

# Evaluation of the Caring for Refugees with NCDs Project

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Evaluation information at a glance	
<b>Title of the evaluation:</b>	Evaluation of the Caring for Refugees with NCDs Project
<b>Timeframe covered:</b>	2014-2020
<b>Expected duration:</b>	8 months
<b>Type of evaluation:</b>	Qualitative programme evaluation
<b>Countries covered:</b>	Cameroon, Jordan, Rwanda, Uganda
<b>Evaluation manager / contact in UNHCR:</b>	Michael Woodman
<b>Evaluation team:</b>	<p>Team Leader – Adrianna Murphy, senior public health researcher</p> <p>Evaluators – Éimhín Ansbros, medical doctor and public health researcher, and Enrica Leresche, nurse and public health researcher</p> <p>The team members are all affiliated with the London School of Hygiene and Tropical Medicine but undertook the evaluation as independent consultants.</p>

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## Executive summary

**BACKGROUND:** Non-communicable diseases (NCDs) are the leading cause of morbidity and mortality worldwide. Refugees affected by NCDs face interrupted care and humanitarian and public health systems that are often weakened, overburdened, and ill equipped to manage chronic conditions. In partnership with Primary Care International (PCI), a United Kingdom-based non-governmental organization focused on continuing medical education, UNHCR developed a capacity-building project, entitled “Caring for Refugees with NCDs Project”, which aimed to improve the quality of NCD care for refugees in UNHCR’s care. The project aimed to reduce NCD morbidity and mortality through the development of evidence-based clinical guidelines and their adoption by clinicians at community-level. The project’s objectives were: 1) to improve awareness of NCDs among public health and clinical staff; 2) to improve knowledge of NCD management among public health and clinical staff; 3) to improve NCD clinical practice among public health and clinical staff; and 4) to improve a systems approach to NCDs management. The project initially focused on Jordan, Kenya, Burkina Faso, Algeria, and Bangladesh from 2014 to 2016, and, later on Rwanda, Tanzania, Uganda, Democratic Republic of Congo, Ethiopia, Cameroon, Burundi, and Chad from 2017 to 2019. The main activities of the project were conducted through a Training of Trainers (ToT) approach. This involved a week-long, in-person ToT programme, provided by PCI staff to NCD champions selected from UNHCR and implementing partner teams. It was intended that these champions would then cascade training to their colleagues and lead the restructuring their programme’s NCD services. Follow-up support was provided via peer-led social media groups set up by PCI.

**AIM:** This evaluation aims to assess the relevance, coherence, effectiveness, efficiency, impact, and sustainability of the project and related organizational changes in UNHCR’s work on NCD care and management. The findings of the evaluation will be used to support learning and accountability; to guide programme practices to improve NCD care in refugee operations; and to document lessons learned from implementation and field practice.

**METHODS:** The evaluation was guided by the Organisation for Economic Cooperation and Development - Development Assistance Committee (OECD-DAC) criteria for evaluation of humanitarian action, to understand whether the project did the right things (relevance); whether it fit the different contexts in which it took place (coherence); whether it achieved its objectives (efficiency); how well resources were used (effectiveness); what difference the intervention made (impact); and finally, whether the benefits would last (sustainability). Four countries were selected for the evaluation: Cameroon, Rwanda, Tanzania, and Jordan. The methods used included a) a review of programme materials provided by PCI and UNHCR and b) semi-structured qualitative interviews of purposefully- selected UNHCR, PCI or implementing partner staff. Interviews were conducted in English or French. Interviewees included PCI (8); UNHCR headquarters (4); UNHCR country level programme officers (PHOs, 6); and field implementing partner (18). Semi-structured interviews were guided by a topic guide, which was designed around the OECD-DAC criteria. They explored the organizational and contextual constraints to implementing the project. The evaluation was carried out remotely since the Covid19 pandemic-related travel restrictions prevented the

evaluators from making planned visits to the country programmes. The evaluation was undertaken by a team of three public health researchers, with experience of working in humanitarian settings and with humanitarian implementing organizations. The team included members with health services research, evaluation, programme management and medical and nursing backgrounds.

## Key findings

*Relevance:* The NCD training was recognised as relevant, timely and filling an important gap in NCD knowledge and systems. It highlighted for personnel engaged in NCD care delivery that they lacked appropriate clinical tools, data collection and procurement systems. The focus on diabetes, hypertension, cardiovascular disease, chronic obstructive pulmonary disease and asthma was perceived as relevant and largely corresponding to the most common NCDs encountered in the target refugee populations. Implementing partners appreciated the practical nature of the PCI trainings and easy-to-use guidelines. Of particular benefit was the focus on the facility-level organization and management of an NCD Programme. Feedback suggested that future trainings could cover additional NCDs, NCD complications and comorbidities. The appropriate selection of relevant trainees was perceived to be particularly important and that there was potential to include a broader range of health worker cadres. The selection criteria varied from country to country and, for example, resulted at times in selection of trainees who were due to leave their posts or who were non-clinical.

*Coherence:* The guidelines were aligned with World Health Organization (WHO) guidelines and the UNHCR Essential Medicines List. In some cases, trainings entirely changed the way NCD care was delivered, with creation of NCD teams and chronic care tools and structures. The training also resulted in greater standardization of NCD among different implementing actors, which was perceived as improving the quality of care and patient experience. In other cases, some aspects were perceived as poorly matched with the practical realities and misalignment with national or local (private) practice, which created tensions for implementing teams. Delays in drug supply were highlighted as one particular challenge. The UNHCR Essential Medicine List was adapted to align with the PCI training content in tandem with the delivery of training. This often resulted in a lag time of several months before the supply chain was adapted and the relevant supplies were available to trainees. Medication stock-outs were also raised as an issue, which respondents linked to poor consumption and inventory monitoring, and delays in placing medication orders. PCI staff recognised the importance of addressing coherence between their training and the local health system and made efforts to adapt content during brief site visits undertaken immediately before the trainings took place. PCI was constrained by the scope of their terms of reference and by their limited capacity to influence broader systemic issues.

*Effectiveness:* The project was perceived as effective in achieving its overall objectives. The NCD project significantly changed the way NCD care was provided, resulting in more structured care delivery with the introduction of registers, patient files, appointment and recall systems. However, the need for improved monitoring was emphasised and PCI introduced a monitoring tool in the second round of country trainings. In many cases, monitoring data were incomplete and, thus,

project effectiveness was difficult to measure. Challenges included the lack of guidance on how to use the PCI tool, internet connection issues, or the fact that the tool was external to UNHCR health information and monitoring system. Where cascade training was most effective, this seemed to depend in part on positive leadership from the UNHCR Public Health Officers (PHOs) and the implementing partner management team. Key factors limiting effectiveness appeared to be a lack of clarity around the expectations and support for cascade training and a variation in ownership of the project by UNHCR PHOs and/or implementing partners. For example, there was no standardised guidance on how cascade training was to be done.

*Efficiency:* Overall, all stakeholders felt that significant impact was achieved with the budgets allocated for the project. For the selection of trainees, most, but not all stakeholders felt that the “right” people were selected and that they represented a broad range of clinicians. However, some felt that the selection was inefficient due to the inclusion of clinicians who were due to imminently leave their projects and there was variation in understanding of how people were selected. Both PCI and implementing partners felt the time allocated for face-to-face training was short, particularly as the number of topics that needed to be addressed increased as the project progressed. The PCI training team was very welcome in all settings and the high quality of the training content and delivery were appreciated by all. By contrast, interviewees questioned the longer-term efficiency of training being delivered by a United Kingdom-based organization, external to UNHCR, and of receiving long-term support virtually from distant experts. A need for local expertise to provide more consistent and immediate support was identified.

*Impact:* Implementing partners and country PHOs reported that the project had a significant impact on improving NCD care and outcomes. It was felt that the approach to NCD management introduced by PCI helped to strengthen earlier case detection and diagnosis, reduce late-stage acute complications, improve prediction of supply need, raise awareness of NCDs amongst communities, build autonomy of primary health care staff, and encourage increased patient trust in and engagement with services. However, the extent of impact of the training is difficult to confirm given the limitations and variability of current UNHCR monitoring data and systems. UNHCR and implementing partners suggested that the Balanced Score Card was a useful monitoring tool, when implementing partners engaged with it, and that further adaptations could improve NCD quality monitoring. It is also difficult to assess the long-term impact of the NCD project. While the immediate objectives were clear, the longer-term desired outcomes (such as improvements in treatment adherence or reduction in acute complications) and how these were linked to the overall aim of the project, were not made explicit at the outset through a Theory of Change or logic model and were, thus, difficult to monitor.

*Sustainability:* The sustainability of the NCD project and its achievements was the most commonly raised, complex and difficult issue to address in this evaluation. Several factors were identified that cast doubt on the sustainability of this training model, that would need to be addressed in subsequent iterations of this project or in other NCD training initiatives. The challenge of maintaining quality of care in the long-term and meeting expectations created by the PCI NCD project was also raised. First, high turnover of implementing partner clinical staff was repeatedly raised as a major

barrier to sustaining the improvements in awareness, knowledge and practice attained by the NCD project. Second, the sustainability of remote, peer-led training support was questioned both by most stakeholders. WhatsApp groups were found to be very useful but for a limited life span. Limited network connectedness and self-motivation seemed to be common barriers to accessing remote support, and follow-up support calls that PCI made to trainees were not well attended.

## Key recommendations

- Continue NCD care capacity-strengthening activities. Overall, the NCD training responded to a major gap in NCD care knowledge and systems and was reported to have significant positive impact on NCD care. Continued investment is required to sustain the benefits of this project and further improve access to high quality NCD care for refugees and other persons of concern.
- Increase participation of senior public health and clinical staff in the trainings. This may improve sustainability as senior staff are likely to: 1) remain employed by the partner organization for longer; 2) hold influence within the organization; and 3) increase participation and adoption of new knowledge and skills. Incorporation of senior partner staff in the trainings may also encourage ownership over the process and responsibility for the programme, instead of trainings being perceived as something imposed by UNHCR headquarters. Where they are already active, including Community Health Workers (CHWs) in NCD training may also improve sustainability and reach of NCD care, but this should bear in mind existing CHW workloads.
- Consider complementing local staff training with specialized trainings for higher-level regional or national staff from government or implementing partner Non-Governmental Organizations (NGOs). These individuals may be in a position to institutionalize and prioritize NCD training within their regional or national health care programmes and to facilitate continuous practical training for field-level health .
- Support increased cascade training. This can be achieved by: 1) producing standardised guidance on how cascade training is to be done; 2) agreeing on timelines, audiences for the training, resources and other support; and 3) implementing a system to monitor the roll out and coverage of cascade training.
- Improve monitoring of NCD care with a list of simple and clear indicators for NCD systems, processes and clinical outcomes. The introduction of an electronic medical record for NCD patients is recommended to improve patient follow up and to allow cohort monitoring. Introduce audits of patient files and integrate them into the Balanced Score Card.
- Create a system for continuous learning and professional development. Enable training participants to access a learning repository including online training modules and on-site support and exchange groups. Learning materials may be developed and maintained by an external agency but owned by UNHCR to ensure sustainability. They should be accessible to past, current and future cohorts of trainees.