

**CARE International
West Bank and Gaza**

**West Bank: Health assistance to people living in communities whose
rights are inadequately protected in the West Bank – WBG936 -
ECHO/PSE/BUD/2012/91014**

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Disclaimer•

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Executive summary

Under funding from the European Commission Humanitarian Office (ECHO), CARE International and its national partners have designed and implemented a project in most marginalized communities in the West Bank. Identification of target communities, scope of work and monitoring of progress was in line with the health and protection cluster reflected in its strategy to complement health and protection work. While the obvious gap in access to basic healthcare services was the leading one to fill, emergence of protection aspects, especially isolation, annexation, demolition of housing and livelihood structures formed an area, where protection and advocacy are needed in a structured manner.

The current project has formed the practical application to the mentioned strategy and by ensuring access to care, the purpose was also to identify, manage and report protection-related incidents at the individual and community level and use data for advocacy. The right to health, protection and livelihood were the leading principles behind the project with emphasis on most marginalized communities and community groups such as women, children, chronically ill and people with disability.

Evaluation of the project was designed not only to inform about the extent to which this project has achieved its healthcare and protection objectives, it was developed to also inform about future strategies to adopt especially in terms of connectedness, impact and potential sustainability and exit strategy adoption.

A comprehensive methodology was developed with utilization of quantitative and qualitative research approach to examine evaluation domains. Within the quantitative component, the research has elaborated on client-perceived quality of care, knowledge about certain diseases and perceived role of the project in addressing protection issues. The qualitative component has been utilized to review context based on field observations, interview with key stakeholders (institutional and community) and desk review of project reports.

Findings of the project have been supportive to many of the domains and in favor to design, implementation and impact. The project in its current design is highly relevant to the context of humanitarian situation in the West Bank. It has been successful in defining target communities, develop specific healthcare and protection interventions and achieve targets stated in the project proposal. Served communities have identified the project as vital in ensuring access to health care. On the other hand, future interventions need to take into consideration the changing environment and dynamic of vulnerability and be open to flexibly respond to emerging needs in new communities or cease interventions in communities with less need.

The project in its design and mode of operation has provided a proper calculation of need and hence package of service to be offered in given communities. Connection with the formal system of care, namely the ministry of Health is a clear area for improvement

from both CARE International and Ministry of Health side. On one hand, the project needs to fit into a larger mosaic of care, whereby implementing NGOs complement MOH services and link to its policies and referral frame. On the other hand, MOH needs to exert effort in training, orientation of project staff with its policies protocols and modes of referral to ensure better connectedness and complementarity. Agreement on locations, package of services, referral, monitoring requirements and financial tariff needs to be agreed on and implemented in accordance with national policies.

More advocacy work at the level of Ministry of health is needed, as target communities needs to benefit from the national health insurance scheme under the public health law. This would entail redefinition of entitlement, accessibility and financing of care provided in these locations. And while the capacity of Ministry of Health might be challenged by the inclusion of new beneficiaries due to financial and human resources deficit, future interventions in this project need to make the proper support and assistance to MOH fulfilling its healthcare provision obligations

Findings on quality of care from client perspective varied remarkably among communities based on expectations, providers and location. While reliability and package of services have been perceived positively by all stakeholders, mainly clients, both clients and policy makers have reported issues related to client-provider interaction. This is an area of concern as future projects need to specifically address quality issues and make sure client rights and satisfaction are fully respected.

Sustainability and exit strategy are extremely important domains that need to be addressed in future interventions. This however cannot exist in an environment with low level of predictability and where frequent shift to emergency is hindering any developmental attempts. Cooperation with national healthcare institutions, local community authorities and national civil society organizations would form an opportunity for sustaining most of the health care provision and protection functions. Dialogue on this aspect needs to start immediately and form a leading principle for future projects in these communities.

Improvement of Protection environment has been a new function introduced to the work of mobile health team approach. While this has been clear in the philosophy of the project and has been an innovative approach to serve the needs of communities beyond healthcare, it is not clear to which extent has this function been transferred to district and local level practitioners. Project documents have shown achievement of targets in this perspective however, more work is needed to mainstream the protection mandate within the mobile team. Reports and data produced within this domain need to be translated in structured advocacy program at the level of CARE International and beyond.

Table of abbreviations

| | |
|----------|---|
| ECHO: | European Office Humanitarian Office |
| HWCS: | Health Work Committees |
| PMRS: | Palestinian Medical Relief Society |
| MOH: | Palestinian Ministry of Health |
| UNRWA: | United Nations Relief and Work Agency for Palestinian |
| Refugees | |
| NGOs: | Non Governmental Organizations |

West Bank: Health assistance to people living in communities whose rights are inadequately protected in the West Bank – WBG936 - ECHO/PSE/BUD/2012/91014

I. Introduction:

The overall situation prevailing in the occupied Palestinian territory is characterized as a protracted protection crisis resulting from the lack of respect to international human rights and humanitarian laws and due to the very denial of the basic human rights of the Palestinian people in the West Bank and Gaza strip.

To date, Palestinian residents of the West Bank are still subject to a multi-restrictive regime comprised of physical obstacles such as checkpoint and road blocks, the Separation Wall as well as the Israeli settlements, which deprive their freedom of movement, a basic human right that constitutes a pre-requisite to other basic human rights including the right to education, work, and healthcare. The most vulnerable are those communities who reside in Area C of the West Bank, in the vicinity of Israeli settlements, and in enclaves between the Separation Wall and Green Line (e.g Barta'a, An Nabi Samuel). This system “.has continued to contribute to the fragmentation of the West Bank, impacting the daily lives of Palestinians

Israeli settlements and the impunity surrounding settlers activities remain a concerning phenomenon. Many reports have highlight the difficulties in the form of physical violence and other harassment by Israeli settlers faced by Palestinian residents, in particular those who live in the vicinity of Israeli settlement and the Jordan Valley's area, on a daily basis. The Israeli human rights organization Yesh Din, which is monitoring the Israeli authorities' enforcement of the rule of law on Israeli settlers, has found that over 90 percent of complaints regarding settler violence filed with and closed without indictment.¹

“Improvement of protection environment” was recognized as a key goal of the overall humanitarian response in oPt², and therefore a greater integration of protection dimensions into the humanitarian actions was encouraged through active protection programming in all sector responses. Better targeted and coordinated advocacy initiatives for the respect of international humanitarian and human rights law (CAP 46) has been encouraged and promoted. The 2012/2013 Consolidated Appeal Process for oPt outlined

¹¹.Displacement and Insecurity in Area C of the West Bank, UN OCHA, August 2011.

² Consolidated Appeal Process for oPt (LINK)

two strategic objectives that set the basis for the humanitarian response plan. Health and protection aspects are covered by the first strategic objective, which aims to “Enhance the protection of populations in Gaza, Area C, the Seam Zone and East Jerusalem by promoting respect for IHL and human rights; preventing or mitigating the impacts of violations; improving equitable access to essential services; and ensuring the effective integration of protection considerations in service provision interventions.”³

Access to health care and services by Palestinians is impeded due to the Israeli restrictive policies imposed on their movement throughout the West Bank. It is reported that there is a lack of adequate primary and secondary health care facilities in remote areas.

Therefore, Palestinians are forced to do a long detour, ranging between two to three hours, to avoid physical obstacles on the roads in order to reach health facilities in the nearest cities. On the other hand, local and international organizations have reported on restrictions on their movement, especially in Area C of the West Bank, preventing them from reaching communities to provide health care, which compound the vulnerability of the most affected population. According to 2012/2013 CAP, the total number of Palestinians in need of nutrition and health in oPt stands at 2,248,804, and 2013 Requirements per Health and Nutrition cluster was 15,788,178.⁴

According to the most recent CARE assessment, many of the communities surveyed do not have safe and easy access to health services due to one or more protection risks, such as lack of permanent health services, impaired access to curative health service, proximity to Israeli checkpoints preventing access to primary / secondary health service, surrounded by Israeli settlements, isolated by the Barrier (Seam zones) or living in close military zones.

II. Project evaluation:

In line with the terms of references and submitted proposal, the evaluation team has stated the following key research questions:

- 1- To which extent has the project responded to actual health services needs in target communities
- 2- To which extent has the project contributed to protection of target populations and how?

³ 2013 CAP, January 2013

⁴ 2013 CAP

- 3- How can the project achievements contribute to establishing a system of sustainable healthcare services responding to needs of communities within a formal system?
- 4- What protection mechanisms and practices are suggested to mitigate, eliminate exposure of target communities?

Response to mentioned research questions was achieved through addressing the standard domains of the evaluation and taking into consideration the perspectives of different community and institutional stakeholders.

Selections criteria of communities:

Out of communities surveyed by CARE in five West Bank districts (North, South and Center), the evaluation was based on selection of a sample of vulnerable communities affected by one or more of the following factors:

- Isolated communities located behind the Barrier
- Located near settlement and at risk of settlers violence
- Lack of access to nearby cities, towns, and neighboring villages because of physical barriers (checkpoints, agricultural gates, earth mounds, roadblocks, etc.)
- Communities who needs to cross CP in order to have an access to health service
- Communities located in a military zone
- Communities located in Area C
- Communities that have no health service providers

In specific terms and as proposed, the following domains were addressed:

- 1- **Relevance/appropriateness:** Within this criterion, the evaluation will examine to which extent the project was responding to the nature of emergency occurring in target communities and the relevance of interventions to the nature of emergency.
- 2- **Connectedness:** The evaluation will try to highlight if possible the ability of the project to provide a proper connection to development of services and link emergency response to longer-term developmental needs of communities and institutions involved.
- 3- **Coverage:** As such, the evaluation will look into the extent to which the project was able to reach significant proportion of affected communities, especially looking at children, women, chronically ill and disabled.

- 4- **Quality:** The evaluation will measure qualitative and quantitative achievements of the project in terms of being able to deliver stated outputs. Special focus in this criterion will be the ability of the project to provide a reasonable level of healthcare services to target communities and community groups. In addition, the evaluation will look into the ability of the project to offer protection to those in need and offer referral when needed.

- 5- **Sustainability and exit strategy:** within this domain, the evaluation focused on key stakeholders` perceptions on the ability of the project activities to merge into the formal healthcare and protection frame and the capacity of the formal healthcare institutions benefit from project achievements and sustain them. In particular, the research team considered the Ministry of Health as the ultimate duty bearer in this perspective.

- 6- **Impact:** it is not expected that a humanitarian response project is going to reach measurable long-term impact on the lives of those served. However, within this evaluation, effort will be exerted to detect and highlight any long-term developmental gains at the level of individuals and institutions.

Inception report:

Upon review of project document and initial meetings with project leadership, an inception report was submitted highlighting the initial impressions and suggesting methodological approach to the evaluation. Inception report was not meant to draw conclusions about the project, rather to highlight significant impressions observed by the researchers based on reading project proposal, interim report and other accompanied documents. Both stated impressions and questions raised were then verified through the project evaluation activity and field testing.

In line with proposed methodology and TOR, a desk review of project documents was done for the health services and protection components of the project. It is worth notion that while the interim report has indicated adequate achievement for the protection component within the reporting period (107 cases out of 160 target), evidence on the process and field materials are still to be examined to inform about the process and methods used in the field to address this component.

CARE international has employed significant field experience, history and active involvement in the health and nutrition cluster to develop coordinated and systematic interventions in most in need communities. Coordination with relevant international agencies has been a clear observation within this project and beyond. Synergy and cooperation with other international stakeholders will be further explored within this evaluation.

Notion on involvement of target communities and end users in the design is a clear advantage to ensure relevance and mobilize community acceptance and support. This is a good practice that will be highlighted and further explored through the evaluation.

III. Methodology:

A combination of quantitative and qualitative methods was utilized to examine evaluation research hypothesis within selected domains. Detailed methodological approach and tools as explained in annex 1

The evaluation aimed at reaching key stakeholders and providing a 360 degree exploration and review. The following stakeholders were targeted using different tools to examine intended domains. Table below explains the structure of evaluation in terms of stakeholders and domains:

| | 1 Relevance | 2 connectedness | 3 Sustainability and exit strategy | 4 Effectiveness and quality | 5 Impact |
|----------------------------|------------------------|----------------------------|---|--|---------------------|
| Community members | X | | X | | X |
| Healthcare providers | X | X | | X | |
| Project staff | | | X | X | |
| HNC members | X | X | | | X |
| National authorities (MOH) | X | X | | X | |

- 1- **Community members:** men, women, people with chronic diseases and disabled in addition to people experiencing protection-related incidents. To identify relevance, connectedness and coverage, the evaluation will utilize quantitative methods to explore access to and experience of CARE. Community leaders formed form key stakeholders in terms of relevance and efficiency. Community leaders formed the basic source of information about protection issues and while trying to explore individual protection incidents, the evaluation tried to spot the

ability of the project to cooperate with local communities for ensuring local frames for protection and advocacy.

- 2- **Health care providers and authorities:** looking at adequate provision of essential package of services, complementary role of different healthcare providers in matching the need of target population and the ability of the project to offer a platform for coordinated healthcare provision and hence help the national healthcare system respond to needs of target communities and ensuring continuity of care and to some extent sustainability.
- 3- **Project staff:** looking at effective implementation and management of the project, ability to produce intended results and efficiency in delivering care and protection services.
- 4- **Health and nutrition cluster partners:** identify coherence of the project with the health and nutrition cluster approach and assess the integrated role between health and protection cluster the project has been able to support and to which extent the project has been successful in meeting healthcare needs and protection at the same time.

Tools:

As both qualitative and quantitative methods are planned for this evaluation, the following tools were utilized for respective stakeholders:

| Tool | Stakeholder | Notes |
|--|--|---|
| 1- Individual interview | Project management (CARE and partners), national authorities, HNC selected members | |
| 2- Focus group discussions | Women, men, youth, healthcare providers, community leaders | |
| 3- KAP survey (questionnaires) | Mothers | Sample from each location was agreed on |
| 4- Satisfaction survey (questionnaire) | Users of health services | Sample from each location was agreed on |
| 5- Protection survey | Users of health services | Sample as above |

Locations:

To represent all communities in respect to district, size, nature of vulnerability and implementing partner, the following locations were selected for inclusion in the evaluation sample:

| Location | District | Partner |
|---------------|---------------|---------|
| Khalet Numan | Bethlehem | HWCs |
| Nabi Samuel | Jerusalem | PMRS |
| Barta`a | Jenin | PMRS |
| Wadi ghrouz | Hebron | PMRS |
| Deirat | Hebron | PMRS |
| Twaneh | Hebron | PMRS |
| Odeiseh | Hebron | HWCs |
| M. Samou` | Hebron | HWCs |
| Ein Shibli | Nablus | HWCs |
| F. Beit Dajan | Nablus | HWCs |
| Tana | Nablus | PMRS |
| Ousarin | Nablus | PMRS |
| Yanoun | Nablus | PMRS |
| Maleh | Jordan Valley | HWCs |

Research team conducted interviews with the following key informants, policy makers and project managers:

- a. ECHO
- b. Project manager- CARE International
- c. Project manager- partner (PMRS, HWCs)
- d. MOH official (central, district)
- e. Health cluster officials
- f. Community leaders
- g. Community members (women and men)

List of met individuals and proceedings of meetings are presented in annex (3) for further review.

Limitations:

The evaluation research has been subjected to some limitations stemming from the need to coordinate field work in difficult to reach areas within a short time frame. The comprehensive design of the evaluation methodology incorporating different stakeholders at central and peripheral levels, combination of quantitative and qualitative methodology

had demanded expansion of research team to include field workers and posed logistical burden on research team.



IV. Findings:

1- Relevance:

CARE international has followed a structured, scientific approach to identify vulnerability and provide argument for the need of target population in terms of deprivation to health services, exposure to violence and/or other practices resulting in diminished mobility, deprivation from income and livelihood. Criteria set for selection of target communities are both appropriate and are in line with the health and nutrition cluster standards.

Selected communities in the West Bank represent a wide variety of communities affected by different access barriers, violence and restrictions to livelihood. Clustering communities into geographic clusters is a good operational strategy and helps in systematic response to needs. While the evaluation study has been focused in selected representative sample of communities with diverse nature of exposure, it is expected that findings observed there are representative to project locations unless otherwise indicated within the discussion.

Suggested approach for identification of needs for health services provides a good basis for interventions thereafter followed in target communities. Structuring interventions within a demographic and epidemiological frame has been a good practice observed for the design, reported implementation and reporting on project achievements and progress. Systematic review of this aspect was provided within the evaluation study through review of reports, observing the work of mobile clinic in the field and assessment of the quality from client perspective.

CARE International has deployed a well structured approach in selection and identification of locations for the project. In terms of vulnerability, selected locations of this project have been those identified by the humanitarian community as hardly hit by the wave of settler violence, movement restrictions, annexation, demolition of houses and livelihood structures, military operations and other means of exposure related to occupation. This impact of exposure was clear in limiting communities` access to livelihood, work opportunities and exacerbated the poverty levels leading to another barrier to healthcare from the economic side. Repeated exposure to violence, demolition operation annexation and harassment has led to a situation, where psychological wellbeing of families and children has been affected and it is possible to note that children in the project locations are affected by a high level of stress.

Woman from Nabi Samuel:
Not only elderly has the frustration and feeling of helplessness, children here in the village behave and act like elderly

Another woman from Khalet Numan:
A group of children on their way back from kindergarten were detained in the Cage at the checkpoint awaiting coordination. My husband went to see the situation and children were terrified and crying in the cage

Alternatives for health care in project locations are extremely limited. While MOH, UNRWA and private sector exist in or around some locations as alternative providers for healthcare, in all locations both frequency, service hours and cost in the private sector stand as critical barriers to accessing services.

Table: example of healthcare services available in Barta`a enclave*

| Provider/ time | Sat. | Sun. | Mon. | Tues. | Wed. | Thu. | Fri. | notes |
|-----------------------------|------|------|------|-------|------|------|------|---|
| Mobile team/ 9:00- 14:00 | X | | | X | | X | | |
| MOH/ 8:00- 14:00 | | X | | X | | X | | With a resident nurse |
| UNRWA | | | | | | | | Based on agreement with the mobile team, UNRWA contributes with medications |
| Private | X | X | X | X | X | X | X | On call |
| Specialized services | | | | | | | | Only available through referral |
| Laboratory | | | | | | | | Basic tests only, all other including sugar testing needs referral |

*for Barta`a, it important to note that we are talking about a number of communities within the enclave (Barta`a village, Khirbet Abdulla-younis, Eastern Mnitar, western Mintar, Im rihan) with a total original population of around 9000 people.

Movement restrictions in the form of coordination requirement, checkpoint delays and unpredictable environment stand as barriers even to service provision making it more difficult for service providers to offer services. MOH facility in Barta`a serves only those residing within the town of Barta`a and holding a health insurance identification

representing only 20% of the population according to municipality information. Residents of other enclave locations have limited access to MOH services as service within this facility is linked to those holding governmental health insurance. The Ministry of health covers many of project locations with services in accordance with the Ministry policy for entitlement based on health insurance scheme. It is also important to note that MOH faces difficulties to coordinate for the access of the MOH teams especially whenever there is a change in the team or replacement at time of vacations, sick leaves, etc.

Operationalization of this policy in such disadvantaged locations makes it difficult for those not enrolled in the health insurance to access MOH services and this in some locations form significant portion of the community. Furthermore, referrals provided for people in need for specialized services occur largely to out of MOH facilities, which results in many cases in magnifying the cost and limiting the ability of people to seek such services.

Calculation of need for the package of service at MOH follows the population size. In the case of project-targeted communities, this is leading to significant undermining of needs, especially for those chronically ill, elderly and disabled. In the case of Barta`a, MOH clinic operates based on the assumption that Barata`a population is 4000-5000 people. This calculation is overlooking the additional 8000-10000 people living in the area in the form of merchants and their families residing in the area and workers in Israel using Barta`a as their refuge. Also, this calculation overlooks residents of the other five locations in the enclave bringing the number of people living in the area to about 15000 as reported by the municipality council.

Composition of the mobile health clinic in terms of staffing, equipment and supplies has been set in a reasonable manner. As would have been expected from such a model of care and also confirmed by the residents of all visited communities, the GP, women's health, laboratory, health education and drug supply meets most of the need in these locations. It is worth mentioning however that when specialized service of medication is needed, these are difficult to access through the clinic and referrals form an obstacle for those in need. Specific examples were given in Nabi Samuel, Barta`a and Khalet Nu`man where travel for specialized care, laboratory testing and medications becomes extremely difficult and expensive for patients with cancer, diabetes and disabled.

Inclusion of health education component to the package of services seems to be an important addition to the mobile team. From field visits and measurement of knowledge about specific health issues, it remains unclear to which extent this component has covered the actual needs in terms of information, practices and alternative actions to be taken in cases of need.

Danger signs in pregnancy, child care, management of chronic diseases and first aid were the most important subjects addressed by the health education component of the project, though not implemented in all communities due to organizational capacity, community

interest and funding, data from selected communities in the north and south demonstrated high knowledge about these topics. This improved knowledge was due to the project efforts, but also due to existence of other agencies working on health promotion programs addressing women`s health in the project locations. evaluation team have observed a synergic effect of such interventions especially in Barta`a.

Findings of knowledge test are included in annex (2). From evidence gathered through this quantitative assessment and although represented a sample of convenience, inform about the importance to include health education as an integral component of programs in isolated communities. Provision of skills-based health education would provide target communities with the know how to deal with emerging health issue, especially in times of closure and limited access.

Within the quantitative component, the research tool included 13 elements that would qualify as exposure to protection issue. 100% of the respondents to the quantitative tool reported exposure to one or more of those. This is a striking finding indicating the relevance and need for protection to be included in future projects in these areas.

Relevance of the protection function of the project has been identified by some of the communities, healthcare managers and cluster members. In fact and even with the new approach to use mobile health teams as a protection means, it is fair to say that protection function has been installed within the concept and practice of the project, but more is needed to improve this function and better respond to protection needs of target communities.

CARE International project leadership and advocacy officer were clear about the practical implementation of protection initiatives within this healthcare provision project. Work on the ground has shown that protection function has been successful in some of the locations such as Tana, where physical presence of the mobile team for a period of two weeks with mobilization of national and international agencies prevented from evacuation of the area.

In conclusion to this chapter, testimonies and observations from the field confirm the high relevance of the project and its appropriateness as a health care delivery mode compensating for lack of other alternatives. Its structure, mode of operation and high reliability clearly indicate that CARE International and its partners were able to offer these communities a safe-guard in terms of access to basic health services.

As a new concept in the humanitarian response in Palestine, the project has been also relevant in terms of being able to provide protection to target communities through direct interventions in terms of identification of cases, treating health consequences and report on them to the protection cluster.

Protection in Palestine remains a relevant area of work as far as reasons for this remain on the ground. Operationalization of protection function however needs to take into consideration the nature of crises, local context and the best vehicle for it.

2- Connectedness:

It is the research team`s understanding that connectedness is a major domain in this evaluation. While relevance has been established and supported by evidence, this section is going to discuss the issue of connectedness and ability of this project to make proper link at the following levels:

- a- **Humanitarian response to development:** This evaluation focused on the recent phase of project implementation during 2012-2013. This phase has been the one following many years of project implementation in the same communities and more or less within the same concept and operation.

The humanitarian crises and needs in Palestine remain and have been protracted with unpredictable exacerbation and mode of impact on Palestinians. Exposure to violence, isolation and annexation policies continue to affect people in the West Bank leaving a large number of communities in dare state of physical, social and economic conditions. Within such an environment, it is obvious that basic human rights to movement, access to livelihood, healthcare and education become negatively affected and this continues in the project locations to various extents and forms.

In conclusion of this paragraph, the need for healthcare and protection interventions are and remain highly needed regardless of the momental conditions prevailing in these communities. On the other hand, and due to the fact that the situation on the ground is constantly changing, a need for creative models for intervention is highly recommended with a flexible and changeable definition of vulnerability and hence ability to move the project focus towards needy communities when relevant.

While the project in nature is a good sample of humanitarian response to crises affected isolated communities, it is worth acknowledging that the design of the project, mode of implementation and monitoring of progress have been conducted in a manner demonstrating significant developmental features and provide an example to follow for monitoring healthcare services within a developmental environment.

- b- **Connection and link with the formal healthcare system in the country:** it is clear that the project has been successful in providing needed healthcare services to communities. Within its current mode of operation however, the project has led to first legitimate dependence of communities on the mobile teams as a source of free of charge services and medications supply. This particular aspect has been in some cases criticized by the staff of the project and MOH senior officials. On the

other hand and most importantly, the project with its high reliability and adequate coverage to basic primary healthcare needs has formed an asset to the formal healthcare institutions such as MOH to provide their obligation in terms of providing services for Palestinian communities under their control within the West Bank. While this fact has been confirmed by both CARE International and MOH officials, it is to state that there needs to be a clear pathway by which this obligation is transferred to MOH especially in locations, where MOH can have access. To identify these locations, where MOH needs to expand its services and take over responsibility for healthcare provision, a review of locations needs to take place with respect to ability of MOH teams access and coordination/ logistics arrangements needed within the Palestinian authority institutions or with the Israeli authorities.

It is noted that it goes beyond this evaluation study to provide a magic solution for this particular point, but it is critical that in future interventions, this is taken into account and by continuing the mobile team model, this needs to take into strategic and practical frame the issue of full coordination and connection to the formal healthcare system represented mainly by the ministry of Health. Within the recommendation section, the research team will suggest a formula for such coordination.

- c- **Continuum of care:** It is well recognized that this project has been meant to offer basic services to communities in difficult conditions and it is difficult to review its interventions from sophisticated perspective and complicated health system development background. On the other hand, it is important to see interventions in this project as filling a gap in the integrity of care occurring in target communities due to physical, social or economic barriers. In evaluating this, the research team tried to examine to which extent has the project interventions supported the continuity of service within three levels:

- a. **Community- primary- secondary care:**

By providing basic package of primary healthcare services corresponding to level 2 system within the ministry of health, the project provided GP services, women`s health clinic, laboratory and health education services in a structured manner largely responsive to the needs of target population.

Days of service were allocated based on the number of population and vulnerability in terms of access and availability of alternative service providing institutions. In general, this has been conducted in systematic way and only disruptions reported were those related to delays in access to locations and unforeseen reasons. This has provided adequate filling of gap when it relates to availability of basic services at the primary healthcare level.

Looking at the community side of the continuum, and based on data gathered by the qualitative and quantitative research, it is clear that this had significant variation among locations, where some locations such as Tana, Hebron and Bethlehem were covered by health education in general reflective of improved knowledge of beneficiaries about danger signs and health practices pertaining to mothers, children and chronically ill. However, in some locations, especially in the north, this component was weak and even missing with beneficiaries in Nabi Samuel and Khallet nouman not recalling attending health education events. Weakness of health education component was caused by the lack of resources allocated to support this function and therefore, health education activities were conducted in sporadic and non-systematic manner to beneficiaries attending the mobile health team.

The third very important aspect, which is the referral to specialized services when needed, this was a clear disconnect and while the project has been able to provide proper and timely referral to cases in need, most of referrals occurring within this project have been based and facilitated by practitioners in the mobile team. In all cases, this was beneficial and resulted in facilitating access to specialized service. However, in other cases, and as reported in Barta`a, Nabi Samuel, Osarin, Maleh and Tana this was lacking clear referral destination connection to referring destination. Referral to private sector was a common practice in most of the locations, which has resulted in increasing the cost of such services.

Some best practices were documented in the referral system from Nabi Samuel, when referring physician (who used to work with the mobile team and previously with MOH) was following the case and facilitating provision of specialized services for those in need at MOH facilities or hospitals. This observation has been reported in Nabi Samuel and was linked to the physician having good connections with MOH system.

b. Pregnancy- delivery- postpartum care:

Humanitarian situation in Palestine has brought to the surface the suffering of pregnant women and their infant in accessing health care services, especially those life-saving. During the tight closures imposed on the communities of the West Bank and during military operations in Gaza, many women and/or infant died due to delays in accessing care.

This project and many others have tried to ensure smooth access to antenatal, safe delivery and postnatal care for women and their babies. Through review of project records, interview with communities and observations in the field, it is clear that the project has fulfilled its function in ensuring access to pregnant women in a structured manner. Women`s health clinic was perceived as a highlight of the project and no complication was reported in the project areas indicating a high quality implementation of women`s health program.

Female doctors employed within this project have been well received by clients and highly respected by women for their support, understanding and professionalism. It is important however to note that function of women`s health program was restricted to pregnancy monitoring and follow up and many other women`s health issues such as menopause, chronic illnesses and cancers were not possible to manage through existing project activities.

c. Exposure- management- protection care

While the concept of protection within the project was clear to policy makers within CARE International, health and protection cluster, data collected from the field through field visits, questionnaires and discussion with mobile clinic staff reflected an area that needs to be improved. From project reports, it was obvious that there were protection cases documented and some advocacy action taken locally and internationally. Again as a new aspect of implementation strategy, it is expected that further improvements are needed in the area of connectedness clarity of the concept and its programmatic implications need to be transferred to people on the ground with the same clarity to allow these teams spot, well manage and document cases and protection observations.

CARE International has been actively involved in the development of referral system for protection cases between health and protection cluster. A referral mechanism and tools were developed, but yet to be tested and used within this and similar projects. To avoid sporadic and anecdotal reporting on protection cases, it is essential that practitioners and mobile team members are trained on issues related to protection, human rights and referral mechanism.

Further connection is needed towards the Palestinian authority institutions, in particular the Ministry of Health and ministry of Social Affairs to ensure that protection is covered from its social and political perspectives.

d- Community empowerment for demand and self-care:

This domain forms a critical one in making both the proper connection between humanitarian response and development and also provides the proper platform for enabling communities increase their ability to cope with challenging environments in a short and long term run. The evaluation tried to examine the extent to which this project has defined community empowerment as a strategic area of intervention and most importantly how much of investment has been done on improving communities` resilience and capacity to deal with health issues pertaining to target populations with focus on children, women, elderly and disabled.

Through interventions aiming at enhancing community resilience, specifically in Tana and Nabi Samuel, interventions have led to more active role of communities to demand health services, advocate for the rights of population in accessing health care, but this did not lead to enhanced and sustainable healthcare services in these communities.

While this observation is limited to those communities included in the evaluation sample, it is of concern that the project have been able to provide services, ensure access to protection when needed, but on the mid and long run has created a sense of dependence on the project activities among both communities and institutions. Again, it is to emphasize that it goes beyond the evaluation study to identify means by which to respond to this particular issue, it is advisable that within future interventions within this project, a structured local community and institutional capacity building effort is exerted to empower communities and community institutions for demand of services and be active in ensuring availability of both healthcare and protection services.

3- Efficiency and Quality:

Issues of coverage with specific needs such as antenatal and postnatal care are well articulated and appropriate for such interventions as this helps interventions identify and reach-out for especially at risk population groups. Within the evaluation, further exploration of coverage was done to examine coverage with other services of similar nature such as care for disabled, chronically ill people and elderly. The evaluation tried to examine the regularity of services and explore the reliability of mobile teams in reaching target communities and providing services.

Inclusion of health awareness component to the project was an excellent idea. Within the continuum of care, knowledge on healthy practices, identification of danger signs and timely access to care forms a critical issue that enhances survival and mitigates the impact of closures or denied access to care. The current evaluation has explored the extent to which this project has been able to improve people`s knowledge against the baseline.

Establishment of complaint and feedback mechanism is a sign of quality that usually lacks in humanitarian response programs. The evaluation will explore this aspect and look into what information has been gathered through this mechanism and how the project has been addressing community complaints.

Within this domain, and in addition to evaluating project documents and progress reports, the evaluation looked at the process of operation of the mobile team from three perspectives: project management, health authorities and clients. Project has fully complied with it stated objectives and targets in terms of reach, coverage and reliability of services to target communities.

In spite of difficulties in access caused by coordination challenges with checkpoint and security authorities, the project has been able to provide services in a regular manner, especially when it comes to GP service, women`s health services laboratory and dispensing of basic medications. In some indicators related to number of beneficiaries, the project has even exceeded its targets reflective of beneficiary interest and high uptake. In the case of health education, client-perceived quality and health authorities, this was not supported as clients were complaining from in-adequate health education focus and in many cases reported unfriendly treatment of providers to clients.

Perceived quality of care

| | Frequency | Percent | Valid Percent | Cumulative Percent |
|-----------------|-----------|---------|---------------|--------------------|
| Valid excellent | 10 | 11.9 | 11.9 | 11.9 |
| good | 43 | 51.2 | 51.2 | 63.1 |
| acceptable | 23 | 27.4 | 27.4 | 90.5 |
| bad | 8 | 9.5 | 9.5 | 100.0 |
| Total | 84 | 100.0 | 100.0 | |

Client perception on provided care is positive in general. With only 9.5% of interviewed classifying service as bad. This finding can be considered as a positive sign in favor of services, but combining it with below findings of about 40% of clients reporting not being examined well by the doctor in addition to generally short time of consultation shown in tables below indicates an information bias caused by the fear of communities to lose the service if they classify it as of poor quality.

Examined well by doctor

| | Frequency | Percent | Valid Percent | Cumulative Percent |
|-----------|-----------|---------|---------------|--------------------|
| Valid yes | 51 | 60.7 | 60.7 | 60.7 |
| sometimes | 16 | 19.0 | 19.0 | 79.8 |
| no | 17 | 20.2 | 20.2 | 100.0 |
| Total | 84 | 100.0 | 100.0 | |

Consultation time- minutes

| | Frequency | Percent | Valid Percent | Cumulative Percent |
|-----------|-----------|---------|---------------|--------------------|
| Valid .00 | 5 | 6.0 | 6.0 | 6.0 |
| 2.00 | 5 | 6.0 | 6.0 | 11.9 |
| 3.00 | 17 | 20.2 | 20.2 | 32.1 |

| | | | | |
|-------|----|-------|-------|-------|
| 4.00 | 14 | 16.7 | 16.7 | 48.8 |
| 5.00 | 18 | 21.4 | 21.4 | 70.2 |
| 6.00 | 1 | 1.2 | 1.2 | 71.4 |
| 7.00 | 3 | 3.6 | 3.6 | 75.0 |
| 8.00 | 2 | 2.4 | 2.4 | 77.4 |
| 10.00 | 10 | 11.9 | 11.9 | 89.3 |
| 15.00 | 4 | 4.8 | 4.8 | 94.0 |
| 88.00 | 2 | 2.4 | 2.4 | 96.4 |
| 99.00 | 3 | 3.6 | 3.6 | 100.0 |
| Total | 84 | 100.0 | 100.0 | |

Central government health authorities were skeptical about the quality of care and reported that the mobile team operation has frequently created confusion for MOH, especially that the cost sharing regime of MOH was disrupted by the mobile team free of charge policy and caused significant disturbance.

As for protection, while 100% of interviewed within the quantitative component of the evaluation reported exposure to one or more of violations, only 13% reported to the clinic with complaint about it and only 3% of interviewed reported that their case was documented by the mobile team members.

91% of respondents said that they believe the mobile health team could help in solving protection problems.

4- Sustainability/ exit strategy:

While there is a clear coordination and complementarity mechanism with UNRWA, this coordination and complementarity was thoroughly explored and linked to MOH for the goal to identify opportunities for sustaining interventions and mainstream them within a formal system of care. Within this aspect, it was the intention to examine to which extent this intervention has provoked MOH buy-in and its intention to mainstream services within its system as part of its responsibility as the ultimate duty bearer for health care provision.

The protracted emergency in Palestine has created a situation, where humanitarian response interventions have become a long-lasting need. The emerge of settler violence, annexation policy and the wall has created a complicated context for humanitarian response programs, where exacerbation is not predictable and impact of the crises is having a culminating effect on affected populations. Access to care,

social services and livelihood becomes impaired and protection becomes a serious concern.

The project under evaluation has been a creative and practical example for interventions addressing both access to healthcare needs and protection. For the last eight years, CARE International has been implementing this project creating reasonable short-term solution to access to healthcare challenges. As reported in other section of the evaluation report, the project has been able to address protection issues and spot, treat and report some cases of violations against individuals and communities. For the nature of context and conflict in the country and nature on interventions required to respond to special crises in Palestine, sustainability cannot be discussed rather connection with the formal system of care and exit strategy becomes a need.

The current project has been in active dialogue with national authorities at central, district and local levels in addition to target communities for the aim to capitalize on project achievements, mainstream services within the formal healthcare system and ensure access to care in a sustainable manner. In some instances, this effort has been successful with the ministry of health extending its network of mobile health services to locations of the project in Hebron and Tubas.

Connection and cooperation with UNRWA in Barta`a enclave and Al Nabi Samuel has been a good example in which UNRWA provided resources to support operation of the mobile team in the environment, where its staff cannot enter the location and the mobile team in turn providing services in substitute to UNRWA system. This cooperation has been formalized in the form of MOU between the two agencies reflective of appropriate practice in mainstreaming care and reaching partnership. This however has not materialized into formal inclusion of target communities under the formal healthcare system in a coordinated complementary manner among different public sector providers.

As this domain stands as a critical one in our evaluation, the evaluation team has conducted in depth review of options for sustainability of service and exit strategy for project interventions. While it is advisable that services are to be offered by formal healthcare providers through the system of care, the current situation of PA, UNRWA and civil society organizations will need to make a gradual transfer of responsibility to ensure stability and avoid disruption of care. Disruption of care has occurred in Atuf community for a period of 7 month due to premature transfer of responsibility to Tubas directorate and has resulted in significant frustration to target community.

The Ministry of health is the ultimate regulator and stakeholder in healthcare provision in Palestine. Through the governmental health insurance scheme, MOH is providing primary, secondary and tertiary services to 100% of Gaza strip population and around 60% of West Bank population.

Access to and enrolment in this frame is easy and at low cost with a wavering system for unprivileged groups. The Presidential declaration has granted all Gaza strip residents the free of charge enrollment in this scheme and this has led to significant benefits. Similar situation can be extended to residents of project locations identified as unprivileged and in a transitional period, could be transferred to governmental insurance scheme implemented in full cooperation with other service providers.

5- Impact:

Similar to sustainability, this humanitarian response project was not expected to achieve impact level effect. From the health point of view however, it is possible to demonstrate that the project has been effective in securing health services and ultimately has prevented occurrence of complications related to poor access. On the protection side, there has been an impact on most of surveyed communities in terms of identifying and reporting cases of violations. The mobile team has assisted a number of cases, documented violations and reported them to the protection and health cluster. Advocacy campaign around Susia has resulted in massive attention of Palestinian authority to the location and suffering of people residing there. In spite of the difficulty associated with this domain, CARE International has succeeded in mobilizing international society for this case leading to satisfactory impact in sustaining basic social services in the area.

Work in Tana was an outstanding example, where the project has protected local communities and mobilized national and international response for the aim to preserve community structures, resources and livelihood.



V. Conclusions and recommendations:

The project forms an excellent practical example on humanitarian response programs responding to a complex and protracted emergency. Identification of vulnerability, calculation of needed services and setting the frame for interventions are good practices that helped the project implementation and enhanced its relevance.

Developments on the ground throughout the period of implementation have supported the selection of locations in many cases. In some cases however, the level of need would not support continuation of such intervention. In future programs, continuous review of need is empirical to allocate resources in most in need communities. In practical terms, the project needs to be flexible to accommodate emerging needs in some communities and if needed, cease interventions in communities with no need or in those transferred to MOH system.

The project has been perceived as extremely helpful and vital by beneficiaries in most served communities. District health authorities, community leaders and beneficiaries see that the project is an essential asset supporting their resilience and alleviating significant burden associated with accessing healthcare. It is clear that connection of the project to formal healthcare system however is done on ad hoc basis and future interventions need to take this particular issue into consideration.

Perceived quality of care is variable among communities and providers. Analysis of quality assurance data is needed on regular basis and again future program needs to make concrete steps towards improving quality of care, compliance with standards of care and protocols and medical ethics. Provider-client interaction appeared to be an issue with concern for many beneficiaries and hence there is a need to address in future programs

Entitlement for services needs to build on both vulnerability of target populations and also on expanding governmental insurance scheme to include people in hardest hit locations. Dialogue with the ministry of health on this issue needs to start immediately taking into account the Ministry's capacity at district level and strategy related to covering target locations with services. The public health law adopted by the Palestinian Ministry of health articulates clearly health service entitlement for vulnerable community groups. This forms an opportunity to use for the benefit of people living in many of the project locations.

While the issue of copayment has been refused by the donor for valid ethical and contextual reasons, this needs further review as to align system of services with the formal MOH system. This would allow for closer cooperation and enable developing realistic exit strategy.

Established definitions, frame of management and reporting on violations have proved functional to certain extent in this project. Widening the scope of protection function into the mobile health team project needs further investment in capacity building and clarification of information flow at the field level.

Advocacy has been successful in a number of incidents related to protection. Capitalizing on those successes is vital and scaling up of protection will require adoption and inclusion of clear standard operating procedures related to case identification, management, and reporting for field, district and central levels. This frame needs also to feed into to the higher levels through the cluster and beyond with a clear perspective for utilization in advocacy at the local and international levels.

VI. Annexes:

- 1- Methodological approach to evaluation
- 2- List of key informants interviewed with proceedings of interviews
- 3- Summary description of quantitative findings pertaining to satisfaction with services, knowledge and protection
- 4- Inception report
- 5- Proceedings of meeting with ECHO representatives
- 6- Qualitative and quantitative research tools
- 7- Photo gallery