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Evaluation of the Caring for Refugees with NCDs Project

DECEMBER 10, 2021

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UNHCR Evaluation Service

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

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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.

Table of Contents

List of abbreviations

AHA	Africa Humanitarian Action (AHA)
CHWs	Community Health Workers
HIS	Health Information System
IMC	International Medical Corps
M&E	Monitoring and Evaluation
MoH	Ministry of Health
MSF	Médecins Sans Frontières
NCDs	Non-Communicable Diseases
NGO	Non-Governmental Organization
OECD-DAC	Organisation for Economic Cooperation and Development - Development Assistance Committee
PCI	Primary Care International
PHO	Public Health Officer
ToT	Training of Trainers
UNHCR	United Nations High Commissioner for Refugees’
WHO	World Health Organization

Introduction and background

The United Nations High Commissioner for Refugees' (UNHCR) Global Strategy for Public Health (2014-2018) highlighted a commitment to "facilitate access to integrated prevention and control of NCDs"[1]. In line with this strategy, UNHCR initiated a series of operational changes aimed at improving NCD care. As part of this strategy, the agency launched a project in 2014 named 'Caring for Refugees with Non-Communicable Diseases (NCDs)'. The aim of this project was to improve NCD care received by UNHCR beneficiaries by strengthening NCD care delivery skills of UNHCR and partner staff in several refugee settings. The project consisted of two phases, 2014-2016 and 2017-2019 [2, 3] The planned completion date of the second phase was postponed due to the Covid-19 pandemic and the project was adapted to be implemented remotely in 2021.

To measure progress and achievements of the project, and to enhance learning in improving NCD care provision and integration in primary health care, UNHCR contracted an external team after a competitive recruitment process to conduct an evaluation of the project. The team consisted of Team Leader Adrianna Murphy and Evaluators Éimhín Ansbro and Enrica Leresche, all public health researchers, with experience of working in humanitarian settings and with humanitarian implementing organisations. The team included members with expertise in health services research and evaluation as well as medical and nursing backgrounds. The team members are affiliated with the London School of Hygiene and Tropical Medicine but were contracted as independent consultants. The evaluation took place from January to September 2021 and focused specifically on the Caring for Refugees with NCDs project in Cameroon, Rwanda, Tanzania, and Jordan. This report summarises the Caring for Refugees with NCDs project and presents the methods and findings of the evaluation. It also offers some recommendations to consider for improving future UNHCR capacity-building initiatives in the area of NCDs.

Background

NCDs are now the leading cause of morbidity and mortality globally [4, 5] . In humanitarian crisis settings in particular, NCDs are a growing problem [6]. This is due to global epidemiological and demographic changes, as well as to an increasing number of refugees and other persons of concern coming from countries with longer life expectancy and a higher prevalence of NCDs [6-8].
Consequently, humanitarian actors, such as UNHCR, are faced with the challenge of supporting long-term care for chronic NCDs, such as diabetes, cardiovascular disease and hypertension, and related conditions [9-11]. They are faced with this challenge in contexts where the existing health systems are, in some cases, poorly coordinated, fragmented, and under-resourced, and where humanitarian

actors do not have established NCD care programmes [12-15]. There is a gap in evidence surrounding NCD care in general in humanitarian settings [7, 11, 16], and a specific gap related to approaches that can improve the capacity of clinical staff to manage NCDs, and that are sustainable in resource-constrained health systems [4, 11]. In response to a need to improve NCD care in humanitarian settings, and in line with its 2014-2018 Global Strategy for Public Health, UNHCR initiated a series of operational changes related to NCDs (Box 1). As part of this strategy, the agency launched a project in 2014 named 'Caring for Refugees with NCDs'.

Box 1. UNHCR global initiatives to improve NCD care

1. Updating of UNHCR's Essential Medicines List to include updated NCD medication in line with clinical protocols and WHO guidance;
2. Co-leading an informal Interagency Working Group on NCDs in Humanitarian Settings, made up of UN organisations, NGOs, academics and civil society and meets twice a year sharing information and working on areas of common interest to improve NCD care in humanitarian settings;
3. Drafting an Operational Guidance document for addressing NCDs in humanitarian settings which has been field tested and is due for publication soon;
4. Improving data collection on NCDs at health facility level through the following:
    a. UNHCR's upgraded integrated Refugee Health Information System (iRHIS), which is an online, cloud-based system for providing realtime health data for strategic planning, evaluation, advocacy and research purposes;
    b. Health facility assessments using the UNHCR Balanced Score Card tool.

The "Caring for Refugees with NCDs" project

In 2013, UNHCR launched a request for proposals to develop a dedicated NCD capacity-building project, initially called '*Guidance and Training to improve the quality of care for Refugees in Non-Communicable Diseases*'. Through a competitive bidding process, they selected Primary Care International (PCI) as the project partner. The agreed overarching aim of the project was to: '*Reduce harm and death from the most significant NCDs amongst refugee populations, through the development of credible evidence-based guidelines and their effective adoption by doctors and clinical officers in community based settings'*. The first phase of the project was to take place between 2014 and 2016. The first four countries to be included, selected by UNCHR, were Jordan, Kenya, Burkina Faso, and Kurdish Iraq. However, due to security concerns, Kurdish Iraq was removed from the project and a second visit to Kenya was added in its place [17-19]. The first year of the project was used as a pilot phase, and, after this first year, the contract was extended to include Algeria and Bangladesh [20]. In 2016, UNHCR launched a further call for proposals to extend the project from 2017 to 2019 and, again, selected PCI as the partner following a competitive bidding process. This second phase included a different range of countries: Rwanda, Tanzania, Uganda, Democratic Republic of Congo, Ethiopia, Cameroon, Burundi, and Chad [2, 21]. The second phase of the project

was aimed at achieving a wider geographic coverage, providing a degree of training and systems strengthening in more countries rather than an in-depth approach in fewer countries.

Project objectives and activities

Project-related documents were reviewed for the evaluation and are briefly summarised below.

The main objectives of the '*Caring for Refugees with NCDs'* project were the following:

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;
4) To improve a systems approach to NCD management.

To achieve these objectives, the key activities agreed between PCI and UNCHR were the following:

1) Roll out of a Training of Trainers (ToT) Programme, including learning material, in clinical and system level NCD management for UNHCR and partners' public health staff (medical doctors, clinical officers) at regional and country level. The ToT Programme was to include a variety of forums, such as group workshops, individual coaching, diagnostic tools, action learning, remote learning, online resources, and case study discussions;
2) Development of adapted screening and clinical management protocols based on country protocol and discussions with Ministry of Health (MoH), if required, including the community-based management approach for follow-up of persons with NCDs;
3) Development of a system of continuous professional development for local and regional trainers which might include e-portfolios, follow-up calls with trainees, on-line forums, and access to a specific library of material, which integrate with the current UNHCR competency framework;
4) Implementation of a communication strategy to ensure that participants are cognisant of the benefits of and developments in the UNHCR NCD training programme and general NCD clinical updates. The communication strategy might include email, newsletters, podcasts, meetings, and other facilities;
5) Development of a monitoring and evaluation framework;
6) Two two-day meetings in Geneva in 2017 and one additional two-day visit in 2018.

The diseases focused on included diabetes (especially Type II); hypertension; asthma and chronic obstructive pulmonary disease; and cardiovascular disease (ischaemic heart disease, cerebrovascular disease, peripheral vascular disease and heart failure.)

Purpose and scope of the evaluation

UNHCR sought to evaluate the *'Caring for Refugees with NCDs'* project to support its efforts to improve NCD care for refugees and other vulnerable populations. The main aim of this evaluation was to assess the relevance, coherence, effectiveness, efficiency, impact, and sustainability of the project and related organisational 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; to demonstrate what worked well, why and for whom; and to document lessons learned from implementation.

Evaluation methodology

Analytical framework and key questions

The framework that guided the evaluation is based on the Organisation for Economic Cooperation and Development - Development Assistance Committee (OECD-DAC) criteria for evaluation of humanitarian action (Relevance/Appropriateness; Coherence; Efficiency; Effectiveness; Impact; Sustainability). Framework components are outlined below with key questions proposed for each component.

Table 1: OECD-DAC criteria for evaluation of humanitarian action

OECD-DAC component	Key questions
Relevance: Did the intervention do the right things?	• How appropriate and relevant was the overall design of the Training of Trainers approach and other project activities to the needs of refugee communities and partners (MoH and/or NGO) implementing NCD care across the various country contexts?
Coherence: Does the intervention fit?	• How did the project relate to the overall context, system resources, and actors already in place for NCD care in each setting?
Effectiveness: Did the intervention achieve its objectives?	• To what extent were the NCD project's intended outcomes and objectives achieved at the clinical care provider level across the countries that implemented the project?
Efficiency: How well were resources used?	• What resources were expended per country and in total in implementing the NCD project?
Impact: What difference does the intervention make?	• What effect did the project have on desired outcomes (e.g. health worker knowledge, procedures followed as trained, health outcomes)
Sustainability: Will the benefits last?	• To what extent would the project and its impacts be sustainable beyond the period of initial implementation?

Countries to be evaluated

The evaluation focused on four case study countries: Cameroon, Rwanda, Tanzania (Phase 2 of NCD project) and Jordan (Phase 1 of NCD project). Details of the *'Caring for Refugees with NCDs'* project in each of these countries are outlined in Table 2. Countries were selected to achieve variation in terms of region, language, health system, profile of the conflict setting/refugees, duration of time since the ToT Programme was implemented, and perceived success of the programme implementation. While these were the focus countries for the evaluation, where documents and evaluation interview participants raised points related to other countries involved in the NCD project, these were also considered in the evaluation findings.

Table 2: Details of the "Caring for Refugees with NCDs" project four evaluation countries

Country/Region	Date of Train the Trainers Implementation	Official language in which UNHCR operates	Refugee profile	Number of staff trained	UNHCR implementation/ operational partner participating in evaluation
Cameroon/West and Central Africa	June 2019	French	Refugees from Central African Republic and Nigeria	32	Africa Humanitarian Action (AHA)
Rwanda/East and Horn of Africa	Nov 2017	English	Refugees from Burundi, DRC	16	Alight, Save the Children
Tanzania/East and Horn of Africa	Feb 2018	English	Refugees from Burundi, DRC	22	Tanzania Red Cross, Médecins Sans Frontières (MSF)
Jordan/Middle East	2014 and 2015	English	Refugees from Syria, Iraq	20	International Medical Corps (IMC), Jordan Health Aid Society

Data collection

Data were collected using the following methods, and triangulated to inform the final analysis:

1. **Review of programme materials**

   Programme materials were provided by PCI and UNHCR. These included statements of work, ToT training documents, PCI planning tools, country reports, Monitoring and Evaluation (M&E) frameworks and related data and recommendations, and a Master's student thesis [2, 3, 17-25].

2. **Semi-structured qualitative interviews**

   Semi-structured interviews were conducted with the following groups, with all participants purposively selected based on their role, and either i) familiarity with the UNHCR NCD project planning or implementation, or ii) capacity to comment on its sustainability. Interviews were conducted in English or French.

   i. PCI staff (n=8)

   PCI Programme and project management staff, clinical directors, associates, and advisors involved in planning and implementing the NCD project.

   ii. UNHCR staff (Headquarters) (n=4)

   UNHCR Geneva staff in functions related to the PCI NCD Project: Senior Public Health Officers (PHOs) currently and previously responsible for NCD project, Health Information Systems Officer, Chief of Public Health Section.

   iii. UNHCR Country level PHOs (n=6)

   UNHCR Country Senior PHO for each country and additional PHO where there was one with knowledge of the NCD project (Cameroon and Jordan).

   iv. Implementing partner country-level staff [n=18; Tanzania (3), Rwanda (3), Cameroon (6) Jordan (6)]

   NGO staff in camp settings where NCD project was implemented; either trainees of the NCD project or staff otherwise familiar with NCD care in the camp.

Interviews guides followed the OECD-DAC criteria, exploring specifically the organisational and contextual challenges and barriers to implementing the project. Guides were semi-structured in that they offered a menu of possible questions relating to each criterion but were not intended to be prescriptive. Only questions relevant to each interviewee were asked and the interviewee was encouraged to direct the interview towards topics they felt were important. The semi-structured topic guides for clinical staff and management staff (PCI and UNHCR) are included as Appendix 1.

The evaluation team initially planned to travel to the countries involved in the evaluation to conduct clinical observations and to undertake interviews in person. This was not feasible due to Covid-19-related travel restrictions. This precluded us from performing interviews with the Persons of Concern who received NCD services before and/or after the UNHCR/PCI training took place and subsequent changes were made. Thus, the evaluation relies on subjective reports of current practice from providers and key stakeholders in each of the study countries. Every effort was made to mitigate the risk of bias by including as many stakeholder perspectives as possible and by comparing these with PCI reports written closer to the time the project was implemented.

Ethical considerations and data management

Ethical approval and oversight for the conduct of the study was received from UNHCR. Approval was also received from the London School of Hygiene and Tropical Medicine Ethics Committee to conduct stakeholder interviews with UNHCR and PCI staff, with a view to publishing a selection of findings in a peer reviewed journal. Informed verbal consent was sought from all study participants and written consent was sought for those interviews that may be included in a publication. Findings have been presented in aggregate across countries rather than at the level of individual country or individual camp setting. No identifying information (e.g. job roles or specific setting information) are shared in the report.

Secondary data were analysed thematically along the OECD-DAC criteria for evaluation of humanitarian action, and a table presenting the detailed data extraction is available in Appendix 2. The secondary analysis of existing documentation was used to develop qualitative interview tools and was triangulated with findings of the primary data collection.

All study-related qualitative data and audio-recordings were stored on the project SharePoint site held on a secure server and accessible only to the research team. No personal information, such as addresses of participants or names, were collected in the qualitative data phase. There was no need for data transfer. MS Teams was used, where possible, as it was the most secure teleconference option available and was approved by UNHCR. An alternative (Zoom) was used where the participant expressed a preference for this. In the case of Zoom, passwords were used for participants to join each call. Audio recordings were destroyed on finalisation of transcription, where relevant, and on finalisation of this report.

Key findings

Findings from each country included in this evaluation are shown in Table 3. The overall findings of the evaluation are then discussed in detail according to the OECD-DAC criteria (Relevance, Coherence, Effectiveness, Efficiency, Impact and Sustainability).

Table 3: Summary of main evaluation findings by country

Cameroon	• Timing and practical nature of training, especially the space allowed for discussion, were valued and relevant; • Inclusion of MoH staff in trainings facilitated uptake of the guidelines as implementing partner was working within and supporting MoH facilities; • Practice changed dramatically after the training: patient registers introduced, first-line medication ordered, patient follow-up and lifestyle counselling organised; • Challenges were experienced in securing medicines indicated by PCI guidelines, especially as facilities supported by UNHCR represent only a small proportion of MoH facilities and thus did not have influence over system changes; • In remote places it was challenging for trainees to participate in WhatsApp groups or online discussions for follow-up support after training, and this resulted in de-motivation and a sense of isolation; • Staff turnover and over-dependence on trained individuals (both partner and MoH trainees) affected the sustainability of the programme, and participants advocated for a more systemic approach to capacity strengthening.
Rwanda	• Project addressed a major need as previously there was no comprehensive NCD Programme, no protocols, registry or monitoring. Training in patient support and empowerment in particular filled a gap; • Practical approach promoted by PCI training was valued, particularly hands-on practical sessions (e.g. how to use a salbutamol inhaler themselves); • Project was perceived as highly effective in terms of improving clinical knowledge, reduced late-stage acute complications, and raising awareness of NCDs in the community due to community screening. Registration of patients allowed for better prediction of medication supply needs; • Effect is difficult to evidence, due to limitations of monitoring data; • Some PCI guideline and training content did not align with realities of camp setting and what was available in terms of equipment; • Lack of clarity in how impact of training was monitored and desire for improved monitoring to support motivation; • Resources and support for cascade training were insufficient; refresher trainings and regular support would be welcome; • Anticipated challenges with maintaining quality of care and meeting expectations created by introducing NCD project; • Perceived need for better alignment of UNHCR-supported care with MoH care, to support integration of refugees into national system; • Would benefit from a joint review of state of NCD care now, how it has developed and where challenges remain, especially in the face of Covid adaptations, to inform next steps in NCD resourcing and programming.
Tanzania	• Prior to training there was a major unmet need in terms of NCD detection and management and thus the project filled an important gap;

	• Some effort was made to contextualise training through baseline assessments sent to PHO, but overall content and delivery of training was perceived as determined by UNHCR headquarters and PCI; • PCI training and guidelines offered a more practical, simplified approach to NCD treatment compared to medical school training; • Availability of medicines was an initial challenge, as project led to unforeseen increased demand (unforeseen as had no registry in place for forecasting before the PCI project) • Engaging Community Health Workers (CHWs) first in cascade training made use of the fact that they were already active in the community (for screening, follow up) and this was viewed as improving patient experience; • Attention to NCDs helped advocate for prioritisation nationally (NCDs now included in country action plan); • Continued effectiveness will depend on consistency of resources; better monitoring data to show impact would support efforts to advocate for funds; • Staff turnover was a challenge to sustainability but how to institutionalise the approach to NCD management was unclear; • Need expressed to encourage ownership of and responsibility for the programme by country operations and implementing partners, including management as well as clinicians vs. something imposed by headquarters.
Jordan	• Project addressed a major need as NCD care in Zaatari camp was non-standardised, fragmented and lacking in chronic care systems and tools prior to PCI training. • Training resulted in significant reorganisation of care: implementing recall systems, patient files, creating specific clinic days and an NCD focal person. It inspired greater involvement of the multidisciplinary team, with training of and task sharing to nurses and health educators. • Key advantage was the subsequent standardisation and continuity of NCD care provided within the camp, the improved communication between implementing organisations and improved outcomes and trust for patients. • Content was perceived as coming from PCI but the selection of target NCD conditions was considered relevant and in keeping with local epidemiology. • Coherence was an issue as the PCI approach differed from NCD care available from the well-developed, private system in Jordan. • Interviewees expressed need for regular follow-up support and supervision, including access to a technical referent, repeat of face-to-face training and expansion of conditions covered to include e.g. patients with renal impairment. • Sustainability was supported by implementing partner dedicating significant time and budget over three months to developing NCD service, employing specialist staff, and embedding the PCI approach. This helped to mitigate staff turnover as systems were in place to train new staff. • Anticipated challenges included a potential cut in budget and need for guidelines to be updated.

Relevance

How appropriate and relevant was the overall design of the project activities to the needs of refugee communities and partners implementing NCD care across the various country contexts?

The NCD project was initiated by UNHCR in response to a growing burden of NCDs in refugee camps and a gap in clinical training of camp staff. The countries where the NCD project took place were selected by UNCHR headquarters, based on need and the size of refugee populations, but also on practical considerations, such as country-level support for the project and security considerations. The content, related materials, and approaches used in the NCD training, including which diseases to focus on, were developed by PCI, based on previous experience and on input from UNHCR headquarters as to disease priorities.

The following main themes emerged in relation to relevance:

Timely response to gap in NCD management

Although the need for NCD training was perceived to have been identified by headquarters, it was recognised as relevant and timely and as filling an important gap in clinical knowledge. In Jordan, in particular, the prominence of NCDs among Syrian refugees required an urgent improvement in the NCD response. Some implementing partners referred to the training as a "wake-up call" that highlighted the need for better-organised NCD care and they wished they could have had the training earlier. Prior to the NCD project, none of the implementing partner organisations included in this evaluation provided a comprehensive and accessible NCD care component at primary level. The lack of tools and systems required for chronic care delivery, including accessible treatment protocols, disease registries and patient files for monitoring of NCD patients, meant that NCD diagnosis and care was delivered in an ad hoc, unstructured and non-standardised way, with gaps in continuity of care. For example, in Tanzania, only 1% of UNHCR beneficiaries were being treated for diabetes whereas the estimated prevalence of diabetes was approximately 4%. The project was also viewed as particularly timely in Cameroon, as it coincided with a review of UNHCR budgets and thus informed budget allocation to NCDs based on treatments that were more cost-effective. Trainees themselves recognised that the care they were providing before was "not perfect" and that the new knowledge gained allowed them to initiate different classes of medications and to "use the medication better".

Relevant disease focus

Overall, country-level staff would have preferred to have had some input into choosing the conditions and diseases included in trainings. However, the conditions and diseases included in the PCI training

- diabetes, hypertension, cardiovascular disease and chronic obstructive pulmonary disease and asthma - were perceived to be largely 'the right ones' and corresponded to the most common NCDs seen in the populations treated by the implementing partners. Hypertension and diabetes were perceived as particularly important given they were commonly undiagnosed until patients presented with acute complications and had to be referred (e.g. diabetic ketoacidosis, requiring hospitalization). Some implementing partners highlighted a need for focused training on mental health as a common co-morbidity of NCDs, or at least an increased focus on psychosocial support for NCD patients. The training in patient support and empowerment that was provided was viewed as very valuable and previously absent and as something that could be prioritised in future trainings. Others felt that the focus was narrow and suggested the inclusion of other conditions such as epilepsy, hypothyroidism, cancer and palliative care in future training sessions, depending on the local epidemiology.

Practical training content and materials

Implementing partners appreciated the **practical nature of the PCI trainings and the tools that were provided to carry out treatment guidelines**. The practical approach to treating NCDs introduced by PCI was perceived as more appropriate for resource-limited camp settings compared to theoretical training offered in medical school or "complicated" international guidelines. Many participants reported that the project provided them with easy-to-use tools for supporting NCD programmes and for training nurses and other staff, such as concise 1 to 2 page, step-wise guidance on how to diagnose, assess severity, initiate, monitor and adjust treatment, that focused on "a few important things". Hands-on trainings, for example, how to use a salbutamol inhaler or conduct a diabetic foot check, were highly valued, as were practical sessions on how to interact with patients (e.g. consultation technique). As one clinical practitioner described:

"We *were given tools to be able to do the diagnosis, like hypertension, asthma, chronic obstructive pulmonary disease and diabetes, in very practical terms. I realised what tools are needed to follow-up on these patients. Even if there are no registers, each participant was taking the responsibility to ensure a patient follow-up and implementing this was really new for my centre and it is the first time that it was done.*"

Of particular benefit was the focus not only on treatment but on the **facility-level organisation and management of an NCD Programme**, including tools and guidance for maintaining patient files, a patient register, and appointment system. This was particularly true for those NGOs that did not have any chronic disease care programmes in place prior to the training (e.g. Red Cross in Tanzania) as opposed to those that did (e.g. MSF in Tanzania). PCI increasingly recognised the value of training

on operational considerations for delivering NCD care as the project developed, and, as a result, this aspect was more prominent in the Phase 2 trainings than in Phase 1.

Feedback suggested that trainings would be even more relevant to partners' needs if they covered additional NCDs, such as epilepsy, NCD complications or more complex patients with comorbidities, such as kidney failure, and if they included more practice sessions. Trainees also wished they had access to materials to support community-based activities (e.g. easy to understand infographics) and a smaller pocket version of guidelines for use in the clinic. Finally, they highlighted the need for supportive supervision (e.g. every 2-3 months), ideally in person, and for access to a "technical referent" who could advise on patients whose complexity was above the technical capacity of the trainees. A challenge for PCI, in this respect, was that the budget allocated to follow-up was very limited, so they did not dedicate personnel to this component. (The issue of follow-up support is addressed in more detail under "Sustainability", below.)

Selecting trainees from different clinic roles and disciplines

Those delivering the training suggested that the correct selection of trainees was particularly important. The selection criteria varied from country to country. They felt the **selection was ad hoc, favoured clinic managers over medical staff in some instances, and at times did not take sustainability into consideration,** for example, by selecting clinicians who were due to imminently leave their projects. They suggested that if further iterations of the project took place, that selection criteria could be specified and could take a more multidisciplinary approach, to include nurses and pharmacists in particular.

Coherence

How did the project relate to the overall context, system resources, and actors already in place for NCD care in each setting?

Fit with existing health system

The guidelines introduced by the PCI training were aligned with WHO guidelines and the UNHCR Essential Medicines List was updated in 2019 to take into account the evidence-based treatment recommendations in the PCI guidelines. The need to align PCI guidelines to national guidelines, where possible, was recognised by PCI early in the project and, in most cases, there was alignment, as many national guidelines are modelled after WHO guidelines. Where PCI and national guidelines did not align, discrepancies were discussed during the trainings and in some cases PCI made minor changes to adapt the PCI guidelines to local requirements through discussion with local stakeholders,

including pharmacists. One example was in Cameroon where discussions took place to ensure that clinicians would have a sufficient stock of long-acting and rapid-acting insulin as well as appropriate laboratory tests to be provided through the national health system (and supported by AHA). In some settings with a high prevalence of hypertension, screening guidelines were adapted to include a higher age cut-off to prevent systems becoming overwhelmed.

Despite attempts to adapt and contextualise guidelines, in practice, **where PCI guidelines and national practice did not completely align, this created some difficulties for country-level staff in implementing the guidelines**. For example, where medicines introduced by the PCI guidelines (e.g. salbutamol inhalers) did not match those on the national Essential Medicines List (e.g. oral salbutamol), or those commonly used locally, such as theophylline for asthma, ordering sufficient supply of the PCI-recommended medications was challenging, particularly for programmes that work through the national medicine supply chain. This was compounded by the fact that the introduction of more comprehensive NCD screening and treatment led to a sudden and unforeseen increase in demand for medications in a system where budgets and procurement were often based on previous numbers of patients (defined on a yearly basis). Another key reason for delays in drug supply seemed to be that the UNHCR Essential Medicine List was being adapted to align with the content of the training in tandem with the trainings being delivered, so there was no time to allow for the supply chain to be adapted and to ensure the relevant supplies were available in time for trainings. For example, in Tanzania, there was an 8-month lag time for the supply chain to catch up after the trainings took place. There was a perception among non-UNHCR stakeholders that the speed with which medicines could be procured depended on the determination of the UNHCR PHO; however, UNHCR medicine procurement can regularly take over 6 months as it is done as part of an agency annual order, placed internationally. Delays in medicine supplies and the need to adapt were described by all stakeholders:

"*Medication supplies are such a cumbersome process. There was at least a years' delay between a UNHCR local operation putting in its supply request, then getting to the region, the capital, Geneva, getting ordered, or it wasn't all ordered because there is not enough budget, and only months later the medicine arrived. So, you know… we were not indicating anything special, and we did not introduce very fancy things, but if the supply did not change for 18 months, which is often the case, then these changes would not happen in time*".

"*The guidelines that we studied at the training were conventional. In the field we always adapt because there might be a rupture, such as for furosemide, we administer it for hypertension with comorbidities. If do not have nicardipine, I really adapt, because we are often in stock-out, so we adapt and we do with what we have*".

The important role played by suboptimal pharmacy management was also raised in relation to medication stock outs, in particular poor monitoring of consumption and inventories, and failure to place orders on time. Together these highlight the importance of strong pharmacy management both at field level and along the whole supply chain, in order to avoid stockouts.

Misalignment between medicines recommended by the guidelines at the UNHCR-supported primary care level and what was being prescribed locally at external primary care facilities or at secondary care level also created a challenge, resulting in practitioners having to "re-educate" patients that returned to their clinic after receiving care elsewhere, so that they would again accept the medications prescribed at the clinic.

Fit with system: the case of Jordan

Jordan was a particularly complex case with respect to coherence due to the prominence of a well-established private health care system. Implementing partners emphasised that the training had indeed brought about coherence in a previously fragmented and unstandardised system within the camp. The training had improved communication between the different health facilities, and consistency and continuity of treatment for patients within the camp setting, which in turn engendered greater trust from the patients. However, while the UNHCR/PCI guidance largely aligned with NCD care offered in the Jordanian public health system, it differed greatly from the private sector. Unlike other case study country settings, Jordan has a prominent private sector, that UNHCR contracts to provide limited secondary and tertiary level care for its beneficiaries. When patients were referred to private hospitals, doctors adapted their existing medications to second- or third- line, expensive treatments. Camp-based doctors then had difficulty in convincing patients to return to first-line treatments. In order to address this, a referral focal point was introduced to communicate with private providers in order to better align prescribing.

PCI recognised the importance of addressing coherence between their training and the local health system early on but were limited by the scope of the project's terms of reference and by their limited capacity to influence systemic issues, such as supplies of medicines and other equipment and alignment with local NCD care delivery. It was suggested in interviews that it may have been a missed opportunity that national health care structures were not involved to a greater extent and that there was not greater engagement with the national health service.

How (and whether) the PCI guidelines and updates could be shared with a broader range of stakeholders beyond NCD champions and could be understood by actors at other levels of the system outside the camps (e.g. district hospitals) appears to be an unresolved issue. However, there is an

example of a small-scale initiative in Cameroon, where one UNHCR PHO, together with a small sample of trained staff, set up a newsletter that was then shared nationally. Another example, mentioned earlier, occurred in Tanzania where MSF was provided with PCI's training materials and they proceeded to take the lead on training HCWs in other camps following PCI's training model, dedicating MSF personnel and budget resources to this.

Fit with camp context

Baseline assessment surveys for each project setting were conducted before the training began. Projects were contacted in advance and asked about availability of medicines and equipment. As above, while overall, the training was viewed as relevant to the needs of camp settings, and in some cases to have entirely changed the way NCD care was delivered in the camp, some aspects were perceived as **poorly matched with the practical realities of camp resources in some settings.** As one example, from Alight in Rwanda, electrocardiograms and x-rays (for e.g. to identify heart failure or help diagnose chronic respiratory disease) were not available in the camp so patients had to be referred to the district hospital. Some lab reagents were also unavailable at the PHC level in the camp, and some dietary recommendations were perceived as unrealistic. In other settings, there were reports of missing basic supplies, such as sphygmomanometers or peak flow meters. The reported ease of accessing all supplies indicated by the PCI guidelines differed across NGOs and related to the size and budgets of the NGO (for e.g. MSF in Tanzania appeared to have better access than some smaller NGOs) and remoteness of the facility. The following quotation demonstrates how some aspects of the training content were not coherent with camp realities.

"*For diabetic patients, there was also the question of educating patients about their diet. But here the people do not grow things, and incomes are low, so we try as well as we can to help them to be able to do that….For chronic obstructive pulmonary disease we would need a radiography so we could not put that part into practice in my area. Patients who would present signs of respiratory insufficiencies were difficult to diagnose so we would refer them, also for tuberculosis, we need to refer them, because we are not able to do a good diagnosis. Otherwise, we were given tools to take care of most of NCDs patients*".

Effectiveness

To what extent were the NCD project's intended outcomes and objectives achieved at the clinical care provider level across the countries that implemented the project?

There is an **overall perception that, beyond any challenges experienced, the project was effective in achieving its objectives** (i.e. improving NCD awareness, clinical knowledge and clinical

practice among trained staff and a systems approach to NCD management)**.** This is particularly so as many programmes were starting with a complete absence of any organised NCD care delivery. Key themes related to effectiveness were the following:

Improved approach to NCD care

The NCD project significantly changed the way NCD care was provided in all the country projects included in this evaluation. Interview participants emphasised that care was delivered in a more structured way with the introduction of registers, patient files, appointment and recall systems. Clinics were better organised, guidelines were visible on the wall, specific disease-based clinics or chronic care clinics were segregated from other primary care services, an NCD focal person was introduced and the approach was more team-based with the initiation of training of nurses, health educators, and CHWs in some settings. Patient health education was also introduced. Workload, while initially increasing during the embedding period, was decreased in some settings as more patients were achieving clinical control and review of stable patients was task-shared to nurses and reduced in frequency. Clinicians seemed very happy and "comfortable" with the changes. As one clinician expressed:

"If the objectives were to improve the care for the NCD patients, I think that the project reached its objectives. What changed is that we give more importance to these patients, we communicate better with them, we also understand and explain that they need to take medication all their lives, we get interested in their lives, their person".

Need for improved monitoring of effectiveness

After the first round of training, PCI designed a monitoring and evaluation framework that included indicators for measuring achievement of each of the four project objectives. This was based on a simplified version of a HIV supervision and monitoring tool and included, for example, the number of patients diagnosed according to specific criteria (for clinical practice objective), whether a registry of all NCD patients was maintained (for systems approach objective) and the number of nurses trained. An action plan and training log for cascading of training was also introduced. Input from implementing partners was sought at baseline, mid-point and end-point, but the duration of time between these varied across countries. **In many cases, monitoring data were incomplete and it is unclear what, if any, thresholds were agreed as an indication of project "effectiveness".** Issues relating to difficulty using the data upload platform developed by PCI, lack of guidance on this platform and unreliable internet access all likely affected whether countries shared monitoring data. There was also a view among implementing partners that this monitoring effort was external to their organisation and to UNHCR, and this may have made collecting data feel like additional work, for a project of which

they had no ownership. From the PCI perspective, monitoring was perceived to be an important component that was poorly done because data collected by UNHCR did not track the number of new or follow up patients, medication availability or clinical outcomes. The limited M&E system introduced by PCI captured some indicators in relation to NCD care, but it was not integrated within the broader UNHCR health information systems.

Inconsistency of cascade training

The ultimate goal of the "Training of Trainers" was for those trained (the "NCD champions") to in turn train other practitioners in the camp on the NCD guidelines. In practice, this "cascade training" had variable success, even within countries. For example in Nduta, Tanzania, 177 clinicians were trained, apparently by only 3 trainers), whereas in Nyarugusu, also in Tanzania, only 21 clinicians were trained by 9 of 14 eligible trainers. In Phase 1, the structure of the training was intentionally kept open by PCI to allow for a case-by-case adaptation, but the **lack of clarity around the expectations and support for cascade training and variation in ownership of the project by UNHCR PHOs and/or implementing partners** appeared to be a key factor affecting its success. Subsequently, in Phase 2 the requirements for cascade trainings were specified and defined as being 8 hours of training, adapted to the context, supported by a trainer's toolkit. Monitoring of cascade training was also included in PCI's monitoring and evaluation framework, but only 2 of the 4 countries included in this evaluation (Rwanda and Tanzania) provided that information. As a result, **the exact extent to which cascade training was completed and effective in all the project countries in unknown.** As mentioned above, issues with accessing and using the data upload platform may have impeded data entry.

More broadly, however, there was a perceived lack of standardised guidance on how cascade training was to be done, with limited agreement as to timelines, audience for the training, resources or other support. Implementing partners did not appear to have a common understanding of the expectations regarding cascade training and PCI staff felt expectations were poorly communicated to the implementing partners. Some implementing partners (e.g. MSF in Tanzania, IMC in Jordan and AHA in Cameroon) dedicated budget and/or time to embed the new knowledge into practice, putting regular training sessions and systems in place to orient new staff. MSF had also cascaded the material to other organisations using PCI's materials. Staff in each of these settings felt that the content had become "regular practice" and they were comfortable with it. In settings where time and resources allocated to cascade training were limited or absent, several trainings seemed to occur in an ad hoc manner. In some cases, partners suggested that more resources were needed to support cascade training, for example, refresher trainings and practical resources, such as funding to book rooms and print materials and dedicated time.

The one-week training did not seem to include enough content or teach specific skills in how to train others. Management staff from both PCI and UNHCR agreed that the expectation that people can be trained technically on NCDs for one week and then go on to train others is likely unreasonable, even "risky". But where cascade training was more effective, this seemed to depend in part to the degree of leadership and investment in the project on the part of the UNHCR PHO and the implementing partner management team. PCI staff felt that additional resources, time and structured supervision would be needed for cascading of the training to take place and therefore the effectiveness of this element was very variable. Specific successes included MSF in Tanzania and IMC in Jordan, which both dedicated time and resources to embedding the new knowledge into practice and cascading the training to medics and other clinical cadres. As PCI, and in some cases UNHCR, did not have any say in who specifically was sent for NCD training in the first place, it was difficult to assess trainees' capacity for cascade training in advance and to select only those with high capacity.

Efficiency

What resources were expended in implementing the NCD project and how well were these used?

This evaluation did not focus on the efficiency of financial resources allocated to this project, and overall it was felt by all stakeholders that significant work and impact was achieved with the budgets allocated for the project. We focused rather on the human resources and time that were devoted to the project's implementation. Our findings focus on the following themes:

Selection of trainees

Overall, stakeholders were satisfied with the selection of clinical staff to participate in the PCI NCD training. Most, but not all stakeholders felt that the "right" people were selected and that they represented a broad range of clinicians, and those with whom we spoke that were selected reported feeling "lucky". As mentioned above 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 terms of how clearly stakeholders understood how people were selected.

In Cameroon, staff selected for the training included MoH staff, and this was perceived as improving efficiency of dissemination and implementation of the PCI NCD guidelines, given that the main implementing partner worked within and supported MoH facilities. In all countries included in this evaluation, there were some cases where clinical staff sent to trainings by implementing partners were near the end of their contracts and were due to change posts shortly, and this was considered an inefficient use of the training place. It was not known whether that trainee would be able to

implement or cascade the skills acquired during the training in their new position. Another issue raised was the perceived legitimacy of the staff who were trained and resistance among other staff to be trained by trainers.
Related to the above was the issue of staff turnover, but this is discussed in more detail in the "Sustainability" section below.

Time and resources allocated for training

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 over the duration of the project. There was a general feeling among trainers that more preparation of trainees could be done in advance of the face-to-face training sessions to make more efficient use of the limited face-to-face training time. The level of baseline knowledge was very low and often varied among trainees, so trainers spent time teaching basic knowledge and had less time to do case-based teaching/practical sessions, resulting in a more didactic approach than had been intended. It is not clear how to most efficiently cover material in advance of face-to-face training, as much of the training content identified as important to stakeholders in this evaluation (practical sessions, consultation techniques, training skills, camp visits) is best covered in person. It is also unclear whether adding more days to the training would effectively address the issue of lack of sufficient time or whether the training model needs to be replaced or complemented by something more continuous and long-term. In PCI's new online training content, they have included a "leaner review" and "community of practice", where feedback is solicited as to whether the content and teaching approaches are working and what can be done differently. The strategic decision to focus on more countries in Phase 2 rather than developing the project in fewer settings in greater depth also had an impact on the level of follow-on support available to each country.

Some implementing partners also felt that the funds for printing training (and cascade training) materials were insufficient.

Inefficiency of remote support

The PCI training team coming from the United Kingdom was very welcome and the high quality of the training content and delivery were appreciated by all country-level UNHCR and implementing partner staff. In particular, the different and potentially more objective perspective that foreign trainers could offer was recognised and valued. PCI also sought to identify local champions early in the process in order to mentor these champions to support cascade training and instigating change within their own setting and service after PCI's departure. But the constraints involved in long-term, remote support

led interviewees to question the efficiency of such support being delivered by distant experts online and, in the longer term, identified a need to develop local expertise for ongoing, accessible support. PCI allocated personnel to providing distance mentoring and in person refresher trainings, where budget allowed, and this was done more systematically in Phase 2. However, PCI faced several constraints in providing longer term support, including a lack of time, a large number of countries to cover, a limited budget as well as local connectedness and timing issues. WhatsApp groups were created for implementing partners to seek advice from each other. These were self-directed and engagement waned after approximately 6 months, an issue that was exacerbated by the high turnover of trainees. Several interviewees expressed having developed important trainee-trainer relationships with the PCI team despite the short physical presence of PCI, but they also expressed some frustration with not being able to discuss daily practical issues encountered in the field more directly and regularly.

Impact

What longer term difference has the project made for NCD care in refugee camps supported by UNHCR?

This evaluation was not designed to quantify long-term impact of the project on health outcomes, and the limitations of UNHCR monitoring date precluded any measurement of long-term impact. (See more on monitoring data limitations below). Nevertheless, from a qualitative point of view, implementing partners and country PHOs expressed that the project had a significant impact on improving NCD care and outcomes in the camps. It was felt that the approach to NCD management introduced by the PCI training helped to strengthen earlier case detection and diagnosis, reduce late-stage acute complications, improve prediction of supply need, raise awareness of NCDs in community due to community screening, build autonomy of primary health care staff, and encourage increased patient trust in and engagement with services.

<u>Limitations of monitoring data</u>

The extent of impact of the training on the above outcomes difficult to confirm given the limitations of UNHCR monitoring data. The project's independent M&E data collection did not include indicators beyond those related to the project's immediate objectives, and, as mentioned above, those M&E data were incomplete and not integrated in the UNHCR Health Information System (HIS). The UNHCR Balanced Score Card system monitors service availability and readiness, including staffing, medicines and equipment, infrastructure, communication, patient exit interviews and observation of clinical consultations. It is not designed for measurement of morbidity or mortality. The UNHCR HIS relies on data being shared with UNHCR by implementing partners. Current indicators present aggregate data on number of consultations, diagnosis by NCD category and cause

of death, if known. While changes to the HIS are being considered (the use of linked electronic medical records for longitudinal follow-up of patients and integration with host country data systems), the data are currently of too poor quality to monitor NCD morbidity and mortality using UNHCR HIS data due to limited functionality of the system, including syncing issues and software bugs. Most clinics have some form of patient record system, but this rarely includes follow-up data for all patients. PCI recognised the need for more comprehensive patient records for monitoring and preformatted records were shared with the trainees. However, it is difficult to know how well these templates fit with the recording formats already used in the clinics.

Difficulty to measure the outcomes through a theory of change

In Phase 2, a Theory of Change was proposed by PCI, based on four pillars: the provision of evidence-based protocols, the training of trainers, engaging leadership in system level reviews and coaching and continuous development activities. However, the outcomes proposed in the Theory of Change (efficient clinical management, early diagnosis, community awareness, streamlined procurement, increased adherence to treatment and patient follow-up, and strong system leadership) were difficult to measure or were not included systematically in the existing routine monitoring process. It has therefore been challenging to assess the impact of the NCD project. While the immediate objectives were clear (improving clinician awareness, knowledge, practice and a systems approach), **longer-term desired outcomes such as improvements in treatment adherence or reduction of acute complications were difficult to measure,** because the outcomes identified in the Theory of Change, the PCI project monitoring tool and the existing UNHCR and partner field monitoring systems were not systematically aligned.

Sustainability

To what extent would the project and its impacts be sustainable beyond the period of initial implementation?

The sustainability of the NCD project and any gains it achieved was the most commonly raised, complex and difficult to address issue in this evaluation. There were several factors identified that cast doubt about the sustainability of the training model in its current form and would need to be addressed in any subsequent iterations of this project or other NCD training initiatives.

High staff turnover

As mentioned under “Efficiency” above, **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. Training selected clinical staff created a dependence on those staff to disseminate and sustain the knowledge gained, but many of these staff were not permanent, and in some cases had moved on shortly after the training or were not able to address more systemic issues. Of those implementing partner staff that were interviewed for this evaluation from Jordan, only one had participated in the NCD project training. In Tanzania, priority was given to cascade training of CHWs, who were already active in and known to the community, and who are more likely to be from the community and more permanently based there.

Challenge of maintaining quality of care

Another issue related to sustainability is the **challenge of maintaining improved quality of care in the long-term and meeting expectations created by introducing an NCD project**. As a more comprehensive programme was rolled out, more patients were enrolled, and it is unclear whether demand could continue to be met without compromising quality of care. Evaluation participants noted the need for regular training support and refresher training, but also for a system of monitoring quality of care. Currently, neither the PCI M&E framework nor either of the UNHCR data collection tools (Balanced Score Cards or HIS) are designed to monitor quality of care. Country-level UNHCR staff also perceived the capacity to ensure quality of care as linked to the consistency of resources for NCD care provided by UNHCR and highlighted the importance of being able to show impact to advocate for resources.

Sustainability of remote support

As mentioned under “Efficiency” above, the sustainability of remote training support was questioned. WhatsApp groups were found to be very useful but for a limited life span. **Network connectedness and self-motivation both seemed to be common barriers to accessing remote support**, and some approaches attempted (follow-up calls, Facebook groups) were unsuccessful. As mentioned, an additional reason offered for this was the lack of budget allocated to the follow-up support or supervision. There were requests from trainees for more frequent refresher trainings, in particular for those countries where trainings occurred long ago. More recently, NCD trainings undertaken under the auspices of the UNHCR/PCI partnership have taken place via a new blended learning hub, the ‘PCI Academy’. This initiative includes facilitators who are working closer to field contexts to include a greater diversity of experience. The community of practice within PCI Academy includes previous champions (from Lebanon or Uganda) and expands the possible reach of peer-to-peer support. PCI has also offered previous trainees remote refresher training and online NCD management training in French and English via the PCI Academy.

Conclusions

The UNHCR-PCI Caring for Refugees with NCDs capacity building project was relevant, timely and improved provider confidence and patient experience of NCD care. The NCD conditions chosen, training modalities and guidelines were relevant, and efforts were made to align them with existing guidance and practice, where possible [24]. The project was perceived as efficient, and examples of essential and concrete changes to programme organisation and clinical practice were offered. However, to improve efficiency, future iterations of the programme could strengthen the effectiveness and sustainability of training by carefully selecting trainees, better supporting the implementation of cascade training, and better mitigating the challenges of high staff turnover [8, 11]. The true impact of the programme proved difficult to capture because of limitations to existing monitoring tools but improvements to these systems are underway [4, 5, 26]. Finally, providing a more robust and long-term system of mentoring of trained personnel would be important to address in future initiatives [13, 27]. All participants interviewed in this evaluation expressed gratitude for the learning experience and were confident that they were providing improved care for refugees affected by NCDs.

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.

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Annexes

Annex 1: Overview of the evaluation methodology

Evaluation theme (OECD-DAC criterion)	Evaluation question	Key issues considered under each theme	Data sources
Relevance	Did the project do the "right" things?	The appropriateness and relevance of the overall design of the Training of Trainers approach and other project activities to the needs of refugee communities and partners (MoH and/or NGO) implementing NCD care across the various country contexts. To be considered for this theme are the disease burden and existing NCD health services in each context, and the input of country partners into the project planning.	• Semi-structured interviews with PCI, UNHCR and NGO staff. • Secondary data analysis including documents from 2014-2019.
Coherence	Does the intervention fit the local NCD health service context?	The relationship of the project to the overall context, system resources, and actors already in place for NCD care in each setting. This will focus on fit with existing NCD services and resources.	• Semi-structured interviews with PCI, UNHCR and NGO staff. • Secondary data analysis
Effectiveness	Did the project achieve its objectives?	The success of the NCD project in achieving its intended outcomes and objectives at the clinical care provider level across the countries that implemented the project. This will focus largely on operational changes such as health worker knowledge and procedures followed as trained.	• Semi-structured interviews with PCI, UNHCR and NGO staff. • ToRs for PCI NCD project • PCI country M&E reports • Secondary data analysis
Efficiency	How well were project resources allocated and used?	The resources – human and financial- that were expended per country and in total in implementing the NCD project and how these compare to outcomes achieved. This will focus less on details of the financial budget for this project and more on whether stakeholders considered it good value for money, sufficient and sustainable.	• Semi-structured interviews with PCI, UNHCR and NGO staff. • ToRs for PCI NCD project • Secondary data analysis
Impact	What difference does the project make for those practicing and receiving NCD care?	The effect the project has had (or is expected to have) on desired outcomes, for e.g., health outcomes and patient experience. As there are no quantitative data currently available to estimate these outcomes, this will focus on perceptions of outcomes among all included stakeholders.	• Semi-structured interviews with PCI, UNHCR and NGO staff • Secondary data analysis
Sustainability	Will the project and its benefits last?	The extent to which the project and its impacts can be and will be sustained beyond the period of initial implementation, either within the NGO programmes or in the broader local health system. This will consider financial and logistical sustainability as well as issues of ownership and investment in the project by implementing partners.	• Semi-structured interviews with PCI, UNHCR and NGO staff • Secondary data analysis

Annex 2: Secondary data analysis for triangulation

Date	Report	Country	Relevance	Coherence	Effectiveness	Efficiency	Impact	Sustainability
2019	PCI, Lucinda Hiam, review of report recommendations	Overall Phase 2	• *Focus* on clinical care, drugs/equipment/training, while screening appears as being an issue. • *Training participants*: horizontal approach. What about people who decide & manage PHCs (top) or people affected (bottom)?	• *Guideline content*: The equipment/EML/PCI guidelines do not fit always the national practice (local purchases, drug replacements) • *Guideline availability:* PCI guidelines seem not to be available very easily, possible disconnect between these guidelines and field guidance, to check. • *Trade-off while increasing patients:* The capacity to deal with many patients if screening is increased might be an issue if equipment/medication are missing, to check.	• *Screening* is an issue: capacity to identify patients early seems challenging. • *Guideline availability*: The fact that protocols were not distributed broadly might be an issue to modify quality of care • *The quality of care* is difficult to measure through the monitoring system and scores.	• *MedLog:* The supply of medication/equipment seems problematic: intermediaries? Bureaucracy - lack of understanding of the supply chain in each setting • *M&E:* The difficulties in monitoring might be undermining the capacity to measure efficiency of the program: re-usable patient cards for instance as for MCH	• *Model:* Champions were trained, shared good practice and have access to resources and websites	• Essential list of medication: The alignment of EML and specific equipment with MoH guidelines is difficult. Why? • Guideline content: How much guidelines are used and can be used in each country is difficult to understand.
2014	PCI report to the mission to Kenya 31 August to 20 September 2014	Kenya	° 3 GP make a 21-day visit.	° Guidelines adapted along WHO and UNHCR essential medicine list ° Session about diabetes and Ramadan was added to the program.	° 2 x 5 day workshop for doctors, nurses and clinical officers for (19 people and 14 people) and 2x 3 days parallel workshop were run for community health workers ° 2x 3 days workshops for 2x 20 community health workers (5 from each camp). ° 3 days TOT for 8 clinical officers and nurses from the initial group ° At the onset, NCDs represent 3% of the total consultations, no guideline seems to be in place; none do community screening, no central registry for NCD patients in place; no protocols; regular supplies of NCDs drugs. ° EB guidance was provided ; whole system approach to NCDs, practice of skills. ° 10g monofilament and Peak flows not available, lack of access to some important lab tests	° Pre-post test is performed: 61,4 to 71,4 scores in %; lack of awareness in cardiovascular diseases; difficulties in setting up FUP systems with the patients as there are no records. ° Doctors, nurses and clinical officers: Change of patient lifestyle was debated; Formulation of action plans ° CHW: information about lifestyle, early identification, importance of the follow-up, practical skills, education sessions is practiced.	° Proposed changes by people trained: better screening, improved documentation; 3 months prescriptions; further training of staff; improve the translation of interpreters!	° Visit to the county level MoH and visit of the referral hospital, no guidelines in place. ° Recommendations: gather information through the HIS and collect data on NCDs specifically; start registers; order specific equipment; train translators in the camp; train CHWs in the camp; train clinician in clinical audit, develop a package of ongoing training; use mass media.

2019	**REPORT** PCI, Mid-term report Sept 2019 To be read with Annex 1 M&E Annex 2: partners Annex 3: review of PCI recommendations Annex 4: milestone progress	**COUNTRY** Ethiopia Uganda, Tanzania, Rwanda Cameroon Chad DRC, Burundi	**RELEVANCE** • M&E : Has been adapted several times, scores are collected by local clinician. Difficult to understand whether follow-up calls used to verify the quality of the data provided in the M&E allow to cross-check what happens in terms of quality of care. • Feedback: challenges include essential lab supplies, medication, organisation days, records, community screening: Is this captured enough in the score? • Learning platform is the website; Interagency meetings: only PCI actors were involved, no local actors; Difficulty to follow-up by distance. • Focus: Increased screening is recommended by PCI while the ability to ensure adequate stocks is difficult. • Trainings: Longer trainings were asked by local staff; Participants selected by UNHCR/Partners; Selection of a package of 4 NCDs is questioned. • Health system issues are difficult to measure (stockouts) and are not addressed by the intervention.	**COHERENCE** • Content of the Guidelines: Diabetes, Hypertensions (including hypertension in pregnancy, severe hypertension), asthma, COPD & smoking cessation, cardiovascular diseases. ° Guideline content: new training sessions compared to Phase 1. Clinical updates shared with PCI website directly to champions exclusively but do not seem to involve other staff (PHC, partners, MoH). • Patient record: Pro-format patient record shared with DRC - difficult to understand whether these formats are coherent with the system; records and follow-up system are recommended by PCI, no notion of how this might be done and addressed. • MedLog: Access to basic equipment and essential investigation is challenging - integration with other tools? National/UNHCR • Availability of guidelines: Need to distribute clinical guidelines to all staff; • Communication strategy involving UNHCR staff; newsletters; learning platform. • PCI partner: flexibility and ability to adapt	**EFFECTIVENESS** • Objectives: improve quality of care and strengthen the clinical and community-based management of NCDs for Refugees • Aim: reduce NCD related mortality and morbidity. • Outcome 1: Improved awareness: 17 different gov repress. contacted. 228 staff trained. Presence of action plans. Staff turnover issues seem to have been addressed in Rwanda. • Outcome 2: improved knowledge: Increased scores in people trained; WhatsApp support group in Tanzania. Proportion trainers who did a cascade report: 852 participants receiving cascade trainings. • Outcome 3: improved clinical practice. Quality of care: based on diagnosis made using correct criteria; increased scores in Rwanda. Uganda impossible to confirm. Ethiopia difficult to follow up. Prescribing habits difficult to FUP. • Outcome 4: Improved system approach: Medication stock-out did not improve in any setting. Uganda: improved registers.	**EFFECIENCY** Summary of activities: • Resource allocation: Provide guidelines: Materials/protocol: 7 core clinical guidelines. Adapted training sessions. French/English. Few participants accessed the online updates. WhatsApp more successful. Sessions run on service management/records, prescribing habits. FUP refresher: meeting with UNHCR/partners. Pre-post training quiz to measure clinical knowledge improvements. Longer term improvements more difficult to ensure. • Develop an M&E framework: Scores: adapted; baseline-6 months-12 m; scores looking at clinical practice and system approach. Number of new patients. Master comparison of scores, reliability and validity of the data are issues mentioned. • Model: CPD system developed: reliable internet is an issue; self-learning updates are low. WhatsApp: interesting think tank. Distance mentoring. Refresher trainings for early countries recommended by PCI. • Guidelines content: NCD package rolled out: 4 key diseases/desired medicine/prescribing habits. 8 workshops and 3 FUP sessions were organized.	**IMPACT** • *Management:* Challenges mentioned by the national staff & from PCI differ form the key objectives: access to essential lab/equipment; supplies, dedicated clinics; records; community screening - these all relate to systemic issues; System issues remain: HR/Supplies/patient FUP • *Action plans:* The implementation is not described • *Focus on Increased knowledge*: longer follow-up is not taking place. Increased knowledge seems be related to increased quality of care directly. Increased knowledge of other staff after cascade trainings is not measured. Training appreciated; impact on practice is difficult to measure. • M&E: Monitoring is not sent on time, not complete, difficult to triangulate, made by distance and exclusive (PCI-Champions) • *Quality of care*: not measured in patients. • *Access to care:* No cross-analysis with UNHCR monitoring data (number of new cases, number of referrals) over the same period of time.	**SUSTAINABILITY** • HR turnover is an issue in all countries. Systemic issues seem to be worrisome for PHC and difficult to approach. Continuous development is difficult when staff change all the time. • M&E: FUP of the project seems to be done in parallel to the UNHCR HMIS system and seems to introduce new data to collect and combine in scores. ° Discussion in GVA: cascade training would be sessions that amounted to 8 hours of training.

2019	**REPORT** King's College dissertation Elizabeth Kinsky	**COUNTRY** Overall	**RELEVANCE** • *Model*: framework relates to TOT specifically, then there is the assumption that it will be transformed in a different functioning within a context. Individual, organizational and supra-organizational dimensions are included. • *Capability approach*: freedom to achieve wellbeing, change understood as the capability, without considering systemic constraints. • *Selection of participants*: recruitment day: clinical skills, international experience, teaching skills - issues around power are not included.	**COHERENCE** • *PCI partner:* Training provided by PCI staff outside the camp • *Model*: Cascade training is expected to account for the knowledge of the other clinic staff, without perhaps considering who might have the authority to train whom in such settings. • *Model:* ToT trainings adapted to local needs, 1-5 days visit, UNHCR and local stakeholders and work on the alignment with national plans.	**EFFECTIVENESS** • 4-5 days training focusing on NCDs management • Stock-out problems, lab equipment problems, follow-up problems. • Pre-post training tests show increased knowledge following the initial training. • How Scores are calculated is less clear: 40 records chosen randomly, looking at clinical care and management. • Tanzania, Rwanda, Uganda: started 1-2 NCDs days. • Records: Rwanda 4/7 camps MoPH NCDs records; Tanzania not standardized; Uganda teams use lists of patients. • Screening: Rwanda 6/7; not in Uganda; Patient FUP is an issue.	**EFFECIENCY** • *M&E* tools/guidelines shared with Master trainer: how they align with MoH or UNHCR HMIS is unclear. • *Model*: Dependency on Master trainers to collect/analyze/critique scores. • High staff turnover in the camps, participants would need to be selected systematically, but selection criteria are missing. • *M&E:* 40 random patient records looking at clinical practice and improved system approach: not related to the number of patients seen in consultation. • *Staff turnover*: Rwanda: 11/16 Masters; Tanzania 50% delivered a training; Uganda all master trainers remained after the training. • *Implementation plan* formulated together with UNHCR staff - what about partners and MoH actors and other actors in the system?	**IMPACT** • *Model*: Master trainers were trained and have improved their knowledge and skills to train colleagues, training material is provided. • *M&E:* The relationship between the ToT and the patient health outcomes is difficult to establish	**SUSTAINABLITY** • *M&E* tool does not capture long term outcomes; FUP calls are taking place after the training. • *Guidelines content:* Guidelines not always aligned with national guidelines • M&E: Different scoring system used over time • *Staff turnover* can hinder the sustainability of the project • *MedLog:* Medication stock-out is an issue for quality of care and for sustainability.
2019	**REPORT** Annex 1 M&E scores Master comparisons	**COUNTRY** Phase 2	**RELEVANCE** • *M&E:* Scores relate to records that are auto analysed by the Master trainer • *M&E:* Follow-up: Results are shared with PCI but not sure whether there is a discussion at the level of the field.	**COHERENCE** • *M&E:* No apparent relationship with UNHCR HMIS system • *M&E:* Difficult from this monitoring sheet to understand what the intervention really brought in terms of access to quality care.	**EFFECTIVENESS** • *M&E:* Difficult to understand the relationship between the improved scores, or not, and the number of people trained and/or the stock-out of drugs/equipment.	**EFFICIENCY** *M&E*: The lack of completion of the monitoring tool might be related to HR turnover, lack of motivation, other type of difficulties. Efficiency is very difficult to measure with scores that merge different components.	**IMPACT** *M&E:* The impact of the intervention is difficult to measure with this tool.	**SUSTAINABILITY** *M&E*: Whether the PCI tool is supporting or completing the development of the UNHCR HMIS or MoH data collection is difficult to assess.

2019	**REPORT** Annexes 2-4 Collation of records recommendations (Cameroon, DRC, Ethiopia, Rwanda, Tanzania, Uganda, Burundi)	**COUNTRY** Phase 2	**RELEVANCE** • *M&E*: Cascade training monitoring: trainers are expected to write a report on the training: pre-post tests or attendance sheets are not mentioned to be required. • *Focus on awareness:* screening proposed at triage (and not necessarily in communities first) - Ethiopia • *Focus on Awareness*: Proposition to have a small-scale survey done in Gambella - the capacity to follow-up on the results (more patients) is not critiqued in this proposal. • *MedLog:* Biochemistry testing is a priority for different countries including the issue with referral of patients to hospitals able to do the testing (Ethiopia) • *Language:* Task shifting and insufficient command of English for some staff (Ethiopia): proposition to have trainings of English for some staff before the PCI trainings. The possibility to shift to local languages is not mentioned.	**COHERENCE** • *Essential list of medication*: Replacement of drugs: issues of feasibility and acceptability for prescribers and patients are not mentioned; UNHCR drug lists not always coherent with national lists - changes need to be aligned with UNHCR EML list (Ethiopia) • *Health system*: necessity to link the plans with the system in place; Include hospital staff in trainings (DRC) - secondary care prescriptions are not aligned. • *MedLog*: Providing some equipment outside UNHCR list is a recommendation (Ethiopia) • Integration of the documentation with MoH practice (Ethiopia & Rwanda) • *Guideline content*: Clinical management guidelines of advanced diseases, referrals and ethical dilemmas are issues - Ethiopia - or alignment with hospital care - Burundi.	**EFFECTIVENESS** ° Supplies are an issue: relationship with the pharmacist and people in charge of logistics is not clear in different settings. Clinical supplies remain an issue for simple things such as sphygmomanometer, blood glucose, or peak flows (Ethiopia-Rwanda-Uganda-Burundi and have an effect on the overall effectiveness • *Patient record*: UNHCR is liaising with the MoH in DRC to use a national file if existing. Patient FUP system could be based on TB/HIV examples (day books). • *Systemic issues:* Integrate staff turnover and the knowledge of guidelines: provide guidelines for all clinical staff is recognized. • *Patient record*/recall of patients is an issue in different settings and has not been discussed initially. • *Management:* Clear managerial support is recommended for Champions in Rwanda, but the relationship between the champions and their roles in the PHC clinic and health system overall is not clear.	**EFFECIENCY** • *Resource allocation:* The resources seem to be used for initial trainings only, but without any resources to support the cascade trainings, which then need to be supported by local partners (See DRC). • *Focus on clinical knowledge*: Localized initial training focused on clinical knowledge without considering the system (community workers, other staff, pharmacist) with issues around this re-surfacing: need for MedLog, managerial skills, broader involvement. • *Health system*: Issues around referrals from the community (health posts) - Ethiopia - or to hospitals - Burundi. • *Resources allocation*: There does not seem to be resources in the budget to discuss/implement/follow-up on the ground camp action plans - relating to triage/registers/staff awareness/training: issues related to the PHC system (example: no triage in Burundi). • *Resources allocation*: Ethiopia/Uganda recommendations include budget for cascade trainings. • *M&E:* Issues with the understanding/completion of the monitoring tool (Ethiopia, Rwanda) and apparent disconnect with the key issues reported on (MedLog).	**IMPACT** • Presence of motivated staff and sense of there being a sort of momentum • Action plans are drafted and being discussed • *Health system:* Discussions seem to take place with partners and at the level of the system as issues emerge.	**SUSTAINABILITY** • *MedLog:* Biochemistry testing: training, maintenance, FUP is challenging (Ethiopia); reliance on UNHCR system vs. MoH system • *Patient record*: Question of the Inclusion of the patient record in the usual system.

2019	**REPORT** PCI recommendations for contract extension February 2019	**COUNTRY** Phase 2	**RELEVANCE** *Focus on increased knowledge:* Priorities: strategic engagement, increased trainings. Systemic issues are mentioned (patient pathways, medical supplies, lab equipment) but there is no proposition to address these concretely.	***COHERENCE*** • Model: System strengthening, and management would be the next priorities, difficulty in proposing something that would allow to increase the efficiency of the program • Guideline content: Alignment of guidelines/NCD packages is identified as being an issue, not addressed in the next steps proposed.	**EFFECTIVENESS** •1780 healthcare workers trained (direct/cascade) • Increased awareness has been shown • Model: Cascade trainings difficult to follow-up and effect difficult to show. • Quality of care: How the quality of care changed is difficult to measure	**EFFECIENCY** Next priorities: • *Communication*: Strategic engagement/regional workshops • *MedLog*: Equipment and medical supplies management: better scope, e-learning, tailoring: broader health system is not mentioned. • *Screening*: the integration in the overall work of the PHC is not mentioned. • *Strengthening the health system*: MedLog issues are mentioned, but no training or involvement of managers of the system mentioned. Issues with records are mentioned. • *Resource allocation*: No mention of budget for cascade trainings/dedicated MedLog or focal person to be trained	**IMPACT** *Focus on increased knowledge:* Knowledge of the staff Awareness of the clinic staff	**SUSTAINABILITY** *Model:* Issues around coherent packages, MedLog, HR turnover have not been explored in what is proposed for the next Phase.
2015	**REPORT** Formatted report PCI Jordan	**COUNTRY** Jordan	**RELEVANCE** 3 English GPs field visit; 5 days orientation and 5 days ToT in Jordan: total 13 days of visit. ToT: problem solving approach based on clinical scenario. ToT: participants with weaker English skills did not benefit as much from the training. Nurses training: Arabic simultaneous translation. Coordination of the different skills: might be an issue in Jordan.	**COHERENCE** Access to the JHAS Irbid: registered refugees only. Not clear who decides whether refugees are deemed vulnerable. IFRC Azraq: challenging coordination with IMC. 2014 PCI field guidelines approved by MoH and available in English and in Arabic. The provision of supplies for all partners is variable (MSF, vs MdM local procurement). Doctors' and nurses' roles are approached, but how far these fits into the Jordanian model is not explored further.	**EFFECTIVENESS** Project objectives: reduce harm and death from NCDs through the development of credible guidelines and their adoption. JHAS clinic Irbid: Screening of complications: does not appear to take place systematically; patients treated by internists and not GPs. JHAS clinic Zaa'tari: patients seen by internist, receive 3 months medication. Health education introduced. MSF clinic: patients seen by a GP; stable patients receive 3 months medication; patient follow-up by SMS IMC clinics: screening by a nurse, consultation by GP, medication for 1 month; education by the nutritionist. No systematic screening of complications. MdM clinic: GPs refill prescriptions; use of PCI protocol unclear CHWs: work in the camp, how, what they do is not clear. IRC Mafraq: GP sees patient, no guidelines, essential medication is introduced, given for 1 month, health education by GP, mobile clinics.	**EFFECIENCY** IMC clinic: patients need to come every day for the insulin: no fridge. In 2015, 16 GPs attended the training, only 3 from 2014. Small minority of nurses attended the course in 2014.ToT: there seems not to be any pre-post tests to measure the learning outcomes of the participants. Participants from a variety of organizations and skills and change over time: is this the best approach, from outside or should the MoH be involved differently? Recommendations made by PCI: junior doctors are employed; case-finding and screening of patients should be improved; screening for complications is crucial and should be improved, including possibly together with WHO; develop a set of indicators to follow up on the quality of care; better use of CHWs; group of trained staff should be created.	**IMPACT** ° JHAS clinic Irbid: medical records are computerized and can be accessed by any JHAS facility in the country. Data analysis is performed centrally; 3months drugs provision for stable patients. ° JHAS clinic Zaa'tari: systematic record, 3 months medication, but no systematic screening for complications, consultations by an internist ° MSF clinic: paper basd records; monthly reports centralized by MSF online. ° MdM: computer-based list of patients, paper based clinical records. Nurses limited role was defeated: how did that happen? Did it result in a change in the clinics? ° Overall changes: better awareness, protocols used more often; 3 months treatment, better records, better follow-up of patients.	**SUSTAINABILITY** °Meeting with MoH at the beginning, MOH expresses the need to work on communication skills. ° JHAS Zaa'tari: high staff turnover from the pool of doctors trained (all 6 trained are gone). Training: only 3 GPs trained from 2014 TOT. Majority of nurses trained in 2014 were not present in 2015. About half of Nurses/doctors work for the MOH. ° Meeting with JHAS president for partnerships with UNHCR and WHO EMR to discuss monitoring software. ° Overall challenges: internists see GPS, nurses are not used as they could, free access is an issue.

2014	**REPORT** PCI Report to the mission to Jordan from 7 to 29 June 2014	**COUNTRY** Jordan	**RELEVANCE** ° 3 GPs for 22-day visit ° Draft guidelines based on WHO; UNHCR and aligned with Jordanian guidelines ° Arabic translation was needed; for the doctors training was needed for written dialogues and teaching material. ° GPs feel devaluated, undervalued ° Nurses worried that the systems will not allow them to implement changes	**COHERENCE** ° Parallel workshops are run for doctors 6 days/nurses 3 days ° Meetings with clinic staff, GPs and internists to understand how the system works ° Discussion with senior managerial staff of JHAS: recommendations: enhance role of GPs, ensure a 3-month drug supply for stable patients; develop a clinical software; improve the coordination between the pharmacy/lab	**EFFECTIVENESS** ° Focus on patient registration, clinical evaluations by nurses and GPs and protocols. ° From clinics visits and from JHAS discussions: All patients are seen by an internist, GP unable to prescribe medicine. ° GP training: Screening, long term management was discussed; skills practice; inappropriate use of insulin; ° Nurses training: practical skills and part of the guidelines were discussed. Application of the knowledge was difficult.	**EFFECIENCY** ° Patients are asked to see the doctor once per months: patient frustration and additional work for the doctors. ° Theoretical knowledge of doctors is good, difficulty to apply it. Knowledge gaps in COPD/asthma ° GPs feel impotent: need approval of an internist to propose a change. GPs should prescribe & follow patients. ° PCI recommendations: focus more on equipment; develop referral criteria; full NCDs package training; partners should develop a clinical software.	**IMPACT** ° No patient individual file. Patient health booklet bar coded. ° Saudi clinic: patients are given medication for one month, but it is not sufficient. Stok-outs are frequent. ° Lack of clinical software for the records of the patients ° Pre-post test for doctors (Results?) ° Training test nurses: pre-51.5% and post 67%.	**SUSTAINABILITY** ° Meeting with Dr. Tarawaneh from the MoH: discussion of a training package that can be used by a nucleus of trained clinicians, to be used potentially nationwide. Has to be in line with the new guideline for family practitioners ° Visit to a camp commercial supermarket in Z'aatari with a lot of refined sugar, to be considered in the trainings. ° Difficulty to change the lifestyles of patients was debated (and defeated!) . What about in the Field?
2017	**REPORT** PCI final report 2017	**COUNTRY** Phase 1, year 2, contract extension, second part of the project, focus on report on Jordan Bangladesh and Algeria.	**RELEVANCE** ° Language barriers mentioned in some settings ° Training needs: inclusion of other staff including CHWs is requested by some UNHCR PHOs, as CHWs are important for patient follow-up, in Burkina Faso and Bangladesh. ° Framework for M&E should be developed to capture better what is happening	**COHERENCE** ° Nurses and doctors were trained in Algeria and Bangladesh. ° MoH developed guidelines, not always up to date and not easy to use, lack of awareness of the staff in relation to these guidelines. ° Discrepancies with MoH guidelines were explained during the workshop, based on evidence and discussed in the trainings. ° Only minor changes were necessary for the local adaptation and implementation of the guidelines.	**EFFECTIVENESS** ° Objectives: improving the quality of care for people living with non-communicable diseases. From UNHCR quote: The supplier will provide screening and clinical management tools. ° First phase: Specific objectives: adaptation of general protocols and guidelines to 4 countries; completion of 4 weeks trainings to roll them out; generalized clinical guidelines for 4 main NCDs; presentation of the lessons learnt. ° Second phase: objectives were adapted to develop a clinical toolkit. ° Pre-post test clinical scores increased to a 70%-80% regardless of the baseline and increasing confidence in clinical practice. ° PCI produced seven field guides. ° Systematic patient databases are hard to find. UNHCR HIS remained unsatisfactory.	**EFFECIENCY** ° ToT in Jordan: important staff turnover. ° List of essential medicine: difficult to convince clinicians and staff in some settings such as Bangladesh and Algeria. ° Standard equipment should be provided in all countries. ° E-learning is a good option in theory, in practice connectivity issues was not easy to manage ° UNHCR HIS system is not efficient to capture data on prevalence of NCDs	**IMPACT** ° The impact of TOT has proven hard to track. ° TOT in Kenya and Jordan ° Burkina Faso, Bangladesh, Algeria: ToT not done. The local partners did not request them. ° Main changes mentioned: some partners have dedicated NCDs clinics, prescription habits changed, 3 months prescriptions done for selected stable patients; Specific equipment is more broadly available, databases and records were set up including patient follow-up, health education is more integrated in the consultations; ° Need for more integration and better-defined formal roles, to be proactive. Lessons could be learnt from TB and HIV. ° More use should be done from CHV ° Longer impact is weakened by the high turnover of clinical staff, especially doctors.	**SUSTAINABILITY** ° E-updates on guidelines were tested, with Facebook ° Partnership meeting in GVA in 2016, MSF staff training and training of WHO doctors in norther Syria ° Among clinical staff, clinical skills were weaker than theoretical knowledge ° Some ToT participants adapted clinical guidelines for their CHWs for some key diseases ° Strategy is developed based on the recognition that training clinicians will have a little impact on care, and the strategy includes community care. ° Staff turnover is an important issue. PCI worked with UNHCR officers to identify and nurture cohorts of champions ° A whole system approach would allow that progress last, including material, lab tests, clinical records and audits. ° Recommendations: improve systems, long term approach to learning ° Develop strong clinical teams that will resist high staff turnover

2015	**REPORT** Guidance and training to improve the quality and care of refugees in NCDs. End of year 1 report.	**COUNTRY** Phase 1, part 1, Jordan and Kenya.	**RELEVANCE** ° Recommendation by PCI: clear clinical guidelines need to be established.	**COHERENCE** ° First week: visit to MoH officials and clinicians ° Kenya: camp settings, UNHCR partners ° Jordan: Non-camp settings, NCD task force including MoH	**EFFECTIVENESS** ° Main objective: to reduce harm and death from the most significant Non-Communicable diseases amongst refugee populations, through the development of credible evidence-based guidelines, and their effective adoption by doctors and clinical officers in community-based settings. ° Kenya: training of doctors, clinical officers and nurses ° Jordan: training of doctors, nurses and health educators ° Skills and motivation increased, practical problem solving, and clinical examination skills were improved. ° Routine screening was weak; peak flows not used ° More data should be fed in the HIS.	**EFFECIENCY** ° Teamwork would need to be improved: task shifting with nurses and allowing more time for consultations ° Community health workers are the vital link to the community and their roles could be extended. ° Most clinics had records, but not a record of all patients to call or re-call patients and organize a follow-up ° No systematic screening of high-risk patients who come at a later stage, implying high referral costs ° PCI recommendation: systems need to be established to allow stable patients to receive medication for 3 months. ° PCI recommendation: referral criteria need to be established and not the workload of the clinician alone. ° PCI recommendation: Budget re-allocation to early screening and follow-up instead of costly referrals.	**IMPACT** ° The quality of patient care is not seen as essential to the work performed. ° Discussions took place on teamwork ° Lack of registers: little audit activity is undertaken	**SUSTAINABILITY** ° High staff turnover is mentioned ° Recommendations made by PCI: train trainers who have an authority to train others and include training modalities in the staff's contract. Trainings should include administrators and managers.
2019	**REPORT** Improving the Quality of Care and Strengthening Clinical and Community-based Management of NCDs in Refugee Operations	**COUNTRY** Cameroon 1 to 15 June 2019	**RELEVANCE** ° High number of refugees from CAR and Nigeria ° Budget issues so staff must prioritize ° Clinical records are poor	**COHERENCE** ° MoH staff are involved in the trainings ° National medical supply system is centralized and depends on the MoH ° Initial visits to MoH, regional fund for medical supplies, UNHCR & partners	**EFFECTIVENESS** ° 32 participants (13 doctors) mostly working in hospitals. ° Training delivered in French ° Time spent on registers and quality of care ° Clinical examination of the foot and storage of insulin were really useful ° Training cascade plans were made	**EFFECIENCY** ° Pharmacist from the 'fond regional' was also present in the training ° training tailored to working realities and based on what people were used to work with ° Feedback from participants described in the report: clear and practical training	**IMPACT** ° Doctors seem to have an important increase in post-test knowledge, more important than the one for nurses. ° FB from the participants: guidelines are useful and practical clinical guidance as well	**SUSTAINABILITY** ° FB from participants: longer trainings, more printouts. ° Collection of baseline data is planned ° Start WhatsApp groups ° FUP on training cascade plans ° Adjustments on drugs used with the pharmacist of the regional fund ° FUP on patient registers

Annex 3: Terms of reference

Terms of reference for the consultant
Evaluation of UNHCR Project 'Caring for Refugees with NCDs'
Team Leader

General Background of Project or Assignment:
UNHCR's aim is to reduce morbidity and mortality from the most significant NCDs through improving
the quality of care, ensuring the rational use of medicines, and strengthening the clinical and community-based management of NCDs amongst refugees.

UNHCR launched a call for proposals from suitably qualified organisations in 2014 to implement an NCD project. Primary Care International (PCI) was selected as the partner to roll out capacity building
activities. The key activities carried out from 2014 to 2019 are as follows:

1. Roll out of a ToT program (including learning material) in clinical and system level NCD management for UNHCR and partners' public health staff (medical doctors, clinical officers) at regional and country level.
2. Development of adapted screening and clinical management protocols based on country protocol and discussions with Ministry of Health (MoH) if required including the community-based management approach for follow up of persons with NCDs.
3. Development of a system of continuous professional development for local and regional trainers.
4. Implementation of a communication strategy to ensure that participants are cognisant of the benefits of and developments in the UNHCR NCD training program and general NCD clinical updates.
5. Development of a monitoring and evaluation framework.

The project was implemented in the following countries:
Jordan, Algeria, Bangladesh, Burkina Faso, Kenya, Rwanda, Ethiopia, Tanzania, Uganda, Burundi, Chad and DRC

Overall purpose and Scope of Assignment:
The key evaluation questions to be addressed in the evaluation are listed below.
The evaluation will be conducted by a team of three persons, the Team Lead and two Team members.

Role of the Team Leader:

- Overall design and implementation of the evaluation.
- Develop the workplan, timelines and methodology of the evaluation to be agreed with
- UNHCR.
- Ensure thorough project document review and relevant literature review.
- Lead the design of interview tools, their validation and quality control of data collected both quantitative and qualitative.
- Monitor the work of team members, timeliness, deliverables and quality control.
- Lead the coordination, planning and collection and collation of data from field operations.
- Lead the analysis of data and presentation/ tabulation of data and triangulation of data.
- Ensure that the key evaluation questions and sub questions are addressed.
- Liaise with UNHCR Public Health Section and Evaluation Service providing regular progress updates (weekly).
- Lead the drafting of findings and reports (inception, prefinal and final).

Phase 1 (Inception): 20 days. Desk review of all relevant project documents and design of the evaluation methodology. The deliverable of this phase will be the evaluation inception report that should present the approach, methodology, detailed planning data collection tools to be used.

Phase 2 (Fieldwork and data collection): 55 days. Detailed assessment and data collection from at least 4 other countries where the project was implemented through methods such as surveys and key informant interviews with UNHCR and partner staff. This will involve holding briefing meetings with country UNHCR PHOs at capital and field level and visits to primary health care centres where clinical NCD services are being provided if travel becomes possible in context of COVID 19 pandemic. During this phase there will be a weekly contact with the evaluation supervisor to monitor progress.

Phase 3: (Report preparation): 13 days. The draft report will be shared with UNHCR for review and comments and inputs on the draft reports should be incorporated into the final report within 5 days after receipt by consultant. The deliverables will include the draft final report and final report.

Key evaluation questions (KEQ) and Sub questions (SUQ):
KEQ 1: How appropriate and relevant was the overall design of project activities to the needs of refugee communities and partners implementing NCD care?
KEQ 2: To what extent were the NCD project's intended outcomes and objectives achieved, and to what extent did these outcomes contribute to the goal of improving NCD care?
SUQ 2.1. What were the major factors influencing the achievement or non-achievement of the objectives?
SUQ 2.2. What were the specific changes in caregivers' NCD knowledge and care practices and how did these changes contribute to improved NCD care?
SUQ 2.3. To what extent did the project improve the diagnosis and care provided to patients with NCDs?
KEQ 3: How could the organisational set-up of the project, the tools and systems used in the delivery of the project be improved in future?
KEQ 4: What were the major factors which influenced the achievement or non-achievement of sustainability of the project including to what extent were the lessons learnt and tools developed from the project countries disseminated to non-project countries or applied to other UNHCR tools?
SUQ 4.1. To what extent were longer term considerations taken into account in project design and implementation?
SUQ 4.2. To what extent did the project contribute to improving capacity of Ministries of Health and partners?
SUQ 4.3. Did the project contribute to increased inclusion of refugees in national programmes and coordination?

Methodology to be followed:
Refer to and make use of relevant internationally agreed evaluation criteria such as those proposed by OECD-DAC and adapted by ALNAP for use in humanitarian evaluations1.
Reflect an Age, Gender and Diversity (AGD) perspective in all primary data collection activities carried out as part of the evaluation – particularly with refugees.
Employ a mixed-method approach of desk-review, interviews and in country case studies (2). This should incorporate qualitative and quantitative data collection and analysis tools, including caregiver and provider surveys, and the analysis of monitoring data as available, by measuring the following outcomes:

- Improved awareness of NCDs amongst public health staff and clinicians
- Improved knowledge of clinicians on evidence based NCD management

[1] See for example: Cosgrave and Buchanan-Smith (2017) Guide de l'Evaluation de l'Action Humanitaire (London: ALNAP) and Beck, T. (2006) Evaluating Humanitarian Action using the OECD-DAC Criteria (London:
ALNAP)

- Improved clinical practice for care of NCDs
- Improved NCD services (system approach): organisation of services, supplies, follow up of patients and monitoring

The evaluator is responsible to gather, analyse and triangulate data (e.g. across types, sources and analysis modality) to demonstrate impartiality of the analysis, minimise bias, and ensure the credibility of evaluation findings and conclusions.

Qualitative data will be collected, inter alia, through stakeholder interviews face-to-face and by remote methods (e.g. Skype).

Quantitative data will be collected from the following sources:

- Health information system (HIS): data will be used to monitor service coverage and impact;
- Facility registers and other routine data sources will be used to assess needs and monitor program quality.
- Facility checklist will be used to monitor facility capacity for service provision.
- Patient clinical records.
- Observation of clinical NCD consultations with patient consent.
- Surveys.

Measurable outputs and delivery dates:

1. Inception report, 20 work days after commencement
2. Draft Final Evaluation Report, 75 work days after commencement
3. Final Evaluation Report and Presentation, 88 work days after commencement