Final evaluation for the “Emergency health care service provision for Syrian refugees in Jordan”, 2021

Phenix Center for Economic and Informatics Studies
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Abbreviations

DoS	Department of Statistics
ENT	Ear Nose Throat
ESRD	End-Stage Renal Diseases
PCRF	Palestine Children Relief Fund Organization
ITS	Informal Tents Settlements
IRJ	Islamic Relief Jordan
IRW	Islamic Relief Worldwide
MOH	Ministry of Health
MOPIC	Ministry of Planning and International Corporation
NGO	Non-Governmental organization
SDG	Sustainable Development Goals
UNHCR	United Nations High Commissioner of Refugees
QRC	Qatar Red Crescent

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Executive Summary

The purpose of this evaluation was to determine the overall success of the Healthcare Aid for Syrian Refugee project conducted by Islamic Relief Jordan. To do so, the project was analyzed through the framework of the OECD Evaluation Criteria in order to gauge its relevance, coherence, effectiveness, efficiency, impact, and sustainability.

Key Findings:

Relevance

Broadly, the project was found to be highly contextually relevant. Interviews with external partners and other actors within the field, as well as focus group discussions with beneficiaries, revealed that the project addresses a clear and real need for healthcare amongst Syrians and other disenfranchised populations. Mobile health clinics were found to reach individuals who may not otherwise have access to care, and the fact that both primary, secondary, and tertiary health services were provided at no cost to recipients enabled individuals to receive services which would otherwise be unaffordable.

Furthermore, the project was found to be in alignment with community needs, with beneficiaries noting that the most important services were covered by the project. However, beneficiaries also noted that there were some areas which were not covered which they still required services, such as dental and eye care. In some areas, no alternative care provider was available for these services. The project was also seen to align with the needs of stakeholders, such as MoH and UNHCR, as revealed through key informant interviews with field partners, government representatives, and representatives from the UNHCR.

Finally, all services (mobile health clinics, secondary and tertiary healthcare, and health awareness sessions) were found to be considered generally accessible by the beneficiary population. That being said, some beneficiaries of secondary and tertiary services reported difficulties in reaching the hospitals which their procedures took place, in particular women and Syrians. Finally, services were broadly considered social and culturally accessible by all beneficiaries, with participants feeling that cultural values of privacy and modesty were respected, as well as reporting a general sense of respect from IRJ staff and their partners. Women were more likely than men to report that they felt comfortable and respected by IRJ staff.

96% *reported being treated with high levels of respect.*

Coherence

The project was found to be coherent with other stakeholders, particularly the work of IRW's partners within the field. In particular, IRJ was found to have formed valuable partnerships with grassroots CSOs which have assisted in identifying and targeting vulnerable populations. Routinely, IRJ was spoken of very highly by partners, including representatives from other INGOs, the UNHCR, and governmental partners. Furthermore, the project was found to align with international standards of healthcare provision within humanitarian contexts, based on standards established by WHO and Sphere.

However, the project was found to lack some internal coherence; in particular, inconsistencies were found in how referral processes were conducted as well as follow-up on complaint mechanisms. Furthermore, the project was found to have consistent challenges with name recognition amongst beneficiaries, who received services but were unaware that those services were provided by IRJ. That being said, there were also clear efforts made to improve internal coherence, such as utilization of the united database.

Effectiveness

Effectiveness measures the extent to which planned outcomes were achieved, and that these outcomes were equitable across populations. Broadly, the program was found to be highly effective, meeting and exceeding targets for planned outcomes in terms of both the number of beneficiaries as well as their overall satisfaction.

72% *Reported moderate to high satisfaction with MHCs*

97% *Reported moderate to high satisfaction with awareness sessions*

91% *Were very satisfied or satisfied with secondary and tertiary services*

Broadly, all populations reported high levels of satisfaction with IRW services. However, Jordanians were more likely than Syrians to report that they had received the help that they needed at mobile health clinics (MHCs), as well as had generally higher satisfaction rates. However, within focus group discussions, participants said that they felt that treatment was equitable across nationalities.

One area in which the effectiveness of the program was somewhat lacking was within its feedback and complaints mechanism. While there was a mechanism present, many of the beneficiaries within KIIs and FGDs were unaware of it or unsure how to utilize it. Furthermore, additional interviews indicated the response to feedback and complaints was not always systematic and could be improved with greater community input in the future.

Efficiency

80% *reported MHC wait times to be good or very good.*

The intervention was found to be highly cost efficient, with several provisions made which allowed for increased cost efficiency, ultimately allowing the IRJ team to exceed the number of beneficiaries in every program area.

Furthermore, delivery of services was found to be generally quite timely, with the vast majority of service recipients for both mobile health clinics as well as secondary and tertiary healthcare reporting that wait times were reasonable. In particular, participants in focus group discussions reported that wait times were significantly better than that of alternative care options, such as the public health clinics.

Impact

Broadly, the intervention was found to be highly impactful for beneficiaries, both in terms of immediate and long-term impacts. For example, 85% of secondary and tertiary healthcare recipients reported long-term positive health impacts from their surgery, with 58.5% reporting that their health improved immensely post-surgery. Furthermore, the health awareness sessions were found to be highly effective and impactful for beneficiaries, with 99% of participants reporting gaining new knowledge and improved understanding of health topics through engagement in awareness sessions.

85% *Reported that they have had long-term health improvement after surgery*

99% *Reported better understanding after health awareness sessions*

There were also a number of positive unintended impacts, such as the role of the project in increasing information about COVID-19 prevention measures, and in particular vaccine safety. KIIs revealed that a number of beneficiaries who were hesitant or unwilling to get vaccinated elected to do so after consultation with IRJ staff. Finally, the creation of networks with local CSOs and international organizations led to the creation of a detailed database of beneficiaries, which has assisted in optimizing the delivery of services not only for IRW's beneficiaries but its partners as well.

Sustainability

Some aspects of the intervention were found to be sustainable in that their impact would be continuous in the aftermath of the project, such as increased health awareness and improved life quality for the majority of patients of surgeries. However, other aspects of the project – more specifically, the hemodialysis component - require continued support in order for the benefits to be sustained. The initiative's sustainability can be increased through a focus on developing MOH's local capacity; however, there are associated challenges with this as well. With regards to environmental sustainability was taken into consideration at the design and implementation of the initiative, such as through the responsible disposal of waste.

The benefit of beneficiaries having increased health awareness is likely to continue, particularly as IRJ staff noted in the interviews that they would ensure that community leaders were present in the health awareness sessions in order to allow trickling down of information to their household and community members.

Key Recommendations:

1. Improve transportation to and from hospitals for secondary and tertiary healthcare recipients.
2. Increase services available for beneficiaries.
3. Invest in outreach components at the local community levels.
4. Improve integration with MOH.
5. Improve awareness of IRJ amongst beneficiaries.

6. Improve internal consistency in the application of policies and procedures.
7. Improve post-surgery communication for secondary and tertiary service recipients.
8. Continue to target under-represented areas, such as rural camps, in future interventions.
9. Replicate efforts of negotiating prices to ensure the most efficient cost during the procurement of supplies and service so that the best price can be obtained for future interventions.
10. Adjust mechanism for medicine distribution for dialysis patients.
11. Improve feedback and complaints mechanism.
12. Increase clarity of the schedule and location of the mobile health clinics.
13. Standardize surgery eligibility criteria.
14. Increase the budget to allow a larger number of beneficiaries to be served and to cover a wider variety of services, specifically including more surgeries.
15. Consider implementing similar initiatives addressing the healthcare needs of the Syrian population to improve their access to quality healthcare, quality of life, and mortality rate.
16. Design a comprehensive approach at a programmatic level rather than single projects.
17. Include preventative and early warning awareness to more common and chronic health issues for the awareness-raising component to ensure more long-term impact.
18. Invest in the development of the MOH's health services.
19. Consider implementing a training-of-trainers component to awareness sessions for local CBOs and community leaders.

1. Introduction:

Islamic Relief Worldwide has contracted Phenix Center for Economic and Informatics Studies to conduct an evaluation of its Healthcare Aid for Syrian Refugees in Jordan Project. Islamic Relief Worldwide (IRW) is an international aid and development charity aiming to alleviate the suffering of the world's poorest people. Islamic Relief USA (IRUSA) is a 501 (c)(3) tax exempt charity, based in the United States, that strives to alleviate poverty, hunger, illiteracy, and diseases worldwide regardless of color, race, religion, or creed. In Jordan, Islamic Relief is committed to serving those in need, especially refugees from countries such as Syria, Iraq, Yemen, Palestine living in camps and host communities in Jordan. The Kingdom currently hosts an estimated 1.3 million Syrians, constituting about 10% of the population. Over the course of the last three years, IRW, through Islamic Relief Jordan (IRJ) has conducted the project IRUSA-funded "Healthcare Aid for Syrian Refugees" aiming to enhance access to healthcare services for Syrian refugees in Jordan. This project came as part of a bigger program that started in 2014. Syrian refugees received free healthcare during the first years of the crisis (2012 -2014), after which they became only eligible for 80%-reduced rates similar to uninsured Jordanians rates. However, in early 2018, due to Jordan's inability to cope with the increasing needs, national authorities canceled the reduced rates for refugees living outside camps, making health care unaffordable for the majority of refugees. All these factors placed additional pressure on international NGOs to cover the shortage in healthcare needs. The overall objective of the project is to reduce the mortality rate on the one hand and improve the health situation for Syrian refugees and poor Jordanian families in Jordan. This evaluation examines how well the project was able to meet its goals, lessons learned for future interventions, and its adherence to international standards.

Information about the project:

The project aimed to provide Syrian Refugees with primary, secondary and tertiary healthcare according to their needs. Also, Hemodialysis service coverage for end stage renal disease patients. In addition to that, the project aimed to raise health awareness in the community to reach the ultimate goal of reducing mortality rate and improved health situation for the Syrian refugees and poor Jordanians families in Jordan.

Overall, the project reached 35,595 beneficiaries, 9164 Jordanian, 26,126 Syrian and 305 patients of other nationalities. The demographic composition of the targeted population indicated that the most targeted group was females 62% while the percentage of males was 38%. The most served age group were children up to 17.

Health awareness sessions were implemented within the following geographical areas: Ramtha, Jerash, Mafraq, Amman, Irbid, Zarqa, Ma'an and Karak. 2,698 participants attended 63 health awareness sessions on the following topics: first aid (with a first aid kit), personal hygiene (with hygiene items for kids and adults), winter diseases (medicinal herbs), breast cancer (honey and antioxidants), asthma (nebulizers) and diabetes (no distributed kit). While 1547 of the participants received health kits from IRJ, relative to the topic that was given. IRJ cooperated with Palestine Children's Relief Fund (PCRF) and the Danish Refugee Council (DRC) in providing health kits, while IRJ;s medical doctors conducted the health session. In the light of the COVID-19 pandemic, IRJ conducted awareness sessions through phone calls for 932 beneficiaries on COVID-19 and how to protect themselves from the pandemic.

A total of 3 mobile medical teams operated under this intervention, reaching 32,100 beneficiaries in the North and South of the Hashemite Kingdom targeting areas where beneficiaries lacked access to primary healthcare.

Secondary and tertiary healthcare components covered the cost of surgery for targeted beneficiary areas and served patients across Amman, Mafraq, Ramtha, Zarqaa, Irbid, Ajloun, Jerash, Ma'an, Karak, and Tafilah. The service was available at four governorates (Amman, Mafraq, Irbid and Karak) and six hospitals. The patients were identified through the following channels: mobile health clinic, referred by other stakeholders such as CBOs and other NGOs, hotline number and finally IRJ's field offices. The secondary and tertiary healthcare service were provided to 787 Syrian and Jordanian patients. The table below breaks down the distribution of beneficiaries who received tertiary care by age and gender:

Gender Group	# of Surgeries
Men (over 18)	198
Women (over 18)	258
Boys (under 18)	216
Girls (under 18)	115
Total	787

The hemodialysis services were provided to Syrian patients living in Amman, Irbid, and Karak. The service was provided at three contracted hospitals, one in Amman, one in Karak and one in Irbid. The cumulative number of patients covered under this component was 17, with end stage renal failure covered with haemodialysis sessions. 10 patients were targeted each month, 6 of whom were covered from the start of the project in 2017. If a patient sadly passed away due to their illness, they were replaced by a new patient who would then be covered under the project. Each patient attended 9-13 dialysis sessions a month.

1.1. Methodology:

This evaluation report will require a variety of research tools to obtain data and information that allows us to conduct both quantitative and qualitative in-depth analyses. Phenix Center conducted the evaluation through the application of a mixed approach methodology to conduct the research; while quantitative data were collected through surveys with all groups of beneficiaries, qualitative data stems from in-depth interviews and Focus Group Discussions.

IRW is a certified CHS agency and therefore uses the CHS standards as an overarching framework to assess the quality and accountability of programs and to complement the DAC criteria when undertaking evaluations. The following criteria were taken into consideration as a framework of evaluation: Relevance; Effectiveness; Efficiency; Coherence; Sustainability and Impact.

OECD/DAC-Criterion	Core Humanitarian Standard	Application in this evaluation

Relevance	CHS 1: Humanitarian response is appropriate and relevant CHS 4: Humanitarian response is based on communication, participation and feedback CHS 6: Humanitarian responses are coordinated and complementary	Phenix Center assessed to what extent IRW has used a relevant and appropriate design of its action in the project and if the project addressed the needs of the beneficiaries of the action. Secondly, Phenix Center has assessed to what extent the project design is aligned with government priorities and health sector priorities and local capacities in the different governorates. Thirdly, Phenix Center has determined geographical, financial and socio-cultural accessibility of the action, and how IRW incorporated feedback from beneficiaries throughout the intervention. Lastly, it determined in how far people were excluded from the services and the reason for exclusion, as well as to what extent host communities were also able to benefit from the services were provided by IRW.
Coherence	CHS 6: Humanitarian responses are coordinated and complementary	Phenix Center assessed to what extent IRW took into consideration the context factors on the ground (political stability, communities, timing, and demography) in designing the project, and which role the relationship with the Jordanian health sector played. Furthermore, it has assessed the coherence of IRW's project with other policies and programs of other stakeholders and service providers operating in the same context and at the same time and location. Phenix Center will also evaluate the internal coherence of the project with other IRW programs.
Efficiency	CHS 2: The Humanitarian response is effective and timely. CHS 9: Resources are managed and used responsibly	Phenix Center assessed if the project was cost-efficient and whether there would have been alternatives to the action. In addition, Phenix has assessed if IRW allocated its resources sensibly and if it implemented the action in a timely way.
Effectiveness	CHS 2: Humanitarian response is effective and timely. CHS 5: Complaints are welcomed and addressed CHS 8: Staff is supported to do their job effectively, and are treated fairly and equitably	Phenix Center has assessed to what extent IRW's project goals were reflected in the project outcome, and if the project outcomes were appropriate, timely and meaningful. This included an assessment of major factors influencing the achievement of the project outcomes (also those unintended) and the identification of obstacles. Furthermore, Phenix Center evaluated if IRW's action delivered results equitably for all genders, age groups and people with disabilities. Phenix Center also reflected on the complaint mechanisms IRW put in place and if they contributed to fulfilling the needs of the beneficiaries. Phenix Center also evaluated the way in which IRW has dealt with these complaints on a programmatic level. Phenix Center also evaluated how far staff were supported in their work and could make fast decisions without unnecessary delay while being treated fairly.

Impact	CHS 3: Humanitarian response strengthens local capacities and avoids negative effects. CHS 6: Humanitarian responses are coordinated and complementary CHS 7: Humanitarian actors continuously learn and improve	Phenix Center assessed if IRW has achieved long-lasting effects on the patients' and participants' lives and if these impacts reflect the overall project goals. This included an assessment of long-term results and institutional changes. Further, Phenix Center examined if the impact of IRW's action was different for one or more parts of the action and concerning different groups, such as gender, age, disability and other factors. In addition, Phenix Center has assessed the impact of COVID-19 on the action. Phenix Center also assessed if IRW has adapted its action based on context factors and feedback in order to achieve the project goals.
Sustainability	CHS 3: Humanitarian response strengthens local capacities and avoids negative effects.	Phenix Center evaluated how far IRW has considered the sustainability of its intervention through capacity building of partners and laying the groundwork for the long-term success of the project without additional support from IRW. This included an assessment regarding possible negative impacts on the community because of the action. In addition, environmental sustainability was considered.

Other theoretical underpinnings further guided the design of the evaluation, in order to determine the weighing of the abovementioned criteria. This includes a human rights-based perspective in consideration of the complex vulnerabilities faced by Syrian refugees in Jordan. Phenix' Center work and analytical framework is informed by international human rights standards and law articulated in the International Bill of Human Rights. Our human-rights based research approach seeks to analyse obligations, inequalities and vulnerabilities, and to tackle discriminatory practices and unjust distributions of power that undermine human rights. In particular, with regard to this evaluation, international law and literature on the Right to Health, especially the statements of the World Health Organisation (WHO) and the Office of the High Commissioner for Human Rights informed the development of the evaluation tools.

This means that Phenix Center also put particular focus on the following elements of the aforementioned criteria:

- Availability of the health care provision by IRW and if the quantity of its services and facilities was sufficient
- Accessibility of the health care provision with regards to non-discrimination, physical accessibility, financial accessibility and information accessibility
- Acceptability of the health care provision by IRW with regards to respectful and medical ethics and culturally appropriate provision of services in the Jordanian context, including sensitivity to age and gender
- Quality of the health care provision by IRW with regards to scientifically and medically appropriate service provision

This analytical framework informed the assessment and evaluation of the Healthcare Aid for Syrian Refugees Project in Jordan and the design of the evaluation tools.

This evaluation report has utilized a variety of research tools to obtain data and information that allows us to conduct both quantitative and qualitative in-depth analyses. Phenix Center conducted the evaluation

through the application of a mixed approach methodology to effectively conduct comparative research; while quantitative data were collected through the survey, qualitative stems from in-depth interviews and Focus Group Discussions.

For the quantitative component of this analysis, three surveys were conducted targeting beneficiaries of three different components of the project: mobile health clinics, secondary and tertiary care, and health awareness session recipients. Due to the small number of beneficiaries, individual interviews were conducted with hemodialysis beneficiaries rather than surveys. After survey data was collected, data was cleaned and analyzed. For some measures, two-sided significance tests were performed using a 90% confidence level in order to determine if findings were statistically significant, particularly regarding disparities between various subgroups (nationality, age, gender). Demographics of each survey can be found in Annex 1: Demographics of Surveys.

2. Evaluation Criteria

2.1. Relevance:

Relevance can be defined as the extent to which the intervention objectives and design respond to beneficiaries, global, country, and partner/institution needs, policies, and priorities, and continue to do so if circumstances change. In order to determine the relevance of the project, it is necessary to examine whether it took into consideration the context of operations, met a real need of its beneficiary population, and was accessible for the population it was intended to serve. As such, the analysis examined relevance across three main dimensions: contextual relevance (3.1.1.), alignment with community and stakeholder needs (3.1.2.), and accessibility (3.1.3.). Broadly, the project was found to be relevant across all of these dimensions:

Table 1: Summary of Findings (Relevance)

Dimension	Section	Findings
Contextual Relevance	2.1.1.	The project can be considered highly relevant within the context, as it addresses particular gaps in healthcare service provision for Syrian refugees and vulnerable Jordanians. In particular, it provides no-cost healthcare services to those who otherwise would not have been able to afford care, and to those within remote and hard-to-reach areas who are unable to spatially access healthcare services.
Alignment with Community Needs	2.1.2.	The project was found to broadly align with stakeholder needs, with beneficiaries noting that the most important healthcare services were covered. Health awareness session attendees noted that the topics of the session were relevant to their health interests. However, there are some key areas where beneficiaries reported needing services, which were not covered, including dental & eye care. Furthermore, the project was found to be relevant to the needs of other stakeholders, including MoH and UNHCR.
Accessibility	2.1.3.	As services were provided at no-cost, all services offered by IRJ's programs can be considered financially accessible. Services were generally considered spatially accessible by beneficiaries. However, beneficiaries of secondary and tertiary services reported difficulties reaching the hospital where their procedures would take place; this was a more common challenge amongst women and Syrians. Services were very broadly considered socially and culturally accessible by all project beneficiaries, with participants feeling that cultural values of privacy and modesty were respected, as well as reporting a general sense of respect.

2.1.1. Contextual Relevance

This project was found to be highly relevant to the specific context of Syrian refugees in Jordan and addressed key service gaps faced by Syrian refugees and disenfranchised Jordanians when accessing

healthcare, including mitigating high costs of medical services, providing medications which may be unavailable or unaffordable within governmental clinics, and providing clinical access in areas which may not otherwise have.

For most Syrian refugees, the high costs of healthcare leave them unable to access the care they need. Furthermore, in October 2014, the Ministry of Health (MoH) announced that it will no longer provide free treatment for Syrian refugees in Jordan, and that treatment costs for Syrians will be that of non-insured Jordanians (45 piasters per person, per visit). While these rates may appear to be affordable, key informant interviews revealed that medical costs can quickly amalgamate when factoring in costs of transportation and medicine (which is purchased at full price). Furthermore, Ministry of Health clinics and hospitals are not available in all governorates. There are no governmental hospitals in the Governorates of Aqaba and Tafilah. Additionally, key informant interviewees noted that beneficiaries in areas, which are remote and hard-to-reach, including informal tented settlements (ITSs), may not have any mechanism for traversing the long distances between home and healthcare centers. Additionally, many Syrian Refugees have chronic diseases that need continuous follow-up and medication provisions, along with the acute infections and the diseases that need surgical intervention which are getting harder to be achieved with less capabilities and limited infrastructure. The Covid-19 pandemic has exacerbated socioeconomic challenges for everyone, refugees and host communities alike. Over a third of Syrian refugees lost their source of income amidst the pandemic, making the financial barriers to healthcare more challenging to overcome.

As such, this intervention was specifically designed to mitigate these challenges. Through providing a mobile clinic, individuals within remote areas were able to be reached. For example, refugees living within Rukban camp, an informal tented settlement located in the unadministered space between the Jordanian and Syrian border, have no access to routine medical services as there are no medical facilities at the camp and camp dwellers are unable to enter Jordan without explicit permission and security detail.[1] The mobile nature of the clinic allowed IRJ to provide much needed services to these highly vulnerable populations who otherwise may not have access.

Furthermore, the no-cost approach of the IRJ mobile health clinics has provided much-needed assistance affording medications and routine health services, including both refugees and host community, particularly for individuals with chronic illness, disease, and disability: over 70% of mobile health clinic beneficiaries reported that they or a household member had chronic illness or disability. For example, during the early stages of the project, IRJ was the only organization in Jordan to cover end-stage renal diseases (ESRD) with full coverage of the service that included the cost of hemodialysis missions (12-14 session per month for each patient), all regular medications, vitamins, blood units and Iron, all regular lab tests (ex: blood test, kidney function test, hepatitis test), and hospital admission and minor or major surgical intervention if needed. However, due to budget constraints, IRJ ceased coverage for services other than dialysis itself in order to be able to continue providing dialysis services coverage. During interviews dialysis patients noted that they would be unable to afford this life-saving procedure without IRJ; however, they also noted that they were unable to cover the cost of their other medical needs.

2.1.2. Alignment with Community and Stakeholder Needs

As experts in the Jordanian healthcare field indicated in KIIs, access to quality healthcare is a huge challenge amongst Syrian refugee populations and Jordan's most vulnerable, particularly for chronic illnesses and

[1] Christou, W. (2020, December 1). Al-Rukban camp has no doctors, but that could change. Syria Direct. https://syriadirect.org/al-rukban-camp-has-no-doctors-but-that-could-change/

especially for those who are undocumented or living in remote areas. Focus group discussions (FGDs) confirmed this, as beneficiary participants overwhelmingly stated that finding affordable, quality healthcare was a challenge for them. Broadly, FGD participants noted positive perceptions of the project and the services, which were delivered, specifically mentioning how the project provided them healthcare access, which they may not otherwise have had. Similarly, all the hemodialysis patients in the KIIs noted that without IRJ's support, they would have been unable to cover the cost of the life-saving procedure.

"They saved my life. The cost of my hemodialysis was 40 JDs per week. I couldn't afford that – no one I know can."- FGD Participant

That being said, there were also a number of needs mentioned by beneficiaries during Focus Group Discussions that were not addressed by this project. This included a need for eye care, dental care, nerve and neural damage, psychological and mental health, hearing aids, and orthopedic services (specifically knees and joints). Upon follow up with IRJ staff, it was noted that some of those unmet needs were referred elsewhere, while others were not as there were no other organizations providing these services at that time and/or in the relevant area. Furthermore, while the project did provide much-needed health services to the population, the rotational nature of the mobile health clinics meant that beneficiaries were not always able to access healthcare whenever they needed it, as they had to wait until the clinics returned to their area. This was confirmed within survey findings, as only 20% of beneficiaries reported being able to consistently access medical care whenever they needed it. However, the vast majority (>95%) said that they were able to access care at least some of the time, indicating that Mobile Health Clinics did provide healthcare services for those who were least likely to have regular healthcare access, such as people living within remote and hard-to-reach areas and informal tented settlements (ITSs).

Furthermore, health awareness sessions (Outcomes 1.2. and 1.3.) can be considered highly relevant to needs of the population. 99% of participants in health awareness sessions reported feeling that the topic of the session was relevant to their interests and needs. For future sessions, participants were also asked if there were any additional topics which they felt were relevant to their community and would likely to receive more awareness in. 97.7% said that they felt there were additional topics that they would like to learn about, with the most popular topics being cancer prevention (19.3%), hygiene (36.4%), women's health (18.2%) COVID-19 (68.2%), and Other (29.5%). Within focus group discussions, women in particular mentioned a need for health awareness sessions on children and infants' health, specifically mentioning breastfeeding.

Additionally, the project should be assessed in context with its relevance according to other stakeholder needs, including the MOH and other actors within the healthcare field. According to one KII with a representative of the UNHCR, the intervention was able to achieve its relevance due to the fact that a baseline study was conducted prior to the implementation, as well as due to the continued communication with other actors within the field, allowing for relevant adaptations in response to challenges as they occurred.

2.1.3. Accessibility

Finally, in addition to being contextually relevant and addressing specific beneficiary, community, and stakeholder needs, in order to fulfill OECD-DAC standards for project relevance, the project must also be accessible for the targeted beneficiaries, and have equitable levels of accessibility across gender and nationality demographics. For the purpose of this evaluation, we have considered accessibility in two distinct frameworks: spatial and financial accessibility, as well as social and cultural accessibility.

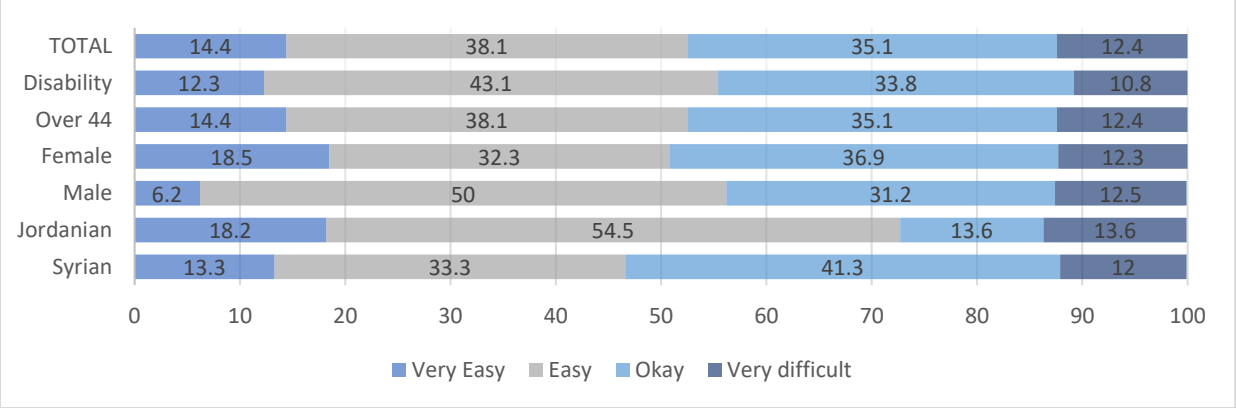
Spatial and Financial Accessibility

Accessibility, both financially and spatially, of healthcare services is a major component mentioned in both Sphere and WHO guidelines for humanitarian health interventions. Financially, all services offered through this project were free for any and all beneficiaries, both those from the host community and refugees. Financial accessibility was thus a cornerstone of the project and the project can undeniably be considered financially accessible for all beneficiaries.

Additionally, the spatial accessibility of the Mobile Health Clinics was considered, with "accessibility" referring to the ease or difficulty of patients' ability to physically go to location of the Mobile Health Clinics within their community. Participants were also asked the following questions: "How would you rate your ability to go and receive help at the health clinics? Was the location easily accessible to you?" The majority of Mobile Health Clinic beneficiaries (52.5%) reported that they found the clinics to be either easy or very easy to access, with an additional 35.1% reporting okay access. Approximately 12.5%, however, said that access was 'very difficult'. Disaggregating these results by nationality, age, disability, and gender (Figure 1: Accessibility of Mobile Health Clinics), we see that broadly, Jordanians were more likely to report that access was easy or very easy than Syrians. This finding could be related to the fact that areas in which the Mobile Health Clinics were more likely to serve Jordanians were less rural, and as such the Mobile Health Clinics could be parked in a central location.

Furthermore, people with disabilities and/or caretakers were also asked regarding the ease to which they could physically access mobile health clinics; notably, no significant disparities were seen between those with household disabilities and those without.

Figure 1: Accessibility of Mobile Health Clinics



Additionally, in KIIs with IRJ staff, it was noted that staff would listen to requests of member of the community after visiting to take into consideration where to park the health clinics for increased accessibility in the future.

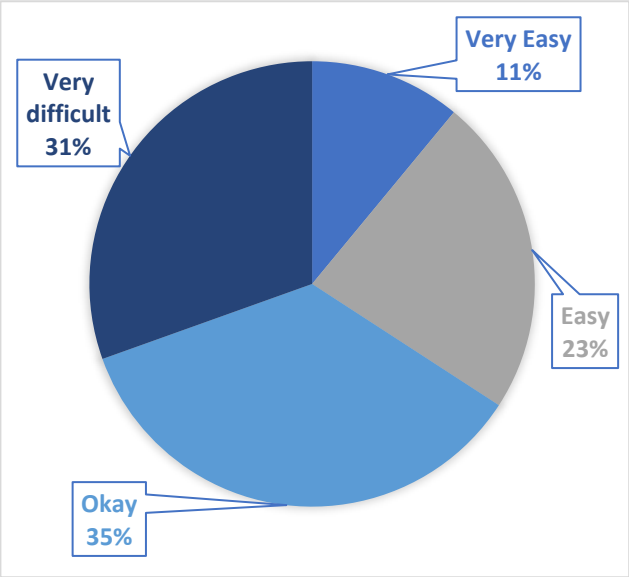
In addition to ease of access, participants also were asked about consistency of the location of the mobile health clinics. Cumulatively, 45.4% reported knowing when the mobile health clinics were close to them all of the time or most of the time. Another 39.2% reported knowing when the mobile health clinics were nearby sometimes, while the remainder (15.5%) reported only knowing whether they were close by one time. Examining these results by nationality and gender, Syrians in general reported more consistent knowledge of when clinics were nearby than their Jordanians counterparts, with 31.8% of Jordanians reporting they only knew that clinics were nearby one time, compared to only 10.7% of Syrians. This discrepancy can perhaps be explained by the fact that Syrians generally reported greater dependency on the Mobile Health Clinics: 28% of Syrians reported mobile health clinics as their usual place of receiving health services, while only 5% of Jordanians did so. As such, Syrians may be more likely to keep track of clinic schedules. Additionally, during FGDs, Syrian beneficiaries noted that they often learned of the mobile health clinic's locations based on information channeled through Whatsapp or Facebook groups designed for Syrian refugee, which is a part of the sub-culture for Syrian refugees in Jordan. As such, these social media channels can be an excellent solution for future projects to use in order to advertise the location and time of mobile health clinics.

For those receiving secondary and tertiary health services through IRW's referral program, accessibility of can be considered the feasibility through which beneficiaries could both physically access services as well as how easy it was for them to provide the necessary documentation to receive these services. In general, the evaluation study population reported relative ease, but 23.2% did say that Islamic Relief could improve its program by facilitating transportation to and from the hospital. During earlier stages of the project, patients withdrew from getting the service due to inability to afford transportation costs, especially those who need to reach the hospital regularly such as hemodialysis patients. According to KIIs with IRJ staff, creating new partnerships with more hospitals allowed for a reduction in patients' transportation distances and costs.

Syrians (23.6%) were more likely than Jordanians (12.5%) to agree that the program could improve through providing better transportation for beneficiaries, and women (35.1%) were more likely than men (13.3%) to feel so. However, no disparities were found between people with disabilities and people without disabilities. Furthermore, 78.1% reported that providing necessary documentation was easy or very easy, while less than 5% reported it as very difficult or impossible. Disaggregating these results by nationality, gender, disability status, and age, no significant differences were found across age groups or household disability status, though men were slightly less likely to find document provision easy than their female counterparts. Furthermore, while Syrians generally reported considerable ease in providing documentation, they were the only ones who found it to be difficult or impossible. This can be perhaps be attributed to the fact that many Syrians have arrived in Jordan without any documentation.

Finally, recipients of secondary and tertiary healthcare services were also asked about their ability to go to the hospital where their surgery was to take place and receive help (Figure 2). They were asked to answer the following question: "How would you rate your ability to go and receive help at the hospital where the surgery was to take place? Was the location easily accessible to you?" As such, this question explored the physical accessibility of hospitals, including transportation access and distance from the hospital. Broadly speaking, the majority of participants stated receiving help was either very easy, easy, or okay. However, when asked to rate their ability to go and receive help at the hospital where the surgery was to take place in reference to the accessibility of the location, 30.5% said that going to the hospital was very difficult for them. Examining by nationality, gender, disability, and age, women (37.8%), and those over the age of 44 (43.5%) were more likely than average to report that going to the hospital was very difficult for them. Furthermore, Syrians were more likely to say that it was very difficult than their Jordanian counterparts. Interestingly, however, people with disabilities and their caretakers were more likely than non-disabled people to report that it was 'very easy,' with no significant difference between rate of which members of households with disabilities and members of households without disabilities reported access to be 'very difficult' (28.2% and 31.5%, respectively). This is an indicator that transportation is a challenge for rights-holders. Staff interviews with IRJ showed that the number of partnered hospitals has increased over the years, allowing rights-holders to visit hospitals closer to their location.

Figure 2: Ease of Going to Hospital of Surgery Location and Receiving Help



Cumulatively, these results indicate that the spatial accessibility of the program was considered within program design and participants generally had few accessibility-related issues. However, there are key areas which may need to be improved upon program continuation. Namely, accessibility to the mobile health clinics was a challenge for some patients who could not walk upstairs due to a mobility-impairing disability. As an adaptation strategy, the project's team members adapted this feedback by providing the health services in the rooms of partner Community Based Organizations (CBOs), and house visits were also conducted if needed.

Social and Cultural Accessibility

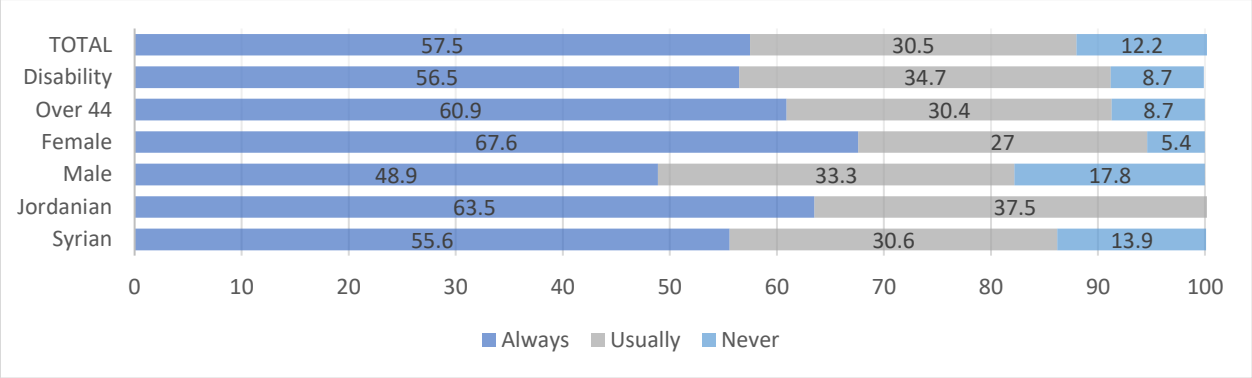
In addition to the importance of geographical and financial acceptability, the Core Humanitarian Standard (CHS 1 & CHS 4) as well as WHO and Sphere standards emphasize the importance of socio-culturally appropriate, people-centered approaches to healthcare. As such, it is important to understand how IRJ's Healthcare Aid Project matched sociocultural contexts: this can be done through examination of accessibility of information, respecting cultural norms regarding health and privacy, and analyzing the

overall degree of respect that beneficiaries received. Broadly, IRJ's services were found to be highly socially and culturally accessible, based on the following results:

Beneficiaries of the mobile health clinics were asked about whether staff respected their privacy, including respecting gender preference of care, covering, etc. Broadly, results indicated that the vast majority of participants felt that staff respected privacy, with 23.7% reporting that their privacy was respected to a great extent, 69.1% in an appropriate manner, and only 7.2% to a small extent. No participants said that their privacy was not respected. These results were generally similar across nationality and age levels. However, discrepancies were found between males and females, with female beneficiaries more likely to report that staff respected privacy than male beneficiaries. Similarly, all participants reported that they felt respected by staff, with 75.3% reporting that they were respected to a great extent, and 24.7% reporting that they were treated with some respect. No significant disparities were found between age, nationality, or gender.

Similar results were found within beneficiaries who received secondary and tertiary healthcare, with nearly all participants reporting that the staff treated them with great respect (50%), with respect (46.3%), or with some respect (2.4%), with no significant disparities were found across age, nationality, or gender. Furthermore, 75% of secondary and tertiary healthcare recipients who received home visits for determining eligibility felt either "at ease" or "somewhat at ease" during their home visit. Interestingly, Jordanians were more likely than Syrians to report feelings of being anxious or afraid during the home visit, though no significant disparities were found across gender. This could be because they were more anxious that they would not receive assistance following the house visit; however, due to the nature of the survey, it is difficult to determine the exact cause.

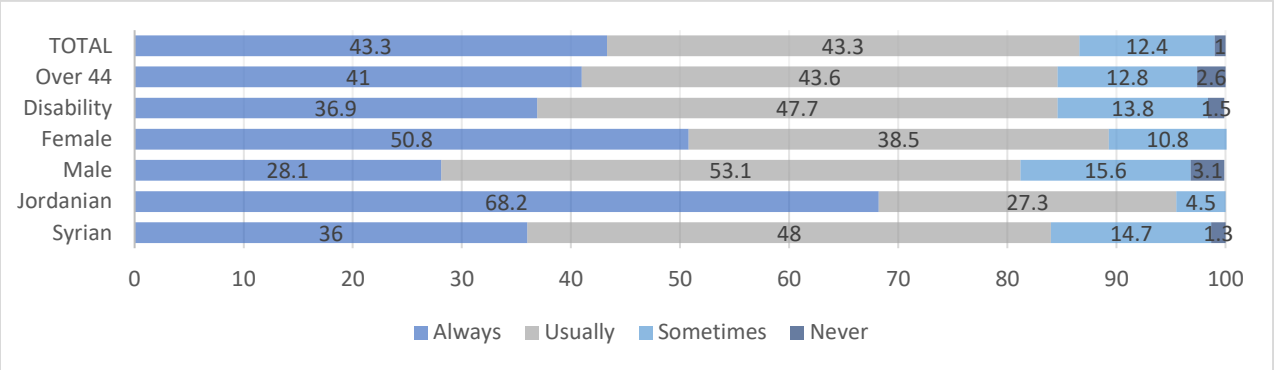
Figure 3: How often did staff explain treatments and diagnoses to you in a way that you fully understood? (Secondary and Tertiary Healthcare Recipients)



Both mobile health clinic and secondary and tertiary healthcare beneficiaries were also asked about the degree of accessibility of the information which they received from IRW staff and partners. Across all demographics, a clear majority of secondary and tertiary healthcare recipients felt that information was delivered in a way which was easily understood (Figure 3); however, disparities were found across gender and nationality: 13.9% of Syrians felt that treatments and diagnoses were never fully explained, compared to 0% of Jordanians. Furthermore, 17.8% of men felt that treatments and diagnoses were never fully explained, compared to only 5.4% of women. Similar results were found among mobile health clinic beneficiaries (Figure 4), the vast majority of whom reported that they always or usually fully understood explanations of treatment plans or diagnoses. However, like secondary and tertiary healthcare recipients,

male and Syrian sub-groups reported generally lower levels of understanding than the female and Jordanian sub-groups. However, unlike secondary and tertiary healthcare service recipients, mobile health clinic beneficiaries with household disabilities reported lower overall levels of understanding than their non-disabled counterparts.

Figure 4: How often did staff explain treatments and diagnoses to you in a way that you fully understood? (Mobile Health Clinic Beneficiaries)



That being said, beneficiaries in both groups broadly reported that they felt comfortable asking questions in the event that they did not understand something. For mobile health clinic beneficiaries, 92% reported being either very comfortable or comfortable asking questions, while 100% of secondary and tertiary healthcare recipients reported feeling comfortable to a great extent or to an appropriate extent. This indicates that, while participants may not have fully understood healthcare diagnoses and treatments, staff were able to create an environment which made beneficiaries feel comfortable to ask for clarification and further explanation.

Finally, participants in health awareness sessions were asked about the accessibility of information provided: namely, was it provided in such a way that was easily understandable for them. No participants reported that information was not understandable, with 65.9% reporting that sessions were conducted in a way that understandable to a great extent, 31.8% reporting that it was conducted in an appropriate manner, and 2.3% reporting that it was conducted in a way that was understandable to a small extent. No significant disparities were found between different age levels, nationalities, or gender.

Cumulatively, these results indicate that the intervention considered cultural norms, particularly regarding respect for privacy. Furthermore, the intervention was found to ensure that information regarding health and diagnoses was accessible for beneficiary populations, with the majority of participants reporting that things were explained to them in a clear way and that they felt comfortable asking questions in event that they did not understand.

2.1.4. Relevance Conclusion and Recommendations

Examining these factors holistically, we find that the project was relevant to the context in which it was taking place, and took into consideration the specific challenges and social dynamics within a post-conflict refugee context (see Section 3.1.1.). Secondly, the project was found to address a relevant community and stakeholder need, as it provided health services for those who may otherwise not have been able to afford

them (Section 3.1.2.). That being said there were a number of health service needs that beneficiaries expressed which were not addressed during the project, and could perhaps be considered in future iterations of this or similar projects. Finally, the intervention was found to be mostly accessible for the target population, though this also represents an area in which the project could improve (Section 3.1.3.) As such, we can determine that this project fulfilled OECD Relevance criteria, but has some areas in which it could improve its relevance for the community:

Recommendation #1: Improving transportation to and from hospitals for secondary and tertiary healthcare recipients. 31% of secondary and tertiary healthcare service recipients said that it was very difficult for them to go to the hospital of their surgery location to receive help. While the cost of post-surgery transportation is paid to the patient after the surgery check out, providing transportation both prior to the surgery as well as after surgery will improve program responses as well as empower beneficiaries to maintain the health benefits associated with the procedure through routine follow-up care.

Recommendation #2: Increasing services available for beneficiaries. Some beneficiaries in FGDs expressed a desire for increased services. One suggestion was to increase the number of surgeries eligible for coverage within IRJ's projects, and further expand the scope of the project to include dental, nerve, eyecare, and gynecology.

2.2. Coherence:

Coherence can be defined as the compatibility of the intervention with other interventions in a country, sector or institution, and is inclusive of both external and internal coherence: Internal coherence addresses the synergies and interlinkages between the intervention and other interventions carried out by the same institution/government, as well as the consistency of the intervention with the relevant international norms and standards to which that institution/government adheres. External coherence considers the consistency of the intervention with other actors' interventions in the same context. This includes complementarity, harmonization and co-ordination with others, and the extent to which the intervention is adding value while avoiding duplication of effort. As such, this evaluation examined coherence across three main dimensions: coherence with other stakeholders, coherence with international standards, and internal coherence. Cumulatively, the project was found to be mostly coherent:

Table 2: Summary of Findings (Coherence)

Dimension	Section	Findings
Coherence with Other Stakeholders	2.2.1.	Other stakeholders felt that the intervention of IRJ was coherent with other services provided without duplication, as mobile health clinic allowed them to access under-serviced areas, and dialysis in general is not covered by other organizations in Jordan.
Coherence with International Standards	4, 2.2.2.	The intervention was found to be in coherence with international standards.
Internal Coherence	2.2.3.	Internal coherence of the project can be improved.

2.2.1. Coherence with Other Stakeholders

Findings from the KIIs show that IRJ has formed valuable partnerships with grassroots CSOs as well as national and international NGOs throughout the duration of the project, including the Qatari Red Crescent, the Noor Al-Hussein Foundation, UNHCR, the International Organization for Migration, the Danish Refugee Council, and the Palestine Children's Relief Fund. Within KIIs with other stakeholders, IRJ was described as an "essential partner" and "one of the best in the field". For instance, their support of beneficiaries of QRC when a funding crisis led to QRC being unable to provide care was cited as an example of their collaboration. When asked to describe the experience of working alongside IRJ within the field of providing care for Syrian refugees, a Public Health Associate at UNHCR described them as being "communicative, cooperative, and among the best in terms of cooperation", noting that IRJ's regular attendance of monthly meetings supported the coherence of its project with policies and programs of other stakeholders and service providers operating within the same context. Specifically, the coverage of hemodialysis was cited across all KIIs as being a service that is scarce or inaccessible to Syrian refugees in Jordan. Additionally, it was noted that the mobile health clinics allowed IRJ staff to reach ITSs and provide services to beneficiaries in remote areas. Key informant interviews with experts also revealed that mobility clinics are essential for reaching patients in ITSs and remote areas, who are unable to reach other health clinics and who show low health utilization of MOH clinics.

During interviews, it was made clear that there is a perception among other organizations in the field that the IRJ's intervention as being supportive of the Jordanian health system, thereby reducing the "burden" of providing healthcare for Syrian refugees and filling a gap or unmet need for providing healthcare for undocumented Syrian refugees. However, one area of concern mentioned by an expert in the Jordanian healthcare field was the concern that services were being provided in parallel to the Jordanian healthcare system, rather than in support of it. One suggestion for future programming was to include within the health awareness sessions on how refugees can access care through MOH clinics. The provision of services to Jordanians as well as Syrians supported the coherence of the project overall. Jordanians also would utilize the clinics to access medicine that was unavailable in MOH clinics.

Furthermore, these findings were also replicated within quantitative data. Survey respondents for secondary and tertiary healthcare services were asked about the mechanism through which they were referred to IRJ's medical assistance program. For the majority of participants (67%), they were referred directly through field offices. However, a considerable number were referred through IRJ's hotline number (18%), while another 7.3% were referred through other CBOs and NGOs. For participants in health awareness sessions, over half (55.7%) of respondents said that they heard about the sessions through CBOs, NGOs, or another charity. This indicates that IRJ has worked with other partners within the field to coordinate services.

2.2.2. Coherence with International Standards

A summary of how well this project aligns with international standards can be found in Error! Reference source not found.. However, we can specifically examine how the project aligns with standards for patient-centered care. Table 3 : Compliance with Good Practices at Mobile Health Clinics % details findings

regarding good practices for dignity, respect, communication, and privacy of patients at mobile health clinics. As seen within the table, the vast majority of Mobile Health Clinic beneficiaries felt that they were treated with dignity at the clinics. Furthermore, over 85% assessed communication as 'very good' or 'good.' Participants noted that staff always or usually listened to them carefully and that conversations were always or usually held in private so that any medical information was not disclosed and was protected, in line with good practices regarding confidentiality and dignity. These results are indicated that the majority had a positive experience with receiving IRJ's services. However, they also indicate that there is room for improvement with regards to communication between staff and rights-holders.

Table 3 : Compliance with Good Practices at Mobile Health Clinics %

	Very Good	Good	Moderate	Poor
How would you rate your experience being treated with dignity at clinics?	28.9	59.8	11.3	0
How well did the staff communicate with you?	25.8	59.8	14.4	0
	Always	**Usually**	**Sometimes**	**Never**
How often did staff listen carefully to you?	41.2	45.4	13.4	0
How often were your talks with your doctor done privately, so others could not overhear?	30.9	54.6	11.3	3.1

Furthermore, focus group discussions with participants revealed that beneficiaries of mobile health clinics generally had positive perceptions of the clinic infrastructure and sanitation. During interviews, IRJ staff shared procedures for ensuring cleanliness and maintenance of the clinic and its equipment.

For beneficiaries of secondary and tertiary health services, the degree to which the IRJ team upheld good communication and follow-up practices with participants was examined. Compliance with these practices is important not only for building patient trust, but also ensuring that health outcomes remain positive in the long-term. In general, beneficiaries noted high levels of satisfaction with pre-surgery communication. However, 28% of participants also noted that after their surgery they did not receive any communication; this was also cited as a major area in which the program needed to improve, with 20% of survey respondents agreeing that there was a need for greater post-surgery communication. However, in interviews with IRJ staff, it was reported that every surgery recipient also received follow-up visits. Thus, there is a possibility that these individuals who reported not receiving communication may not have identified IRJ as the organization communicating with them, which could be symptomatic of a larger recurring name-recognition challenge, as explored within section 2.2.3. Internal Coherence.

This thus represents a specific area in which IRJ can improve its secondary and tertiary healthcare program. Additionally, in KIIs and FGDs, some hemodialysis and primary service beneficiaries noted instances where they did not receive a follow-up or referral. One beneficiary in an FGD noted that his daughter had been struggling with pain in her leg, but that they did not receive follow-up from IRJ. In a KII with a hemodialysis patient, he noted that he requested cash assistance from IRJ, but did not receive follow-up on his request.

Table 4: Compliance with Good Communication Practices (Secondary and Tertiary Healthcare) %

	Very Good	Good	Moderate	N/A
How well did the staff communicate with you after initial consultation?	29.3	59.8	11.0	0
How well did staff community with you after your surgery	28.0	35.4	8.5	28.0

2.2.3. Internal Coherence

With regards to internal coherence and synergies between the interventions on healthcare and other IRJ interventions, it was noted that the united database provided an excellent reference point and allowed for reduced duplication of efforts, in particular with needs assessment of beneficiaries. Patients in KIIs were not aware of other IRJ initiatives. However, a challenge of the database was that some of the participants of the FGDs were included in the database despite not receiving services by IRJ. However, this confusion could also be attributed to a lack of name brand recognition for beneficiaries with IRJ, as follow-up questions indicated that they indeed did receive healthcare services, but did not recognize IRJ's name as an organization. This is a challenge that was confirmed through KIIs with IRJ's staff, one of whom noted that at times beneficiaries would mistake IRJ's name during follow-up. Other IRJ projects implemented at the time include cash transfers, which could overlap with the targeted beneficiary group.

Additionally, internal coherence takes into consideration the consistency of the intervention with the relevant standards the organization has set for itself. As the FGDs and surveys have revealed inconsistencies in the application of referral criteria and follow-up on complaints mechanisms, this indicates that internal coherence could be improved.

For an in-depth analysis of the project's coherence and alignment with international standards, please see Section 3. Alignment with International Standards.

2.2.4. Coherence Conclusions and Recommendations

The intervention is in coherence with other stakeholders, as the KIIs with experts in the health sector and with other actors in the field show. Additionally, surveys, FGDs and KIIs with beneficiaries indicate high quality of services which is in coherence with international standards. However, intersections and integration between other programs could be strengthened. Additionally, beneficiaries were not aware of IRJ's other projects, indicating that IRJ's visibility and branding among targeted populations could be strengthened. As such, internal coherence could be improved. Recommendations include:

Recommendation #3: Invest in outreach components at the local community levels. This will allow beneficiaries to know more about IRJ's ongoing interventions, which would improve the coherence of future activities.

Recommendation #4: Improving integration with MOH. Greater integration of MOH strategies and programs into the planning and design stages of interventions, as well as building ongoing collaboration to

support the development of MOH's capacities. Staff could be trained to be more aware of MOH national strategies.

Recommendation #5: Improving awareness of IRJ amongst beneficiaries. This study found that beneficiaries were at times unaware of the role of IRJ in providing their care, and did not know about other IRJ projects. As such, there is a need to improve awareness of IRJ as an actor, in order to ease monitoring and evaluation processes. Staff should be trained not only in the services they provide but also in IRJ's other programs, as well as how to best inform beneficiaries of such programs when relevant.

Recommendation #6: More internally consistency in the application of policies and procedures. Based on our findings, there is a need to improve internal coherence of the program through increasing consistency of use of procedure, including for evaluation criteria, referral criteria, post-surgery communication and response to complaints and feedback mechanisms.

Recommendation #7: Greater post-surgery communication for secondary and tertiary healthcare service recipients. Over 20% of participants noted that more support and follow-up was needed post-surgery. Furthermore, 28% of beneficiaries reported that they did not receive follow-up communication after their procedure from IRJ staff.

Recommendation #8: Continue to target under-represented areas, such as rural camps, in future interventions. A baseline needs assessment could be conducted before such future initiatives to ensure that support is given to the in-need communities.

2.3. Efficiency

Efficiency can be defined as the extent to which the intervention delivers, or is likely to deliver, results in an economic and timely way. This refers to the conversion of inputs (funds, expertise, natural resources, time, etc.) into outputs, outcomes and impacts, in the most cost-effective way possible, as compared to feasible alternatives in the context. "Timely" delivery is within the intended timeframe, or a timeframe reasonably adjusted to the demands of the evolving context. Based on these criteria, two specific areas were examined: cost efficiency and timeliness. Generally, the intervention was found to be generally efficient both in terms of cost as well as timeliness, though timeliness of medicine distribution needs to be improved:

Table 5: Summary of Findings (Efficiency)

Dimension	Section	Findings
Cost Efficiency	2.3.1	The intervention was found to be highly cost efficient, with several provisions made which allowed for increased cost efficiency, ultimately allowing the IRJ team to exceed the number of beneficiaries in every program area.
Timeliness	2.3.2.	The intervention was found to be conducted in a timely way, with most survey participants reporting satisfaction with clinic wait times and service delivery times. However, beneficiaries noted a key challenge regarding the timeliness of medicine distribution.

2.3.1. Cost Efficiency

Generally, this project was found to be highly cost efficient. There were a number of project changes which occurred during the duration that allowed budgeted resources to be utilized in the most efficient and impactful way possible, including:

- Reallocation of funds for software development to allow tracking of medical records and medicine stocks within the mobile clinics.
- 9-month extension due to delays in government approvals and COVID-19.
- Revised budget to recruit an additional medical team.
- 2-Month extension to utilize project savings and to bridge gaps between phase 2 and phase 3 services.

The intervention was cost-efficient in its ability to exceed targets within the same budget:

- Due to negotiations and favorable prices received from the suppliers regarding the health kits.
- Due to lower costs than anticipated based on negotiations with service providers and partnership with organizations such as the PCRF, the intervention was able to service a higher number of patients needing surgical interventions. Additionally, the team exceeded the target of the surgical interventions because the team had lower costs than anticipated based on negotiations with suppliers.
- Through establishing relationships with multiple hospitals and negotiating for better prices, the IRJ team were able to be more cost-efficient in meeting the intervention's outcomes.
- Through choosing generic medication over brand-name medications and negotiating with pharmaceutical suppliers, the IRJ team were able to be more cost-efficient in meeting the intervention's outcomes.

These negotiations allowed the project to take place at an increased efficiency in cost.

2.3.2. Timeliness

With regards to timeliness, generally, mobile health clinic beneficiaries reported that wait times at the mobile health clinic were prompt, with 15.5% reporting them as very good, 64.9% reporting them as good, and 17.3% reporting them as moderate. Furthermore, disparities across nationality and gender were not significant. However, those over 44 were slightly more likely than younger counterparts to report slower wait times; that being said, only 5.1% of respondents over the age of 44 reported wait times as 'bad'. Furthermore, participants were asked how often they had to wait to receive services at the mobile health clinic; given the rotational nature of services and the fact that the clinic is not present every single day in each area, most (89.7%) reported wait times of less than three days, with approximately half saying that they were able to receive services the same day as when they needed them.

For secondary and tertiary healthcare recipients, only approximately 8.5% reported that the program needed to reduce wait times, while the remainder felt that wait times were reasonable and did not need improvements.

Regarding the timeliness of medicine distribution, it was noted during one of the KIIs with a dialysis patient that medicine arrives at the end of the month, which caused some issues if medicine was needed at the

beginning or in the middle of the month, particularly for emergency cases, as approvals would take some additional time.

Additionally, one evaluation of timeliness includes whether the timeframe was reasonably adjusted to the demands of the evolving context. Within consideration of challenges such as delayed MOH approvals, weather conditions, and the COVID-19 crisis, it can be considered that the timeframe adjustments were reasonable and in line with the demands of the evolving context.

2.3.3. Efficiency Conclusions and Recommendations

Broadly, the intervention was found to be highly efficient, both in terms of financial management as well as timeliness of service delivery. However, one area stands out as in need of improvement, which is the mechanism through which beneficiaries receive medications:

Recommendation #9: Adjust mechanism for medicine distribution for dialysis patients. As noted by beneficiaries, the current mechanism allows for medication to only be distributed towards the end of the month, and required approvals to receive early. This is in line with the monitoring and evaluation policies of IRJ; however, it may present issue in the event that medicines were needed urgently. As such, a re-adjustment of the medicine provision system may be considered.

Recommendation #10: Future interventions should replicate the efforts of negotiating prices to ensure the most efficient cost during the procurement of supplies and service so that the best price can be obtained. Additionally, the existing networks and connections within players of the health field in Jordan should be maintained in order to ensure efficiency in future interventions.

2.4. Effectiveness:

Effectiveness can be defined as the extent to which the intervention achieved, or is expected to achieve, its objectives, and its results, including any differential results across groups. The OECD-DAC criteria for determining effectiveness of a project focus specifically on whether the proposed outcomes of the project were met, and whether those outcomes were delivered equitably across gender, nationality, and age. Furthermore, it is important to examine whether complaints were addressed in order to assess the degree to which the project was adapted to ensure effectiveness throughout the program period. Broadly, this evaluation has found that the planned outcomes were all either achieved or mostly achieved (Section 3.4.1.). Furthermore, outcomes were generally equal across populations, though there are a few key areas where statistically significant differences in outcomes were found, indicating that there are some areas in which adjustments should be made to improve equitable outcomes (3.4.2.). Finally, IRJ was found to have a formalized feedback and complaint mechanism through a hotline system, and complaints were taken into consideration by the team whenever possible. However, KIIs and FGDs with beneficiary indicate that in some cases, beneficiaries were unaware of the complaint mechanism or did not receive follow-up.

Table 6: Summary of Findings (Effectiveness)

Dimension	Section	Findings

Achievement of Planned Outcomes	2.4.1.	• The intervention successfully achieved planned outcomes.
Equitability of Outcomes	2.4.2.	• Jordanians were more likely than Syrians to say that they received the help they needed at MHCs. • Jordanians had generally higher rates of satisfaction with Mobile Health Clinic services than Syrians. • FGD participants noted that they felt that that the services were equitable, regardless of factors such as nationality.
Feedback and Complaints	2.4.3.	• A feedback and complaints system was present • However, some beneficiaries in FGDs and KIIs noted that they were unaware of the system, or did not receive follow-up.

2.4.1. Achievement of Planned Outcomes:

Central to determining the overall effectiveness of the program, in alignment with OECD criteria, is examining the extent to which the intended outcomes of the project were achieved. Through an examination of project documents, the following intended project outcomes were identified:

Table 7: Intended Outcomes

Outcomes	*Outcome 1: Improved Health Conditions for the targeted beneficiaries through a mobile health facility*	*Outcome 2: Improved quality of life and access to healthcare services for the target population*
Outputs	Output 1.1: 30,000 beneficiaries in Jordan benefited from quality primary healthcare services through 2 mobile clinics.	Output 2.1.: Improved access for secondary and tertiary healthcare for 610 beneficiaries in Jordan during the project period
	Output 1.2: Enhanced health knowledge through awareness sessions provision for 1000 beneficiaries in Jordan during project duration.	
	Output 1.3.: Distribution of 1,000 health materials according to the need and the topic discussed in the sessions	

Examining output 1.1., project documents indicate that mobile health clinics provided primary health services to 32,100 beneficiaries, exceeding targets. Furthermore, survey results indicated that participants were generally satisfied with mobile health clinic services, with 72.1% reporting being very satisfied or somewhat satisfied. Only approximately 3.1% of participants felt dissatisfied with services, and less than 1% said that they did not receive the help that they needed. Furthermore, 85.6% of mobile health clinic beneficiaries felt that staff at mobile health clinics communicated with them either very well or well, with the remaining 14.4% reporting the communication was moderately good. As such, we find that output 1.1. was effectively achieved.

Examining Output 1.2, intended outcomes were achieved and exceeded. According to narrative reports, 1,766 people participated in health awareness sessions. Survey results also indicate that these awareness sessions were perceived as very useful for participants: 96% of survey participants reported being very satisfied or satisfied with the awareness sessions, and 97.7% reported having greatly or appropriately improved understanding of the topic which was covered. Topics included first aid, personal hygiene, winter diseases, and diabetes, among others. As such, we find that output 1.2. was effectively achieved. However, while there were sometimes evaluations of changes to knowledge levels from the baseline in health awareness sessions, evaluations were not done following all health awareness sessions.

For Output 1.3., project documents indicate that 1,537 individuals were provided health kits, which exceeded project targets of 1000 individuals. While not every participant in health awareness sessions received a kit, 83% felt that the distribution of the kit was fair and depended on clear criteria; this percentage is quite close to the proportion of participants who received a kit (84%). Finally, 88.6% of health awareness session participants reported that sessions are their preferred means of receiving information, with only approximately 1% preferring to read brochures. Reasons for this are varied. During FGDs and KIIs, it was made clear that being able to ask medical questions to health care professionals was extremely significant for beneficiaries as a motivating factor; beneficiaries also trusted information coming directly from medical professionals more than information coming from brochures or social media posts. Additionally, the impact of health kits on the effectiveness of the health awareness sessions cannot be under-stated. During a KII, one staff member noted: "You can tell people how to take care of a burn, but if you don't actually provide them with the first aid kit, they won't be able to take care of their children if they get burnt. You can advise people to brush their teeth or practice other forms of hygiene, but if they can't afford a toothbrush and toothpaste, then their teeth are not going to get brushed." As such, we find that output 1.3. was effectively achieved.

Examining Output 2.1, project documents indicate that 787 individuals were provided with surgical interventions, with an additional 17 patients who were provided with weekly hemodialysis sessions which they otherwise would not have been able to access. Of the participant sample, Error! Reference source not found. shows the proportion of patients receiving each type of healthcare service. Additionally, 84.1% stated that their health has improved either greatly or somewhat following the surgery, with more than half saying that it has improved greatly. Over 90% stated that they were either very satisfied or satisfied with the services that they received as a whole. That being said, approximately 15% stated that their health has either gotten worse, stayed the same, or initially improved but has now gotten worse. Furthermore, around 28% of participants said that they did not receive any post-surgery follow-up from the IRJ team, with 22% of participants saying that 'more support and follow-up' post-surgery was necessary. As such, we find that Output 2.1. was mostly achieved, but there are several areas for improvement in order to maximize effectiveness out outcomes.

2.4.2. Equitability of Outcomes:

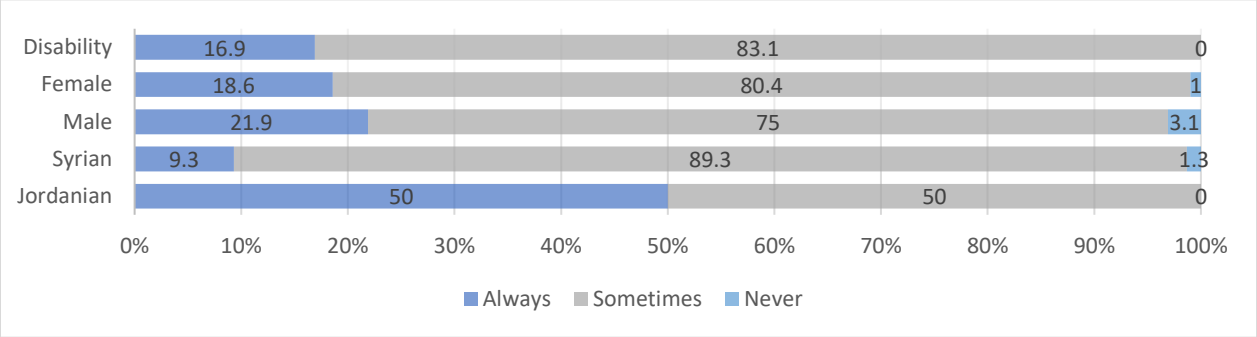
While the project was able to achieve demonstrably positive outcomes for nearly all participants, it is important to determine if these outcomes varied across demographics to determine if the project was applied equitably and fairly across all areas. Across all of the analyzed programs (Mobile Health Clinics, Secondary and Tertiary Health Services, and Awareness Sessions), few significant disparities were found across gender, nationality, and age group in terms of service delivery, satisfaction with services, and quality

of services; as such, we can say that outcomes were generally equitable. This was confirmed within focus group discussions, where participants noted that there was no discrimination in treatment: "Citizens and refugees were treated the same," one beneficiary noted. That being said, there were some areas in which disparities did arise, indicating that equitability of outcomes can still be improved to close gaps on these specific metrics.

Mobile Health Clinic Beneficiaries

When examining the results for Mobile Health Clinic Beneficiaries, it is important to recognize that, broadly speaking, Syrians are much more likely to rely on the Mobile Health Clinics as a form of primary healthcare than Jordanians, with 28% of Syrians saying it was the usual place they went to seek care, while only 4.5% of Jordanians said so. In the FGDs, Jordanians noted that they would rely public hospitals or military hospitals, while Syrians noted that they would rely on the UNHCR or non-profit organizations such as Caritas or the Red Cross. This is an indicator of the need within these communities, as Jordanians are able to access and utilize healthcare from public clinics by the MOH more easily than Syrian refugees, and are likelier to have health insurance. Thus, the varied level of healthcare access that Syrians and Jordanians have helps to explain sharp disparities in the receipt of healthcare seen between Syrian and Jordanian Populations in Figure 5. Jordanians generally have greater healthcare options than their Syrian counterparts, and do not need to rely on humanitarian aid to receive care.

Figure 5: In the last 12 months, did you receive healthcare when you wanted it?



For individuals who accessed mobile health clinic services, Jordanians were more likely to report that they have received the help which they needed (Figure 6). That being said, only a small number of Syrian participants (1.3%) reported that they did not get the help they needed at all. Similarly, people with disabilities and their household members were less likely than their non-disabled counterparts to report that they received the help that they needed, though very few (1.5%) reported not receiving any help at all. Similarly, satisfaction levels with mobile health clinic services were slightly higher amongst Jordanians than amongst Syrians, though very few Syrians (4%) reported complete dissatisfaction (Figure 7). Furthermore, female beneficiaries also reported generally higher level of satisfaction than male beneficiaries with the services that they received from mobile health clinics. Within focus group discussions, female beneficiaries emphasized feeling respected by the staff and feeling comfortable with the staff. Female beneficiaries were also more likely to be receiving service from female staff. Finally, people with disabilities generally had lower satisfaction rates than people without disabilities, however, like Syrians, very few reported complete dissatisfaction. The lower rate at which people with disabilities and their household members reported receiving the help the needed, as well as their lower overall satisfaction with services, may in part attributed to the greater likelihood of people with disabilities to have health challenges

that require specialist attention, and as such were not provided within the scope of the mobile health clinics.

Figure 6: Experience at Mobile Health Clinics

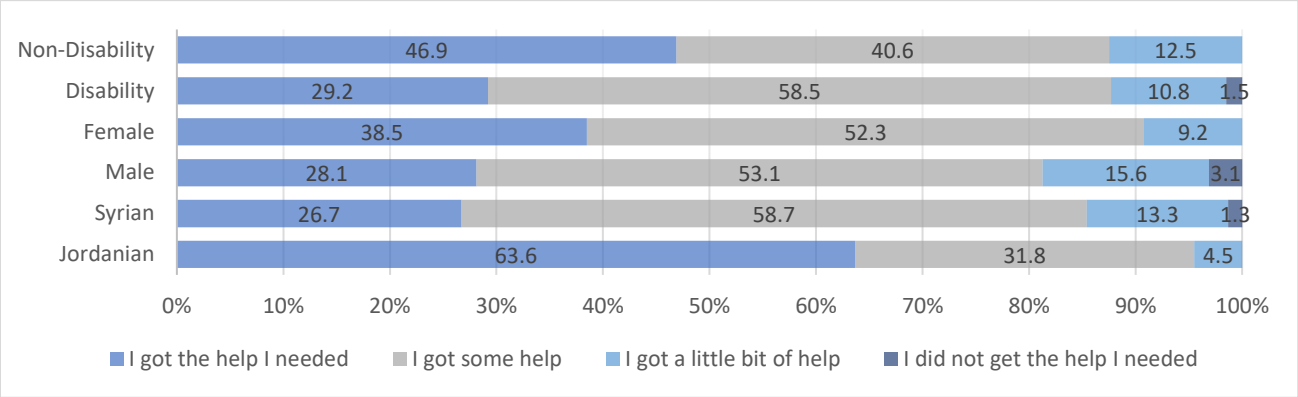
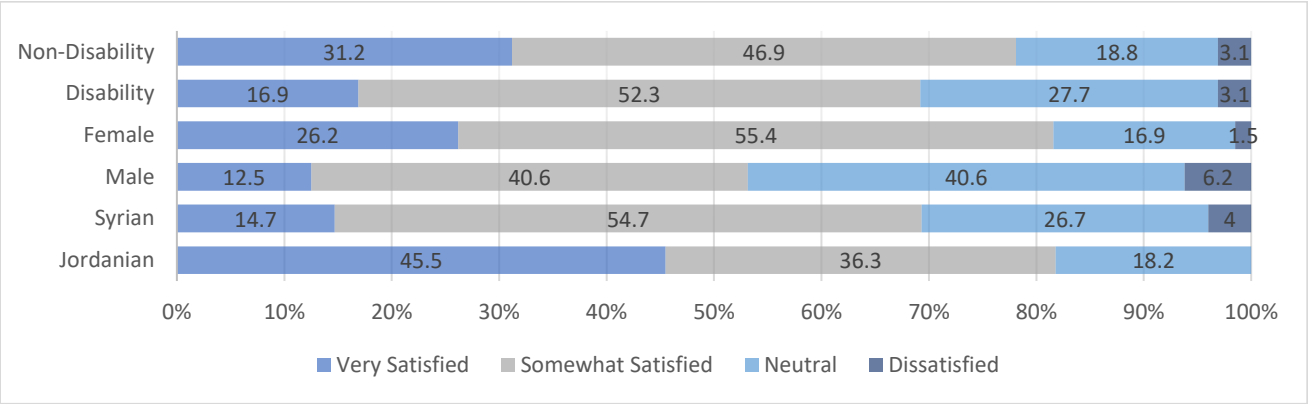


Figure 7: Satisfaction with Mobile Health Clinic Services



Awareness Session Participants

For Awareness Sessions, satisfaction was found to not vary significantly across nationality or age.[2] However, men were less likely with women to report high levels of satisfaction, with highest rates of dissatisfaction also being found among male participants (Figure 8: Satisfaction with Awareness Sessions).

Similarly, men were less likely than women to report a great deal of improvement in their understanding of the topic covered within awareness sessions, with 52.6% of men and 73.9% of women reporting great deal of improvement. Furthermore, Syrians were slightly less likely than Jordanians to report a great deal of improvement, and were more likely to say that they experienced moderate improvements than Jordanian participants. That being said, only approximately 2% of Syrian reported no knowledge gain, indicating that 98% still identified some benefit to their participation in the awareness sessions.

[2] Given the 10% margin of error, differences across nationality cannot be considered statistically significant.

Furthermore, survey findings found that Syrians (94%) were the most likely to say that awareness sessions were their preferred form of knowledge dissemination.

Figure 8: Satisfaction with Awareness Sessions

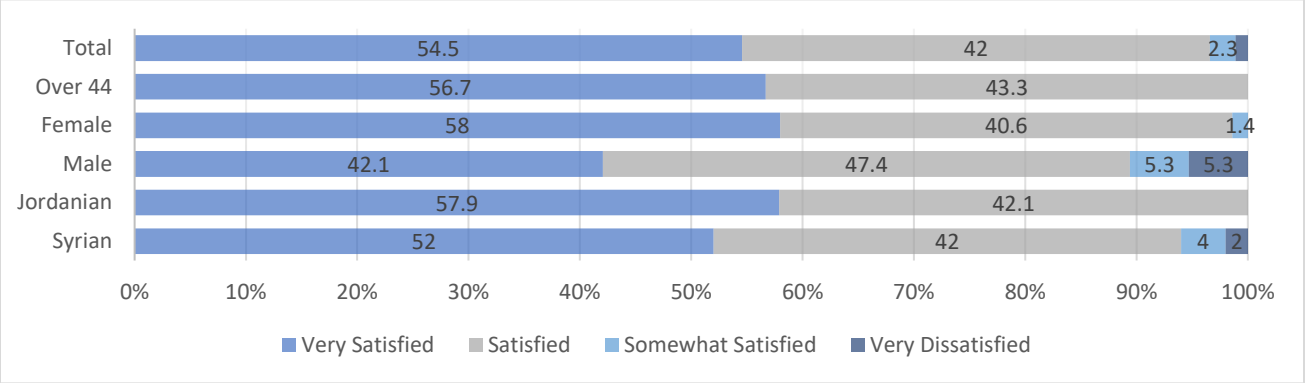
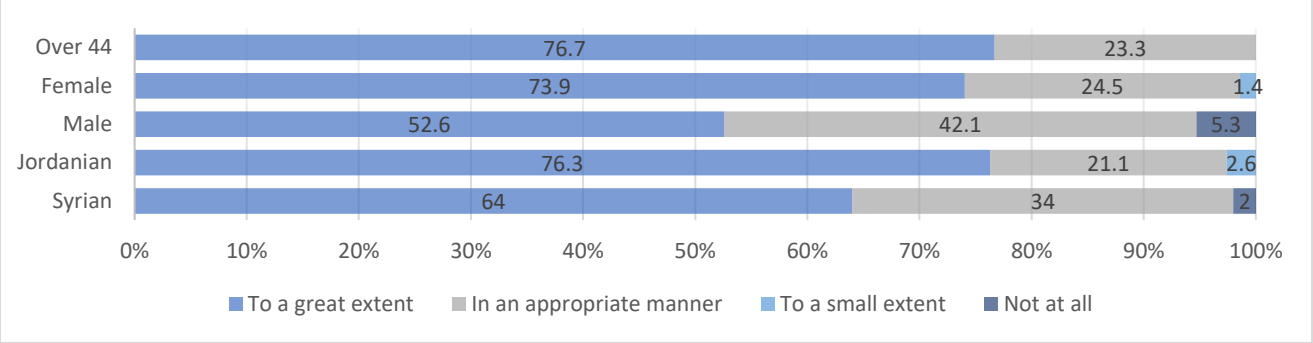
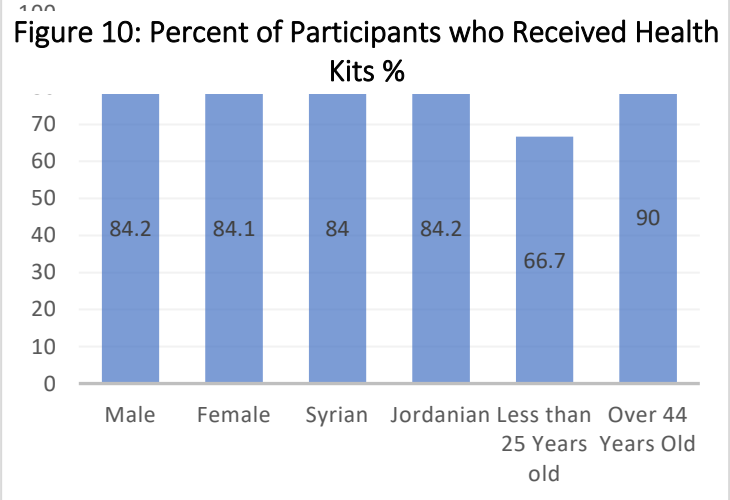


Figure 9: Improvement of Understanding



Examining the relevance of session topics to the interests and health needs of participants, there were no significant differences across gender, age, or nationality; a vast majority of participants in every category reported that health sessions were relevant. Finally, provision of health kits also took place during the awareness sessions; these health kits were not distributed to every participant, however, and eligibility for kits depended on a number of criteria which varied between different types of kits. For example, Children's Hygiene kits were distributed only to those between the ages of 7 to 18, while breast cancer awareness kits were given only to women between 20-60 years of age. 70% of all available kits were to be distributed to Syrians, while 30% were to be distributed to Jordanians, in line with governmental rules regarding humanitarian aid operations. It thus becomes important to ensure that no single group felt disproportionately excluded from receiving

Figure 10: Percent of Participants who Received Health Kits %



health kits. Findings show that distribution was quite equitable across gender and nationality. However, older participants (44 years or older) were significantly more likely than the youngest participants (25 years or less) to receive health kits. However, due to the small sample size (only 6 under the age of 25), the margin of error regarding health kit provision is quite large. As such, these results are not statistically significant. In KIIs with IRJ staff, it was noted that there were certain criteria in place for the distribution of health kits, aiming at the distribution of one health kit per household, with a distribution of approximately 70% Syrians and 30% Jordanians receiving health kits during health awareness sessions, and with different criteria for different kits (based on age, disability/having the relevant chronic illness such as asthma or having a member of the household with that chronic illness, sex – for breast cancer health kits specifically, etc.). The knowledge and experience of local CBOs was also relevant to the distribution of health kits as well as gathering participants for health awareness sessions.

Another factor for the relevance of health awareness session lay in the fact that the topics would change depending on seasons. For example, in winter, wounds from burns are more common in ITSs as tents lack heat and refugees turn to unsafe heating practices – such as fires - to shelter from the cold. The staff would conduct health awareness sessions relevant to burn wound care during the winter season.

Secondary and Tertiary Health Services

Finally, beneficiaries of secondary and tertiary health services were also examined to ensure that all outcomes were delivered equitably. Firstly, examining overall satisfaction rates (Figure 11: Satisfaction with Secondary and Tertiary Health ServicesFigure 11), we can see that those over the age of 44 were more likely to report being very satisfied with their services than average. However, there were no significant differences in those reporting to be 'very satisfied' across nationality and gender. However, Syrians were more likely than Jordanians to report being 'somewhat satisfied', and males more likely than females. As such, we can see that Jordanian and female beneficiaries reported generally higher satisfaction rates then their Syrian and male counterparts. Importantly, individuals with disabilities and/or their household members actually reported generally higher satisfaction rates with secondary and tertiary health services than their non-disabled counterparts, in contrast to satisfaction rates regarding mobile health clinic services.

While health improvements are dependent on a number of factors, many of which are outside of the control of the IRJ team, it is important to determine if there are any significant differences in health outcomes across gender and nationality (. Age was not factored into this analysis, as age of the patient can have a considerable impact on recovery and surgery outcomes. The proportion of individuals who reported that health had improved greatly or somewhat did not vary significantly across nationality or gender. However, Syrians were more likely than Jordanians to report that their health stayed the same following the surgery. People with disabilities and/or their household members were more likely to report that their health improved greatly or somewhat than non-disabled counterparts.

Figure 11: Satisfaction with Secondary and Tertiary Health Services

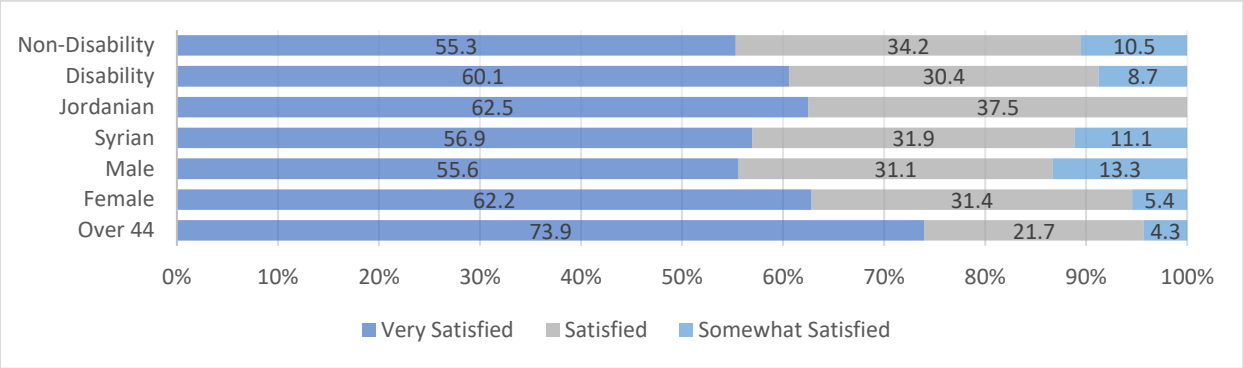
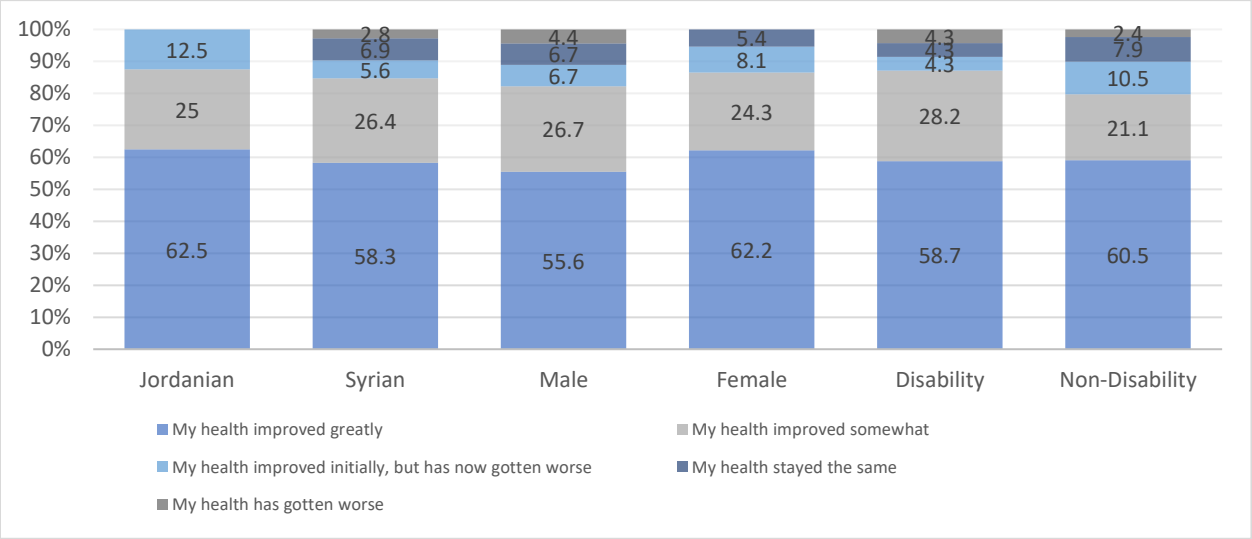


Figure 12: Post-Surgery Outcomes



Furthermore, in order to determine eligibility for secondary and tertiary healthcare services, the IRJ team developed a system for determining eligibility criteria, which included a home visit. However, the application of this system was not found to be uniform across all beneficiaries. For example, only 31.7% of participants reported receiving a home visit prior to their surgery. That being said, when examining this by various demographics, no differences were found across gender, nationality, or age regarding the likelihood to receive home visits. Within key informant interviews with IRJ staff, reasons for not conducting home visits were explored. It was noted that home visits were at times irrelevant for patients who had already had a home visit and needs assessment. Home visits are also notably not the most efficient systems for determining eligibility, particularly for urgent surgeries. As such, different measures for ensuring that the beneficiaries are eligible for IRJ's services should be developed.

Finally, participants were asked about what aspects of the secondary and tertiary healthcare service program need to be improved (Table 8: Beneficiaries' Perceptions of Areas which Need Improvement). Examining these impacts across gender and nationality can provide insights into the degree to which the program's design worked or did not work for beneficiaries, and if any particular demographics were impacted by certain program shortcomings. Non-disaggregated results can be found within Table 8.

Significance testing was then performed for each question across nationality, gender, and age to determine if there are any statistically significant differences in responses.

Within nationality, Syrians were more likely than Jordanians to report needs for reduced wait times. Within KIIs, potential reasons for this were explored. Firstly, areas where many Jordanian citizens were present (e.g. outside of remote ITSs) are likelier to have more people who are utilizing the MOH's clinics. Jordanians also would utilize the clinics to access medicine that was unavailable in MOH clinics.

Across gender, women were more likely than men to report need for easier transportation to and from the hospital, with 35% of women stating that this was a necessary program improvement. In general, women in Jordan are more impacted by the lack of accessible public transportation, as they are more likely to face sexual harassment and more likely to be the primary caretakers of young children, increasing cost and difficulty of accessing hospitals through public transportation. Additionally, women are less likely than men to be the head of household, and thus have less flexibility with income to be spent on travel.

Table 8: Beneficiaries' Perceptions of Areas which Need Improvement

Area of Improvement	% Who Agree
Reduced Wait Times	8.5
More Support and Follow-up Before Surgery	4.3
More Support and Follow-up After Surgery	22.0
Improvement treatment and professionalism from staff	1.2
Easier transportation to and from the hospital	23.2

2.4.3. Feedback and Complaints Mechanisms

The project also included a feedback and complaints mechanism through hotlines, which participants in FDGs were actively aware of. Hotline numbers were available within the mobile health clinics, and were provided to patients receiving secondary and tertiary care, as well as beneficiaries attending health awareness sessions. As such, participants were able to voice concerns about anything that they were dissatisfied with, which would then be logged on the register of complaints. Additionally, beneficiaries were able to request follow-up. Moreover, some patients were able to visit the IRJ field offices in-person to register a complaint or provide feedback, or otherwise communicate directly with staffers in the field. The hotlines were free to callers.

Staff described those complaints by beneficiaries as being rare and noted that they would respond to beneficiaries' requests through meeting them whenever possible. However, staff also noted that complaints and requests would often include things that were not possible due to budget constraints or that were out of scope of the project, such as the creation of full-time clinics or providing coverage to surgeries that were out of the scope of the project. The response procedural policy to complaints or feedback is to refer the complaint or feedback to the relevant entity or personnel within IRJ, investigating complaints, and replying to the beneficiaries with the result of the complaint or feedback.

However, some beneficiaries in the FGDs noted that they were not aware of the feedback and complaints mechanisms, or that they did not receive follow-up. Additionally, the feedback and complaints mechanism could be expanded on to allow for further inclusion of beneficiaries who did not have a working phone and

could not physically access the IRJ's offices. One challenge for a feedback and complaints mechanism could be to accommodate for anonymous complaints or feedback from beneficiaries who are unable to read or write.

To increase the inclusivity of the feedback and complaints mechanisms, IRJ staff could verbally emphasize that they are receptive to receiving feedback as an addition to the current methods of informing patients of how to submit feedback and/or complaints.

2.4.4. Effectiveness Recommendations and Conclusions

Based on these findings, the project was largely effective in achieving its proposed outcomes fairly and equitably.

However, there were some key areas which should be improved to improve the effectiveness of the intervention. The following recommendation should be taken into consideration with restrictions such as limitations in budget.

Recommendation #11: Greater clarity on schedule and location of mobile health clinics. Creating mechanisms that allow beneficiaries to know the schedules and timelines of the mobilities.

Recommendation #12: Improving feedback and complaints mechanisms. Ensure that beneficiaries are aware of complaint mechanisms and feedback mechanisms, and ensure both equal access and that cases are responded to and followed up on. Beneficiaries could be consulted in both the design stages of future projects as well as during the implementation of the project regarding which channels would be effective and how to make the channels more accessible to them.

Recommendation #13: Standardization of surgery eligibility criteria. The review found that a majority of respondents said that they did not receive pre-surgery home visits, which were a part of the process for determining service eligibility. In order to ensure transparency, maintaining standardized eligibility criteria and assessment processes is essential. If home visits are not a practical or optimal mechanism for determining eligibility, and alternative process must be developed which can be implemented uniformly across all potential beneficiaries.

2.5. Impact:

Impact can be defined as the extent to which the intervention has generated or is expected to generate significant positive or negative, intended or unintended, higher-level effects.

Table 9: Summary of Findings (Impact)

Dimension	Section	Findings
Long-Term Impacts	2.5.1.	Broadly, the intervention was found to be highly impactful for recipients, particularly the secondary and tertiary healthcare

		services. Additionally, KIIs with hemodialysis patients indicated that the services were deeply impactful for them on an individual level.
Impacts Across Sub-Groups	2.5.2.	Impacts across sub-groups were found to be relatively equitable. In instances where they were not equitable, women were actually more likely than men to experience positive impacts.
Implications for Replicability and Sustainability	2.5.3.	Community members expressed feeling that the project was highly impactful, and that they desired the project to be continued and scaled-up in future iterations.

2.5.1. Long-Term Impacts:

The long-term intended result of the project is improving the access of quality healthcare of vulnerable Syrian refugee communities in Jordan, reducing mortality and improving life quality. IRJ's provision of life-saving procedures – including both tertiary services such as surgeries and dialysis – created long lasting and transformational effects on the lives of participants. Participants noted improved mental health outcomes as well as improved economic capacity and livelihoods across their entire families in the aftermath of one family member receiving healthcare. As seen within Figure 12: Post-Surgery Outcomes, a vast majority of secondary and tertiary healthcare recipients noted that their health improved post-surgery, with 58.5% saying that it improved greatly. During FGDs, these sentiments were echoed by patients, who emphasized that services received by IRJ – particularly surgeries – were impactful to their lives and to the lives of members of their households. One patient in a FGD stated: "I can't understate the impact that the surgery has had on my life. How can I measure the impact of something that allowed me to sleep without pain for the first time in months?"

Additionally, the project had positive impacts that were not necessarily intended. For example, one unintended impact of the project in the aftermath of the COVID-19 pandemic was increased awareness in the population on the Coronavirus, specifically with regards to preventative measures such as social distancing, masks, and especially vaccines. KIIs showed that beneficiaries who were otherwise hesitant to take the vaccine or did not believe in the Coronavirus felt comfortable asking questions and trusting IRJ's medical staff, particularly in primary healthcare and awareness sessions contexts. Additionally, the health awareness sessions would often cover greater ranges of topics due to the presenters creating sufficient room for questions, comments and interaction with beneficiaries. For example, one female medical staff member noted that she frequently provided information on gynecological and reproductive health, breastfeeding, pregnancy, and early childhood care during health awareness sessions.

Through health awareness sessions, participants were able to receive information on the prevention of disease. KIIs with healthcare experts in Jordan indicated that prevention of disease is frequently one of the most impactful solutions to the healthcare challenges in the Syrian population, noting that undocumented refugees, urban refugees, and refugees living in ITSs are particularly vulnerable to the gap in equitable health care treatment. Additionally, experts revealed through interviews that challenges in under-utilization of refugees of MOH health clinics – due to barriers such as distance, pricing, and bureaucratic challenges – meant that prevention of disease is of heightened importance.

KIIs with partners of IRJ showed that the networks built with/between local CSOs and international CSOs were impactful, as were the collection and creation of a detailed database on beneficiaries. The creation of these networks, alongside the collection of data, was cited as a positive impact of IRJ's project.

2.5.2. Impacts Across Sub-Groups:

As seen within Section 3.4.2., outcomes were generally equitable across sub-groups. However, in instances where results were not equitable, women were actually *more likely* than men to note positive experiences and high rates of satisfaction.

2.5.3. Implications for Replicability and Scalability:

Within the Focus Group Discussions and interviews with beneficiaries, it was made clear that the community feels there is a need for these projects and a desire for it to continue and to be scaled up. In particular, the need for eyecare, dental care, nerve and neural damage, psychological and mental health, hearing aids, and orthopedic services (specifically, knees and joints were mentioned) was noted within the FGDs.

Additionally, during KIIs with experts on healthcare in Jordan and partnered organizations such as UNHCR, PCRF, and QRC, it was noted that the hemodialysis component of the project was urgently needed withing the Jordanian context, as IRJ was at times the only organization providing this service, and continues to be the only organization providing this care to Syrian refugees in the South of Jordan. A scaling-up in terms of coverage of other chronic illnesses was noted, with chemotherapy for cancer patients being mentioned as an unmet need for the Syrian refugee population.

IRJ are currently implementing a similar project, indicating successful replicability.

2.5.4. Conclusions and Recommendations:

The intervention generated positive impact on the life of beneficiaries through providing them with access to quality primary, secondary, and tertiary care; hemodialysis treatment; and increased health awareness. Additionally, the intervention had an unexpected impact of improving COVID-19 awareness and reducing vaccine skepticism. Another positive impact was improved mental health and financial well-being of households benefiting from the intervention, as reported by FGDs and KIIs. The following recommendations to increase the level of impact include:

Recommendation #14: Increase budget or locate additional funding to allow a larger number of beneficiaries to be served and to cover a wider variety of services, specifically including more surgeries. This could be in the form of new phases of the same project, or new projects with different donors.

Recommendation #15: Consider implementing similar initiatives addressing the healthcare needs of the Syrian population to improve their access to quality healthcare, quality of life, and mortality rate.

Recommendation #16: Designing a comprehensive approach at a programmatic level rather than single projects. While single projects such as this one do have significant impacts, these impacts can be maximized

through adopting a comprehensive approach into all healthcare activities, and ensuring that these activities complement each other. In particular, interventions can take into consideration a preventative and early-warning approach in order to maximize impact while reducing overall health risks amongst the target population.

Recommendation #17: Include preventative and early warning awareness to more common and chronic health issues for the awareness-raising component to ensure more long-term impact. Jordan has exhibited an epidemiological shift from infectious disease to chronic disease. As such, preventative medicine has become increasingly important in the overall health scheme; however, Jordanians may lack the awareness of factors which contribute to long-term chronic illness. In order to ensure that healthcare services comprehensively address the health needs of the community, adding a preventative medicine component to awareness sessions as well as the comprehensive approach through which IRJ operates its health programs.

2.6. Sustainability:

Table 10: Summary of Findings (Sustainability)

Dimension	Section	Findings
Sustainability	2.6	Some aspects of the intervention were found to be sustainable in that their impact would be continuous in the aftermath of the project, such as increased health awareness and improved life quality for the majority of patients of surgeries. However, other aspects of the project require continued support in order for the benefits to be sustained. The initiative's sustainability can be increased through a focus on developing MOH's local capacity; however, there are associated challenges with this as well. Environmental sustainability was taken into consideration at the design and implementation of the initiative, e.g. responsible disposal of waste.

Sustainability can be defined as the extent to which the net benefits of the intervention continue, or are likely to continue.

IRJ's thorough databases and support to partners have allowed for further networks of support to be developed across the field. In particular, IRJ's mobile health clinics have enabled the organization to provide services to ITSs in remote regions that are otherwise inaccessible and where the population is without care. IRJ's staff have mapped the existence of these "forgotten" communities and connected their residents to other projects with partners, allowing other organizations within the field to be able to more easily service these populations in the long-term. This benefit is likely to continue in the aftermath of the intervention.

One consideration for the improvement of sustainability following the end of the project was related to purchasing a hemodialysis machine and donating it to the Ministry of Health to be used in a public hospital

on both patients from the host community, with a potential agreement for the MOH to also provide this service to Syrian refugees for free or for reduced cost. This suggestion was examined through the KIIs and was a subject of disagreement. One health expert noted that this would potentially be challenging to implement, as public hospitals in Jordan have received donated equipment that is "gathering dust" and going unused due to high costs of operating the machines, or a lack of capacity among employees on how to use the machines. On the other hand, another expert stressed the significance of developing the capacity of local institutions to avoid the challenges of parallel systems of healthcare existing for refugee and host populations.

Secondary and tertiary healthcare services (in particular, life-changing and life-altering treatments, including surgeries) can provide long-term benefit to individuals, households and communities. Early detection of an illness through a primary care examination can similarly hold long-term benefits for individuals.

Health awareness sessions contributed to long-term increase of health literacy among the population. As mentioned in the Impact section, one of the results of the project that can provide ongoing benefit to individuals and communities beyond the project time period is increased awareness on vaccines, and individuals showing less vaccine hesitancy with regards to the COVID-19 vaccine. This is especially significant when considering that the pandemic has impacted refugee populations more harshly than host populations, and with considerations to the detrimental impact of the virus on people with disabilities – as well as Long Covid leading to the development of chronic health conditions within previously-healthy individuals. The benefit of beneficiaries having increased health awareness is likely to continue, particularly as IRJ staff noted in the interviews that they would ensure that community leaders were present in the health awareness sessions in order to allow trickling down of information to their household and community members.

Within the dialysis component of the project, it is clear from KIIs with rightsholders that without additional support, they would be unable to continue receiving the life-saving treatment.

The benefits of surgical care for patients are more long-term, as many of the surgeries conducted throughout the project are life-altering and will improve the patients' quality of life in the long-term.

With regards to environmental sustainability, according to KIIs with IRJ's staff, environmental considerations relevant to the intervention were factored into the design and implementation of the project. For example, waste disposal was discussed with members of IRJ's staff during the KIIs, and it was affirmed that the waste disposal processes were designed with both hygiene and environmental factors in mind.

2.6.1. Sustainability Conclusions and Recommendations:

Some components of the project lend themselves to long-term benefit, such as life-saving and life-altering surgeries as well as increased health awareness in communities. However, as noted by beneficiaries and experts alike in the KIIs and FGDs, once the intervention is concluded, patients will be unable to access treatment. Different stakeholders had different suggestions for how to improve sustainability. Improvements and recommendations to sustainability may potentially include:

Recommendation #18: Investing in the development of the MOH's health services, such as by purchasing a hemodialysis machine and donating it to a public hospital in order to service the host community and possibly with an agreement to provide a certain number of free or discounted services to the refugee community. However, prior to this commitment, there should be a dialogue with the MOH to ensure that the equipment – for example – is needed, that there are sufficient resources for maintenance, and to provide training to MOH staff on how to operate and maintain the equipment if needed.

Recommendation #19: Consider implementing a train-the-trainer component awareness sessions for local CBOs and community leaders.

3. Alignment with International Standards

The World Health Organization's Global Health Cluster has developed a number of key domains for ethical humanitarian intervention.[3] Under these standards, healthcare interventions should be: people-centered, safe, equitable, effective, integrated, timely, and efficient. These standards are aligned with the Core Humanitarian Standard and incorporate Sphere's Minimum Standards for Healthcare as a practical expression of the right to healthcare in humanitarian contexts. This section will provide a brief summary of the project's alignment with these standards, while the analysis section of the report has provided more details regarding the findings.

Domain	Standard	Findings:
People Centered	*Presence of Feedback & Complaint Mechanism*	A feedback and complaint mechanism is present, and beneficiaries in interviews and FGDs were aware of it. Beneficiaries are able to reach IRJ staff by hotlines and email.
	Healthcare is Dignified and Compassionate	According to the surveys, FGDs, and interviews, the vast majority of beneficiaries described their experience positively and that it was marked with respectful treatment by IRJ staff.
	Patient rights are upheld: informed consent, privacy, and confidentiality	Patients agreed that they felt their privacy was respected. Broadly, results indicated that the vast majority of participants felt that staff respected privacy, with 23.7% reporting that their privacy was respected to a great extent, 69.1% in an appropriate manner, and only 7.2% to a small extent. No participants said that their privacy was not respected. For mobile health clinic beneficiaries, 92% reported being either very comfortable or comfortable asking questions, while 100% of secondary and tertiary healthcare recipients reported feeling comfortable to a great extent or to an appropriate extent. A clear majority of primary, secondary and tertiary healthcare recipients felt that information was delivered in a way which was easily understood, and all health awareness session participants described information as accessible.
	Healthcare is Accessible	52.5% of mobile health clinic beneficiaries reported that access was very easy or easy. 12.5% reported access to be very difficult. Jordanians were more likely than Syrians to find access to mobile health clinics be very easy or easy. 45.4% reported that they knew when mobile health clinics were close-by always or most of the time. 78.1% of secondary and tertiary health service beneficiaries reported that providing necessary documentation in order to demonstrate eligibility for secondary and tertiary healthcare services was easy or very easy.
	Healthcare is Relevant and Meets Patient Needs	According to KIIs, surgical care is a prominent need among Syrian refugees, being especially important after becoming completely unaffordable with the latest changes in coverage policies by the government. According to the baseline assessment studies conducted by IRJ's team, more than 5 out of 10 of all household members reported a need for medications. During FGDs and interviews, patients mentioned healthcare needs that were unable to be met by the project as they were not covered within the scope of the project's activities

[3] https://reliefweb.int/report/world/quality-care-humanitarian-settings-june-2020

		(providing services related to the following: dental, nerve, eyecare, gynecology, etc).

Safe	*Safe infrastructure and facilities*	The infrastructure and facilities utilized during the project were safe.
	Disaster preparedness and risk mitigation strategies were developed	Due to the Coronavirus pandemic, risk mitigation strategies were developed and deployed.
	WASH Standards are upheld	Within key informant interviews, IRJ staff, as well as external experts within the humanitarian health field, noted that IRJ upheld WASH standards. External experts and partner organization staff noted that IRJ's clinics are well-known for their cleanliness and high-quality services, confirming their adherence to WASH standards.
	IPC Standards are upheld	According to KIIs with IRJ staff and other actors in the health field, IPC standards were upheld.
	Presence of System for reporting and monitoring medical events	A reporting and monitoring system for medical events was in place through hotlines and was communicated to beneficiaries.
	Presence of policy for reporting abuse and sexual violence	Policies for reporting abuse and sexual violence were in place through hotlines and was communicated to beneficiaries as well as staff.
	Safe management of medications and equipment	Policies and safety standards were in place for the safe management of medications and equipment; staff were trained in this procedure and were able to implement it. Due to pre-emptive concerns regarding medication and equipment moving in the mobile health clinic during transportation times, additional guidelines were implemented regarding positioning of medication and equipment.

Equitable	*Care is impartial and equitable in delivery, is not biased against any age, disability, gender, or nationality group.*	See section 3.4.2. Equitability of Outcomes
	Service delivery mechanisms are equitable	

Effective	*Clinical care is performed effectively*	Participants in FGDs for primary, secondary and tertiary healthcare services noted that the clinical care they received was high-quality and improved their lives
	Advice given by healthcare staff is appropriate and helpful	Participants in FGDs agreed that the advice given by healthcare staff was appropriate and helpful.
	Patients are given follow-up or referral	Patients are given follow-up and/or referrals; however, in FGDs and KIIs, some beneficiaries noted instances where they did not receive follow-up. Please check 3.4 Effectiveness section for detailed analysis on quality and equitability of the referral system.
	Essential package of health services (EPHS) are	According to interviews with IRJ's staff, EPHS are available and referral is possible.

	available or referral is possible	
	Essential medicines are available	At times, according to FGDs with primary healthcare beneficiaries, the clinics would run out of medicine or there would be a shortage, and they noted that antibiotics and some pain killers – including medicine for nerve or spinal damage – was unavailable. However, most rated the availability of medicine as good or excellent.
	Essential devices and equipment are available	Essential devices and equipment are available within the mobile health clinics.
	Adequate number of health staff with diversity of skills, languages, ethnicities, and at least 50% female	Adequate number of health staff with diversity of skills, languages, ethnicities, with equitable gender representation (50% or more female) was present.

Integrated	*Presence of mapped and well-planned referral system with minimal delays*	During KIIs with partner organizations' staff, it was noted that IRJ's referral system was among the most reliable and quickest within the field. The referral system includes phone calls, in which IRJ refers patients to secondary and tertiary care, refers beneficiaries to other programs and partners, and accepts referrals from partners for patients.
	Referral System protocol is standardized	The referral system protocol included phone calls, and at times would be more flexible in order to accommodate emergency cases.
	Monitoring of referrals was conducted	According to IRJ's M&E team, monitoring of referrals was conducted.

Timely	*Patients have reasonable waiting times*	Only 5% of participants reported wait-times were 'bad' for Mobile Health Clinics. Less than 10% of participants felt that faster wait times was a needed improvement for secondary and tertiary healthcare services.
	Patients have functional referral mechanisms	Patients have functioning referral mechanisms, as is supported by the findings of the surveys, FGDs and KIIs.

Efficient	*Healthcare is evidence-based*	Healthcare provided is evidence-based.
	Appropriate medications and equipment are kept in-stock	Appropriate medications and equipment are kept in stock; however, at times medications would run high demand or would be cut off from the Jordanian market.
	There is collaboration between providers to synergize programming	IRJ collaborated with a wide range of providers in the field to synergize programming, including grassroots CSOs as well as national and international NGOs throughout the duration of the project, including the Qatari Red Crescent, the Noor Al-Hussein Foundation, UNHCR, the International Organization for Migration, the Danish Refugee Council, and the Palestine Children's Relief Fund.

4. Recommendations and Conclusions

Holistically examining the results of this assessment, we can see that broadly individuals reported high levels of satisfaction with IRJ's programs. Both beneficiaries as well as key partners within the health and humanitarian services field highlighted the positive impacts of the program. The intervention was found to meet a relevant need, as well as to have accomplished its goals efficiently and coherently. Regarding sustainability, there are some considerations in place for improving the long-term sustainability and extending the ongoing benefit and impact for the community.

That being said, this review has also identified a number of key areas which may require improvement or revision in further iterations or continuation of this project:

Recommendations for Relevance:

The project was found to be extremely relevant contextually and for stakeholder needs. Additionally, relevant changes were made to adjust to the evolving context in the aftermath of the COVID-19 pandemic.

Recommendation #1: Improving transportation to and from hospitals for secondary and tertiary healthcare recipients. 31% of secondary and tertiary healthcare service recipients said that it was very difficult for them to go to the hospital of their surgery location to receive help. As such, providing transportation both prior to the surgery as well as after surgery will improve program responses as well as empower beneficiaries to maintain the health benefits associated with the procedure through routine follow-up care.

Recommendation #2: Increasing services available for beneficiaries. Some beneficiaries in FGDs expressed a desire for increased services. One suggestion was to increase the number of surgeries eligible for coverage within IRJ's projects, and further expand the scope of the project to include dental, nerve, eyecare, and gynecology.

Recommendations for Coherence:

The project was found to be coherent, without duplication, and coordinated effectively with other actors in the field. However, the internal coherence of the initiative and future similar initiatives can be improved.

Recommendation #3: Invest in outreach components at the local community levels. This will allow beneficiaries to know more about IRJ's ongoing interventions, which would improve the coherence of future activities.

Recommendation #4: Improving integration with MOH. Greater integration of MOH strategies and programs into the planning and design stages of interventions, as well as building ongoing collaboration to support the development of MOH's capacities. Staff could be trained to be more aware of MOH national strategies.

Recommendation #5: Improving awareness of IRJ amongst beneficiaries. This study found that beneficiaries were at times unaware of the role of IRJ in providing their care, and did not know about other IRJ projects. As such, there is a need to improve awareness of IRJ as an actor, in order to ease monitoring and evaluation processes. Staff should be trained not only in the services they provide but also in IRJ's other programs, as well as how to best inform beneficiaries of such programs when relevant.

Recommendation #6: More internally consistency in the application of policies and procedures. Based on our findings, there is a need to improve internal coherence of the program through increasing consistency of use of procedure, including for evaluation criteria, referral criteria, post-surgery communication and response to complaints and feedback mechanisms.

Recommendation #7: Greater post-surgery communication for secondary and tertiary healthcare service recipients. Over 20% of participants noted that more support and follow-up was needed post-surgery. Furthermore, 28% of beneficiaries reported that they did not receive follow-up communication after their procedure from IRJ staff.

Recommendation #8: Continue to target under-represented areas, such as rural camps, in future interventions. A baseline needs assessment could be conducted before such future initiatives to ensure that support is given to the in-need communities.

Recommendations for Efficiency:

Broadly, the intervention was found to be highly efficient, both in terms of financial management as well as timeliness of service delivery. However, one area stands out as in need of improvement, which is the mechanism through which beneficiaries receive medications:

Recommendation #9: Future interventions should replicate the efforts of negotiating prices to ensure the most efficient cost during the procurement of supplies and service so that the best price can be obtained. Additionally, the existing networks and connections within players of the health field in Jordan should be maintained in order to ensure efficiency in future interventions.

Recommendation #10: Adjust mechanism for medicine distribution for dialysis patients. As noted by beneficiaries, the current mechanism allows for medication to only be distributed towards the end of the month, and required approvals to receive early. This is in line with the monitoring and evaluation policies of IRJ; however, it may present issue in the event that medicines were needed urgently. As such, a re-adjustment of the medicine provision system may be considered.

Recommendations for Effectiveness:

The project was largely effective in achieving its proposed outcomes fairly and equitably.

However, there were some key areas which should be improved to improve the effectiveness of the intervention. The following recommendation should be taken into consideration with restrictions such as limitations in budget.

Recommendation #11: Greater clarity on schedule and location of mobile health clinics. Creating mechanisms that allow beneficiaries to know the schedules and timelines of the mobilities.

Recommendation #12: Improving feedback and complaints mechanisms. Ensure that beneficiaries are aware of complaint mechanisms and feedback mechanisms, and ensure that cases are responded to and followed up on.

Recommendation #13: Standardization of surgery eligibility criteria. The review found that a majority of respondents did not receive pre-surgery home visits, which were apart of the process for determining service eligibility. In order to ensure transparency, maintaining standardized eligibility criteria and assessment processes is essential. If home visits are not a practical or optimal mechanism for determining eligibility, and alternative process must be developed which can be implemented uniformly across all potential beneficiaries.

Recommendations for Impact:

The intervention generated positive impact on the life of beneficiaries through providing them with access to quality primary, secondary, and tertiary care; hemodialysis treatment; and increased health awareness. Additionally, the intervention had an unexpected impact of improving COVID-19 awareness and reducing vaccine skepticism. Another positive impact was improved mental health and financial well-being of households benefiting from the intervention, as reported by FGDs and KIIs. The following recommendations to increase the level of impact include:

Recommendation #14: Increase the budget to allow a larger number of beneficiaries to be served and to cover a wider variety of services, specifically including more surgeries.

Recommendation #15: Consider implementing similar initiatives addressing the healthcare needs of the Syrian population to improve their access to quality healthcare, quality of life, and mortality rate.

Recommendation #16: Designing a comprehensive approach at a programmatic level rather than single projects. While single projects such as this one do have significant impacts, these impacts can be maximized through adopting a comprehensive approach into all healthcare activities, and ensuring that these activities complement each other. In particular, interventions can take into consideration a preventative and early-warning approach in order to maximize impact while reducing overall health risks amongst the target population.

Recommendation #17: Include preventative and early warning awareness to more common and chronic health issues for the awareness-raising component to ensure more long-term impact. Jordan has exhibited an epidemiological shift from infectious disease to chronic disease. As such, preventative medicine has become increasingly important in the overall health scheme; however, Jordanians may lack the awareness of factors which contribute to long-term chronic illness. In order to ensure that healthcare services comprehensively address the health needs of the community, adding a preventative medicine component to awareness sessions as well as the comprehensive approach through which IRJ operates its health programs.

Recommendations for Sustainability:

Some components of the project lend themselves to long-term benefits, such as life-saving and life-altering surgeries as well as increased health awareness in communities. However, as noted by beneficiaries and experts alike in the KIIs and FGDs, once the intervention is concluded, patients will be unable to access treatment. Different stakeholders had different suggestions for how to improve sustainability. Improvements and recommendations to sustainability may potentially include:

Recommendation #18: Investing in the development of the MOH's health services, such as by purchasing a hemodialysis machine and donating it to a public hospital in order to service the host community and possibly with an agreement to provide a certain number of free or discounted services to the refugee community. However, prior to this commitment, there should be a dialogue with the MOH to ensure that the equipment – for example – is needed, that there are sufficient resources for maintenance, and to provide training to MOH staff on how to operate and maintain the equipment if needed.

Recommendation #19: Consider implementing a train-of-trainer component awareness sessions for local CBOs and community leaders.

Annexes

Annex 1: Demographics of Surveys

Table 11: Final Survey Samples

Survey	Number of Beneficiaries	Sample Size
Mobile primary health clinic patients	32,100	97
Secondary and tertiary care patients	787	82
Health awareness recipients	2698	88

Table 12: Secondary and Tertiary Healthcare Survey Demographics

Gender	
Male	54.9
Female	45.1
Nationality	
Syrian	87.8
Jordanian	9.8
Palestinian	2.4
Age	
Average Age:	40.2
Disability:	
Prevalence of disability or chronic disease	54.9

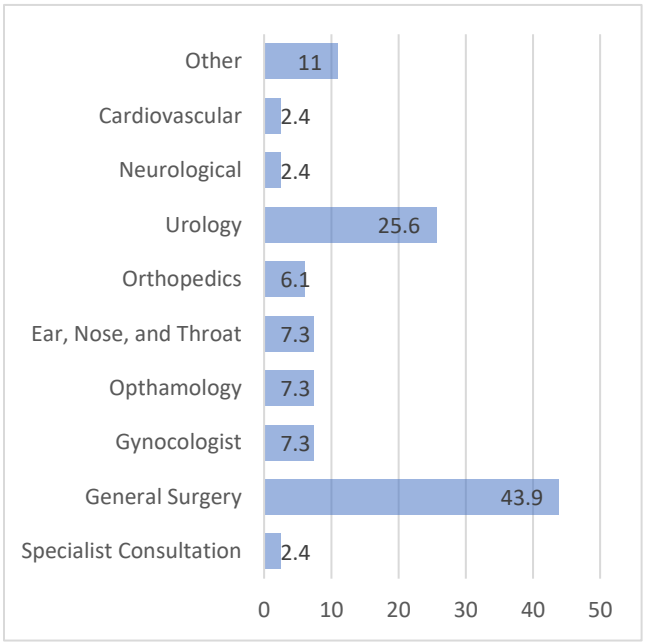
Table 13: Mobile Health Clinic Survey Demographics

Gender	
Male	33.0
Female	67.0
Nationality	
Syrian	77.3
Jordanian	22.7
Age	
Average Age:	41.3
Disability:	
Prevalence of disability or chronic disease	67.0
Last Visit to Mobile Health Clinic	
Last 30 days	3.1
Last Two Months	21.6
Three months or more	75.3

Table 14: Health Awareness Session Survey Demographics

Gender	
Male	21.6
Female	78.4
Nationality	
Syrian	56.8
Jordanian	43.2
Age	
Average Age:	40.2
Location	
Amman	28.4
Zarqa	1.1
Irbid	1.1
Mafraq	12.5
Ramtha	10.2
Karak	21.6
Ma'an	10.2
Other	14.8

Figure 13: % of Secondary and Tertiary Healthcare Beneficiaries Receiving Each Type of Procedure



Annex 2: Survey Tools

Mobile Health Clinic Beneficiaries

استبيان متلقو الرعاية الأولية (العيادات الصحية المتنقلة)

يرجى شكر المشاركين على مشاركتهم. أكد للمشاركين أن مركز الفينيق، هو مؤسسة بحثية مستقلة تم تكليفها بتقييم خدمات الرعاية الصحية التي تقدمها منظمة الإغاثة الإسلامية في الأردن. يرجى توضيح أن هذه مساحة آمنة للتحدث وأي شيء يقولونه لن يؤثر بأي شكل من الأشكال على أهليتهم لخدمات الرعاية الصحية. ستكون نتائج هذا الاستطلاع مجهولة المصدر قبل مشاركتها مع منظمة الإغاثة الإسلامية. الغرض من هذه المناقشة هو معرفة ما إذا كان المشاركون قد استفادوا من مشروع المقدم من منظمة الإغاثة الإسلامية في الاردن وإلى أي مدى وكيف يمكن تحسينه إذا طال أمده لمرحلة أخرى. لا توجد آثار على أتلقيهم العلاج المتعلق بهذا المسح.

القسم 1: المعلومات الديموغرافية
1. العمر: _____

2. الجنسية: _____

3. الجنس:
- ☐ ذكر
- ☐ انثى

4. هل هناك أي أشخاص يعانون من إعاقات أو أمراض مزمنة داخل أسرتك، بما فيهم أنت؟
- ☐ نعم
- ☐ لا

القسم 2: أسئلة المسح

1. في الوقت الحالي، هل تعتبر نفسك وأفراد أسرتك تتمتعون بصحة جيدة؟
- ☐ نعم
- ☐ لا

2. إذا كانت الإجابة "لا"، بشكل عام، كيف تصف حالة صحتك (أو حالة أفراد أسرتك) على مقياس من واحد إلى عشرة (مع كون الرقم 10 في حالة صحية جيدة)؟
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9

☐ 10

3. في الأشهر الـ 12 الماضية، عندما أردت الحصول على رعاية صحية، هل تلقيتها؟
   ☐ دائما
   ☐ في بعض الأحيان
   ☐ أبدًا

4. هل كانت العيادات الصحية المتنقلة هي المكان المعتاد الذي تذهب إليه إذا كنت أنت أو أحد أفراد أسرتك مريضًا؟
   ☐ نعم
   ☐ لا

5. متى كانت آخر زيارة لك للعيادة الصحية المتنقلة؟
   ☐ في آخر 30 يومًا
   ☐ في الشهرين الماضيين
   ☐ منذ أكثر من ثلاثة أشهر

6. كم من الوقت كان عليك الانتظار لتلقي المساعدة في العيادات الصحية المتنقلة؟
   ☐ 1- _____ دقيقة
   ☐ 2 - _____ ساعة
   ☐ 3 - _____ أيام
   ☐ 4 - _____ أسابيع
   ☐ 5 - _____ أشهر

7. كيف تقيم تجربتك في الحصول على اهتمام سريع عند تلقي الخدمات الصحية من خلال العيادات الصحية المتنقلة؟
   ☐ جيد جدا
   ☐ جيد
   ☐ معتدل
   ☐ سيء
   ☐ سيء جدا

8. كيف تقيم قدرتك على الذهاب وتلقي المساعدة في العيادات الصحية؟ هل كان الموقع سهل الوصول إليك؟
   ☐ سهل جدا
   ☐ سهل
   ☐ حسنًا
   ☐ صعب جدا

9. هل يمكنك أن تصف إلى أي مدى عرفت أن العيادات الصحية المتنقلة كانت في مكان قريب منك في يوم معين؟
   ☐ دائما
   ☐ معظم الوقت
   ☐ في بعض الأحيان
   ☐ مرة واحدة
   ☐ أبدًا، لم أعرف

10. في المرة الأولى التي ذهبت فيها إلى العيادة الصحية، هل يمكنك وصف شعورك قبل الذهاب؟
- ☐ مرتاح
- ☐ مرتاح إلى حد ما
- ☐ كان لدي بعض التحفظات
- ☐ قلق
- ☐ خائف

11. في المرة الأولى التي قمت فيها بزيارة العيادة الصحية، هل يمكنك وصف شعورك بعد زيارتك؟
- ☐ حصلت على المساعدة التي احتاجها
- ☐ حصلت على بعض المساعدة
- ☐ حصلت على القليل من المساعدة
- ☐ لم أحصل على المساعدة التي أحتاجها
- ☐ لقد جعلت وضعي أسوأ

12. عندما زرت العيادات الصحية المتنقلة لتلقي العلاج، هل شعرت أن الموظفين كانوا كذلك
- ☐ لطيفين للغاية
- ☐ ودودين
- ☐ محايد
- ☐ غير ودودين بعض الشيء
- ☐ غير ودودين للغاية

13. عندما زرت العيادات الصحية المتنقلة لتلقي العلاج، هل شعرت أن الموظفين تعاملوا معك:
- ☐ مع احترام كبير
- ☐ نوعا ما
- ☐ بدون احترام

14. عندما تزور العيادات الصحية المتنقلة لتلقي العلاج، هل يمكنك القول إن الموظفين احترموا خصوصيتك (اشرح إذا لزم الأمر: الموظفون محترمون إذا كنت تريد أن تتم معالجتك من قبل شخص من نفس الجنس، أو احترام إذا كنت تريد تغطية جزء من جسمك، أو لا أطرح أسئلة شخصية غير ذات صلة)
- ☐ إلى حد كبير
- ☐ بطريقة مناسبة
- ☐ إلى حد ما
- ☐ لم يحترموا الخصوصية ابدا

15. كيف تقيم تجربتك في العلاج بكرامة في الحصول على الخدمات الصحية في العيادات الصحية المتنقلة؟
- ☐ جيد جدا
- ☐ جيد
- ☐ معتدل
- ☐ سيء
- ☐ سيء جدا

16. عند تلقي العلاج في العيادة الصحية المتنقلة، كم مرة تقول إن الموظفين استمعوا إليك بعناية؟

- دائما
- عاده
- في بعض الأحيان
- أبدًا
- لا أستطيع القول

17. عند تلقي العلاج في العيادة الصحية المتنقلة، كم مرة قد تقول إن الموظفين شرحوا خطط العلاج والتشخيصات بطريقة تفهمها تمامًا؟
- دائما
- عاده
- في بعض الأحيان
- أبدًا
- لا أستطيع القول

18. خلال زياراتك لعيادات الرعاية الصحية، ما مدى ارتياحك لطرح الأسئلة؟
- مريح جدا
- مريح
- محايد
- غير مريح
- غير مريح للغاية
- لا أستطيع القول

19. ما تقييمك لتجربتك حول مدى جودة تواصل العاملين في العيادات الصحية المتنقلة معك؟
- جيد جدا
- جيد
- معتدل
- سيء
- سيء جدا

20. أثناء زياراتك للعيادات الصحية المتنقلة، كم مرة تحدثت مع طبيبك، أو الممرضة على انفراد حتى لا يتمكن الأشخاص الآخرون الذين لم ترغب في سماعهم من سماع ما قيل؟
- دائما
- معظم الوقت
- في بعض الأحيان
- أبدًا
- لا أستطيع القول

21. خارج العيادات الصحية المتنقلة، ما حجم المشكلة بالنسبة لك عند زيارة الطبيب أو تلقي رعاية صحية أخرى؟
- لا مشكلة
- مشكلة صغيرة
- مشكلة متوسطة
- مشكلة كبيرة

- ☐ مشكلة خطيرة
- ☐ غير ممكن على الإطلاق
- ☐ لا أحاول أبدا

22. أخيرًا، ما مدى رضاك عن الخدمات التي تلقيتها في العيادات الصحية المتنقلة؟
- ☐ راضٍ جدًا
- ☐ راضٍ إلى حدٍ ما
- ☐ محايد /مقبول
- ☐ غير راضٍ إلى حدٍ ما
- ☐ غير راضٍ ابدا

23. هل هناك أي شيء آخر تود أن تقوله؟
- ☐ لا
- ☐ نعم: _____

شكرا على تعاونكم وأتمنى لكم كل التوفيق في المستقبل

Secondary and Tertiary Healthcare Beneficiaries

استبيان الرعاية الصحية الثانوية

يرجى شكر المشاركين على مشاركتهم. أكد للمشاركين أن مركز الفينيق، هو مؤسسة بحثية مستقلة تم تكليفها بتقييم خدمات الرعاية الصحية التي تقدمها منظمة الإغاثة الإسلامية في الأردن. يرجى توضيح أن هذه مساحة آمنة للتحدث وأي شيء يقولونه لن يؤثر بأي شكل من الأشكال على أهليتهم لخدمات الرعاية الصحية. ستكون نتائج هذا الاستطلاع مجهولة المصدر قبل مشاركتها مع منظمة الإغاثة الإسلامية. الغرض من هذه المناقشة هو معرفة ما إذا كان المشاركون قد استفادوا من مشروع منظمة الإغاثة الإسلامية في الاردن وإلى أي مدى وكيف يمكن تحسينه إذا طال أمده لمرحلة أخرى. لا توجد آثار على أهليتهم لتلقي العلاج المتعلق بهذا المسح.

القسم 1: المعلومات الديموغرافية

1. العمر: _____

2. الجنسية: _____

3. الجنس:
- ☐ ذكر
- ☐ انثى

4. هل هناك أي أشخاص يعانون من إعاقات أو أمراض مزمنة داخل أسرتك، بما فيهم أنت؟
- ☐ نعم

☐ لا

5. أين كانت الجلسة التي حضرتها؟
☐ عمان
☐ الزرقاء
☐ اربد
☐ جرش
☐ المفرق
☐ الرمثا
☐ الكرك
☐ معان

القسم 2: أسئلة المسح

- ما نوع الخدمات التي تلقيتها؟ الرجاء تحديد كل ما قد ينطبق.
☐ استشارة أخصائي
☐ جراحة عامة
☐ أمراض النساء
☐ طب وجراحة العيون
☐ آذان أو أنف أو حلق
☐ جراحة العظام
☐ جراحة المسالك البولية
☐ الجهاز العصبي
☐ القلب والأوعية الدموية
☐ الوجه والفكين
☐ إجراءات أخرى
☐ لست متأكدًا / لا أعرف

- كيف تمت إحالتك إلى الرعاية الصحية الثانوية أو الثالثية؟
☐ من خلال عيادة صحية متنقلة
☐ من خلال المنظمات المجتمعية والمنظمات غير الحكومية الأخرى
☐ من خلال رقم الخط الساخن
☐ من خلال المكاتب الميدانية لمنظمة الإغاثة الاسلامية

- هل تلقيت زيارة منزلية قبل تلقي الخدمة؟
☐ لا
☐ نعم: _____

إذا كانت الإجابة بنعم، فانتقل إلى السؤال 4. إذا كانت الإجابة لا، فانتقل إلى السؤال 5.

- هل يمكنك وصف مدى شعورك بالراحة أثناء الزيارة المنزلية؟
☐ مرتاح جدا
☐ مرتاح إلى حد ما

- محايد
- كان لدي بعض التحفظات
- قلق
- خائف

• إلى أي مدى كان مستوى سهولةتزويد فريق الإغاثة الإسلامية بالوثائق التي يحتاجونها؟
- سهل جدا
- سهل
- متوسط السهولة
- صعب جدا
- غير ممكن

• أثناء تجربتك للحصول على الخدمات الصحية، ما مدى راحتك في طرح الأسئلة لمقدمي الخدمة؟
- مريح جدا
- مريح
- مريح إلى حد ما
- غير مريح
- غير مريح للغاية
- لا أستطيع القول

• بشكل عام، كيف تقيم تجربتك حول مدى جودة تواصل الموظفين معك بعد التشاور الأولي مع الاختصاصي؟
- جودة جيدة جدا
- جيدة
- معتدلة
- سيئة
- سيية جدا

• بشكل عام، كيف تقيم تجربتك حول مدى تواصل الموظفين معك بعد اجراء عملية جراحية لك ؟
- جيد جدا
- جيد
- معتدل
- سيء
- سيء جدا
- غير متاح (لم يتم التواصل)

• كم مرة تقول إن فريق العمل شرح لك خطط العلاج والتشخيصات بطريقة تفهمها تمامًا؟
- دائما
- في بعض الأحيان
- أبدًا (لم يتم الشرح لي)
- لا أستطيع القول

- هل تحسنت صحتك بعد إجراء العملية الجراحية؟
  - ☐ تحسنت صحتي بشكل كبير بعد الجراحة
  - ☐ تحسنت صحتي إلى حد ما بعد الجراحة
  - ☐ تحسنت صحتي في البداية لكنها ساءت الآن
  - ☐ بقيت صحتي على حالها بعد الجراحة (لم تتحسن)
  - ☐ ساءت صحتي بعد الجراحة
  - ☐ أخرى: _____

- كيف تقيم سهولة الذهاب وتلقي المساعدة في المستشفى حيث كان من المقرر إجراء العملية الجراحية؟
  - ☐ سهل جدا
  - ☐ سهل
  - ☐ متوسطة
  - ☐ صعب جدا
  - ☐ غير ممكن

- إلى أي مدى شعرت بالراحة لطرح أسئلة لمقدمي الخدمة حول مواضيع لم تفهمها أو تطلب المزيد من الإيضاحات؟
  - ☐ إلى حد كبير
  - ☐ إلى حد ما
  - ☐ لم أشعر بالراحة

- أثناء تلقيك الخدمات الصحية، هل شعرت أن الموظفين قدموا لك الخدمة:
  - ☐ باحترام كبير
  - ☐ بالاحترام
  - ☐ ببعض الاحترام
  - ☐ بدون احترام
  - ☐ لا ينطبق أو لا أستطيع التذكر

- ما مدى رضاك عن الخدمات الصحية ككل؟
  - ☐ راضٍ جدًا
  - ☐ راضي
  - ☐ راضٍ إلى حدٍ ما
  - ☐ غير راضٍ
  - ☐ غير راضٍ جدًا

- كيف يمكن للإغاثة الإسلامية في الأردن تحسين خدماتها الصحية الثانوية والثالثية؟
  - ☐ تقليل وقت الانتظار
  - ☐ المزيد من الدعم والمتابعة قبل العمليات الجراحية
  - ☐ المزيد من الدعم والمتابعة بعد الجراحة
  - ☐ تحسين المعاملة والمهنية من قبل الموظفين
  - ☐ سهولة النقل من وإلى المستشفى

- ☐ لا شيء مما سبق
- ☐ أخرى: _____

• هل هناك أي شيء آخر تود أن تقوله؟
- ☐ لا
- ☐ نعم: _____

شكرا على تعاونكم وأتمنى لكم كل التوفيق في المستقبل

Awareness Session Beneficiaries

استبيان التوعية الصحية

يرجى شكر المشاركين على مشاركتهم. أكد للمشاركين أن مركز الفينيق، هو مؤسسة بحثية مستقلة تم تكليفها بتقييم خدمات الرعاية الصحية التي تقدمها منظمة الإغاثة الإسلامية في الأردن. يرجى توضيح أن هذه مساحة آمنة للتحدث وأي شيء يقولونه لن يؤثر بأي شكل من الأشكال على أهليتهم لخدمات الرعاية الصحية. ستكون نتائج هذا الاستطلاع مجهولة المصدر قبل مشاركتها مع منظمة الإغاثة الإسلامية. الغرض من هذه المناقشة هو معرفة ما إذا كان المشاركون قد استفادوا من مشروع منظمة الإغاثة الإسلامية في الاردن وإلى أي مدى وكيف يمكن تحسينه إذا طال أمده لمرحلة أخرى. لا توجد آثار على أهليتهم لتلقي العلاج المتعلق بهذا المسح.

القسم 1: المعلومات الديموغرافية

1. العمر: _____

2. الجنسية: _____

3. الجنس:
- ☐ ذكر
- ☐ انثى

4. هل هناك أي أشخاص يعانون من إعاقات أو أمراض مزمنة داخل أسرتك، بما فيهم أنت؟
- ☐ نعم
- ☐ لا

5. أين كانت الجلسة التي حضرتها؟
- ☐ عمان
- ☐ الزرقاء
- ☐ اربد
- ☐ جرش
- ☐ المفرق
- ☐ الرمثا
- ☐ الكرك
- ☐ معان

القسم 2: أسئلة المسح

1. ما هي جلسات التوعية الصحية التي حضرتها؟
   - ☐ الإسعافات الأولية
   - ☐ النظافة الشخصية
   - ☐ أمراض الشتاء
   - ☐ سرطان الثدي
   - ☐ مرض السكري
   - ☐ الربو
   - ☐ أخرى: _____

2. هل شعرت أن الموضوع كان وثيق الصلة باحتياجاتك الصحية؟
   - ☐ لا
   - ☐ نعم

3. هل تلقيت مجموعة أدوات النظافة؟
   - ☐ لا
   - ☐ نعم

4. هل شعرت أن محتويات مجموعة الأدوات الصحية مفيدة وذات صلة بالمناقشة؟
   - ☐ لا
   - ☐ نعم

5. هل شعرت أن توزيع أدوات النظافة كان عادلاً ويعتمد على معايير واضحة؟
   - ☐ لا
   - ☐ نعم

6. كيف سمعت عن جلسة التوعية الصحية؟
   - ☐ من صديق أو أحد أفراد الأسرة
   - ☐ من منظمة مجتمعية أو مؤسسة خيرية محلية
   - ☐ قام مكتب الإغاثة الإسلامية المحلي في الأردن بدعوتي
   - ☐ أخرى: _____

7. ما مدى رضاك عن جلسة التوعية الصحية ككل؟
   - ☐ راضٍ جدًا
   - ☐ راضي
   - ☐ راضٍ إلى حدٍ ما
   - ☐ مستاء
   - ☐ غير راضٍ جدًا

8. هل هناك أي مواضيع أخرى تشعر أنها ذات صلة بك وبمجتمعك وترغب في الحصول على مزيد من الوعي بها؟
   - ☐ لا

□ نعم

9. ما هي المواضيع التي تعتقد أن مجتمعك بحاجة إلى مزيد من المعلومات حول؟ لا تتردد في تحديد كل ما ينطبق
□ الوقاية من السرطان
□ إدارة الألم
□ الربو
□ مرض السكري
□ النظافة
□ أمراض الشتاء
□ صحة المرأة
□ كوفيد -19
□ أخرى: _____

10. إلى أي مدى تم إجراء جلسات التوعية بطريقة يمكنك من خلالها فهم المعلومات المقدمة؟
□ إلى حد كبير
□ بطريقة مناسبة
□ إلى حد ما
□ عفوًا

11. إلى أي مدى شعرت بالارتياح لطرح أسئلة حول مواضيع لم تفهمها أو طلبت المزيد من الإيضاحات؟
□ إلى حد كبير
□ بطريقة مناسبة
□ إلى حد ما
□ عفوًا

12. إلى أي مدى شعرت أن فهمك للموضوع الذي تمت تغطيته خلال الجلسة قد تحسن؟
□ إلى حد كبير
□ بطريقة مناسبة
□ إلى حد ما
□ عفوًا

13. خلال جلسة التوعية الصحية، هل شعرت أن الموظفين تعاملوا معك:
□ مع احترام كبير
□ مع الاحترام
□ مع بعض الاحترام
□ بدون احترام
□ لا ينطبق أو لا أستطيع التذكر

14. كيف تفضل الحصول على معلومات عن الصحة؟
□ خلال جلسة توعية صحية
□ من خلال قراءة الكتيب
□ أخرى: _____

15. هل هناك أي شيء آخر تود أن تقوله؟

□ لا

□ نعم: _____

شكرا على تعاونكم وأتمنى لكم كل التوفيق في المستقبل

Annex 3: KII Topic Guides

Interview: Dialysis Patients

أسئلة مقابلة (مرضى غسيل الكلى)

يرجى شكر المشاركين على مشاركتهم. أكد للمشاركين أن مركز الفينيق، هو مؤسسة بحثية مستقلة تم تكليفها بتقييم خدمات الرعاية الصحية التي تقدمها منظمة الإغاثة الإسلامية في الأردن. يرجى توضيح أن هذه مساحة آمنة للتحدث وأي شيء يقولونه لن يؤثر بأي شكل من الأشكال على أهليتهم لخدمات الرعاية الصحية. ستكون نتائج هذا الاستطلاع مجهولة المصدر قبل مشاركتها مع منظمة الإغاثة الإسلامية. الغرض من هذه المناقشة هو معرفة ما إذا كان المشاركون قد استفادوا من مشروع منظمة الإغاثة الإسلامية في الاردن وإلى أي مدى وكيف يمكن تحسينه إذا طال أمده لمرحلة أخرى. لا توجد آثار على أهليتهم لتلقي العلاج المتعلق بهذا المسح.

• ما هي المدة الزمنية التي استمريت فيها بغسيل الكلى من قبل منظمة الإغاثة الإسلامية في الأردن؟
- 1-3 شهور
- 4-6 شهور
- 6 شهور - 12 شهر
- سنة أو أكثر

• كيف تمت إحالتك إلى هذا البرنامج؟

• كيف كان يوضح لك موظفو مركز غسيل الكلى تفاصيل الإجراءات قبل توصيلك بجهاز غسيل الكلى ؟
.....

• باستخدام أي رقم من 1 إلى 10، حيث الرقم 1 هو الأسوأ و 10 هو الأفضل، كيف تقيم مستوى أطباء الكلى الذين تعالجت عندهم أثناء مشروع منظمة الإغاثة الإسلامية في الأردن؟
_____

• كيف تقييم طريقة شرح أطباء الكلى أوضاعك الصحية وطريقة العلاج بطريقة كان من السهل عليك فهمها؟
كل الوقت
معظم الوقت
في بعض من الوقت
نادرا
لم يشرحوا مطلقا

• ماذا تفعل عندما تواجه مشكلة صحية في المنزل او خارج المستشفى؟

• هل ناقش الأطباء أو الفنيون خطط الرعاية طويلة الأمد معك؟
نعم
لا
اذا نعم: ماذا تتضمن خطط الرعاية طويلة الأجل؟

• كيف أثر تلقي علاج غسيل الكلى الممول من منظمة الإغاثة الإسلامية في الأردن على حياتك؟

• كيف تقيم قدرة موظفو مركز غسيل الكلى على إدارة المشاكل التي كانت تحدث أثناء غسيل الكلى؟

• إذا كانت لديك مشكلة أو شكوى مع العاملين في منظمة الاغاثة الاسلامية ، فهل شعرت بوجود آلية موثوقة يمكنك استخدامها لتقديم الشكوى أو للحصول على الدعم؟

• بخلاف جلسات غسيل الكلى، ما هي احتياجات الرعاية الصحية الأخرى التي لديك؟

أسئلة المتابعة/ الاستدامة:

هل أنت قادر على الوصول إلى هذه هذه الخدمات؟

- هل يدعمك أي جهة أخرى غير منظمة الإغاثة الإسلامية في الأردن؟
- إذا كان الأمر كذلك، فمن؟
- هل ناقشت منظمة الإغاثة الإسلامية في الأردن معك ما سيحدث بمجرد انتهاء المشروع؟
- هل كنت قادرًا على تغطية تكلفة علاجك الطبي؟

إذا لم يكن الأمر كذلك، فهل تمكنت من العثور على منظمة أخرى لدعمك من خلال تغطية تكلفة علاج غسيل الكلى الخاص بك؟

- هل لديكم أي توصيات لتحسين مشروع منظمة الإغاثة الإسلامية الأردنية لمساعدة اللاجئين السوريين؟

Interview: IRJ Staff:

دليل المقابلة (موظفو الإغاثة الإسلامية في الأردن)

عرفنى بنفسك.
قدم مركز فينيكس للدراسات الاقتصادية والمعلوماتية ولخص الغرض من التقييم. اشكر الشخص الذي تمت مقابلته على الوقت الذي استثمره في المساعدة في تقييم هذا المشروع.
بشكل عام ، كيف تقيم نجاح المشروع؟ لماذا ا؟ ما هي الأسباب؟
مقارنة بالمشاريع الأخرى التي عملت عليها ، هل شعرت أنه يمكنك إحداث تأثير أكبر / أصغر على رفاهية الناس ومعيشتهم؟
أي جزء من المشروع (الرعاية الأولية / الثانوية والثالثية / غسيل الكلى / التوعية الصحية) تعتقد أنه أحدث الفرق الأكبر؟
•هل تشعر أن الخدمات المقدمة في هذا المشروع تلبي احتياجات اللاجئين السوريين والمحليين؟
•إذا لم يكن الأمر كذلك ، فما هو برأيك ما يحتاجه اللاجئون السوريون أكثر عندما يتعلق الأمر بالرعاية الصحية
•من برأيك الأكثر ضعفاً بين اللاجئين السوريين؟ ؟

هل تعتقد أن هناك أشخاص تريد الوصول إليهم بالمشروع وتشعر أنهم لم يستفدوا من الخدمات التي يقدمها المشروع؟
إذا كانت الإجابة بنعم ، فكيف تعتقد أنه كان من الممكن الوصول إلى المزيد من الأشخاص؟
هل شاركت في تصميم المشروع والتخطيط؟
إذا كانت الإجابة بنعم ، هل يمكنك وصف عملية تصميم المشروع؟
-ما هي الأدوات التي استخدمتها لتقييم احتياجات الرعاية الصحية للاجئين السوريين؟ - كيف تصف تواصلك مع المجموعة المستهدفة قبل تنفيذ المشروع؟
إلى أي مدى تشعر أن المشروع استهدف احتياجات المستفيدين؟ كيف دمجت الظروف الاجتماعية والثقافية أثناء تصميم المشروع؟
هل تم التشاور مع تصميم المشروع مع أصحاب المصلحة المحليين الآخرين (وزارة الصحة ، منظمة الصحة العالمية ، المفوضية السامية للأمم المتحدة لشؤون اللاجئين)؟ إذا كانت الإجابة بنعم ، فإلى أي مدى تعتقد أن المشروع يتناسب مع المشهد الحالي لتقديم الرعاية الصحية للاجئين السوريين؟
إذا كان الجواب "لا" فلماذا؟

من هم الشركاء الأكثر فاعلية لتقديم الدعم أثناء تصميم المشروع وتنفيذه؟

-بسبب قيود الميزانية ، تم دعم عدد محدود من المستفيدين من حيث الوصول إلى الرعاية الصحية الثانوية أو الثالثة - تكاليف العلاج في المستشفى ، وتكلفة الجراحة وما إلى ذلك.

ما الإجراءات التي اتخذتها للتأكد من أن نظام الإحالة عادل / منصف / قابل للاستهداف؟

لماذا تم التركيز على تقديم علاج غسيل الكلى بدلاً من علاج الأمراض المزمنة الأخرى؟
-هل لديك معلومات عن الحاجة لغسيل الكلى قبل تنفيذ المشروع؟
هل شعرت أنه يمكنك توفير العلاجات المصاحبة التي يحتاجها مرضى غسيل الكلى (مثل العلاجات الأخرى ، والرعاية الصحية العقلية ، والنصائح الغذائية)؟
-إذا لم يكن كذلك ، كيف تعتقد أن هذا أثر على فعالية العلاج لهؤلاء المرضى؟

-هل تعتقد أن الوعي الصحي للفئة المستهدفة قد تحسن نتيجة حملة التوعية الصحية التي تم تنفيذها في إطار المشروع؟

لماذا تعتقد أن جلسات التوعية الصحية كانت ناجحة / غير ناجحة؟

-كيف تأكدت من وصول جلسات التوعية الصحية للجميع؟ هل تشاورت مع قادة المجتمع؟

•تم عقد جلسات توعية حول مواضيع مختلفة ، ما رأيك في جلسات التوعية؟
(1 الأكثر حاجة...
(2 أيهما كان له الأثر الأكبر على المجتمع؟
هل هناك موضوع لن تختاره مرة أخرى؟
ما هي التحديات التي واجهتك أثناء تنفيذ الجلسات؟
إلى أي مدى يؤخذ السياق الاجتماعي بعين الاعتبار؟ مثال: هل تأكدت من أنه عند إجراء جلسة للوقاية من سرطان الثدي ، يمكنك توفير مساحة آمنة للسيدات للحديث عن صحة ثديهن؟
كيف تم اختيار الموضوعات التي سيتم تناولها؟
هل كانت هناك أي تحديات خلال مرحلة التنفيذ لم تكن تتوقعها؟ كيف أثر ذلك على تنفيذ المشروع؟ س - هل تعرف ما إذا كان مقدمو الرعاية الصحية الآخرون على وجه الأرض يواجهون تحديات مماثلة؟ إذا لم يكن كذلك ، فماذا فعلوا بشكل مختلف؟
كيف تعاملت هذه المنظمات مع هذه التحديات؟
س- هل تشعر أنك تلقيت الدعم الكافي من زملائك ورؤسائك للتعامل مع هذه التحديات؟ إذا لم يكن الأمر كذلك ، فما نوع الدعم الذي تحتاجه؟

- •كيف أثر Covid-19 على تنفيذ المشروع؟ على سبيل المثال ، كيف أثرت على التنسيق مع مقدمي الرعاية الصحية الآخرين والسلطات الصحية؟
س- إلى أي مدى استطعت تحقيق أهداف المشروع خلال فترات الإغلاق؟ ما هي الخدمات التي لا يمكنك تقديمها؟

-ما نوع التغذية الراجعة التي تلقيتها من المستفيدين خلال فترة التنفيذ؟ o إلى أي مدى تمكنت من عكس ذلك في عملك؟
oما هي المعلومات التي تود الحصول عليها من المستفيدين قبل البدء في المشروع؟
هل تلقيت أي ملاحظات تشير إلى آثار سلبية غير مقصودة للمشروع على المستفيدين؟

الآن بعد أن أكملت المشروع ، هل هناك أي نشاط كنت ستفعله بشكل مختلف؟

-هل تعتقد أن المشروع حسّن سبل عيش المستفيدين؟
-هل تعتقد أن الإغاثة الإسلامية قد وضعت / تأسست

Interview Guide for External Experts:

دليل المقابلة (لغير موظفي IRW موظفي الإغاثة الاسلامية)
يرجى تزويد المشارك بملخص قصير عن المشروع والفئات المستهدفة ومكوناته. اشكر الشخص الذي تمت مقابلته على الوقت الذي استثمره في المساعدة في تقييم هذا المشروع.

اسئلة عامة:

- كيف تقيمون إمكانية الوصول / توافر خدمات الرعاية الصحية للاجئين السوريين في الأردن؟ لماذا؟
  - **هل توجد فروق بين توافر الرعاية الأولية والثانوية والثالثية؟**

- كيف تقيمون الحاجة العامة لتوفير رعاية صحية إضافية للاجئين السوريين؟
  - **بناءً على معرفتك، ما هي أهم احتياجات الرعاية الصحية للمجتمع/اللاجئين السوريين؟**
  - **هل تختلف الاحتياجات الصحية بين اللاجئين الذين يعيشون داخل المخيمات وخارجها؟**
  - **هل تختلف الاحتياجات بين الرجل والمرأة في مجتمع اللاجئين؟**

- على حد علمك، ما هي التدخلات / الاستراتيجيات الموجودة حاليًا لتحسين الرعاية الصحية للاجئين السوريين في الأردن؟
  - **ما هي المنظمات (بخلاف منظمتك) التي تنفذ حاليًا مشاريع لتحسين الرعاية الصحية للاجئين السوريين؟ ما هو دور وزارة الصحة الأردنية؟**
  - **بغض النظر عما يتم تنفيذه حاليًا، ما هي التدخلات التي تعتقد أنها الأكثر فعالية؟**

- برأيك، ما هي التحديات الرئيسية التي قد يواجهها المانحون عند التخطيط لتوفير الرعاية الصحية للاجئين السوريين؟

أسئلة خاصة بالمشروع:

- قبل مقابلتنا اليوم، هل كنتم على علم بتوفير الرعاية الصحية للسوريين من قبل منظمة الإغاثة الإسلامية في الأردن؟
  - **إذا كانت الإجابة "لا"، هل أنت على دراية بأنشطة الإغاثة الإسلامية الأخرى في الأردن؟**
  - **إذا كانت الإجابة نعم، فكيف عرفت عنها؟ يرجى توضيح ما تعرفه عن المشروع؟**
  - **إذا كانت الإجابة نعم، فهل عملت أو نسقت مع منظمة الإغاثة الإسلامية في الأردن في هذا المشروع؟ إذا كانت الإجابة نعم، كيف تقيم التعاون؟**
  - **ما هو مفهومك العام عن المشروع؟ ما هي أسباب هذا التصور؟**

- إذا كنت تخطط لتوفير الرعاية الصحية للاجئين السوريين في الأردن، ما هي احتياجات الرعاية الصحية التي ستركز عليها؟
- حسب (في اطار منظمتك) معلوماتك، ما مستوى الرعاية الصحية الأولية الذي يتمتع به اللاجئون السوريون؟ **من الذي يقدم هذه الرعاية؟ من يدفع تكاليفها؟**
  - **ما دور الجهات الحكومية أو المؤسسات الأخرى؟**
  - **كيف تقيم مدى توفر الأدوية للاجئين السوريين؟**

- قدمت منظمة الإغاثة الإسلامية الرعاية الصحية الأولية للاجئين السوريين من خلال عيادتين صحيتين متنقلتين. من تجربتك، هل تعتقد أن هذا النوع من العيادات في متناول الجميع؟
  - **ما هي برأيك أسباب عدم استفادة بعض المرضى من العيادة؟**
  - **كيف يمكن تحسين انتشار مثل هذه العيادات؟**

- حسب معلوماتك، هل يحصل اللاجئون السوريون في الأردن على الرعاية الثانوية والثالثية؟

- هل تعرف من يقدم هذه الرعاية؟ من يدفع تكاليفها؟
- كيف تعتقد أنه يمكن تحسين وصول هذه الخدمات الى اللاجئين السوريين؟
- ما هي برأيك أكبر احتياجات اللاجئين فيما يتعلق بالرعاية الثانوية والثالثية؟

• كيف تقيم مدى توفر علاج غسيل الكلى في الأردن بشكل عام؟
- كيف تقيم الحاجة إلى غسيل الكلى بين اللاجئين؟
- كيف تقيمون وصول اللاجئين السوريين المرضى إلى غسيل الكلى؟
- إذا كان الأمر صعبًا، كيف تعتقد أنه يمكن تحسين الوصول إلى خدمات غسيل الكلى للاجئين السوريين؟

• بناءً على معرفتك وخبرتك، ماذا يحدث للمرضى؟ هل تقدم الأدوية المصاحبة التي تكمل العلاج؟

• بناءً على خبرتك، ما نوع الرعاية التكميلية التي يحتاجها مرضى غسيل الكلى لتحقيق أكبر قدر من النجاح في العلاج؟ (هذا لاسؤال خاص بالعاملين في المجال الصحي)

• هل هناك احتياجات صحية أخرى ملحة ينبغي معالجتها في أي تدخل في مجال الرعاية الصحية؟

• بشكل عام، كيف تقيم الوعي الصحي بين اللاجئين السوريين؟
- ما هي أكبر فجوات الوعي واحتياجات المجتمع؟
- كيف تعتقد أنه يمكن تحسين الوعي الصحي؟
- ما نوع التدخل الذي تعتقد أنه سيكون الأكثر فعالية لزيادة الوعي؟

• كيف تعتقد أن Covid-19 قد أثر على توفير الرعاية الصحية للأمراض والأمراض الأخرى في الأردن؟
- إلى أي مدى تعتقد أن ذلك ينعكس على توفير الرعاية الصحية للاجئين السوريين؟
- إلى أي مدى تأثر اللاجئون السوريون بالوباء؟ حسب تقييمك، هل أثرت عليهم أكثر أم أقل من بقية سكان الأردن؟

• ما هي العوامل الأخرى التي تعتقد أنها يمكن أن تؤثر على تنفيذ مشروع تقديم الرعاية الصحية للاجئين السوريين؟

Annex 4: FGD Topic Guides

المحاور النقاشية لتقييم مشروع خدمات الرعاية الصحية التي تقدمها منظمة الإغاثة الإسلامية في الأردن

يرجى شكر المشاركين على مشاركتهم. أكد للمشاركين أن مركز الفينيق هو مؤسسة بحثية مستقلة تم تكليفها بتقييم خدمات الرعاية الصحية التي تقدمها منظمة الإغاثة الإسلامية في الأردن. يرجى توضيح أن هذه مساحة آمنة للتحدث وأي شيء يقولونه لن يؤثر بأي شكل من الأشكال على أهليتهم لخدمات الرعاية الصحية. ستكون نتائج هذه الجلسة مجهولة المصدر قبل مشاركتها مع منظمة الإغاثة الإسلامية. الغرض من هذه المناقشة هو معرفة ما إذا كان المشاركون قد استفادوا من مشروع المقدم من منظمة الإغاثة الإسلامية في الاردن وإلى أي مدى وكيف يمكن تحسينه إذا طال أمده لمرحلة أخرى. لا توجد آثار على تلقيهم العلاج من قبل منظمة الإغاثة الاسلامية.

- هل كنت من المستفيدين من خدمات الرعاية الصحية التي تقدمها المنظمة؟
- هل تشعر أن الخدمات المقدمة في هذا المشروع تلبي احتياجات السكان اللاجئين السوريين والمحليين (الأردنيين)؟
- إذا لم يكن الأمر كذلك، فما هو برأيك ما يحتاجه اللاجئون السوريون أكثر عندما يتعلق الأمر بالرعاية الصحية؟
- هل كانت العيادات الصحية المتنقلة هي المكان المعتاد الذي تذهب إليه إذا كنت أنت أو أحد أفراد أسرتك مريضًا؟ وإذا لا ما هي الجهات التي تذهب اليها ولماذا؟
- هل يمكنك أن تصف إلى أي مدى عرفت أن العيادات الصحية المتنقلة كانت في مكان قريب منك في يوم معين؟
- كيف تقيم تجربتك على مقياس (1 - 10) في الحصول على الاهتمام عند تلقي الخدمات الصحية من خلال العيادات الصحية المتنقلة؟
- كيف تقيم قدرتك على الذهاب وتلقي المساعدة في العيادات الصحية؟ هل كان الموقع سهل الوصول إليك؟
- هل حضرت أي من الجلسات التوعية الصحية التي نفذتها المنظمة؟ ما موضوع الجلسة/ الجلسات التي شاركت بها **(عدد عناوين الجلسات اذا لزم الامر)**

  1- الإسعافات الأولية 2- النظافة الشخصية 3- أمراض الشتاء 4- سرطان الثدي 5- مرض السكري 6- الربو 7- أخرى
- هل شعرت أن الموضوع كان وثيق الصلة باحتياجاتك الصحية؟
- كيف سمعت عن جلسة التوعية الصحية؟
- هل هناك أي مواضيع أخرى تشعر أنها ذات صلة بك وبمجتمعك وترغب في الحصول على مزيد من الوعي بها؟
- هل لديك أي اقتراحات لخدمات صحية أخرى من المفيد تقديمها للاجئين السوريين والمحليين (الأردنيين)؟