapted to local context to address the priority health needs of a community and to empower them to be in charge of their own development and health outcomes.

Specific objectives of the CBHFA programme:

Outcome 1: Refugees from Syria and host communities are more self-reliant and resilient to diseases, disasters and local conflicts

Outcome 2: The protective environment of the most vulnerable refugees from Syria and members of the host communities (women, men, boys and girls) is enhanced and their psychological distress is minimized

Outcome 3: JRCS have strengthened their capacity and enhanced their ability to reach out to most vulnerable groups within the refugee and host communities

2. Evaluation purpose and scope

1. Review the effectiveness, efficiency, relevance, impact and sustainability of the project by reviewing the outputs achieved in relation to inputs provided, and the outcomes achieved as a result of project outputs delivered to date.
2. Analysis of strengths and challenges of the CBHFA project in the context of Jordan, from the Community Health Volunteers (CHVs), Focal persons (FP), trainer and branch manager points of view
3. Documentation of lessons learned and provide recommendations for further improvement in the design, delivery, quality and resourcing of the project to increase effectiveness, efficiency, relevance or impact.

Scope

This evaluation will cover JRCS CBHFA programme implementation supported through IFRC since 2014, in the 6 Governorates of Amman, Jerash, Ajloun, Mafraq, Balqa and Madaba). In addition, this evaluation should examine the level of gender and diversity mainstreaming i.e. how issues specific to groups of men and women of different age and social backgrounds should be taken into account in future, to ensure proper needs assessment and improved effectiveness.

Recommendations addressed to JRCS, IFRC country office Jordan, MENA, GVA should be also included in the evaluation report and assess the intervention from a historic perspective for the last three years.

Evaluation criteria and specific evaluation questions

This evaluation will focus on six of the seven evaluation criteria as well as on coordination, accountability and lessons learning.

1. Relevance & Appropriateness

The extent to which the operation's activities have been suited to the priorities of the target community. The consultant is expected to consider the following questions in measuring relevance/appropriateness:

- To what extent are the objectives of this programme still valid?
- How relevant is the project regarding the beneficiary requirements, local context and needs, such as referral system?
- Is the CBHFA programme aligned to the Jordan country health strategy, plans?
- How does the project compliment intervention of other actors, including relevant Government departments?
- How satisfied with the project are the project beneficiaries?
- What is the stakeholders' viewpoint related to the performance of the project?
- What are the main issues raised regarding satisfaction with the project?
- How well were the target groups identified?
- How satisfied is JRCS – including local branches – with the project?
- What are the main issues raised regarding satisfaction with the project e.g. support received communication, how to improve?
- Was the partnership model of IFRC with JRCS sufficiently detailed and implemented?

2. Coverage

The extent to which the operation was able to reach the populations/areas affected; how the criteria for reaching them were identified/implemented: Thus the consultant will be guided but not limited by the following question in measuring coverage:

- To what extent were the most vulnerable identified and supported by this operation
- To what extent were there inclusion and exclusion errors

3. Effectiveness

To what extent are the interventions likely to achieve its intended results?

The consultant is expected to consider the following questions in measuring effectiveness.

- To what extent have the program objectives been achieved?
- What were the major factors influencing the achievement or non-achievement of these objectives?
- Are the activities and outputs of the programme consistent with the overall goal and the attainment of its objectives?
- Were the supervision and management mechanisms on all levels sufficient in relation to project needs and expectations?
- Were standards of quality defined and did the activities achieve high levels of quality in implementation?
- How effective has collaboration with Ministry of Health and other actors been?

4. Efficiency

The use of time and resources:

- How well were the inputs (funds, people, materials and time) used to produce results?
- Has the scale of benefits been consistent with the cost? Cost-efficiency: (a) To what extent has the funding been utilized to directly assist beneficiaries (b) Have the project support and operational costs been reasonable (%) compared to entire budget and beneficiary assistance?
- How well is CBHFA integrated with other JRCS programmes such as CTP, PSP, Youth and Livelihoods. How can integration be improved in the future?
- Was the project implemented in the most efficient way compared to alternatives?

5. Impact of intervention

These are positive and negative changes produced by the intervention, directly or indirectly, intended or unintended. This involves the main impacts and effects resulting from activities on local social, economic, environmental and other development indicators. Examination should be concerned with both intended and unintended results and must also include the positive and negative impact of external factors.

The consultant is expected to consider the following questions in measuring impact:

- Has there been any unforeseen or indirect positive or negative impact (to the communities, volunteers, NS)?
- Did the project address the needs of all intended beneficiaries in a consistent manner as per project design?

- Did the project achieve its intended impact?
- What real difference has the programme made to the beneficiaries?
- What if any were the unintended positive or negative changes in the lives of the affected populations.
- Has CBHFA interventions contributed to behaviour change in targeted communities, and/or among individuals??

6. Sustainability

- Is there sufficient community ownership regarding the project?
- What are the main factors, either positively or negatively affecting the sustainability of project outcomes?
- Do lessons from the implementation of this project indicate any changes in design in the future to ensure better sustainability?

7. Accountability

The IFRC is bound by enabling action 3 of strategy 2020 to commit to a culture of transparent accountability to our stakeholders. Thus the consultant will be guided but not limited by the following question in measuring our accountability:

- To what extent were beneficiaries involved in the planning, design and implementation of the project/?

8. Coordination

One of the important roles of the IFRC secretariat is to coordinate the activities of Red Cross Red Crescent partners. In order to measure if this role was fully satisfied the consultant will be guided but not limited by the following questions:

- To what extent was this role been fulfilled and was it adequate and constructive
- How adequate was the coordination with non-Red Cross Red Crescent actors, i.e. clusters, in terms of both the information contributed and the information received through the available mechanisms?
- How adequate was the coordination within the RCRC Movement? How well was the action connected to other similar programs implemented by JRCS with PNS support?
- What can we learn from this experience?

9. Lessons learnt

The consultant should consider the following areas to measure whether the issues listed were effective and discuss what worked well, what didn't work well, and what could be done to improve in the future.

- How was each training module/tools selected? How were tools utilized by the volunteers?
- To what extent was the alignment/linkages of CBHFA with other projects (e.g PSP, Youth and CTP) done?
- Were recommendations from previous evaluation reports adopted and implemented?
- How accurate was the data collection for the project (this would allow you to explore issues around digital data collection, etc)

3. Evaluation Methodology

1. Document analysis/review:

➤ Data sources

- All project related documentation such as the project proposal / plans, budgets, financial and narrative reports, guidance documents, photography etc.)
- Past evaluation reports
- Monitoring formats and evaluation reports
- IEC and BCC materials developed by the project

➤ Reference documents

- CBHFA modules used by volunteers
- CBHFA PMER toolkit

2. Community Evaluation

- a) Baseline versus end line data to assess changes in knowledge, attitude and possibly in practices (KAP) (random selection and structured interviews)
- b) Focus Groups Discussions and questionnaires
 - CBHFA: with key community groups who were met with during the project time frame e.g. refugee groups, men/women/youth/other groups, health committees, CBOs, health facilities, schools (students and teachers) etc
 - Community leaders/key persons who have been involved or linked/aware of the project to see the impact of the project
 - Case studies of certain individuals/households
- c) Volunteer/Trainer and CBHFA Staff Evaluation
 - Project wrap up workshops before the evaluation starts for all branches and for HQ/IFRC as well if people are willing to be involved

Evaluation will be carried out by an **external consultant assisted by a locally contracted consultant**. The external Consultant will be hired following IFRC standard procedure for recruitment of Consultants.

The local Consultant will be hired through a transparent recruitment process and identified by professional experience and competencies. The evaluation will be carried out with support from **JRCS/IFRC regional/in country staff** who will assist in the evaluation process. All findings should be evidence based and methodology used explained in the final evaluation report.

4. Deliverables

1. Evaluation of the project
 - a. Inception report and interview guide for qualitative data collection
 - b. Draft report and presentation
 - c. A final evaluation report

The final report should follow the following structure and address (but not limited) to the following:

1. **Executive summary**
2. **Abbreviations/acronyms**
3. **Introduction**
4. **Review aims and objectives**
5. **Methodology**
6. **Impact on beneficiaries**
7. **Recommendations**
8. **Overall analysis and lessons learnt**
9. **Conclusion**
10. **Appendices**

5. Proposed Timeline

Tentatively 1st of February to End February TBC– (Maximum 4 weeks). The whole evaluation process will take 4 weeks, including 1 day for briefing, 12 days field work, 1 day debriefing and 7 days writing the report

6. Evaluation Quality and Ethical Standards

The evaluation team should take all reasonable steps to ensure that the evaluation is designed and conducted to respect and protect the rights and welfare of people and the communities of which they are members, and to ensure that the evaluation is technically accurate, reliable, and legitimate, conducted in a transparent and impartial manner, and contributes to organizational learning and accountability. Therefore, the evaluation team should adhere to the evaluation standards of the IFRC.

7. Confidentiality

All collected survey information will be strictly confidential. No names of survey respondents can be mentioned in any document.

8. Data ownership

All collected data and information related to this survey will become the property of IFRC.

9. The IFRC Evaluation Standards are:

1. **Utility:** Evaluations must be useful and used.
2. **Feasibility:** Evaluations must be realistic, diplomatic, and managed in a sensible, cost effective manner.
3. **Ethics and Legality:** Evaluations must be conducted in an ethical and legal manner, with particular regard for the welfare of those involved in and affected by the evaluation.
4. **Impartiality and Independence:** Evaluations should be impartial, providing a comprehensive and unbiased assessment that takes into account the views of all stakeholders.
5. **Transparency:** Evaluation activities should reflect an attitude of openness and transparency.
6. **Accuracy:** Evaluations should be technical accurate, providing sufficient information about the data collection, analysis, and interpretation methods so that its worth or merit can be determined.
7. **Participation:** Stakeholders should be consulted and meaningfully involved in the evaluation process when feasible and appropriate.
8. **Collaboration:** Collaboration between key operating partners in the evaluation process

Annex1

Responsibilities of the primary evaluator

- Prepare inception report and interview guide
- Prepare survey questionnaire
- Lead the FGD
- Draft report and presentation
- A final evaluation report

Qualifications of the primary evaluator

- Experience of working in Monitoring and Evaluation – required
- Experience of working for the Red Cross/Red Crescent – preferred
- Academic background and practical experience in public health –preferred
- Fluently spoken of Arabic – required

Annex 3

The expected **Outcome / Activities/ Indicators** of the project

Outcome 1: Refugees from Syria and host communities are more self-reliant and resilient to diseases, disasters and local conflicts

- Activity 1: Coordination with Ministry of Health, local authorities and humanitarian actors
- Activity 2: Dissemination of health information at community events, in schools, during household visits and with established community groups and community based organisations through activities and printed materials
- Activity 3: Promotion of healthy lifestyles and good nutrition, including in schools and with youth groups adapting IFRC's initiative "Youth as Agents of Behavioural Change (YABC) "
- Activity 4: Home visits to pre-natal and post-partum mothers to educate and support the mothers in healthy pregnancies, exclusive breast feeding practices, to recognise the danger signs in a newborn and to promote immunisations
- Activity 5: Promotion of routine immunisations for targeted children to participate in National Immunisation Days
- Activity 6: Building the capacity of communities to reduce the risks and impact of emergencies through dissemination of accident prevention messages and basic first aid skills
- Activity 7: Raising awareness with communities about violence prevention and enlisting the support of men and boys to promote a culture of non- violence and peace
- Activity 8: Promotion of child protection with joint training and activities of the CBHFA teams, enforced by the establishment of referral mechanisms
- Activity 9: Establishment of referral pathways and communications to improve beneficiaries' access to health care services

Indicators for Outcome 1:

- Number of people reached by health awareness activities through home visits, community meetings and campaigns, disaggregated by nationality, sex and by age group
- % of home visits conducted to pregnant and lactating women whereby women said they breast fed exclusively for the first 6 months

- Number of people reached with first aid information, disaggregated by nationality, sex and by age group where possible

Outcome 2: The protective environment of the most vulnerable refugees from Syria and members of the host communities (women, men, boys and girls) is enhanced and their psychological distress is minimized

- Activity 1: Organise recreational activities for children (corners including homework clubs)
- Activity 2: Organise guided workshops/resilience workshops for children.
- Activity 3: Organise resilience workshops for caregivers and adults
- Activity 4: Conduct lectures and psycho-educational sessions for male and female caregivers
- Activity 5: Conduct home visits when required
- Activity 6: Organize family trips, festive days and community workshops, summer camps

Indicators for Outcome 2:

- Number of people who participated in psychosocial guided workshops and resilience activities, disaggregated by nationality, sex, age group and type of activity
- % of individuals who participated in the programme who report an increased feeling of safety or ability to handle stress and crisis.
- # of women, men, girls and boys from different activity groups who have participated in joint social cohesion and community activities that have been identified as connecting factors for social cohesion.
- Community members including JRC volunteers (disaggregated by age, sex and nationality) that express an increased respect and appreciation for diversity and trust in different communities

Outcome 3: JRCS have strengthened their capacity and enhanced their ability to reach out to most vulnerable groups within the refugee and host communities

- Activity 1: Identification and recruitment of new volunteers
- Activity 2: Conduct induction course for all new volunteers to introduce the Red Cross and Red Crescent (RCRC) Movement and to enable volunteers to conduct their volunteer work according to the humanitarian principles and values.
- Activity 3: Conduct relevant CBHFA technical trainings for new staff and volunteers and refresher trainings for existing ones.
- Activity 3: Provide the necessary tools to volunteers to enable them implement risk reduction activities in the community
- Activity 4: Provide supportive supervision of community health volunteers
- Activity 5: Monitoring and evaluating of the community health activities

Indicators for Outcome 3:

- Number of trainings facilitated by newly trained CBHFA facilitators who were trained in training skills in 2016
- Number of community health volunteers trained in CBHFA and relevant health topics, disaggregated by sex, nationality and training topic

ANNEX II: JHAS /UNHCR Hospitals

ANNEX II – JHAS / UNHCR Hospitals

JHAS/UNHCR system is the only referral system for secondary healthcare for the Syrian refugees in Jordan. It comprises a central referral hub and an affiliated network of hospitals (source UNHCR):

Center Name	Available To	Address
JHAS Clinics (Jordan Health Aid Society)	Only UNHCR registered refugees	Mafraq Clinic Beginning of Baldyeh st., opposing to Hadeel Pharmacy Third floor
		Ramtha Clinic Next to Ramtha Buses station, behind Al Fardous Taxi company
		Irbid Clinic Hay Badeea, opposite to Princess Rahma Hospital, next to Al Hasad water shop
		Zarqa Clinic Ma'soum Area, Behind Zein Al Abdein Mosque
		One Mobile Medical Unit (MMU) covering the South governorates-

UNHCR will be able to cover the cost of treatment for patients through JHAS clinics if:

- Patient cannot afford to pay for the treatment at PHCs and governmental hospitals (the case have been evaluated as a vulnerable case).
- Patient cannot get a subsidized price for the treatment needed at PHCs and governmental hospitals (hold invalid UNHCR certificate or invalid security card).

ANNEX III: List of Consulted Documents - Bibliography

Annex III - List of consulted documents / bibliography

Internal IFRC-JNRCS-GRC Documents related to the intervention

- * Different internal reports, databases, planning and management documents for the CBHFA projects (IFRC-JNRCS-GRC) and IFRC operations in Jordan (2014-2017)
- * *"CBHFA Internal Evaluation Report Jordan"*, December 2014
- * *"Evaluation Report of the Community Based Health and First Aid (CBHFA) project in the Governorates of Jarash, Ajloun, Amman, Madaba and Mafraq"*, Prof. Sami Khasawnih, 30 December 2015
- * *"Evaluation Report of the Psychosocial Support Programme (PSP)"*, Dr. Dirar Assal, 30 December, 2015

IFRC Policies

- * *"IFRC First Aid Policy"*, 2007
- * *"IFRC Health Policy"*, 2005
- * *"IFRC Volunteering Policy"*, 2011
- * *"Planning Monitoring Evaluation and Reporting (PMER) Toolkit for CBHFA"*, 2013
- * *"Implementation guide for CBHFA"*, 2009
- * *"Maternal, newborn and child health framework"*, 2013
- * *"Strategy 2020"*, 2010
- * *"Project/programme planning, Guidance manual"*, 2010

Documents related to the context

Health related

- * *"Joint Rapid Health Facility Capacity and Utilization Assessment (JRHFCA)"*, Ministry of Health of the Hashemite Kingdom of Jordan, with support from the World Health Organization, the International Advisory, Products and Systems, the Massachusetts General Hospital Center for Global Health, Harvard University and the Jordan University for Science and Technology, January 2014
- * *"Population-Based Health Access Assessment for Syrian Refugees in Non-Camp Settings throughout Jordan"*, UNHCR, International Medical Corps, UNFPA survey. November 2013 – March 2014.
- * *"Assessment of Mental Health and Psychosocial Support Needs of Displaced Syrians in Jordan"*, World Health Organization and International Medical Corps In collaboration with the Jordanian Ministry of Health and Eastern Mediterranean Public Health Network, 2013
- * *"Access to Health Care and Tensions in Jordanian Communities Hosting Syrian Refugees, Thematic Assessment Report"*, Reach Initiative, June 2014
- * *"Mental Health Psychosocial and Child Protection for Syrian Adolescent Refugees in Jordan"*, UNICEF and IMC, December 2014
- * *"Urban Refugees in Amman: Mainstreaming of Health Care"*, ISIM, 2012
- * *"Health Sector Humanitarian Response Strategy: Jordan 2014-2015"*, Health Sector Working Group. Updated May 2015.
- * *"Healthcare Access for Syrian Refugees Lacking Legal Documentation in Jordan"*, SIT Graduate Institute, 2016
- * *"Syrian Refugee Health Access Survey in Jordan"*, UNHCR, Johns Hopkins Bloomberg School of Public Health, Jordan University of Science & Technology and WHO, December 2014
- * *"Health Access and Utilization survey among non-camp refugees in Jordan"*, UNHCR, May 2015
- * *"Health Access and Utilization survey – Access to Health Services in Jordan among Syrian*

refugees”, UNHCR (by Nielsen), December 2016

- * “Analysing equity in health utilization and expenditure in Jordan with focus on Maternal and Child Health Services”, UNICEF and The Hashemite Kingdom of Jordan High Health Council, August 2016

Non-health related

- * “Hidden victims of the Syrian crisis: disabled, injured and older refugees”, HelpAge International and Handicap International, 2014
- * “Strategic Programme Document”, Danish Refugee Council in Jordan, 2014
- * “Jordan Vulnerability Assessment Framework, Key Findings”, June 2015
- * “Jordan Response Plan for the Syria crisis – Executive Summary”, JRP, 2015
- * “Comprehensive Vulnerability Assessment”, Hashemite Kingdom of Jordan, Ministry of Planning and International Cooperation, published in 2016 with 2015 data.
- * “The Jordan Response Plan for the Syria crisis 2017-2019 (Draft)”, JRP, updated January 16th 2017
- * “Five Years into Exile”, Care, June 2015
- * “Running on Empty, The situation of Syrian children in host communities in Jordan”, UNICEF, May 2016
- * “Securing Status: Syrian refugees and the documentation of legal status, identity, and family relationships in Jordan”, NRC, November 2016.
- * “Understanding statelessness in the Syria refugee context”, Institute on Statelessness and Inclusion and NRC, 2016
- * “Living on the margins”, Amnesty International, April 2016
- * “Humanitarian Implementation Plan (HIP Syria Regional Crisis) Version 2”, ECHO, March 2016
- * “Community Consultations on Humanitarian Aid, Findings from Consultations within Syrian and among Syrian refugees in Jordan”, World Humanitarian Summit Istanbul, May 2016
- * “A mapping of social protection and humanitarian assistance programmes in Jordan. What support are refugees eligible for?”, Working Paper 501 - ODI and Maastricht University, January 2017

Others

- * “Cash transfers for refugees, an opportunity to bridge the gap between humanitarian assistance and social protection”, ODI Briefing, January 2017
- * “What Practices are used to identify and prioritize vulnerable populations affected by urban humanitarian emergencies?”, Humanitarian Evidence Programme, January 2017
- * “Evaluation of Humanitarian Action Guide”, Overseas Development Institute London, March 2013
- * “The Sphere Project, Humanitarian Charter and Minimum Standards in Humanitarian Response”, Sphere, 2011 edition
- * Jordan Refugee response, Inter-agency coordination briefing kit, ISWG, May 2016
- * Jordan population and housing 2015 Census, UNICEF¹, 2015
- * Inter-agency Information Sharing Portal Syria, Regional Refugee Response
- * UNHCR Statistics Refugees in Jordan
- * Who is Working Where (CHTF), 2015 and 2017
- * Minimum Expenditure Basket and Survival Minimum Expenditure Basket in Jordan, June 2015 and October 2016
- * <http://urban-refugees.org>
- * “Factsheet – Jordan: Syrian Crisis”, ECHO, January 2017

¹ https://www.unicef.org/jordan/media_10894.html

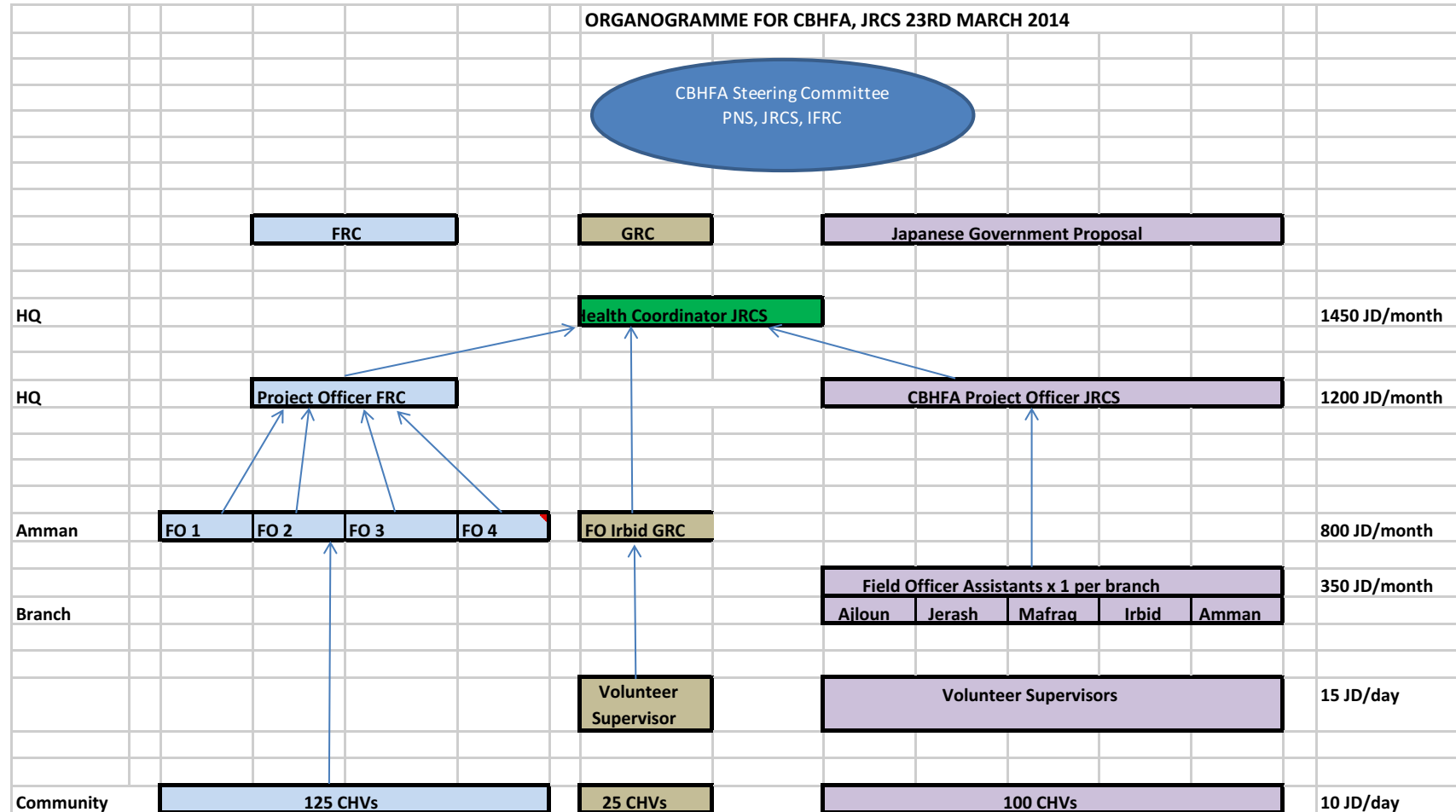
ANNEX IV: List of contacted Key Informants

ANNEX IV – List of contacted Key Informants (KIs)

DATE	LOCATION	TYPE OF DYNAMIC	INSTITUTION	PARTICIPANT'S NAME	POSITION
07 February	Amman	Briefing - Joint Session	JNRCS	Ibrahim Ajlouni	CBHFA Project Officer (GoJ)
07 February	Amman		JNRCS	Osama Kanaan	CBHFA Project Officer (BRC)
07 February	Amman		JNRCS	Nadia Kremeed	CBHFA Project Officer Assistant (GoJ)
07 February	Amman		IFRC	Mika Yamai	CBHFA Delegate
07 February	Amman		IFRC	Maki Igarashi	MENA's Regional Office Health Coordinator
07 February	Amman		IFRC	Robert Ondrusek	MENA's Regional Office Programme Coordinator
07 February	Amman		IFRC	Christopher George	Program Coordinator
07 February	Amman	IFRC	Muftah Etwilb	Head of Country Office	
08 February	Amman	Individual interview	Danish Red Cross	Jacinta Hurst	DRC Head of Mission and (former IFRC Health Coordinator and Interim Head of Operations)
08 February	Amman	Assistance to the Inter – agency Community Health Task Group (CHTG) monthly meeting	IMC, IRD, Medair, JICA, Caritas, JPS, IOCC, UNHCR, MSF France, IFRC-JNRCS		
08 February	Amman	Joint session	Medair	Elsa Groenveld Heidi Giesbrecht	Health & Nutrition Project Manager Health Advisor
08 February	Amman		IRD	Aseel Amin Ola Alshraideh Nawall Najjar	Health Coordinator Health Coordinator Health Specialist
08 February	Amman		IOCC	Aya Abdelqader Lafi	Health Project educator
09 February	Amman		Individual Interview	German Red Cross	Melanie Plöger
09 February	Amman	Individual Interview	ICRC	Raed Aburabi	Health Coordinator
09 February	Amman	Individual Interview	IFRC	Sawsan Abu Rassa	Cash Transfer Officer
11 February	Ajloun	Individual Interview	MoH-Primary Health Care Center	Ali ALQudah	Director of the Ajloun Primary Health Care Centre
11 February	Ajloun	Individual Interview	JNRCS	Nabiha Samardali	Head of the Jordan Red Crescent's branch in Ajloun
11 February	Ajloun	Group Discussion	JNRCS	CBHFA Volunteers	CBHFA Volunteers in the Ajloun branch
18 February	Ajloun	Individual Interview	IRD	Community Health Volunteer	IRD Community Health Volunteer in Ajloun
11 February	Ajloun	Individual Interview	IRD	Community Health Volunteer	IRD Community Health Volunteer in Ajloun
12 February	Salt	Individual Interview	JNRCS	Mohammed Shomali	Head of the Jordan Red Crescent's branch in Salt
12 February	Salt	Group Discussion	JNRCS	CBHFA Volunteers	CBHFA Volunteers in the Balqa branch
12 February	Salt	Individual Interview	Beneficiary - Home visit	Syrian refugee	Syrian refugee family in Salt
13 February	Amman	Individual interview	JNRCS	Mamdouh Alhadid	JRCS Head of The National Center for First Aid and Risk Reduction
13 February	Amman	Individual interview	JNRCS	Khaled Al Shoura	JRCS CBHFA Training Officer
13 February	Amman	Individual interview	IFRC	Marshal Mukuware	Cash based programming Delegate
13 February	Amman	Individual interview	IFRC	khaled Abu Assaf	Finances Manager
13 February	Amman	Group Discussion	IFRC	Community Health Volunteers	CBHFA Volunteers in the Amman branch
14 February	Jerash	Group Discussion	IFRC	Community Health Volunteers	CBHFA Volunteers in the Jerash branch
15 February	Amman	Individual interview	MSF-France	Erwan Grillon	MSF-F Head of Mission Syria crisis
15 February	Amman	Individual interview	MSF-France	Gema Dominguez	MSF-F Medical Coordinator
15 February	Amman	Individual interview	UNHCR	Ibraheem Abu Siam	Health Coordination Sector lead
15 February	Amman	Individual interview	ECHO	Matteo Paoltroni	Technical Assistant - Amman Regional office
15 February	Amman	Individual interview	Embassy of Japan	Hiroshi Seto	Economic Cooperation - Second Secretary
16 February	Mafraq	Individual interview	JNRCS	Ali Shdefat	Head of the Jordan Red Crescent's branch in Mafraq
16 February	Mafraq	Group Discussion	JNRCS	Community Health Volunteers	CBHFA Volunteers in the Mafraq branch
16 February	Mafraq	Group Discussion	Emirati Jordanian Field Hospital	Said -Aln kabi	Hospital Medical Director
16 February	Mafraq	Individual interview	NRC	Rana Salem	ICLA Project Coordinator
18 February	Amman	Joint session	IFRC	Mika Yamai	CBHFA Delegate
18 February	Amman	Joint session	JNRCS	Osama Kanaan	CBHFA Project Officer (BRC)
18 February	Amman	Joint session	JNRCS	Nadia Kremeed	CBHFA Project Officer Assistant (GoJ)
18 February	Amman	Joint session	JNRCS	Khaled Al Shoura	JRCS CBHFA Training Officer
18 February	Amman	Joint session	JNRCS	Mamdouh Alhadid	JRCS Head of The National Center for First Aid and Risk Reduction
18 February	Amman	Joint session	JNRCS	Lina Qamhiya	CBHFA Project Officer Assistant (BRC)
24 February		Written responses	IFRC	Nicholas Prince	Former IFRC Health Coordinator
01 March		Written responses	IFRC	Miki Takahara	Former IFRC CBHFA Delegate

**ANNEX V: Organisation Chart for the
CBHFA Roll out
(13-March-2014)**

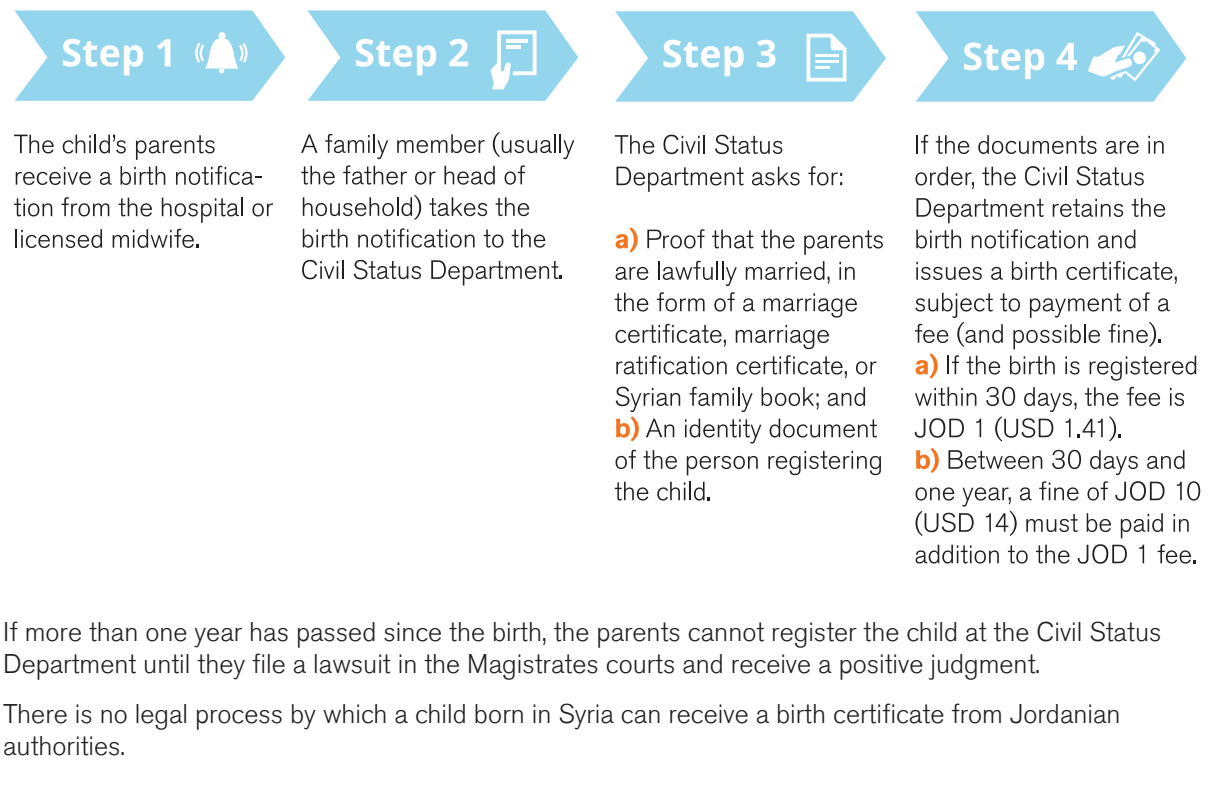
ANNEX V – Organisation Chart for the CBHFA Roll out (13-March-2014)



**ANNEX VI: Diagrams of the Birth and
Marriage certificates'
process**

ANNEX VI – Diagrams of the Birth and Marriage certificates' process¹

Steps to Obtaining a Birth Certificate in Jordan:



¹ Source: NRC report: "Securing Status: Syrian refugees and the documentation of legal status, identity, and family relationships in Jordan", available at: <https://www.nrc.no/resources/securing-status-syrian-refugees-and-the-documentation-of-legal-status-identity-and-family-relationships-in-jordan/>

Steps to Obtaining a Marriage Certificate or Marriage Ratification Certificate in Jordan

Marriage Certificate

To obtain a marriage certificate, a couple must go to the Shari'a court, usually over several sessions, and present the following documents:



1 Proof of identity for the bride and groom;



2 Proof of identity for the bride's guardian and the two witnesses;



3 Health certificate issued by Jordanian Ministry of Health verifying that the bride and groom are not carriers of thalassemia, a genetic disease;



4 Petition for a marriage contract addressed to the court; and



5 An approval letter obtained from the Jordanian Ministry of the Interior in Amman (a requirement that applies only when one or both members of the couple are foreigners)

Once all the requirements have been met, in the presence of two witnesses and the bride's guardian (usually her father), who has given consent to the marriage, the couple will sign a marriage contract and the judge will issue them with a marriage certificate.³⁶ The court fees for a marriage range from JOD 25 (USD 35) to JOD 110 (USD 155).³⁷ There are no fees associated with Mol approval or obtaining a health certificate.

Marriage Ratification Certificate

Couples who married outside the process outlined above – typically, through a marriage officiated by a sheikh – (an “informal” marriage) can legalise and register their marriage by obtaining a marriage ratification certificate.³⁸ A couple whose Syrian marriage certificate or family book was lost, destroyed, or left in Syria can also apply for a marriage ratification certificate.

The requirements for a marriage ratification certificate are the same as for a marriage certificate. However, the court may impose additional conditions, at its discretion, such as requiring more than two witnesses and/or the sheikh who officiated the informal marriage ceremony to come to the court.

Additionally, a fine of JOD 1,000 (USD 1,412) is imposed if the informal marriage was conducted in Jordan.³⁹ In an important accommodation, the Jordanian cabinet has twice established time-limited exemptions (31 October to 31 December 2014; 13 May to 13 July 2015) for informal marriages penalties, allowing couples who married informally in Jordan to receive marriage ratification certificates without paying the fine. Syrian couples are not eligible to receive family books from the Jordanian state.