FAKT Beratung für Management, Bildung und Technologien GmbH

Report
External Mid-Term Evaluation of Humanitarian Aid

Refugee aid in Lebanon

Implemented by
Humedica e.V.

Funded by the
German Foreign Office

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Photo credit:
Cover photo: Medical team in conversation with Syrian family, © Humedica
Qab Elias, © Martin Quack

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CHS	Core Humanitarian Standard
FTS	Financial Tracking Service
ICRC	International Committee of the Red Cross
IOCC	International Orthodox Christian Charities
ITS	Informal Tented Settlement
LCRP	Lebanon Crisis Response Plan
LHIF	Lebanon Humanitarian INGO Forum
MDM	Médecins Du Monde (Doctors of the World)
MMU	Mobile Medical Unit
MoPH	Ministry of Public Health
MSF	Médecins Sans Frontières (Doctors Without Borders)
MTI	Medical Teams International
NGO	Non-Governmental Organisation
OECD DAC	Organisation for Economic Cooperation, Development Assistance Committee
PHC	Primary Healthcare Centre
ROV	Refugee Outreach Volunteer
TOR	Terms of Reference
UNHCR	United Nations High Commissioner for Refugees
VENRO	Association of German Development Non-Governmental Organisations

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1 Summary

Lebanon opened its borders to approximately 1.5 million Syrian refugees. The vast humanitarian needs of the refugees and the host population exceed the capacity of the Lebanese authorities and international support to date has not been sufficient. Humedica provides primary medical healthcare services in the Bekaa Valley, where approximately one third of some 500,000 refugees are living in informal tented settlements (ITSs).

The project consists of mobile medical units (MMUs) that treat acute diseases for one to two days a month in around 35 ITSs. As well as this, there is a midwife and a special case officer who looks after individual patients for further examination and treatment. Humedica also supports the health education measures and aid for chronically ill patients provided by partner organisation *Medical Teams International* (MIT) as well as a healthcare centre by providing medication and financing examinations.

The project meets the humanitarian requirements and the priorities of the main players in the region and is therefore seen as being **relevant**. This also applies for the deployment of mobile teams whose work it has not yet been possible to replace through healthcare centres. The MMUs are to continue to be deployed where the need is greatest, also treating Lebanese patients.

The project is well on the way to reaching its objective, results, and indicators. The medical quality is high and acknowledged by other players. Because of this, the project is deemed to be **effective**. Humedica should continue the cooperation with MTI, ensuring that their respective efforts supplement and bolster one another.

The Humedica team works very systematically and is clearly organised and transparent in its activities.

The design of the project entails a certain amount of work. The team works systematically and towards a specific purpose. Owing to the high long-term workload, there is a risk of personnel dropping out and needing to be replaced. As the evaluation did not identify any significantly more efficient alternatives, the project is deemed to be **efficient**. Humedica aims to reduce the strain of the project team's work and to make it more varied.

Humedica is an official partner in the *Lebanon Crisis Response Plan* and is active in coordination committees. The productive collaborative efforts are praised by the *Ministry of Health*, the UNHCR and partner organisations. Because of this, the **coherence and coordination** of the project can be seen as being positive. Humedica should increase the accountability towards patients and their participation, thereby improving **appropriateness**.

Increased support for healthcare centres and care for especially vulnerable Lebanese villages or population groups would improve the **connectedness** of the project in the medium term.

2 Introduction

In the seventh year of the Syrian crisis, an estimated 1.5 million people who were forced to flee Syria are now living in Lebanon. This means that Lebanon has, by some distance, accepted more refugees than any other country in the world. Since as far back as 2012, Humedica has been providing primary healthcare to the Bekaa Valley, where many of these people live. Here, Humedica works above all with mobile medical units (MMUs) and a midwife in the informal tented settlements (ITSs). As well as this, it helps with individual cases and undertakes cooperative measures with *Medical Teams International* (MTI) and with a primary healthcare centre (PHC). This evaluation refers to the project in 2016 and 2017, the bulk of which was financed by the German Foreign Office.

It is a formative mid-term evaluation and it has the following functions:

1) To learn (internally) from the evaluation results and process
2) To be accountable to the German Foreign Office
3) To raise the (external) profile of Humedica

The evaluation is conducted within the context of the *Lebanon Crisis Response Plan* – i.e. the humanitarian aid system in Lebanon shaped by local authorities, the UNHCR and other humanitarian players – and pursues three objectives:

- To evaluate the intervention approach in the context of humanitarian medical aid in the Bekaa Valley (including medical quality with the aid of medical expert Dr. Tamer Salim El-Balladani)
- To review the processes for providing aid and institutional measures including the identification of strengths and weaknesses
- Recommendations for the remainder of the project

The external mid-term evaluation was conducted by FAKT with the assistance of an additionally commissioned medical expert.

The OECD DAC criteria for evaluating humanitarian aid are used here with specific subquestions (see Terms of Reference in annex). When focusing on these criteria, a number of points have proved to be particularly important for Humedica and a number of areas and questions have been explored in greater depth throughout the course of the evaluation. The decision on this rested with the evaluator.

This report focuses initially on procedure and methodology, followed by an overview of the project context and of the course of the project. After this, the results of the evaluation and subsequent recommendations are presented.

3 Approach and Methodology

The evaluation consisted of three phases: In the brief inception phase, the evaluator and the relevant staff at the Humedica headquarters initially prepared a joint understanding of the evaluation on the roles of those involved, based on the Terms of Reference. The focus for the evaluation was sharpened and the data collection during the field phase was planned. This phase included telephone and e-mail communication, a kick-off meeting in Kaufbeuren with the relevant staff members and and an inception report. In the subsequent data collection phase, monitoring reports and other project documents were analysed. Between 30 January and 4 February 2017, data were collected together with Humedica employees in the Zahlé region in the Bekaa Valley as well as in Beirut (Lebanon). In the third phase – analysis and reporting – the findings were triangulated (different sources, different methods) and the draft report was discussed at the Humedica headquarters. The final report was submitted on 13 February 2017.

A number of characteristics of the ongoing aid project were addressed methodically:

The Syrian crisis has now lasted over five years and the longer the refugees remain in Lebanon, the more important longer-term prospects become for them. Due among other things to growing tensions among its own population, the Lebanese government is anxious to strengthen its own healthcare system and to reduce parallel structures for refugees. This is worded very clearly once more in the Lebanon Crisis Response Plan 2017-2020: "The expansion of the MoPH-PHCC network is prioritized. The establishment of Mobile Medical Units (MMUs) will be limited to exceptional security and emergency situations"[1]. At the same time, Humedica firmly believes that there is still a need for MMUs and notes that state healthcare structures are suffering from corruption and quality problems.[2] The project has already been influenced by this development, for instance with respect to medication for chronically ill patients, which is now no longer distributed by Humedica. Accordingly, interviews on this political context were of particular importance for the evaluation (local authorities, UNHCR, other aid organisations).

Important information about the political context reaches Humedica above all via the UNHCR. Humedica is interested in a realistic assessment of how its own work fits into the overall humanitarian system in Lebanon. Interviews with authorities, the embassy and key aid organisations were also important in this regard.

The growing tensions between refugees and the Lebanese communities did not affect the evaluation trip.

Medical expert Dr. Tamer Balladani, a physician from Lebanon, was also commissioned by Humedica in addition to FAKT and submitted his own report on the quality of medical aid (see annex). The evaluator and the medical expert collected data both together and individually and analysed them separately. The evaluator is responsible for integrating the results into this evaluation report.

Humedica would like to learn from this evaluation; because of this, the relevant Humedica employees were included in shaping the evaluation and in discussions, as far as sufficient time was available and that it was advisable from a methodological perspective. Thereby,

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[1] LCRP 2017-2020 page 93 (http://reliefweb.int/sites/reliefweb.int/files/resources/2017_2020_LCRP_ENG-1.pdf)

[2] See critical assessment in UNHCR 2013-2014 evaluation (TRANSTEC 2015, page 130) (http://www.unhcr.org/research/evalreports/5551f5c59/independent-programme-evaluation-ipe-unhcrs-response-refugee-influx-lebanon.html).

Humedica cannot only learn from the results (in the report) but also from the process of the evaluation.

Data were collected above all from the following sources:

1) Monitoring reports, other Humedica reports and statistics
2) Key documents on humanitarian aid in Lebanon (*Lebanon Crisis Response Plan*, etc.)
3) Observations during the evaluation trip
4) Interviews and discussions
    - Employees of Humedica and partner organisations
    - Local authorities
    - Refugees in the camps, camp coordinators (*shawish*)
    - UNHCR
    - Other aid organisations
    - Independent observers/experts

(See annex for an overview of people interviewed.)

The bulk of the data collection took place during the evaluation trip in the Bekaa Valley and Beirut (between 30 January and 4 February 2017) and included the following sources:

- Monitoring data and reports and further Humedica project documents (other evaluations from the same context have not been available to date)
- The *Lebanon Crisis Response Plan* being implemented by the Lebanese government and international humanitarian assistance and further UNHCR documents
- Observations during the evaluation trip
- Semi-structured interviews and informal discussions with employees of Humedica and partner organisations, with refugees, local authorities, camp coordinators, the UNHCR, other medical teams and other aid organisations

A number of changes were effected in the course of the project, e.g. the midwife expanded the scope of her work to include health education and the project began providing support to partner organisation *Medical Teams International*. However, the situation at the time of evaluation was not fundamentally different from that at the beginning of the project. Some of the monitoring data were not collected from the beginning of the project.

A slight positive bias can be expected given the tendency among certain groups to accentuate the positive aspects of the project, e.g. refugees (out of gratitude or politeness), other humanitarian players (for collegiality reasons) and local authorities (in order to continue receiving international aid). Difficulties and improvement potential referred, among other things, to the design of the project and were brought up above all by Humedica employees. Owing to the triangulation of various data sources and collection methods, it can be assumed that the main results of the evaluation are reliable.

4 Project Context

In spite of its enormous and growing economic, social, demographic and political difficulties and its security problems, Lebanon opened its borders to a large number of refugees from Syria. In October 2016, the Lebanese government estimated the number at 1.5 million

people. Of these, around 1 million people are registered by the UNHCR; since 2015, the Lebanese government has prohibited further registrations. The living conditions of most Syrian refugees are precarious, with over 70% living in poverty. Many have great difficulty renewing their residence permits and meeting the high costs. The vast humanitarian needs not only of the refugees but also of the host population exceed the capacity of the Lebanese authorities. The extensive international aid (2017 requirement: US$2.75 billion) has not been sufficient to date; the aid plan in 2016 was only 46% financed.[3]

Figure 1: Reference map, source: LCRP 2017-2020, page 6

It is important to note, however, that one of the reasons for the vast humanitarian needs is that existing problems in Lebanon – such as unemployment (especially youth unemployment), poverty and the informal labour market – were exacerbated by the large number of refugees. Distribution of wealth is extremely uneven in Lebanon.[4] Because of this, the LCRP

[3] According to Financial Tracking Service (FTS) on 16 January 2017.

[4] With a Gini coefficient of 86.1 according to the Global Wealth Databook 2016, page 107 (http://publications.credit-suisse.com/tasks/render/file/index.cfm?fileid=AD6F2B43-B17B-345E-E20A1A254A3E24A5), Lebanon has one of the highest levels of income inequality in the world.

states that, of the 5.9 million people living in Lebanon, 3.3 million are dependent on humanitarian aid (LCRP 2017-2020, page 10). These deep-rooted problems pose a challenge for the transition from emergency aid to longer-term development assistance.

After over two years without a president, Michel Aoun was elected head of state of Lebanon in October 2016. Since then, the government has been more effective, although it is not clear how long this stability will last. The Lebanese healthcare system is highly complex, fragmented, largely privatised and not very transparent. According to various interviewees, the public healthcare system and, above all, care for the poorer population are not a high priority for the government or, in turn, for cooperative efforts with international players.

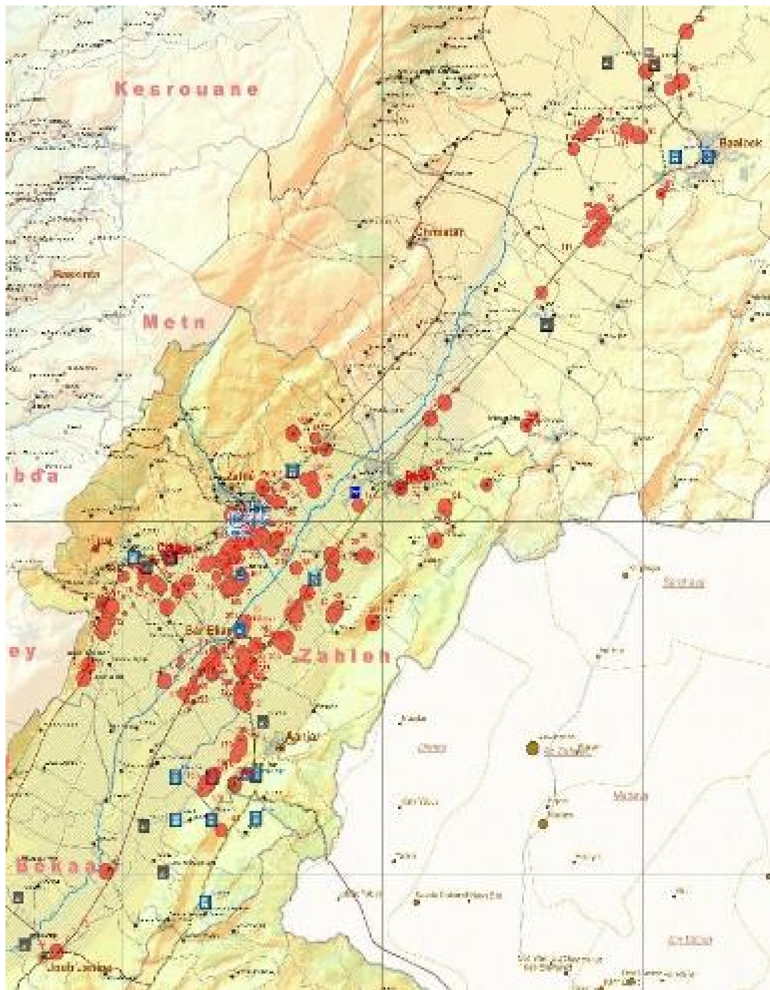

Figure 2: UNHCR Bekaa ITS 2013

Humedica is active in the Bekaa Valley, where an estimated 500,000 refugees live, some 350,000 of them registered. Around one third live in informal tented settlements (ITSs), the others in houses, apartments, garages and other buildings. Aid organisations assume that the ITS inhabitants already belonged to the poorest segment of the population in Syria's rural regions. The ITSs vary in size, are irregularly distributed and are required to keep a distance from villages and main roads.

The Bekaa Valley is also home to many Bedouins who had close ties with Syria and, in some cases, have lived in both states. They are discriminated against and, for the most part, have not had Lebanese nationality for decades and are therefore not entitled to full access to the Lebanese healthcare system.[5]

[5] See Chatty D, Mansour N, Yassin N. 2013: Bedouin in Lebanon: Social discrimination, political exclusion, and compromised health care (https://www.ncbi.nlm.nih.gov/pubmed/23453316).

The security situation in Zahlé is relatively good and far better than in the north of the Bekaa Valley.

Lebanon Crisis Response Plan

The LCRP is based on the Lebanese government's health strategy from 2016. This aims to integrate all aid measures into the national healthcare system by 2020 (LCRP 2017-2020, page 93). This includes strengthening the public system through additional personnel, equipment and training. It also aims to increase the number of primary healthcare centres (PHCs) belonging to the official Ministry of Public Health (MoPH) network. A total of 50 additional PHCs are to be included in the MoPH network.

Mobile medical units (MMUs) are only to be deployed in exceptional circumstances (vaccination campaigns, epidemics, lack of PHCs, security problems). Because of this, the LCRP has not budgeted any funds for MMUs.

Medication for chronically ill patients is provided through a project with the *Young Men's Christian Association* (YMCA). The LCRP states that important humanitarian players such as Doctors without Borders (MSF) and the International Committee of the Red Cross (ICRC) are working outside the scope of the LCRP.

The LCRP sets priorities and formulates goals. How relevant these projects are and how exactly these plans are to be implemented is not clear in every area; this must be structured by the players involved. Great difficulty is also being experienced integrating the aid into the public Lebanese system in other areas – education, for example.

5 Overview of the Project

Humedica has been involved in providing aid to Syrian refugees in Lebanon since 2012. The current project has the following overall objective:

To improve health conditions and the quality of medical aid for registered and non-registered Syrian refugees in informal tented settlements (ITSs) and to reduce the burden on the local healthcare system by providing support for a primary healthcare centre for Syrian refugees and Lebanese in Bekaa.

To this end, three results have been formulated:

1. To improve healthcare in the Bekaa Valley and in the ITSs located outside the city of Zahlé for some 10,000 registered and non-registered refugees through the ongoing use of two mobile clinics and by expanding individual aid for refugees in particularly acute need.
2. To provide information on non-communicable diseases in order to bring about lasting improvement in the life situation of chronically ill patients in ITSs.
3. Free access to medication and special assistance for particularly vulnerable refugees and members of the local population during visits to PHCs.

The project is scheduled to run from 14 February 2016 to 12 February 2018 with a volume of €1.4 million. The current project implementation consists of five pillars:

(1) Two MMUs visit over 30 ITSs every month for one to two days.

(2) The special case officer has dealt with over 200 individual cases since the project began; these cases were forwarded to him by the MMUs for further examination or treatment.

(3) The midwife looks after pregnant women and young mothers and, since September 2016, has also undertaken health educational work. Generally speaking, she works in the same ITS as one of the MMUs.

(4) Since April 2016, Humedica has financed one of two MTI teams for health education on non-communicable diseases and providing assistance to chronically ill patients with two *Community Health Promoters* and with five *Refugee Outreach Volunteers* in each ITS.

(5) As well as this, Humedica finances the PHC in Qab Elias by providing its own medication and by financing eye and teeth check-ups.

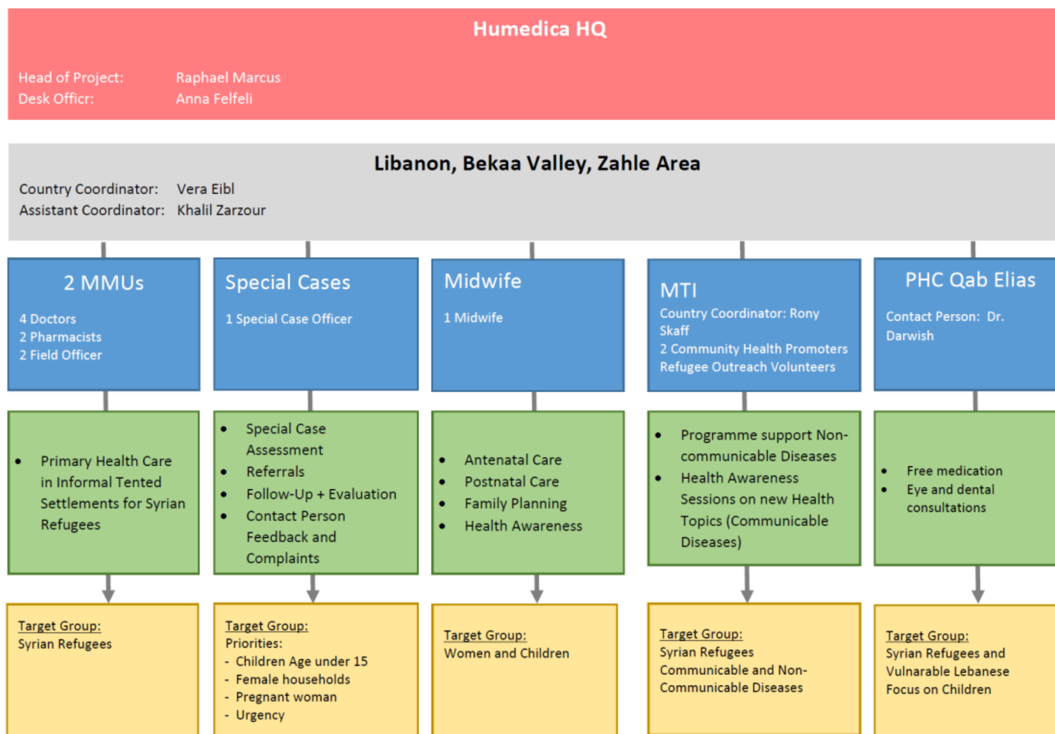

Figure 3: Project structure, source: Humedica

The regional coordinator leads a team of approximately 14 Lebanese employees and coordinates cooperative measures with MTI and the Qab Elias PHC.

As well as this, funds from the *BILD hilft e.V.–"Ein Herz für Kinder*" campaign in 2015 allowed a bus to be purchased and converted to an equipped clinic bus. Once completed and registered, the bus was to be used for one of the two planned Humedica MMUs. After the end of the project, the bus was to be given to Lebanese NGO *Association L'Ecoute.* Owing to outstanding invoices between the companies involved in connection with an insolvency and a death, Humedica has not yet been able to use the bus, which has been converted and ready for use since September 2016.

As the process for registering Humedica in Lebanon has not yet been completed, personnel are working with service agreements. For legal reasons, Syrian citizens are not employed.

Many refugees live in the project region, which can be reached quickly and easily by the main road from Beirut to Damascus. This is one of the reasons why the German embassy sent a number of delegations to visit.

The ITSs supplied by Humedica are found in the Zahlé district to the south. Most of these ITSs are not located within the catchment area of the PHC in Qab Elias, southwest of Zahlé, which Humedica assists. Liaising with other aid organisations in the region, the project selects camps based on healthcare needs (e.g. outbreaks of infectious diseases) and based on whether or not the patients are able to reach PHCs in their local area.

Figure 4: Assisted ITSs south of Zahlé (February 2017), source: Humedica

Generally speaking, each MMU consists of two doctors, a pharmacist and a field officer. If only one pharmacist or only one field officer is available, all of these personnel work together in a larger team.

One day before the visit, the coordinator of the ITSs (*shawish)* is informed and asked to make one family's tent available for the MMU to work out of. In front of the tent, the field officer registers the patients who are examined in turn by one of the doctors and, if necessary, provided with medication by the pharmacist.

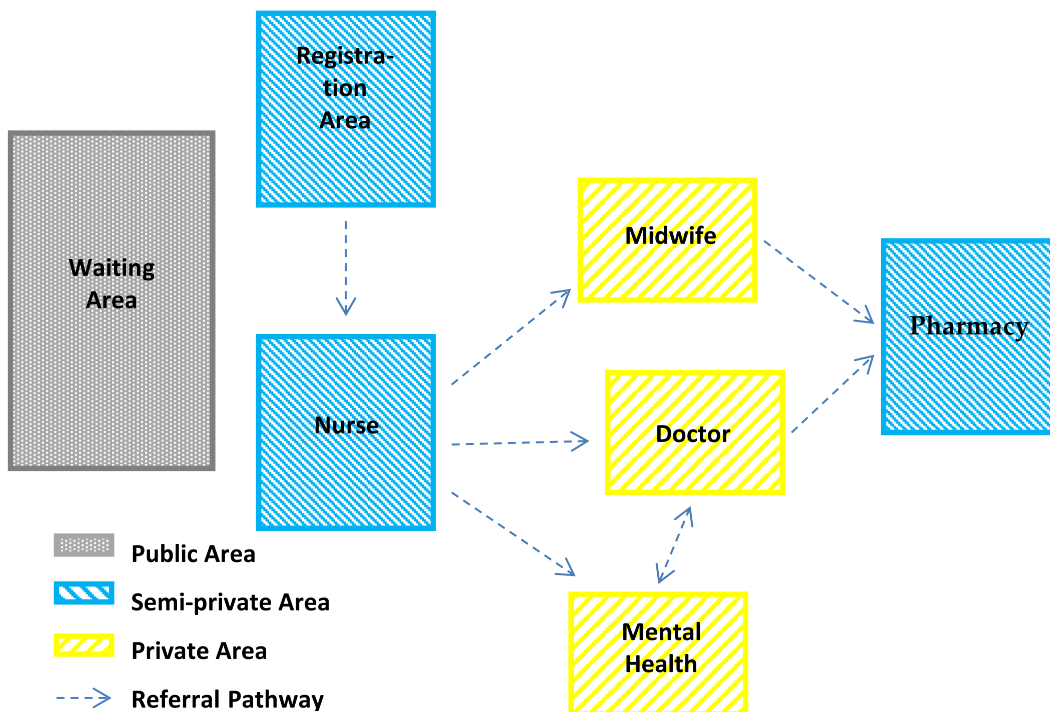

Figure 5: Reference model of an MMU, source: MMU Practical Recommendations

6 Results

The results of this evaluation are reliable given that different sources (own personnel, refugees, other aid organisations, local authorities) and different research methods (analysis of project documents, interviews, observation) yielded identical results for the evaluator and the medical expert.

6.1 Relevance

Background

A project is deemed to be relevant when the project work is in line with local needs and priorities. The evaluation does not include gauging the relevance of the project in global and regional terms, i.e. the degree to which humanitarian aid in Lebanon is provided compared with the need within Syria or in Iraq. The evaluation should take into account the following specific questions:

How are the intervention concept and project design evaluated? Is a realistic approach taken to dealing with objectives, risks, assumptions and indicators? What contribution does Humedica make to the health cluster?

Findings

The need and the priorities of the government and international humanitarian aid are clearly defined at national level in the LCRP. The healthcare sector is in fourth place, with an estimated need of USD 308 million. Within the *Operational Response Plan Health*, the main aim is to improve primary healthcare. The PHCs already had a poor reputation before the Syrian crisis and were only used by the poorest segment of the population. Although the quality of many PHCs has improved in recent years, private practices are still preferred by those who can afford it. Even though Syrian refugees also have their doubts about the quality of care in the PHCs, the number of patients has increased sharply and is putting a con-

2017 TARGET & REQUIREMENT BY SECTOR

People Targeted	Sectors	Requirements (US$)
2,236,299	SOCIAL STABILITY	123.8m
1,959,428	WATER	280m
1,887,502	PROTECTION	163.8m
1,535,297	HEALTH	308m
1,276,000	BASIC ASSISTANCE	571.5m
1,119,171	ENERGY	99.2m
961,388	FOOD SECURITY	507.2m
543,616	EDUCATION	372.6m
536,002	SHELTER	128.7m
65,557	LIVELIHOODS	195.7m

Figure 6: Planned aid per sector, source: LCRP 2017-2020 page 10

siderable strain on the Lebanese healthcare system, particularly from a financial perspective. According to LCRP figures, 16 percent of Syrian refugees did not have access to primary healthcare in 2016, primarily due to cost reasons (LCRP 2017-2020, page 14).

According to LCRP data, the Zahlé region is one of the most vulnerable areas in Lebanon. However, the level of vulnerability is even higher in other regions, such as the north-east and in southern Beirut. Zahlé now has a comparatively good infrastructure and is relatively safe.

It is not clear how many of those who need help are former seasonal workers who relocated their families to Bekaa because of the war. It is also unclear to what extent these are Bedouins and to what extent their situation and needs are different (see footnote 5).

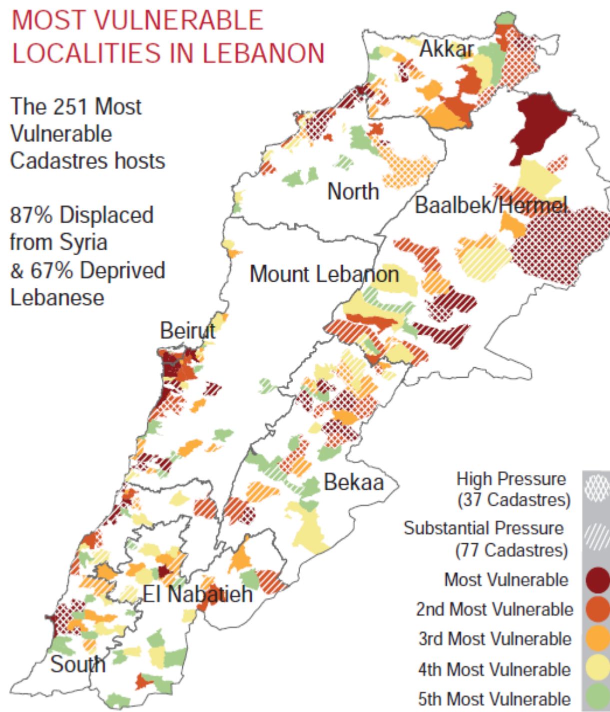

Figure 7: Vulnerable regions, source: LCRP 2017-2020, page 12

In total, very few Lebanese are among those receiving aid from the Humedica project – as is the case with other MMUs or PHCs.

It was clear from the interviews that the local authorities set different priorities than the LCRP. Accordingly, the responsible actors in the Bekaa Valley still feel that there is a clear need for MMUs, particularly for refugees. Many refugees are not mobile, firstly because of the costs involved in visiting PHCs and secondly because many Syrians do not have residence permits. Unlike poor Lebanese, they are afraid of being arrested at checkpoints. A survey of patients conducted by Humedica in August 2016 confirmed that the PHCs do not appear to have been a realistic alternative for many patients to date.

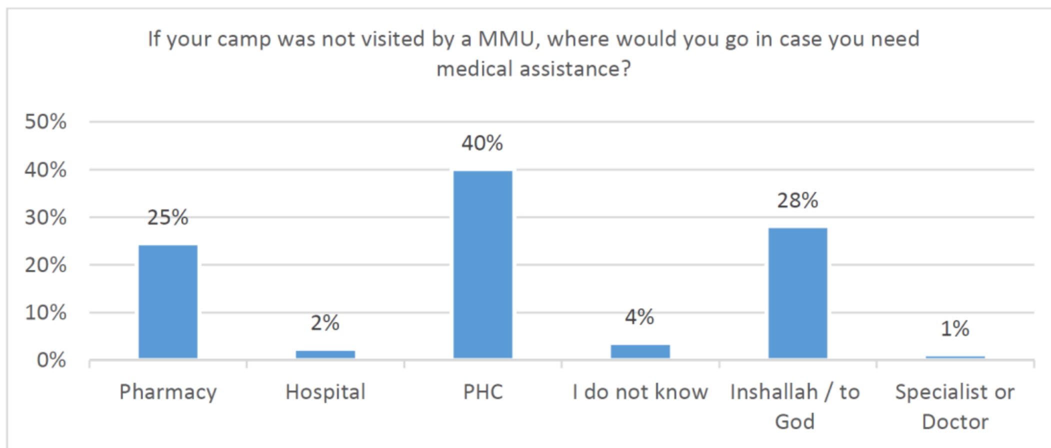

Figure 8: Alternatives to MMUs, source: Humedica (August 2016)

In addition to the lack of information, there are limitations as regards costs and mobility. Statements made during the Humedica patient survey have been confirmed in the interviews. This problem is known to all players:

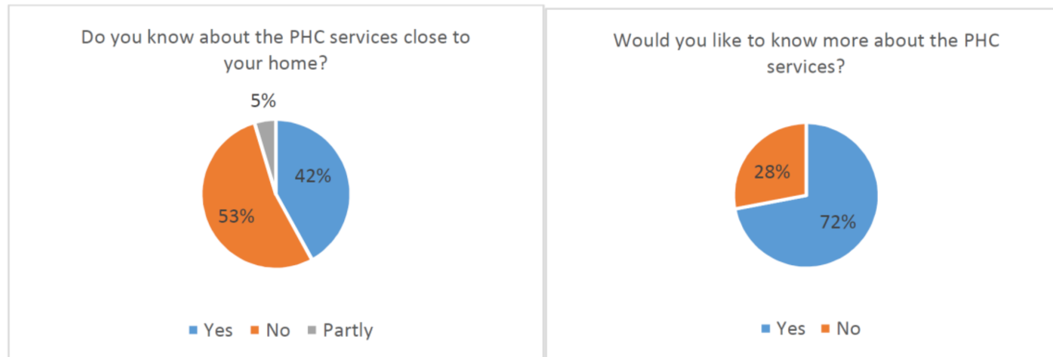

Figure 9: Information on PHCs, source: Humedica (August 2016)

The MoPH states that MMUs diagnose far more respiratory diseases than PHCs – this is presumably because many of these patients do not go to PHCs. In addition, MMUs detect many infectious diseases and therefore also have an important function in disease control. After all, most PHCs have not been able to provide health education in the ITSs to date.

The ministry is burdened with debts from the past and it has not always been possible to identify a clear ministry stance at the various levels in recent years. As well as this, the ministry is not able to exert much control over private organisations such as primary healthcare centres.

Most actors support a transition from the "emergency phase" to the "development phase" – as one interviewee put it, "the situation is chronic, not acute". At the same time, however, there is broad consensus that humanitarian assistance remains necessary in Lebanon even in the seventh year of the Syrian crisis. But any development policy faces the challenge that it must address not only the prospects of the Syrians but above all the problem of poverty and inequality in Lebanon, which is even more politically sensitive. It would be misleading to attribute all problems primarily to the Syrian crisis.

Besides Humedica, there are three NGOs working in the region with MMUs. Humedica is responding to the government's strategy of strengthening the role of the PHCs and, in the past year, has therefore discontinued its work in several ITSs from which nearby PHCs can be reached easily.

Appraisal

Helping to provide primary healthcare in the Bekaa Valley for refugees – and, to a limited extent, to Lebanese people as well – meets the humanitarian requirements. It is also in line with the priorities of the main actors in the region and is therefore seen as being relevant. For the project period and, it is expected, for the term of the LCRP, this also applies explicitly to the use of MMUs. Humedica is visible in the humanitarian system as a relevant aid organisation from Germany with the financial support of the German Foreign Office. The intervention concept is well founded: see Chapter 6.2 *Effectiveness* for indicators and Chapter 6.4 for coordination.

Recommendations

Humedica should continue to liaise with the UNHCR and MoPH on a regular basis to determine where the need for MMUs is especially high and to respond accordingly. To this end, it can be necessary to update Humedica's security assessments.

In order to meet the needs of the Lebanese population, the possibility of including remote Lebanese villages or other high-need Lebanese beneficiaries should be considered.

The monthly rhythm has proved its worth and is coordinated with other aid organisations. However, this should not be implemented as a strict rule and more flexible intervals should be possible if required: both shorter intervals in the event of a greater need and longer as a part of an exit strategy. The need for MMUs should also be considered in connection with the need to avoid beneficiaries becoming dependent on an aid instrument that is planned for a limited period of time.

See Chapter *6.5 Further results* for details on the prospects of supporting PHCs from 2018 onwards.

6.2 Effectiveness

Background

A project is deemed effective when it achieves its purpose defined together with stakeholders and meets its stated intervention objectives. Or if results indicate that the stated outcomes can be expected. The evaluation should take into account the following specific questions:

To what extent are the project objectives reached and what were the reasons for any deviations that might have occurred? How is the quality of assistance to be assessed, particularly the medical quality from the perspective of the medical expert? How are the strategies for strengthening local structures evaluated? Which unplanned (positive and negative) results are identified?

Findings

In every quarter, Humedica determines the extent to which the indicators for the specific objective of the project are reached. The data from the last overview show clearly that most indicators are being reached, with some figures well in excess of the target figure, while others are marginally lower.

Indicators from the logframe	**Reached 15 December 2016 (planned: 45%)**
Additional measures were added to the medical aid programme	
86,400 treatments were carried out after 24 months in the ITSs	35,254 treatments took place (41%)
3,600 antenatal care (ANC) examinations were carried out after 24 months in the ITSs	1,809 ANC visits took place (50%)

More than 90% of patients and 95% of pregnant women rated the quality of Humedica's care as being positive	(Patient survey August 2016 – see below: 84%)
At least 720 patients were referred to the Lebanese healthcare system and its partners	425 patients were referred (59%)
600 ROVs in 120 ITSs were provided with medical equipment	478 ROVs were recruited (80%)
After 24 months, 2,000 affected individuals were informed about chronic diseases and shown how to use medical equipment for chronically ill patients	1,823 people were informed about non-communicable diseases (121%) 346 people were informed about communicable diseases; reached: 17%
At least 12,800 patients at Qab Elias PHC had access to free medication financed by Humedica	4,910 patients had access to free medication in the PHC (38%)
At least 720 patients benefited from the additional measures (eyes + teeth + laboratory tests) at Qab Elias PHC	313 patients benefited from additional measures in the PHC (43%)
At least 200 individual cases were treated and closed	134 individual cases were treated and closed (73%)

The **MMUs** treat acute diseases once a month in approximately 35 ITSs. If necessary, they refer patients elsewhere: to specialists, for laboratory tests, vaccinations or for treating chronic diseases. As many of the men work during the day, it is above all women and children who come to the MMU consulting hours.

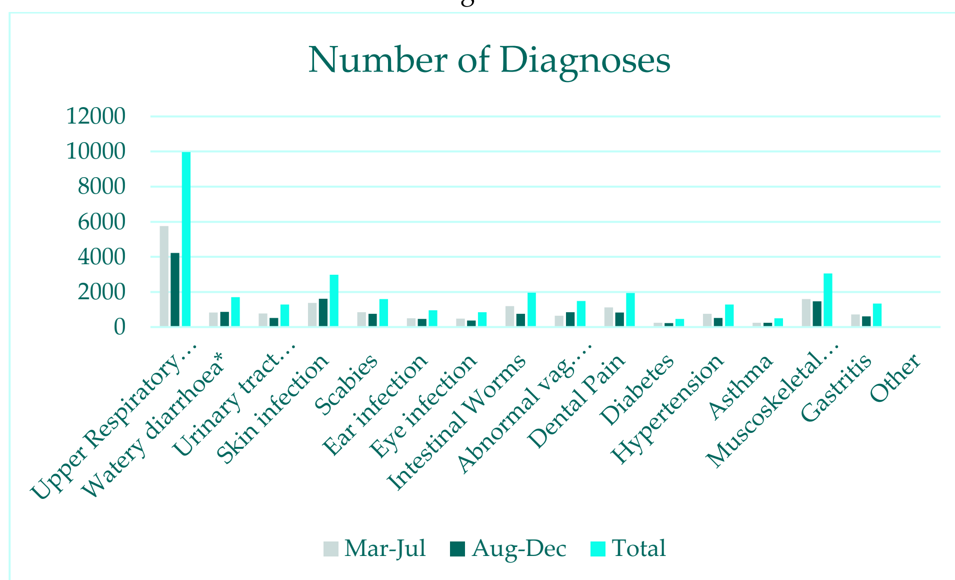

Figure 10: Diagnoses March-December 2016, source: Humedica

In August 2016, Humedica conducted a patient survey that indicated a high level of satisfaction among patients with the work of the MMUs:

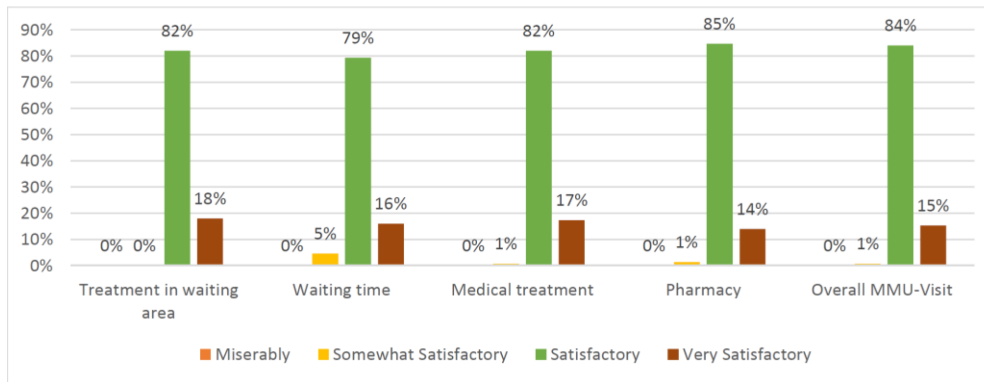

Figure 11: Patient satisfaction, Humedica (August 2016)

This Humedica survey was confirmed in interviews and in talks with *shawish* and patients. Many interviewees stressed that they preferred Humedica to other aid organisations. One *shawish* wrote to Humedica and asked them to provide for his ITS because he was dissatisfied with the other aid organisation. He also stated that patients from other neighbouring ITSs who were provided for by the other aid organisation preferred to come to this ITS when the Humedica MMU was there. Between the MMU visits, many patients only go to pharmacies if needed, and not to PHCs. The UNHCR also confirms the high quality of Humedica's work, which is geared towards the MMU Best Practices, which Humedica was involved in developing. While other NGOs had to deal with problems such as the availability of all medication, this is not associated with Humedica, according to UNHCR. The community workers network, focus group discussions and other NGOs are the main sources of information for UNHCR.

Interviewees mention the following factors for the high quality of MMUs, including in comparison with other organisations: The Humedica teams have a good relationship with patients and are accountable to them. Humedica has qualified, motivated and professional staff. The teams are sensitive and friendly in their dealings with patients. They have a wide and complete range of medication. The *Special Case Manager* and the midwife (see below) supplement the work of the MMUs.

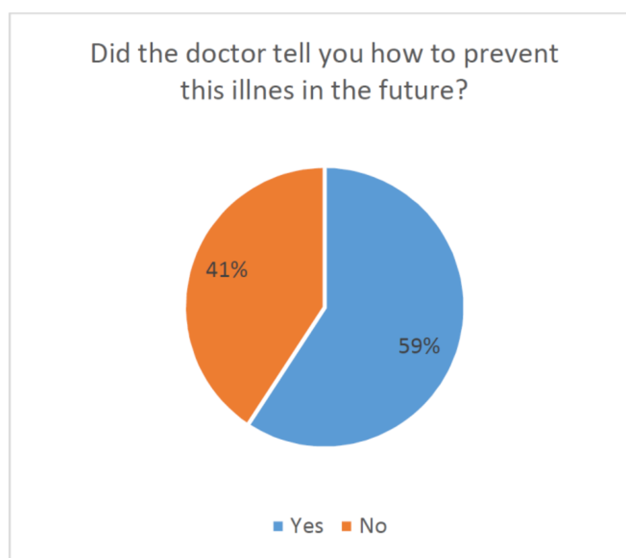

Figure 12: Information on prevention, source: Humedica (August 2016)

The drug therapy is often geared towards symptoms. The check-up by a physician also contains health education, for instance on hygiene, dental care, clothing or smoking. However, poor living conditions exist in many ITSs, leading to respiratory diseases, etc.

The MMU issues a health card containing personal data, diagnosis and therapy. However, most

patients do not bring this card with them on their next visit and Humedica does not keep patient files itself. Other teams – for example, Lebanese NGO *Beyond* – record patient data digitally with the aid of tablets.

Providing patients with medication for acute illnesses via **pharmacists** is working well. In recent years, better financing has made it possible to improve the amount and scope of medication. Chronic illnesses are not treated by MMUs and psychotropic drugs are not issued; these are only available in the PHCs.

The **Special Case Officer** supports secondary care – extending beyond primary healthcare – for patients from all ITSs covered by Humedica. He seeks out suitable specialists and institutions, compares offers, organises examinations or treatments, clarifies financing and, to a certain extent, oversees the process on location. At the time of the evaluation, he was looking after 58 cases, including tonsillitis, heart diseases, eye diseases (such as cataracts) but also psychological disorders. Humedica has established a systematic approach for selecting and treating patients and for documentation.

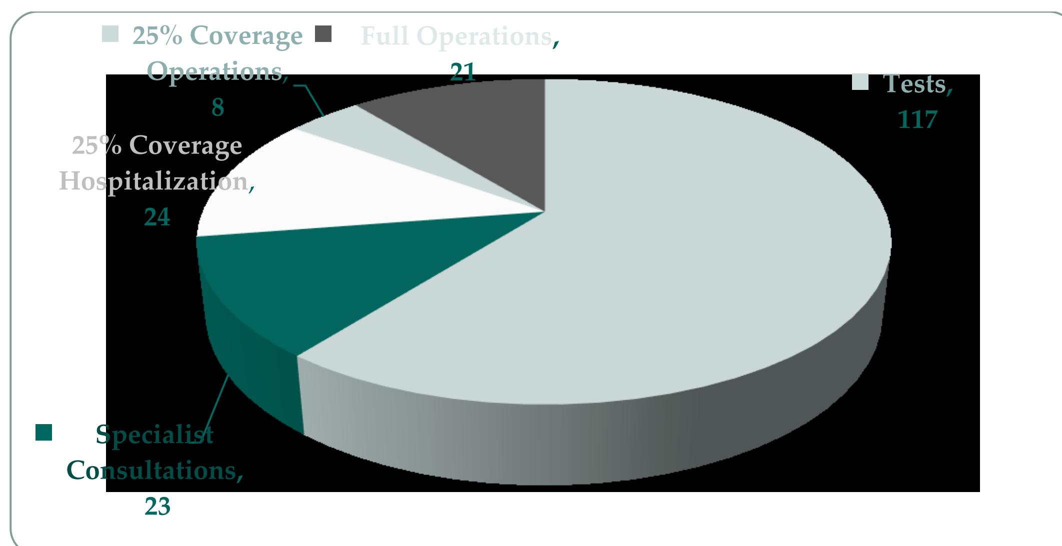

Figure 13: Isolated cases from March-December 2016, source: Humedica

In most cases, Humedica bears 25% of the costs that are not covered by the UNHCR. In the case of non-life-threatening diseases, it covers up to 100% of the costs. In these cases, the *Special Case Officer* uses a special evaluation form. Hospital stays are necessary in a quarter of cases. Cases without financing are also monitored. Every two months, Humedica discusses and decides upon the cases, focusing on life-saving measures and on patients from the ITSs in which Humedica is active. The €2,500 that is available every month is used up. Many patients and families turn to the special case officer with their concerns; between MMU visits, he is often the first point of contact for medical problems.

The midwife provided prenatal care in a total of 1,809 cases in 2016. She also enjoys the trust of many women and, in addition to her prenatal care, postnatal care and family planning work, she is also an important person of trust for other matters up to and including gender-based violence.

Although there are ITSs in which Humedica and MTI (with *Refugee Outreach Volunteers*) both work, they have not worked together on location in the ITSs to date.

Humedica provides financial support for MTI's work on **chronic illnesses and health education**.[6] In a study with 600 persons, MTI identified five topics of particular importance. Each of the two teams consists of two promoters and one driver who identify, train and supervise five ROVs (mostly women) in each of 85 ITSs. The ROVs have information on hotlines and brochures, arrange referrals and give training themselves, for example on breastfeeding. As well as this, they have equipment for measuring blood pressure and blood sugar so that patients with these chronic illnesses do not have to seek out other institutions. The ROVs are further motivated by being provided with jackets, hygiene sets and certificates as well as by the higher social status. MTI runs this project very systematically, with good organisation and concentration. The cooperation with Humedica functions smoothly, without any problems. In spite of the ties between the two organisations – among other things, the MTI Country Manager used to work at Humedica – there is no connection so far between the work carried out by Humedica MMUs and that of MTI's ROVs.

The *Islamic Welfare Association* has been operating a **healthcare centre** in Qab Elias since 1993. It provides primary healthcare for some 23,000 Syrians and 70,000 Lebanese (together with a further healthcare station). The organisation also states that patients come from other localities such as Baalbek. As in other PHCs, the number of patients has risen with the war in the neighbouring country but there are relatively few Lebanese among them – two thirds of the patients are Syrian refugees. The PHC also receives support from other NGOs.

Humedica supplies medication based on a list drawn up by the PHC itself. Some of the medication supplied to the PHC by Humedica is also provided by the MoPH. However, their deliveries are not reliable. The PHC emphasises how important it is that Humedica – unlike other support organisations – delivers based on requirements. The PHC draws up daily lists for distributing this medication. Humedica carries out random testing by calling up patients. However, telephone numbers are not always given. Moreover, Humedica aims at working more systematically on accountability and corruption.

Figure 14: Support for Qab Elias PHC

As well as this, Humedica made arrangements with two clinics regarding laboratory tests from which Humedica receives monthly invoices for the patients transferred there.

An **unplanned effect** of its work observed by Humedica is that the midwife fulfils important functions in the psychosocial field and in health education. Another positive factor is that the medical team can communicate important information – for example from the

[6] As well as this, MTI has been providing support to a PHC since 2016 and sees this work as a step "from emergency to development". In the past year, MTI discontinued work with two MMUs in 62 ITSs on chronic diseases because these are now only to be treated in the PHCs.

UNHCR – in the ITSs because the patients trust them. A negative effect that has come to light is that the sustained high level of expectations that some ITSs have of MMUs is increasing their dependency on the service. Above all, it has proved relatively difficult to reach the bulk of the Lebanese population in need of aid through the work undertaken to date, which would help to curb the growing tensions between Lebanese and Syrians.

Appraisal

All in all, the project is well on the way to reaching its three project goals: to improve healthcare for 10,000 refugees around the city of Zahlé, to provide health education and to ensure better access to the Qab Elias PHC for refugees and locals. The medical quality is high. This evaluation is confirmed by the positive assessments from the UNHCR, the ministry and the German Embassy and by the positive results of the patient survey in August 2016. Because of this, the project is deemed to be effective.

Recommendations

Some of the following recommendations are already being considered by the coordinator and the Humedica team – among other things, this became clear in a team workshop in which aspects were also discussed which are dealt with in this report under relevance or efficiency.

Humedica should continue the cooperation with MTI, ensuring that their respective efforts supplement and bolster one another. Synergy effects are conceivable above all with regard to training ROVs, providing joint care to chronically ill patients, health education, prenatal and postnatal care and involving ROVs in MMU visits. For this purpose, the relevant contacts should be passed on immediately and the number of joint ITSs increased in future.

Possible cooperative measures with other medical players, such as the midwives of international NGO *International Orthodox Christian Charities* (IOCC), should be used.

Given the great need for health education, the MMUs should – contrary to the specifications of the LCRP – continue to provide health education insofar as this cannot be ensured by other means.

Humedica works with MMUs worldwide and should investigate the extent to which teams can keep digital patient files in future. These files

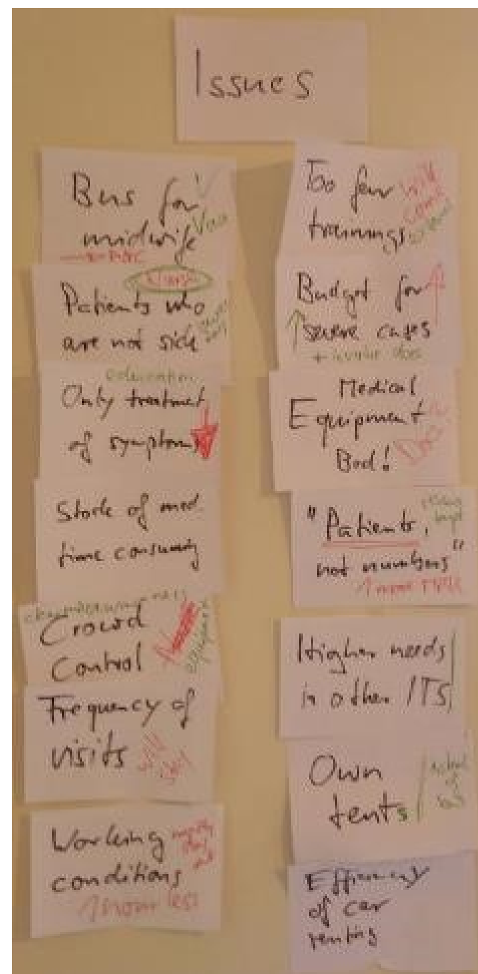

Figure 15: Team workshop with the evaluator

should be compatible with the systems used on location, while complying with data protection requirements.[7]

The internationally supported healthcare system still does not cover the costs for many treatments (particularly problematic at present are cancers and dialysis). As medication for chronically ill patients is now only provided by the state system, Humedica should investigate whether the funds saved here can be used to increase the budget for special cases.

In some cases, the midwives work in tents that must be used by a family at the same time. Humedica should ascertain whether a suitable vehicle could be used for this purpose in order to provide women with the necessary privacy. As well as this, the midwife has also integrated gender-based violence into her work. Humedica should train the midwife and the other medical professionals on this topic and examine the possibility of providing this more systematically in future (see LCRP page 91).

The high number of studies with negative results indicates that the MMUs also meet a psychological need. Given the stigma that is often attached to psychological problems, creating resources for dealing with this within the medical teams would make it much easier for patients to accept such offers.[8] Humedica itself does not have much expertise and should therefore continue pursuing the desired cooperation with players specialising this area.[9]

Further recommendations can be found in the medical expert's report (see annex).

6.3 Efficiency

Background

The efficiency of a project is measured based on the ratio of outputs to inputs. Above all, it is important to determine whether the same outputs could have been achieved with other approaches requiring fewer inputs. An audit was not part of this evaluation. The evaluation should take into account the following specific questions:

Are the funds being used efficiently (including dealing with personnel, fluctuation, registration)? Are the responsibilities in the project clearly distributed, including implementation and monitoring/reporting? Is Humedica efficient in dealing with risks and opportunities?

Findings

The Humedica team works very systematically and is clearly organised and transparent in its activities. As the MMUs travel to a new ITS every one to two days, one family is required to vacate its tent each time and to make it available to Humedica for the duration. It frequently occurs that a large number of patients come, in some cases also from other ITSs in the area, who are registered and classified by the field officer. There are also regular disputes about the order in which patients are seen, about the treatment administered and

[7] For this purpose, IOCC in Lebanon uses www.kobotoolbox.org and https://opendatakit.org/. (Further examples: www.msf.org.uk/sites/uk/files/1._050_MARR_innovation_OCA_FINAL.pdf, https://en.wikipedia.org/wiki/OpenMRS)

[8] Compare SPHERE Handbook 2011, page 333-335 on mental health, the *key actions* include: "Ensure that there is at least one staff member at every health facility who manages diverse, severe mental health problems in adults and children" (www.sphereproject.org).

[9] See SPHERE Handbook 2011, page 334, LCRP page 91 (www.sphereproject.org/handbook) and http://blogs.worldbank.org/arabvoices/syrian-refugees-mental-health-crisis.

about refusing medication to patients who do not have a medical reason or a prescription from a doctor. Procuring medication from pharmacies (including comparative offers) is also time-consuming. The Humedica team is aware of these difficulties and attempts to keep them to a minimum.

In the past year, the team established various processes and forms with a view to systematising, simplifying and documenting the work, for instance when dealing with special cases. The process of including new ITSs has also been systematised, e.g. by Humedica explaining to the *shawish* the conditions for the MMUs, involving him in registering patients and clarifying the medical criteria for dispensing medication. This helps to minimise misunderstandings and difficulties later on.

The work in ITSs – five days a week and full-time, for many months at a time – is challenging and demanding for the team. It is a regular occurrence for medical personnel to be burnt out and leave after some time. It is difficult to hire qualified and motivated personnel, especially physicians. Pronounced hierarchical structures between doctors and the other staff may be standard practice in other contexts, but they often serve little purpose and are not wanted by Humedica. It has been possible to clarify problems in this connection in the past.

The indicator for the number of patients in the MMUs has been calculated in such a way that every doctor treats 50 patients a day. According to the SPHERE standard, this is not an average target figure but an upper limit that should not be exceeded continually. As well as this, there are periods where doctors are sick or on leave. This figure should therefore not be seen as a quantitative target but rather as an upper limit necessary for maintaining a high level of quality. (It is doubtful whether it makes sense to set a target value for "special cases".)

As the project does not have a driver, other staff members – above all the assistant coordinator – are required to assume driving duties. As the process for registering Humedica in Lebanon has not yet been completed, Humedica rents its project vehicles.

The clinic bus sub-project has been completely inefficient to date, the invested time and financial resources not having led to any output to date.

The project was monitored through the coordinator's reports, through monitoring trips and through contact between the administrative office and the coordinator. As well as this, Humedica has begun to introduce the *Quarterly Project Process Evaluation* instrument. The collaboration between the project in Lebanon and the headquarters in Kaufbeuren is working well overall. The responsibilities and decision-making procedures in the administrative office do not always appear to be completely clear and efficient. Humedica makes every effort to ensure that all legal conditions in the host country are complied with in full and seeks legal advice on this. This can lead to very long-winded processes that do not always have a successful outcome. When the project components were monitored last year, it was found that a physician had filled out fictitious patient charts himself. One question that arises when monitoring the Qab Elias PHC is how in-depth the controls should be.

Appraisal

The design of the project entails a certain amount of work. The team works systematically and towards a specific purpose. Owing to the high workload, there is a risk of personnel dropping out and needing to be replaced. The coordinator makes every effort to ensure reliable and systematic project work and actively ensures a high level of quality. To do so, she requires appropriate backstopping from the administrative office. The team is looking

into possible improvements itself. Unforeseen problems have led to major delays in commissioning the clinic bus.

As the evaluation did not identify any significantly more efficient alternatives, the project is deemed to be efficient.

Recommendations

Humedica should counter the high long-term workload for the team by looking into the following options:

- Reducing the daily target of 50 patients per doctor
- Introducing systematic supervision for the teams
- Introducing more internal or external training and variety (e.g. health education in the ITSs)[10]

As well as this, the administrative office should ensure effective backstopping for the project coordinator.

Unlike many other MMUs, this project does not include nurses. Nurses could assume a variety of functions: prioritising patients, performing pre-examinations, undertaking health education and dispensing medicine[11]. They could also assist the special case officer. (A fax machine would also be helpful for the special case officer.)

The project coordination in Lebanon bears a high level of responsibility for the quality of the work, coordination with other players, accountability towards patients and local authorities, and for project staff. Humedica should reinforce the project coordination, for instance including personnel management (vacancies, applications, induction package, employee appraisals, etc.) in the qualification system. Since the rule of law is not implemented in Lebanon in the same way as it is in Germany (as is also the case in many other countries), Humedica should also consider giving the project coordination greater responsibility for dealing with local legal questions correctly, sensitively and efficiently.

Further recommendations can be found in Dr. Ballani's report (see annex).

6.4 Coherence, Appropriateness, Coordination and Connectedness

Background

The coherence of a project refers to the extent to which different humanitarian aid actors pursue the same goals and, in addition to humanitarian assistance, also provide humanitarian protection. A project is deemed appropriate when it is adapted to the specific requirements, strengthens local ownership of the project and demonstrates accountability towards local players. In many cases, humanitarian aid is not sustainable; however, it should take into account more long-term developments without unnecessarily complicating them – this is meant by the criterion connectedness.

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[10] Other organisations reduce workloads by having the teams only work in a camp for half a day and spending the rest of the time in their own health centre.

[11] According to Humedica's legal advisors, the pharmacist is necessary under the given legal conditions – for example, medication cannot be dispensed by a nurse. Unlike other organisations, Humedica does not have any Syrian staff either – this is due to legal reasons.

The evaluation should take into account the following specific questions:

Is the project well-coordinated with other humanitarian aid actors? How is the accountability towards those receiving aid, local authorities and donors to be rated? Which connections and synergies have been established with other players? How is the quality of the cooperative measures, especially with Lebanese organisations (*localisation*) to be rated? Does Humedica apply the humanitarian principles coherently? To what extent are cross-cutting issues (gender, age groups) taken into account? How does Humedica deal with the instructions of the Lebanese government to reduce parallel structures to the national healthcare system and to strengthen the latter instead?

Findings

Humedica is an official LCRP partner and therefore integrated in the Lebanese government's aid system and international humanitarian aid:

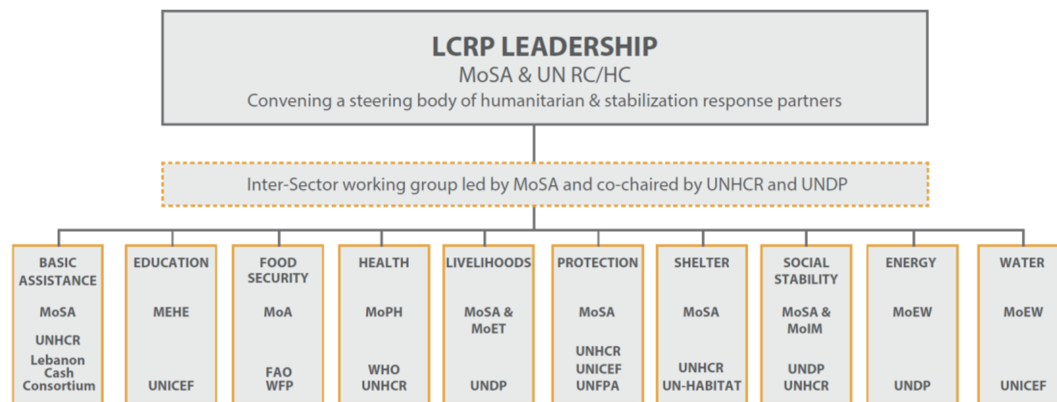


Figure 16: Structure of LCRP, source: LCRP 2017-2020, page 22

The ministry praises the effective reporting and coordination with Humedica; there are no problems. The UNHCR also rates its working relationship with Humedica highly, adding that Humedica responded quickly to the outbreak of infections. Overlaps with organisations were clarified, and coordination and information flow were very good. This positive impression is also confirmed by the German embassy.

Humedica was actively involved in preparing best practices for MMUs and in training. The best practices are not published by the ministry, presumably because it wants to overcome MMUs once the public healthcare system has improved.

Humedica participates regularly in the *Bekaa Health Coordination Meetings* and the *Bekaa Interagency Meetings*, which are organised on a monthly basis by the UNHCR and the *Ministry of Social Affairs* in Zahlé. Insofar as possible, Humedica also takes part in the *National Health Coordination Meetings* in Beirut. Since 2016, Humedica has also been a member of the *Lebanon Humanitarian INGO Forum* (LHIF), which represents the common interests of international NGOs *vis-à-vis* the UN and, in some cases, *vis-à-vis* the government. The LIHF's work focuses above all on questions relating to the legal status of refugees, UNHCR registration, schooling, resettlement, targeting and cash. The healthcare sector has not been a main point of focus to date.

A workshop held by the evaluator with the team on the subject of humanitarian principles illustrated the difficulties regularly involved in putting humanitarianism and impartiality into practice:

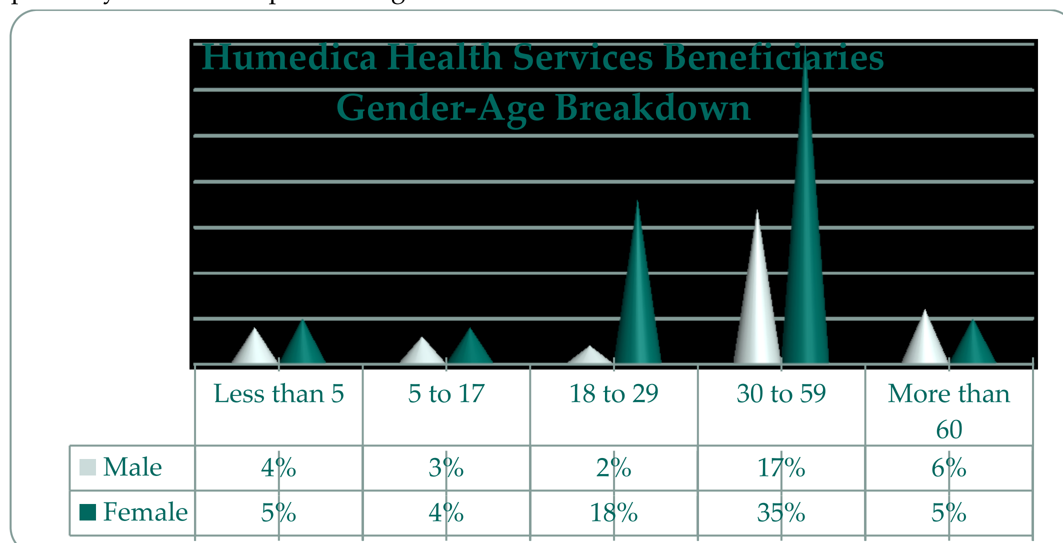
- *Shawish* occasionally ask for medication for their families
- The treatment tent is not always accessible for all patients, or the *shawish* does not always allow everyone access
- The team was uncertain about the extent to which Humedica permits and wishes them to treat Lebanese people
- Special cases are referred from ITSs in which Humedica does not work
- ITSs in other regions have a great need but there are security problems there (see Chapter 6.1 *Relevance*)

The workshop made it clear that the team is aware of these difficulties and thinks them through carefully. The conditions for Humedica's work are clarified with every *shawish* and if, for example, access is not granted to all patients, Humedica will discontinue its work in the ITS.

While Humedica reports systematically to the local authorities, accountability towards patients is only realised implicitly by a relation of trust. Humedica receives feedback and complaints directly from the patients and indirectly from the *shawish* or the UNHCR. In many cases, the *Special Case Officer* is the first point of contact, since he can always be reached by telephone. In August 2016, Humedica conducted a patient survey that gave important pointers for improving its work; findings from this survey have also been used for this evaluation.

As regards coordination in the specific project work, a number of aspects have already been listed under *6.2 Effectiveness*.

Humedica's MMUs bridge a gap in Lebanon's public healthcare system that affects refugees in particular. With the support of the Qab Elias PHC, Humedica also has ties with the public system and helps to strengthen it.



	Less than 5	5 to 17	18 to 29	30 to 59	More than 60
Male	4%	3%	2%	17%	6%
Female	5%	4%	18%	35%	5%

Figure 17: Patients according to gender and age, 6 to 19 August 2016, source: Humedica

Appraisal

The coherence and coordination of the project can be seen as being positive. As coordination leaves much to be desired (especially on the part of the government) and the UNHCR plays a leading role, Humedica's input in the coordination committees and the good ties to the UNHCR are sufficient. Humedica itself is not active in the area of humanitarian protection. It supports the work of other players through its membership of the LHIF.

Local ownership has been minimal to date and accountability is mainly demonstrated explicitly towards local authorities and rarely to patients. Because of this, the appropriateness of the project is limited.

Within the given conditions, sustainability is difficult to achieve and is not a priority in all areas of activity. Owing to the support given to PHCs and to its involvement in coordination mechanisms, the connectedness of the project is seen as being positive as well.

Recommendations

Humedica should increase its accountability towards patients including their participation and feedback. To this end, medical teams could be offered various options: information about Humedica, patient surveys, technical instruments for feedback and complaints (website, text messages), incorporating volunteers, etc. This also complies with the specifications of the *Core Humanitarian Standard* (CHS), to which Humedica is committed.[12]

6.5 Further Findings

The following observations and recommendations do not relate primarily to the quality of the project in question. Rather, these are longer-term perspectives and more general indications that play a role for Humedica in a broader context: Among other things, Humedica is committed to the *Code of Conduct for the International Red Cross and Red Crescent Movement and NGOs in Disaster Relief*[13] and the *Core Humanitarian Standard*[14]. As a member of VENRO, it has been involved in the process for the *World Humanitarian Summit* 2016 and, as a partner to the German Foreign Office, in the latter's quality initiative.

Partnership with local Actors

It is likely that the need for humanitarian assistance in Lebanon will last for several more years. If Humedica wishes to have a longer-term impact, this can only be achieved through effective partnerships with Lebanese actors. If local partners for a project are only sought out after the emergency aid phase – or, worse still, in connection with a possible withdrawal – it is rarely possible to find effective partnerships of this kind. Accordingly, in keeping with the locally led humanitarian response principle, Humedica should not only rely on Lebanese staff but should press ahead with developing an explicit policy on its understanding of partnership and its dealings with partners.

[12] See CHS obligations 4 and 5 and e.g. http://www.alnap.org/pool/files/alnap-rhetoric-or-reality-study.pdf
[13] See http://www.ifrc.org/Global/Publications/disasters/code-of-conduct/code-english.pdf
[14] See https://corehumanitarianstandard.org/the-standard

Visibility

Humedica's patient survey and the interviews have shown that the organisation is not very visible or well known. Information in Arabic is necessary for patients. Better visibility and increased PR work (including social media) – at the very least in English – would, given Humedica's good reputation, also help to recruit good staff.

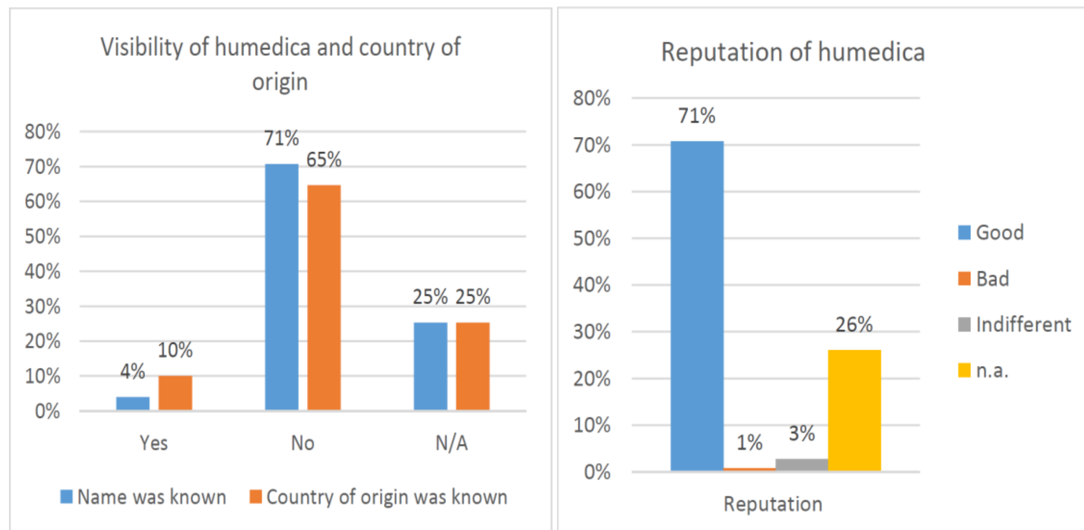


Figure 18: Visibility and reputation of Humedica, source: Humedica (August 2016)

Medium-term perspectives

It is likely that the need for aid will last for several more years. If Humedica wishes to continue with the project after 2017, the possibility of providing increased support to PHCs should be examined and steps taken at an early stage. As well as assuming costs for patients, this support could include financing equipment and personnel (e.g. midwives, training).

To this end, Humedica can build on its own experience and that of other NGOs (also with personal deployment) and seek expert advice from the MoPH and the UNHCR. The UNHCR's aim is for each PHC only to be funded by one international NGO; some of the previously active international NGOs will withdraw.

As the expansion of the network of state-recognised PHCs is not managed centrally, Humedica could provide support to a PHC outside the network, thereby helping it to be included in the state network. Around 15 new PHCs could be included in the Bekaa region, whereby a number of different criteria play a role (no PHC in 5 km radius, 10,000 families).

The work of the MMUs and support for PHCs should be coordinated as closely as possible in order to generate synergy effects, both with regard to medical quality and to information and coordination work. Good information and guaranteed quality in the PHC could be particularly effective in encouraging refugees in the ITSs to use the PHC.

Several years of financing would be required for such a project (e.g. transitional aid from the BMZ, at least two years of renewed financing).

A long-term project such as this should be built on solid structures; above all, this means registering Humedica in Lebanon so that it can hire staff, purchase vehicles, etc.

7 Annex

Project documents

Application, logframe and interim reports for the German Foreign Office

Monitoring data including statistics on medical treatment

Patient survey from August 2016

Agreements and correspondence with partners

Forms, process definitions

List of contacts

Date	Location	Person	Institution	Comment
30 January 2017	Shtoura	Project coordination	Humedica	Briefing with Dr. Ballani
31 January 2017	Zahlé	Project coordination Assistance coordination	Humedica	
31 January 2017	ITS near Zahlé	MMU *Shawish*, refugees	Humedica	With translation
31 January 2017	Qab Elias	Doctor and team	Qab Elias PHC	
31 January 2017	Zahlé	Special case officer	Humedica	
1 February 2017	Zahlé	Country Coordinator	Medical Teams International	
1 February 2017	Zahlé	Doctor, Epidemiological Surveillance Programme	Ministry of Public Health	
1 February 2017	ITS near Zahlé	MMU Refugees	Humedica	With translation
1 February 2017	Zahlé	Healthcare Coordinator Bekaa + deputies	UNHCR	
1 February 2017	Zahlé	Project coordination	Humedica	
2 February 2017	Zahlé	Team	Humedica	Workshop
2 February 2017	ITS near Zahlé	Country Coordinator Public Health Promoters Refugee Outreach Volunteers	Medical Teams International	
2 February 2017	Zahlé	Primary healthcare coordination Bekaa	Ministry of Public Health	
2 February 2017	Zahlé	Regional Programme Advisor Programme Advisor	Caritas international	
2 February 2017	Zahlé	MMU	Humedica	
3 February 2017	Beirut	Employees responsible for development cooperation and humanitarian aid	German embassy	
3 February 2017	Beirut	Country Representative Employees	IOCC	
3 February 2017	Beirut	Country Coordinator	LHIF	

Guideline for interviews

The wide range of criteria allows an open and flexible approach to be taken in the interviews so that interviewees touch upon especially important (positive, negative, interesting) aspects. As a rule, only some of the questions are asked in any one interview, depending on the interviewee's profile:

I. Interviewee (name, function)

II. **General, open-ended questions, prompt if necessary**
- What is your connection with the project?
- How long have you been aware of the project?
- Humedica employees: What would you like to learn about your own work?
- What went well?
- What did not go well?
- What was unique or special?

III. **Targeted follow-up questions on main points**

1. Relevance
   - What connection does the project have with humanitarian aid in the region?
   - What connection does the project have with the Lebanese Crisis Response Plan?
   - Other players: What significance does the project have for your work?
   - What do you find important for the continuation of the project/aid?
2. Efficiency
   - Internal: What were the decision-making processes for major changes within the organisation?
   - Looking back, could more have been achieved or could the same outcome have been achieved with fewer resources?
   - External: What would have been alternatives/what approaches are taken by other organisations?
3. Effectiveness
   - Internal: Which goals were most important for Humedica in the course of the project? To what extent were these achieved?
   - External: How do you rate the effectiveness of Humedica's work (compared with others)?
4. Connectedness, coherence, appropriateness
   - Internal/external: How did Humedica's contribution fit into the overall aid effort?
   - Partner organisation: How did you find working with Humedica? Which aspects are particularly important for you in cooperative efforts such as these?
   - What priority do you give to ethical questions (e.g. about the dignity of refugees, about humanitarian principles)?

List of Informal Tented Settlements

Humedica Pcode	Pcode	PCode Name	Cadastral	Local Name	Latitude	Longitude	Number of tents	Number of Individuals	Discovery Date	Date the site was created	Number of Latrines	No. of 1000 Litre Tanks
26	51127-01-013	Zahlé Haouch El-Oumara Aradi 013	Zahlé Haouch El-Oumara Aradi	Zahlé 7	33,8233	35,9181	62	366	13.03.2014	13.06.2013	49	58
	51127-01-047	Zahlé Haouch El-Oumara Aradi 047	Zahlé Haouch El-Oumara Aradi		33,8229	35,9177	7	53	07.04.2015	05.11.2013	8	8
4	51127-01-002	Zahlé Haouch El-Oumara Aradi 002	Zahlé Haouch El-Oumara Aradi	Zahlé/ al Faida 2	33,8205	35,9018	69	321	12.03.2014	12.02.2013	60	70
3	51127-01-006	Zahlé Haouch El-Oumara Aradi 006	Zahlé Haouch El-Oumara Aradi	Zahlé/ al Faida 5	33,8218	35,9038	127	697	12.03.2014	12.03.2012	89	120
	51127-01-001	Zahlé Haouch El-Oumara Aradi 001	Zahlé Haouch El-Oumara Aradi	Zahlé/ al Faida 1	33,8231	35,9062	58	396	09.05.2014	09.05.2014	42	42
1	51127-01-008	Zahlé Haouch El-Oumara Aradi 008	Zahlé Haouch El-Oumara Aradi	Saadnayel 11	33,8014	35,9099	49	344	12.05.2014	13.03.2012	49	50
5	51231-01-062	Saadnayel 062	Saadnayel		33,80886	35,8961	71	416	15.10.2015	26.09.2015	48	48
27	51127-01-030	Zahlé Haouch El-Oumara Aradi 030	Zahlé Haouch El-Oumara Aradi		33,8265	35,9158	21	132	13.03.2014	13.03.2012	30	34
39	51231-01-022	Saadnayel 022	Saadnayel	saadneyil	33,8021	35,9063	49	286	12.05.2014	13.01.2012	60	45
40	51234-01-072	Qabb Elias 072	Qabb Elias		33,7927	35,8265	37	232	17.03.2015	12.09.2013	23	30
	51234-01-004	Qabb Elias 004	Qabb Elias	Qab Elias 5	33,793	35,8263	8	50	16.04.2014	09.08.2010	7	7
28	51264-01-002	Haouch Qayssar 002	Haouch Qayssar	Qesser 2	33,7595	35,8079	25	207	05.03.2014	05.04.2013	22	20
	51264-01-003	Haouch Qayssar 003	Haouch Qayssar	quesseir	33,7603	35,8085	34	339	05.03.2014	05.03.2013	24	45
11	51267-01-005	Barr Elias 005	Barr Elias		33,7891	35,9413	10	65	07.05.2014	20.03.2012	14	14
	51267-01-006	Barr Elias 006	Barr Elias		33,7894	35,9449	15	90	07.05.2014	27.09.2013	10	16
	51267-01-018	Barr Elias 018	Barr Elias	Bar Elias 24	33,7882	35,9422	115	696	07.05.2014	07.12.2011	120	120
	51267-01-019	Barr Elias 019	Barr Elias	Bar Elias 25	33,7874	35,9422	29	168	07.05.2014	07.04.2011	13	13
13	51267-01-028	Barr Elias 028	Barr Elias		33,7909	35,944	99	588	07.05.2014	27.02.2013	50	30
	51267-01-045	Barr Elias 045	Barr Elias		33,7904	35,9422	61	378	18.06.2014	18.05.2014	50	45
14	51365-01-006	Terbol Zahlé 006	Terbol Zahlé		33,8242	35,9967	61	408	06.04.2014	26.06.2012	32	26
15	51365-01-011	Terbol Zahlé 011	Terbol Zahlé	Terbol	33,8229	35,9993	49	277	06.04.2014	21.07.2012	65	57
16	51365-01-012	Terbol Zahlé 012	Terbol Zahlé	Terbol	33,8181	35,9906	16	71	06.04.2014	25.02.2012	15	15
	51365-01-017	Terbol Zahlé 017	Terbol Zahlé	Terbol	33,8176	35,9907	8	38	06.04.2014	26.01.2012	9	2
36	51383-01-053	Dalhamiyet Zahlé 053	Dalhamiyet Zahlé		33,8125	35,9521	49	352	10.09.2015	20.08.2015	13	15
37)	51383-01-070	Dalhamiyet Zahlé 070	Dalhamiyet Zahlé		33,81359	35,95064	36	185	28.12.2015	03.06.2014		
41	51125-01-148	Zahlé Maallaqa Aradi 148	Zahlé Maallaqa Aradi		33,80358	35,94061	19	109				
	51125-01-151	Zahlé Maallaqa Aradi 151	Zahlé Maallaqa Aradi		33,80313	35,94117	17	101	16.12.2015	13.12.2015	13	11
38	51127-01-084	Zahlé Haouch El-Oumara Aradi 084	Zahlé Haouch El-Oumara Aradi		33,80173	35,90558	36	185			22	0
42	51267-01-014	Barr Elias 014	Barr Elias	Bar Elias 20	33,7792	35,9279	37	225				
35	51383-01-025	Dalhamiyet Zahlé 025	Dalhamiyet Zahlé		33,8121	35,9512	42	272	19.10.2014	08.09.2014	30	
	51383-01-028	Dalhamiyet Zahlé 028	Dalhamiyet Zahlé		33,8119	35,9508	37	188	21.01.2015	08.09.2014	37	
	51383-01-034	Dalhamiyet Zahlé 034	Dalhamiyet Zahlé		33,8201	35,9578	1	8	15.04.2015	27.12.2014	1	

TERMS OF REFERENCE
EXTERNAL MID-TERM PROJECT EVALUATION

PRIMARY HEALTH CARE (MOBILE MEDICAL SERVICES) HUMANITARIAN RESPONSE SYRIAN REFUGEES & HOST COMMUNITIES

BEKAA VALLEY, LEBANON

IMPLEMENTED BY HUMEDICA E.V.
&
FUNDED BY GERMAN FOREIGN OFFICE

1. BACKGROUND AND CONTEXT

humedica Germany is a humanitarian organization, established in 1979 with the mandate of responding to medical and non-medical relief and disaster emergencies in the world.

In collaboration with the German Foreign Office - *Auswärtiges Amt* (AA), United Nations High Commissioner for Refugees (UNHCR) and the local Lebanese Government Ministries, humedica has been serving Syrian Refugees in Lebanon in Bekaa Valley since 2013 under its humanitarian Primary Health Care (PHC) for Syrian refugees within the context of Mobile Medical Units in Bekaa Velley. This was (and is) in response to high level of Syrian Refugees in Bekaa Valley that have no access to medical care services.

The objective of current project is to improve health conditions and quality of medical aid for registered and non-registered Syrian refugees at chosen Informal Tented Settlements. Further, the objective is to reduce the burden of the local Health Care system and to support the governmental Primary Health Care Centers for Syrian refugees and vulnerable Lebanese in Bekaa. *Humedica is working in this context recognizing political realities of Lebanon where the Government is overwhelmed by the influx of Syrian refugees that adds to an already high load of Palestinian refugees hosted in Lebanon.*

Under this project, humedica is running two Mobile Medical Units (MMUs), serving approximately 35 Informal Tented Settlements (ITS) in Central Bekaa Valley, which have an approximate population of 9.000-10.000 individuals. In the MMU, humedica provides primary health care consultations and acute medication for Syrian refugees without any costs. Approximately 3000 patients are registered and treated every month by a team of humedica doctors, pharmacists and field officers. Humedica also responds to health outbreaks and referrals by UNHCR, the Ministry of Public Health and WASH Partners, such as scabies and clusters of diarrhea. Humedica has also deployed a midwife, who provides Antenatal Care (ANC) and Post Natal Care (PNC) and Family Planning services to expectant and lactating women.

Under this project, humedica is supporting the Primary Health Care Center (PCH) (under the administration of Ministry of Public Health) for both Lebanese and Syrian patients. The PHC is provided with acute medication, which is handed out without cost for vulnerable Lebanese and Syrian refugees below 5 years, and supports laboratory and diagnostic tests, dental and eye consultations.

2. EVALUATION PURPOSE

This evaluation is being conducted as per Evaluation Plan approved by humedica e.V in consultation with the German Foreign Office. The overall purpose of the evaluation is to assess the progress and processes made during the past one year's implementation of this project with view of accessing achievements and constraints in attaining project targets and outputs as contained in the project Strategy. The Evaluation will also look at the overall humanitarian Response Plan in Lebanon within the context of health intervention players that include UNHCR, local and international Non-

Governmental Organisations, as well as partners and the role of several Lebanese Government ministries. This should help provide/allow for drawing lessons that will inform the improvement of health intervention strategies its indicators and targets as well as the implementation arrangements in the remaining time of this project.

3. EVALUATION SCOPE AND OBJECTIVES

The objectives of this evaluation are to assess the following:

1. To access the appropriateness, relevance and validity of humedica's PHC concept design and intervention approach within the context of MMU in Bekaa Valley Lebanon
2. To review the service delivery process of the selected PHC and to determine whether activities prioritized were strategically targeted performance of the programme components and/or whether humedica carried out additional activities building on other secondary and tertiary health needs among targeted project beneficiaries
3. To access programme delivery mechanisms, cost effectiveness including institutional arrangements

It is expected that this process will culminate in findings, lessons learned and recommendations in the following areas:

- Whether the project addressed the identified needs/challenges as in the AA project award document, and *also determine whether the project was within the overall Humanitarian Response Plan (HRP) or whether this project's intervention is adding value in closing gaps or pursuing opportunities within HRP;*
- How efficiently project planning and implementation were carried out. This will include assessing the extent of project organizational structure, operations and management support as well as the coordination mechanism used by UNHCR and relevant Lebanese Ministries in supporting the health intervention;
- Ascertain results achieved, constraints and identify areas where progress made as well as areas to be accelerated towards their achievement;
- Ascertain whether humedica and the overall cluster *activities* and other intervention *measures* can be credibly linked to achievement of the outcomes;
- An analysis of the underlying factors beyond humedica's control that influence current *results* (including the opportunities and threats affecting the achievement of the outcome);
- Whether humedica's *cooperation* strategy in Lebanon has been appropriate and effective.

Information from this evaluation will assist in assessing the progress made on the implementation of activities, review of the delivery of allocated resources and understudy whether the project is on-track. The results of the evaluation will also be used by management to make mid-course refinements to the project and also integrate recommendations supportive to strengthening optimality of implementation.

4. EVALUATION QUESTIONS

The evaluation should to the highest extent possible provide responses to the following research questions:

- Are we on track towards achieving the stated *objectives and activities?*
- What progress has been made towards achieving expected *levels of results?*
- What factors have contributed to achieving or not achieving intended results?(Coherence of humedica's PHC intervention, its evaluability, adequacy of human and financial resources allocated, capacity of the team, cluster & government players in implementation challenges, etc.)

- To what extent has humedica's role contributed to overall *health cluster profile (At Bekaa Valley as well as overall Beirut broad level cluster)?*
- *Is* humedica's cooperation framework appropriate and effective?
- What factors contributed to effectiveness or ineffectiveness?

And these questions will be addressed using the following evaluation criteria:

Relevance: Assess *design* and *focus* of humedica's PHC Project. In particular to look at areas that will include the following aspects within humedica's project framework?

- Are the expected project results realistic given the project's timeframe, and humedica's capacities and resources?
- To what extent and in what ways are risk and assumptions addressed in project design?
- Are the inputs and strategies identified realistic, appropriate and adequate to achieve the results?
- Are the indicators SMART? Is the responsibility for tracking indicators clearly identified?
- Is execution, implementation, monitoring and evaluation responsibilities clearly identified?
- Does the programme include strategies to strengthen national capacity in the aforementioned thematic areas?
- Are there inter-linkages among the outcome interventions - i.e. between programme areas, with other UN agencies/Governmental initiatives and other partners, etc?

Effectiveness

- Are the planned *series of intervention measures and their results* on track? Are they going to be achieved within the planned time frame?
- Is the process of achieving results effective? Specifically, to what extent is planned *work achieving desired results?* What is the quality of this *'project's products'*? Is data collected on the indicators of achievement? Do these indicators provide adequate evidence regarding achievement of programme outputs and contribution to outcomes? Is it necessary to collect additional data? What were the *results* in terms of promoting different facets of health (planned/unplanned)? What were the *results* in terms of capacity development (planned/unplanned)?
- Are the programme implementers discharging their roles in a cost-effective and cost-efficient manner? If not, why not?
- Is the reporting and documentation system substantive enough to meet the requirement of quality reporting mechanism?

Efficiency of implementation

- Looking beyond the delivery process, is the project achieving or is it likely to achieve its intended overall intervention objectives?
- Are sound financial and equipment management procedures practiced? Are the financial, human and material resources managed responsibly and efficiently?
- Are monitoring and evaluation systems and processes utilized to allow for adequate assessment of changes in risks and opportunities in the internal and external environments? Did they contribute to effective decision-making in the course of programme implementation?

Connectedness, Coherence and appropriateness

- To what extent are humedica's *interventions interlinked* and also coordinated in addressing the needs within this refugee situation;
- In which *ways have humanitarian intervention activities integrated/increased* accountability and cost-effectiveness in PHC services provided;
- *Is there evidence of humedica's consistency in application of humanitarian principles in its intervention work;*

- To what extent and in what ways are other cross-cutting issues reflected in programming work of the project? Are specific goals and targets set? Are there any efforts to produce disaggregated data (along sex and age) and indicators to assess progress in health service delivery (equity and equality among beneficiaries)?
- To what extent has humedica established mechanisms to ensure sound synergy and complementarity of its interventions with other *implementing agencies*?

Other questions to consider

Given that current implementation is within the 3rd funding cycle (the first two having been annually funded, while the current one is biannually funded), the consultant or consulting firm may also consider areas that include the following:

- To what extent are the benefits of the project likely to be sustained after the intended completion period of this cycle? Are some of the achievements made so far sustainable? Specifically, is it likely that project achievements will be sustained?
- What particular factors or events are affecting the project results? Are these factors internal or external to the project and what exit or preparatory strategies does humedica have on this matter?
- Are there any unexpected positive and/or negative results of the project? Can they be either enhanced or mitigated to achieve the desired impact?
- Is there a more effective way of addressing the challenges(s) and satisfying the needs in order to achieve the outputs and contribute to higher level aims? Are project strategies still valid or should they be reformulated?
- To what extent has the project developed/strengthened the human and institutional capacities so as to ensure sustainability?

5. METHODOLOGY

The evaluation will provide quantitative and qualitative data through the following methods:

Desk study and review of all relevant documents, including UNHCR Syrian Refugees strategy, project documents, annual work plans, progress reports, annual reports and reports of the steering committee.

A qualitative approach will be adopted. Structured and semi-structured, Key informant interviews In-Depth Interviews, and, Focus Group Discussions with project beneficiaries and other stakeholders. The consultant working with humedica Country Coordinator, and the Head office Evaluation Unit will be in the Evaluation Technical Team. The consultant will specifically;

I. Develop an evaluation framework/plan that will be discussed and agreed upon by the Evaluation team
II. Inception Report detailing the evaluation methodology to be agreed to by the Evaluation
III. Review available documentation to obtain a general overview of the programme design and progress
IV. Hold meetings and interview relevant stakeholders including implementing partners of the programme
V. Visit identified project field sites
VI. Conduct data collection and analysis
VII. Draft Evaluation reports
VIII. Incorporate comments of the Evaluation Team and key stakeholders, complete and submit the final Evaluation report

IX. Consulting with Evaluation team to ensure the progress and the key evaluation questions are covered
X. Assuring the draft and final reports are prepared in accordance with these Terms of Reference, especially the checklist for the assessment of evaluation report
XI. Facilitate Evaluation meetings to present the main findings and recommendations
XII. Incorporate management responses in the final report.

6. EXPECTED OUTPUTS

The following outputs are expected by the end of the consultancy;

I. Inception Report detailing consultancy work-plan and proposed processes
II. Draft evaluation report
III. Final endorsed report incorporating comments from humedica. The final report must include, but not necessarily be limited to up to 25 (but not more than) pages and have elements outlined in the quality criteria for evaluation reports
IV. Any knowledge products (evaluation brief, etc?)

7. EXPERTISE AND QUALIFICATION OF THE CONSULTANT

The Consultant or consulting firm will possess a Secondary or Tertiary University Degree plus substantive strong background in evaluation of humanitarian and development programmes. Specifically the consultant should have proven experience and skills in the following areas;

- Over 7 years' experience in conducting programme/project evaluations;
- Sound knowledge and practical experience in humanitarian/development planning and implementation
- Extensive research and analytical skills;
- Excellent writing and oral communication;
- Facilitation and management skills and
- Possess leadership skills and be a team player.
- Knowledge of UN system and UNHCR in particular
-

8. WORKPLAN

The consultancy will be conducted and completed within a one month period, commencing on 5th January 2017

The details schedule is presented in the table below:

9. CONTRACT PERIOD

Task	Place	Indicative time	Total Charged time
Preparation, desk review and preliminary consultative meeting with the humedica HQ team and field online	Place Consultants	2 days	
International travel Field travel and meetings at with key cluster stakeholders	Beirut Lebanon	2 days	
Internal travel field meetings, data review, focus groups discussions, direct and indirect observations Field travel and meetings at visit PHC MMU clinic sites and project beneficiaries	Bekaa Valley	3 days	
Preparation of preliminary outline briefing for the Project Senior Team, & the External Evaluation Team Head Office humedica	Online presentation	3 days	
	Workshop setting presentation	1.5 days	
Preparation of the full report that includes findings and recommendations	At the Consultants place of work	2.5 days	**14 consulting days**

Report on Medical Quality by Dr. Tamer Ballani

1. Introduction:

Humedica is a Germany humanitarian organization with the mandate of responding to medical and non-medical relief and disaster emergencies in the world.

Humedica collaborates with the German Foreign Office, UNHCR (United Nation High Commissioner for Refugee), and Local Lebanese Government Ministries.

2. Objective:

The objective of current project in Lebanon is to:-

1) Improve health conditions and quality of medical aid for registered and non-registered Syrian refugees.
2) Reduce the burden of the local Health Care system.
3) Support the governmental Primary Health Care Centers for Syrian refugees and vulnerable Lebanese in Bekaa Valley.

3. Humedica Establishment Resources:

- I-Two Mobile Medical Units (MMUs):-
- Each MMU consist 2 doctors, 1 pharmacist, 1 field officer.
- A-Serving 35 Informal Tented Settlements (ITS), which have an approximate
- Population of 9.000-10.000.

B- Providing primary health care consultations.

C- Providing acute medication for refugees without any costs.
Approximately 3000 patients are registered.

D- Responds to health outbreaks and referrals by UNHCR, the Ministry of Public Health and WASH Partners, such as scabies and clusters of diarrhea.

II- A midwife, who provides Antenatal Care (ANC)and Post Natal Care (PNC) and Family Planning services to expectant and lactating women.

III- Special Case Officer:

-The officer had job description, follow-up the medical special cases:-

A- Assessment.

B- Referrals.

C- Follow-up and evaluation.

D- Feedback and Complaints.

IV- MTI: Community health promoter's refugee outreach volunteers:

A- Non-communicable diseases program supporting.

B- Health awareness sessions on new health topics.

- V- PHC Qabb Eliass Supporting Primary Health Care Center(PHCC) under the Administration of Ministry of Public Health (MoPH) for both Lebanese and Syrian patients.
- A- Provides medication for patients with acute diseases, which is handed out
- without cost for vulnerable Lebanese and Syrian refugees below 5 years.

B- Supports laboratory and diagnostic tests.

C- Dental and Eye consultations.

4-Assessments:

Humedica centre prepares weekly MMUs Schedules of 35 ITS daily visits. Each ITS will be visited at least once every month. ITS leader (Shaweish/Sergeant) of each camp will be informed in advance and in his turn all refugees who need a medical consultation by the MMUs medical team will be scheduled for the intended visit. Medical consultations findings and prescriptions will be filled on the patient medical chart (card) which is prepared by the field officer.

1*Registration & Record Keeping System:-

-There's a specific chart for all patient must be filled.

A-Full Name, (Father and Mother's name), Date of Birth/or Age, Phone number, Sex, Nationality, Current Residency, Chief Complaint, Service/Type of Treatment, Site (P-code), Registration number with UNHCR for registered refugees.

B-Health card for chronic disease patients only, see (Appendix I).

2*Prior history of the patients:-

-All patient diseases history that had before.

A-Electronically (TAB).

B-Health Booklet (upon birth).

C-Paper-based organized by site.

3*Pre-selection & Crowd Control

A- Priority is recommended to take into consideration Severity of complaint (done by doctor or medically trained staff).

B-In general: first come, first served is a good policy.

4*General Consultation

-Medical consultations and prescription will be performed by either physician then after, when needed, the patient will be referred to the pharmacist.

-Up on consultation findings, some cases would require to be referred to further investigation(s) :-

A-Nutrition Screening (MUAC) in most vulnerable communities for children under 5, and pregnant and lactating women (PLW) be done with referral of cases having acute malnutrition and related complications to the nearest PHC or hospital.

B- Referral to PHC for the completion of the mandatory vaccination based on the MoPH vaccination calendar.

C- Referral to PHC for ANC and PNC care in the absence of a midwife.

5*Reproductive Health

Reproductive Health is handled by a midwife:

A-ANC - Use of pregnancy cards. (Appendix II)

-Refer to PHCC for complementary diagnostic services (e.g.ultrasound) or for management.

B-PNC -Refer to a PHCC for other services needed, including,

But not limited to newborn vaccinations

C-Family Planning& STI

- Counselling, awareness &health promotion activities

- Provision of RH commodities, including family planning kits supported by UNFPA and distributed by MoPH upon request.

6*Drugs dispensary /pharmacy

The patient is referred to the drug dispensary/ pharmacy following the medical consultation. Refer a list of essential drugs and supplies. (Appendix III)

7*Referrals Cases Methodology

A-Methods of referrals to PHC or SHC, depending in severity of case complaint(needs to be done by doctor or medically trained staff)

1-Referring the case directly to a PHCC using a referral from MMU to PHCC.

2-Inter-agency referral form (optional) can be sent by NGO supporting the PHCC for cases in need of follow up.

3- Phone call to PHCC/NGO for urgent cases.(ACF, AMEL Association, Beyond, IMA, IMC, LRC, MdM, Mercy USA, MoPH, MTI, Order of Malta, PCPM, PU-AMI, Relief International, UNFPA, UNICEF and UNHCR)

4- Referring the case to SHC using the TPA referral form and by calling TPA hotline or by referring the patient to the Emergency room of the nearest UNHCR-contracted hospital if his/her condition is urgent. Transportation to be provided by the family or the LRC ambulance if Critical.

B-Partner referral

For services required (e.g. WASH, Protection including SGBV cases, Hygiene, Mental Health, PFA) by emailing the appropriate sector's coordinators using the Inter-Agency referral form. Partners are requested to respect the coverage of partners per activity/hub

8*Reporting Diseases

-Reporting of communicable diseases

Weekly reporting to MoPH-Epidemiological Surveillance Unit, all MMUs are requested to fill in a weekly reporting form.

A guideline for the Medical centers/dispensaries/MMUs surveillance system is available (Arabic and English).

-LCRP partners supporting MMUs commit to reporting on AI as per the relevant health sector indicators.

5.Statistical Approach

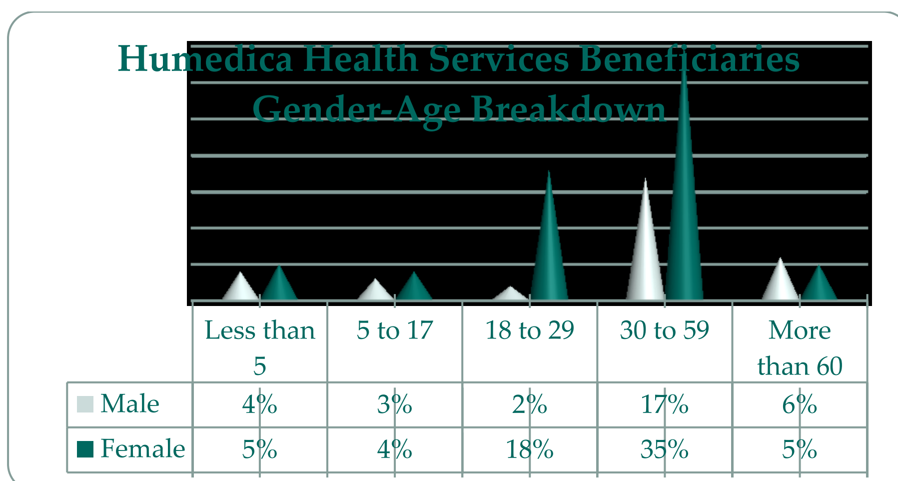
This analysis is based on Humedicas own data, mainly on Humedicas own patient survey 2016.(Survey period from March2016 till December 2016, Survey Area in Zahle:Dalhamiyet, Maallaqa Aradi, Saadnayel, Terbol, Houch Qayssar).

1* Subjects Gender-Age distribution

Among the interviewed and examined subjects were 17% children (0-17) and 59% women (above 18ys). The high proportion of women from 18-59 years can be explained by the time of day at which

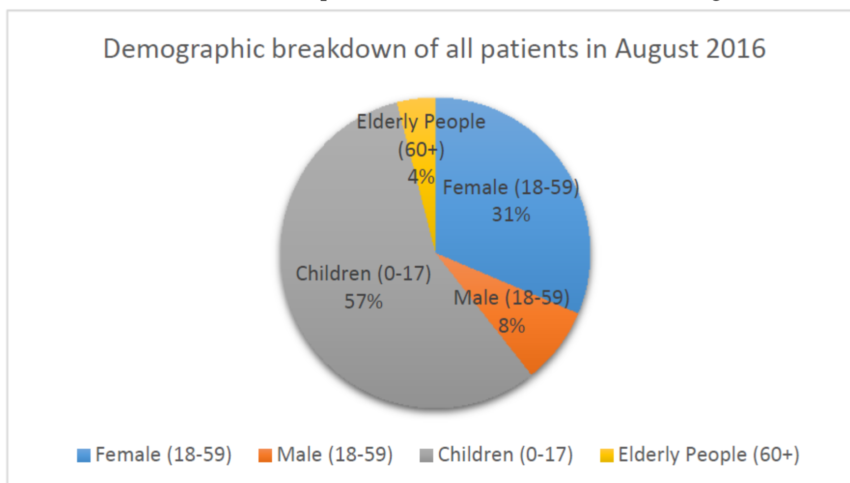
the interviews were conducted. In the morning and early afternoon men are mainly working in the fields. In addition, due to the nature of questions asked regarding needs and services there is a relatively low proportion of interviewed children, especially when compared to the patient statistics for the whole month.

Nevertheless, the demographic composition, especially the high proportion of women, reflects the trend seen in the patient statistics patients in total, thus pointing at a good representation of the Humedica MMU patients.



	Less than 5	5 to 17	18 to 29	30 to 59	More than 60
Male	4%	3%	2%	17%	6%
Female	5%	4%	18%	35%	5%

Source: Humedica Patient survey, August 2016(6th-19th of August), from 150 interviewed Patients were selected randomly and accounted for 13.5% of all patients who visited the MMU during the two-week survey period (1417 patients in 9 ITS).



Source: Humedica Patient survey, August 2016.

*Since the morning and early afternoon men are mainly working in the fields. Nevertheless, the demographic composition, especially the high proportion of women from 18-59 years, reflects the trend seen in the patient statistics for August (3363)patients in total, thus pointing at a good representation of the Humedica MMU patients.

2* Most common diagnosed diseases:

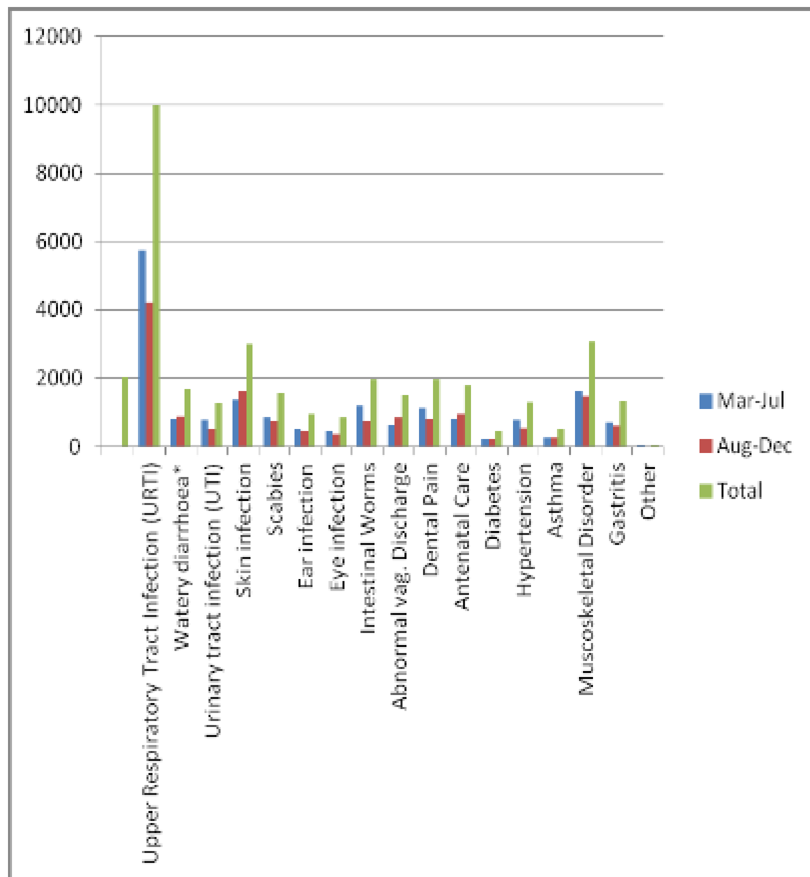
In previous patient statistics results, diseases like 'Upper Respiratory Tract Infection', 'Skin Infection' or 'Watery Diarrhoea' or 'Dental Pain' are always among the top 10 of the most common diseases. As a consequence one can assume that the living conditions in ITS have a negative impact on the overall health status of its inhabitants.

	Mar-Jul	Aug-Dec	Total
	2016	2016	2016
Upper Respiratory Tract Infection(URTI)	5757	4215	9972
Watery diarrhoea	824	874	1698
Urinary tract infection (UTI)	769	512	1281
Skin infection	1379	1608	2987
Scabies	839	751	1590
Ear infection	495	457	952
Eye infection	474	367	841
Intestinal Worms	1200	757	1957
Abnormal vag. Discharge	639	853	1492
Dental Pain	1120	825	1945
Diabetes	240	222	462
Hypertension	762	524	1286
Asthma	252	243	495
Muscoskeletal Disorder	1599	1464	3063
Gastritis	726	606	1332
Other	6	0	6

Source: Humedica Monitoring Data, Mar-Dec 2016.

*In 2015 the highest cause of morbidity was upper respiratory tract infections (URTI), intestinal worms, Skin diseases and Muscoskeletal Disorder. Total patient treated for the period Mar-Dec 2016 around 10000 patients, Morley female and still the main cause of morbidity is URTI and Muscoskeletal Disorder.

Health Infrastructure



Source: Humedica Monitoring Data, Mar-Dec 2016.

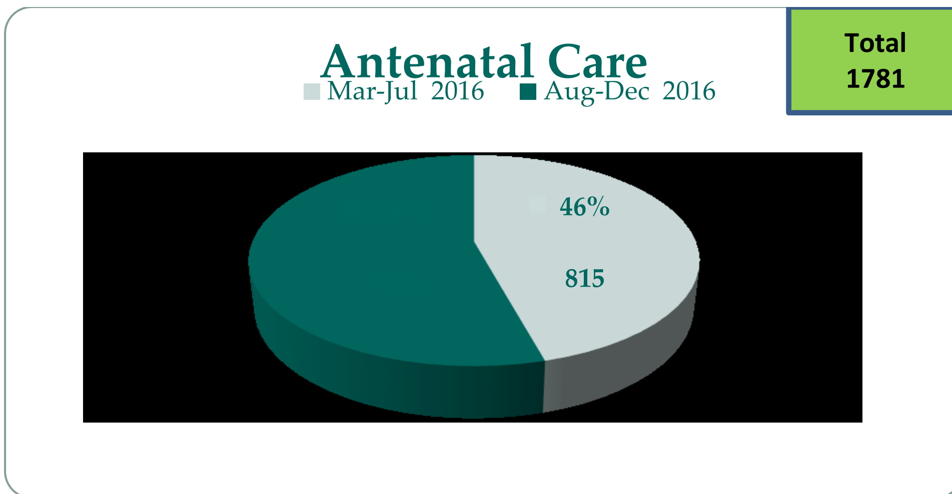
* Prevention is often connected to behavioral change and (hygiene) conditions in the Informal Settlements. The awareness sessions planned through the joint project with MTI should improve health awareness amongst the refugees.

* Furthermore, also in previous patient statistics results, diseases like 'Upper Respiratory Tract Infection', 'Skin Infection' or 'Watery Diarrhoea' or 'Dental Pain' are always among the top 10 of the most common diseases.

3* Antenatal data analysis

Shows that all antenatal cases for all over the 10 month starting from march till December 2016.

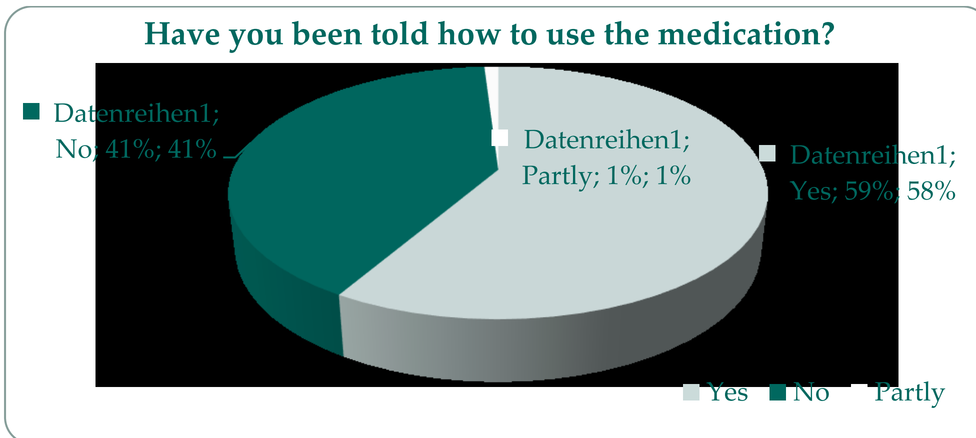
	Mar-Jul	Aug-Dec	Total
	2016	2016	2016
Antenatal Care	815	966	1781



Source: Humedica Monitoring Data of Antenatal cases, Mar-Dec 2016.

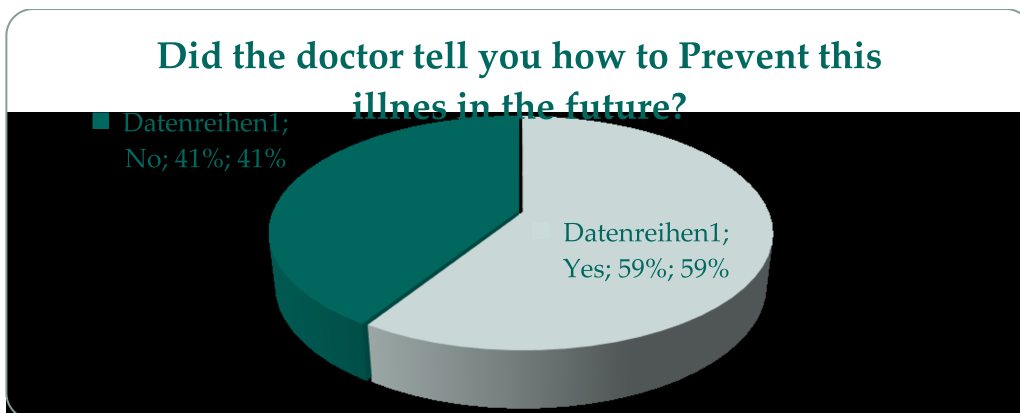
4*Service Areas, Prevention and Medication

-These questions aimed to understand the quality of medical services with regard to good communication between medical staff and patients regarding medication and future preventive measures. In order to follow-up on these issues, patients were asked whether they understood their diagnosis and prescribed treatment. The interviewer tested answers using the patient card.



Source: Humedica Patient survey, August 2016(6th-19th of August).

-80 out of 135 patients with a preventive illness were not informed on preventive measures by the responsible doctor. However, this result might be influenced by the fact that the definition and common understanding of "preventive illness" and "preventive measures" have been unclear. (Yes 41%)

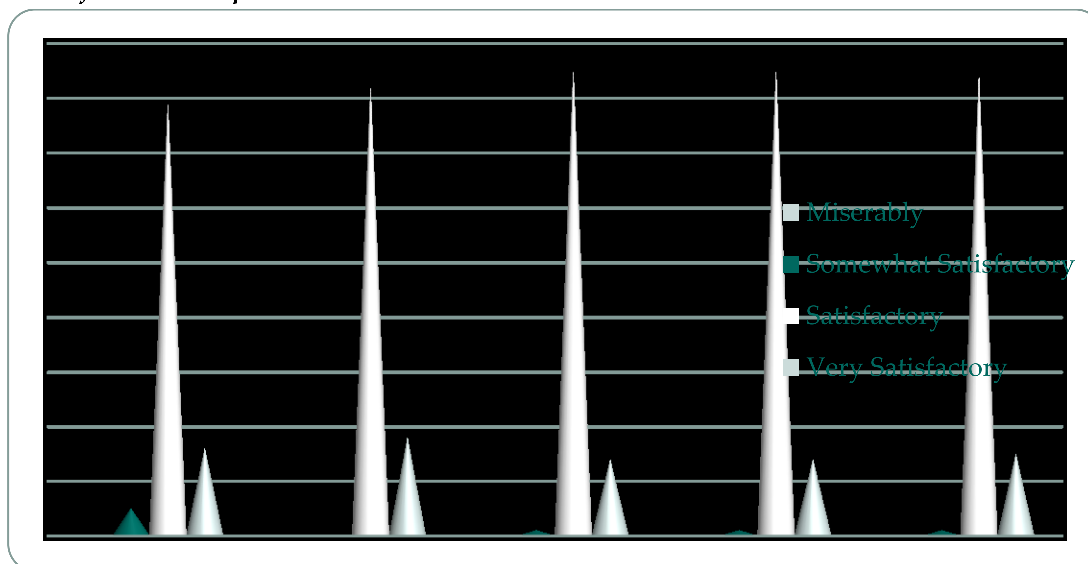


Source: Humedica Patient survey, August 2016(6th-19th of August).

5*Patient Satisfaction

The analysis shows that all categories reached >95% satisfaction, including >14% who were very satisfied with Humedica MMU services. Even concerning waiting time, which is sometimes challenging on busy days, only 5% rated this as only 'somewhat satisfactory', whereas 79% were satisfied. Finally, only 2 persons out of 150 responded when asked "What was not good during [their] visit", which seems to be another indicator of an overall positive and satisfied view on the work of Humedica's MMU. These two complained that the medication they had wanted was not available.

Satisfaction Graphic



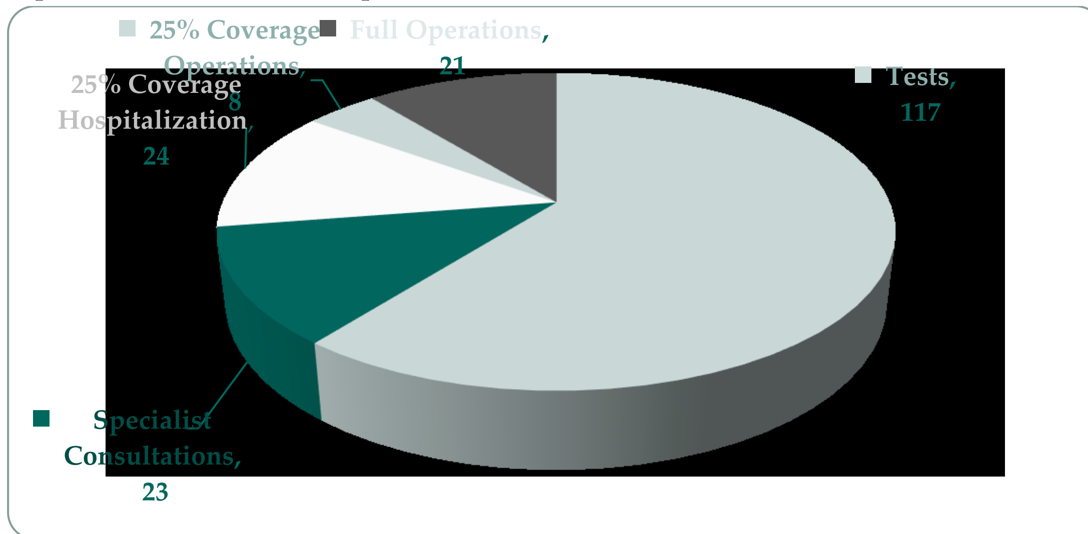
Source: Humedica Patient survey, August 2016(6th-19th of August).

6*Special medical cases covered by Humedica:

- 21 operations cases were totally covered 100%.
- 8 operations were covered 25 %.
- 24 hospitalized cases been covered 25%.
- 23 been send for specialist consultations.

- 117 lab tests been 100% covered which include (Blood test, MRI, Biopsy, EEG , Echo and others.

*Special Medical Cases Graphic 2016.



Source: Humedica Monitoring Data of special medical cases, Mar-Dec 2016.

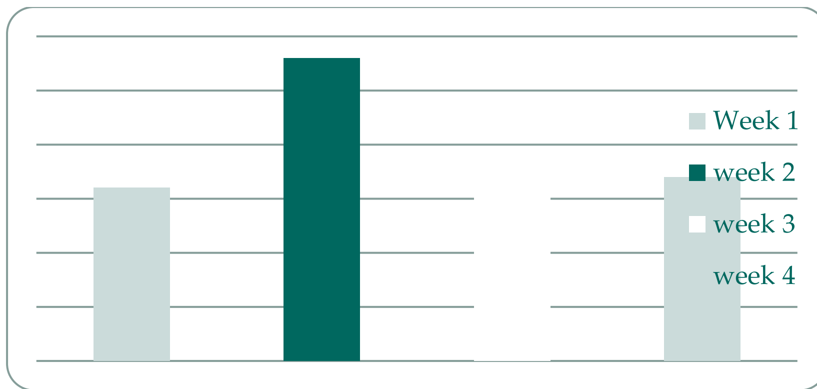
7*Referral Humedica cases:

To PHC and Hospitals and others, we have just selected at Random.

Referrals for April /2016	
Week 1	16
Week 2	28
Week 3	19
Week 4	17
Week 5	
Total	80

Source: Humedica Monitoring Data, April(4 weeks) 2016.

***Referral Cases by Weeks 2016**



Source: Humedica Monitoring Data, April(4 weeks) 2016.

* The increased by 15-20% compared to the 2015 survey results with 2016.
There could be several reasons for this:-

1- Medical Teams International, which is responsible for the treatment of chronic patients in the ITS, decided to stop their MMU services in August 2016.
2- Also be assumed that many more refugees how suffer from chronic health problems (e.g. severe back pain, constant coughing) due to the living conditions of the refugees in ITS.
3- Also, some surveyed persons probably did not understand the difference between chronic and acute health problem.
4- However, in addition it is striking that a majority of 55% indicated that they have been suffering from their disease for more than 3 months.

5- As a consequence one can assume that the living conditions in ITS have
A negative impact on the overall health status of its inhabitants.

*During the interviews and observations the results of the patient survey were confirmed. Additionally, we have taken an oral informed consent from each refugee who voluntarily accept to participate in the survey without any acquisition and coercion. Questionnaires were administered by a native speaker of the Arabic language, so no language barriers interfered with communication, something that helped us more to recognize and respect all the existing ethical issues.

6.Conclusion and Recommendations

After my survey has been done through 3 days, I had a group of results regarding
The Humedica as well as for other health actors in Bekaa Valley :

I-General Issues:-

1- Humedica goals achieved almost the international standards, especially by humanitarians field.

2- Based on those results of collection data, further investigations should be made in coordination with the doctors, and measures to improve consultations on prevention should be discussed.

3-A high satisfaction results among Humedica patients.

4-They used indicators.

5-**A proper overview implemented and issued by all health partners could also facilitate the process**.

6-**The time period for such project monitoring and evaluation were inadequate**.

II-Mobile Medical Unit:

1-Need more predictable way for the patient crowed.

2-A good follow-up for greatest number of refugees patients as consultations but in another way **lowering the time of medical consultation .**

3-There are positive results on the good quality of MMU services and their communications with actor partners(MTI,UNHCR,....).

4-There have been **good educations** by the doctors for using the medications and the **prevention from illness but not enough**.

5-The **MMUs team still missing 2 nurse** (Triage, Performs pre-selection process Measures MUAC in children under 5ys, Measures vital signs, dressings, injections performed ,educational…) .

6-**In the long run, if MMUs shall be substituted by PHCs** .

7-MMUs visits must be every 5 weeks.

8-We must use **the medically- equipped bus and send it to poor and needed areas (Syrian Refugees and Vulnerable Lebanese).**

9-The beneficiaries should have the possibility to give feedback during an MMU is present. **A feasible feedback mechanism should be implemented**.

10-Whenever possible, the **MMU doctors should also highlight possibilities of prevention of illness to the refugees.**

11-**Consultation on preventative measures should remain a part of the MMU medical services and must be stressed continuously quality and accountability to affected people**.

12-With respect to prevention, the analysis reveals that **not enough patients had been informed by the doctors on how to prevent their disease in the future.**

III-Midwife:

1-**Activiting communication and interaction between the midwife and volunteers refugees act walls**.

IV-Special Cases:

1-They had a convenient ways to send patients to PHC canters, with lab testing and follow-up in hospitals.

2-for special medical cases they have a good criteria, even payment way the 25% from the total cost of hospitalisations or 100% depending in the case.

3-**The follow-up to a large numbers of patients per day indicates a lake assessments of the clinical examination.**

4-**Transfered budget, which was placed for chronic medication to special medical cases.**

V-Support of MTIs Outreach and Education-and Prevention:

1- Prevention is often connected to behavioural change and (hygiene) conditions in the Informal Settlements.

2-**Improving Prevention ways because it's a very difficult though and important part of health services.**

3-**The awareness sessions planned through the joint project with MTI should also tackle these issues and improve health awareness amongst the refugees.**

4-Find solutions to the **problems suffered by refugees** such as sewage, heating,...to improve health care, So must focus on need of better lifestyle witch health effects:-

1-WASH needs to be improved

2-Health awareness and prevention

3-Eye and Dental care.

5- Humedica, in cooperation with Medical Team International, can help to spread information, refer patients to PHCs and increase knowledge for chronic patients

VI-Support of PHCs:

1-Suppling PHC center with a good quality and quantity of medications.

2-Syrian refugees are suffering from a lack information on PHC services and subsidized care available to them .

3-The UNHCR coverage and different packages (according to age, condition, refugee status, etc.) offered by different actors in the field prove to be confusing to the ITS inhabitants.

4-It remains a **challenge to inform and refer patients accordingly, especially if the phase-out of MMU services is anticipated in the future**.

5-Implement a cheap transportation system for refugees.

6-Raise awareness of PHC service ,can cover (3-5) ITS.

7-Make sure that non-registered refugees feel comfortable and will not face legal problems because of a PHC visit.

8-Possibilities for **improved coordination between existing PHCs under the MoPH and UNHCR network and Humedica can be explored**, as to refer more patients to the local system when needed and, ideally, to decrease the need for MMUs in the long run.

9-Ideally, an expansion of the public transport system would enable better access to health facilities.

10-**Outreach programs by PHCs can facilitate refugees' access**.

11-Survey also pointed on high number of chronic patients Refugees ,so they should be embedded in the national system through PHCs that are supported by YMCA and offer chronic medication for free in any of the MoPH PHCs.

12-A regular follow up and more sustainable funding would be a better service for chronic patients.

13-**Information and awareness on the registration system and coverage of YMCA however is low**.

14-**Replacing the PHC in Qabb Eliass to the middle of crowded ITS under Humedica care**.

15- **Economic restraints remain and will continue to create barriers to health services in Central Bekaa** .

VII-Efficiency:

1-Do **a contract pharmaceuticals crisis through drug companies**, not pharmacies over a period of 3-6 months.

2-**Prepare the main office** with secretary, landline, fax and complete equipment to give best look for the company.

VIII-Other Issues:

1-Change the place of Humedica main office position ,to become more visible to the public and the Syrian refugees.
2-**Visibility and name of Humedica needs to be better displayed** to the Syrian refugees.
3-Steps such as providing **banners of Humedica and the GFO in Arabic** would improve the knowledge of the Syrian refugees concerning the origin of Humedica and the donor.

Concluding Statement on Medical Quality

In Summary, I can confirm that the medical quality of Humedicas work with regard to the medical standards in Lebanon (including the paper on MMU best practices) is good.

And would like to highlight on good quality and quantity of MMUs team and medications, they had a convenient way to send patients to PHC centres, for special medical cases they have a good criteria, even payment way and follow-up in hospitals, a good awareness sessions planned through the joint project with MTI and high satisfaction results among Humedica patients.

Concluding statement on Efficiency

In Summary, I can confirm that the Efficiency of Humedicas work is good.

And would like to highlight on Humedica needs, team still 2- 3 nurses, urgent using the medically-equipped bus, Replacing the PHC in Qabb Elias to the middle of crowded ITS Under Humedica care, a good contract with pharmacies suppliers over a period of 6 months, transfer the budget for chronic medications to cover more special cases, Prepare main office with better position and full equipments, In the long run, if MMUs shall be substituted by PHCs.

All activities mentioned will increased efficiency of work and decreased the cap between refugees and hosting communities.

Appendix I: NCD patient card example

1)Personal Information:

Given Name:		Age:	
Father's Name:		Sex:	
Mother's Name:		Address/P-code:	
Family Name:		Phone Number:	

•

2)Current Medical Condition: ☐ DM I ☐ DM II ☐ HTN

List any major operations or Hospitalization

Procedure	When	Where	Date

List all the medications that the patient is taking

Medicine	Dose/ How often	Supported By

List when the patient is seen and note any change in the medications provided

Date	Change in Medication/Comments	GP. Signature

Appendix II

بطاقة
المرأة الحامل

وزارة الصحة العامة
الرعاية الصحية الأولية

معلومات شخصية:

رقم بطاقة الأمم المتحدة .... الجنسية ....

الاسم الثلاثي: .... تاريخ الولادة: .... فئة الدم ....

اسم الزوج: .... تاريخ الولادة: ...... / ...... / ......

مكان الاقامة: .... رقم الهاتف: ....

التاريخ الولادي:

عدد:

☐ عدد الحمل .... ☐ عدد الولادات (☐ المبكرة ☐ عند الأوان) ....

☐ عدد الإجهاضات .... ☐ عدد المواليد الاحياء ....

☐ قيصرية .... ☐ تشوهات خلقية ....

الحمل الحالي:

تاريخ آخر دورة شهرية: .... التاريخ المتوقع للولادة: ....

طريقة الوضع المتوقعة: ☐ طبيعية ☐ قيصرية

دواعي الولادة القيصرية: ....

التاريخ الطبي:

سوابق طبية: ....

أدوية مزمنة: ....

سوابق جراحية: ....

حساسية : ☐ كلا ☐ نعم حدد: ....

الزيارة الأولى: اسم المركز الصحي: ....

التاريخ	الوزن	الضغط	الورم في القدمين	فحص البول			دم رحمي
				زلال	سكري	التهابات	

عدد اسابيع الحمل	إرتفاع الرحم	وضع الجنين	نبض الجنين	سكر الدم	Hb الهموغلوبين

الموضوع الثالث: الرضاعة الطبيعية إمضاء المثقف الصحي ....

الموضوع الرابع: أهمية التلقيح الروتيني إمضاء المثقف الصحي ....

مواضيع أخرى: ....

الخدمات التي تشملها هذه البطاقة:

١ تزويد المرأة الحامل بهذه البطاقة من المركز، بعد الكشف عليها من طبيب نسائي

٢ تغطية لمعاينات الحمل + اجراء الفحوصات المخبرية والصور الصوتية اللازمة، خلال الحمل:

- الزيارة الاولى: خلال الثلاثة اشهر الاولى من الحمل
- الزيارة الثانية: خلال الثلاثة اشهرالثانية من الحمل
- الزيارة الثالثة: خلال الشهر السابع
- الزيارة الرابعة خلال الشهر التاسع
- زيارة متابعة ما بعد الولادة

٣ التحويل للمستشفى لإجراء الولادة في المستشفيات المعتمدة من قبل المفوضية العليا للأمم المتحدة لشؤون اللاجئين.

٤ تأمين النصح اللازم للأم قبل وبعد الولادة بشأن الاهتمام بالمولود الجديد ووسائل تنظيم الأسرة والصحة الإنجابية.

ملاحظة: يجب الإحتفاظ بهذه البطاقة وإبرازها خلال زيارات المرأة الحامل للمراكز الصحية ، كما ويجب إبرازها عند الحضور إلى المستشفى للولادة

طبع بدعم من: WHO UNHCR UNFPA IMC

Appendix III: Essential Medication & Suppliesbased on MoPH Essential Medications and Supplies list

Oral medication
Acetylsalicylic acid 100 mg Tab
Albendazole, 400 mg or mebendazole 100 mg Tab
Aluminium hydroxide 400mg Tab
Amlodipine 5 mg Tab
Amoxicillin 250 mg susp.
Amoxycillin 500 mg Tab
Amoxicillin 1g / clavulanic acid 625 mg Tab
Atenolol 50 mg Tab
Azithromycin 250 mg Tab
Cefixime 400 caps Tab
Loratidine Tab
Co- trimoxazole (trimidar) 40mg Susp.
Diclofenac potassium 50 mg or ibuprofen 400 mg Tab
Doxycyclin 100 mg Tab
Enalapril 10 mg
Catopril 25 mg Tab
Ferrous fumarate 185 mg (60mg ir.) / folic acid 0.4 mg Tab
Furosemide 40 mg Tab
Glibenclamide 4 mg Tab
Hyoscine butylbromide Tab
Metformin hcl 1000mg Tab
Metformin hcl 850 mg Tab
Metronidazole 250 mg Tab
Metronidazole, 125mg/5ml, dry powd.fr 100ml Susp.
Omeprazole 20 mg Tab
Oral rehydration salts (ors) low osmol Sachet
Paracetamol (acetaminophen), 500 mg Tab
Paracetamol (acetaminophen), 120 mg/5 ml
Prednisolone 5 mg & 10 mg
Salbutamol 0.1 mg / dose inh Inhaler

External (topical) medication
Benzyl benzoate, 25%, lotion, 1 l, bot. Bot
Betamethasone n 0.1% or hydrocortisone acetate Oint.
Calamine, 15%, lotion, 500 ml, bot. Bot

Gentamycin 5mg drop
Miconazol nitrate, 2%, cream, 30 g, tube
Tetracycline hydrochloride, 1%, eye ointment, ster, 5g, Tube
Zinc oxide, 10%, ointment, 100 g, tube Tube

Injectable medicines
Adrenalin 1mg/ml Amp.
Atropine amp Amp.
Dexamethazone 4 mg / ml Amp.
Lidocaine 1%, without preservatives, 10 ml ampoule Amp.

Supplies
Syringe
Cold box
Card, health, arabic/english a5 recto/verso Piece
Bag, plastic, for drugs, 6 x 8 cm Box
Bag, plastic, for health card, 16 x 22 cm Box
Gloves, surgical, latex, sterile
Table & Chairs for medical team/patient
Safety box & Needle box
Dressings
Hand Sanitizer

humedica
INTERNATIONALE HILFE

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Freundes-Nr. 196620

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Bildung und Technologien GmbH
Dr. Martin Quack
Hackländerstrasse 93
70184 Stuttgart

–

Kaufbeuren, 10.03.2017

Management Response to the External Mid-Term Project Evaluation Consultancy - Evaluationsbericht

Dear Dr. Quack,

Thank you for the work you have undertaken on the above consultancy humedica e.V had with you over the in January 2017. It was an exciting and intense time for us, and, also an opportunity to internally review and access where we are in in our Lebanon Primary Health Care – Mobile Medical Units (MMU) intervention.

As earlier agreed, we are pleased to share with you a short summary of our Management Response to your comprehensive Mid Term Evaluation report on this assignment. In doing so, we build on areas we had discussed with you, and try here to include a wider picture of where we are as an organization, with respect to efforts made to address matters you raised in your report. Also herein we would like to share with you our perceived way forward to proactively deal with opportunities and challenges within the Protracted Refugee Conflict Context in Lebanon.

Our Intervention Rationale & Humanitarian Response Plan issues

- Our strategy for the Syrian Refuges communities (and later the affected host Lebanon's communities) was first established and implemented using humedica own resources, and also working largely through our with our expert medical volunteers from Germany. As this stabilised, we secured AA funding of our programme. We have since grown institutionally at the project level, where we have established our niche as a key Mobile medical Unit service provider. We have also grow as a contributor to the the UNHCR Health Cluster deliberations in Bekaa Valley Lebanon. Further, we also established a host communities PHC component.
- Increasingly, we are compelled to focus thoughts and attention to longer term diseases – these in the past were not generally coverage in most

PHC. But, the protracted nature of Syrian refugees has heightened silent but often costly health needs required by/or among elderly and vulnerable refugees. These include cancer, diabetics among others. Building response here is an area humedica is straddling with, even as it engages its donor – as well as remaining in close consultation with Ministry of health, Ministry of Social Affairs and other INGO partners. This reality is an areas that that often required us to balance between our core PHC, as well as the wider health issues.

- We have stabilised most of our working relations with relevant Government agencies. We remain boutique in project scope and breath, recognising our opportunities and limitations.. In particular, within the context of Lebanon, we can surge up our capacities only within possible absorption capabilities of our project working partners. We remain steady in thinking through here, as we view this as crucial for managing effectively our limited resources from AA as well as from our private donors.
- At a political level, humedica deliberately choses to have a low key, but remains assertive behind the scenes in pushing for what we see and know is critical to overcoming either operational or strategic challenges our intervention faced. This is a strategy we find crucial for Protracted Context where operations can perplexingly be challenging.

Staffing and Operational Issues

- As part of our overall programme stability, we have (with respect to Lebanon office) increasingly adopted a strategy of having representative with knowledge of Head office, leading the programme. This approach has over the last 1-2 years significantly helped improve our stabilisation, management and continuity of our PHC-MMU work.
- We are working to increase the quality and level of our medical capacity. Trainings and general strengthening along lines pointed out in your recommendation is also our priority- as our Lebanon Desk team and field plan for the remaining phase of this project. So, we will be working out so that we improve the quality of our services to beneficiaries.

As we do so, we recognise that

- Building local level working alliance will require proactive management of expectations, so that potential service areas benefit from synergies and that help optimise on resources. We saw this from our working alliance with Medical Teams International. We therefore look forward to explore Mid-wife work cooperation with other local health organisations
- Digitalisation of medical data is crucial but we note this need to be introduced in a way that reinforces our work. We will therefore widely consult as we explore packages and application available, so that we build on lessons learnt and experiences that can help us, as we adopt in our programme.

Partnership Cooperation Framework

- Currently humedica is directly implementing its work in Lebanon. Our registration is in process. Meanwhile, our approach is to keep strengthening our partnership tools so that we will be ready to work further with other local partners once we have the registration (where the programme needs will so demand or can for).
- Within the context of strengthening application of our Humanitarian Principles, we are reviewing templates and existing mechanisms in place within humedica. We see this as crucial to proactively managing relation, operations and also expectations by which we work with potential partners in Lebanon.

Accountability & Transparency

- As part of both strengthening our effectiveness and efficiency we are in the process of considering application of tools and processes helpful to increase our accountability.
- Presently we have applied an Accounting Software for our Lebanon programme, and are regularly building accountable relations and processes across HQ and field through close exchange of information.

We hope this background helpful in enabling you see how humedica is placed in the overall schemes of humanitarian response in Lebanon among Syrian refugee and host communities.

Thank you for agreeing to undertake this important assignment.. You recommendations will be well considered.

Warm regards

Raphael Marcus

humedica e.V.

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Vom Finanzamt Kaufbeuren als
gemeinnützig anerkannt
unter Steuernummer
125/109/10174