
Final Report

Written by ICF Consulting Services Ltd, and independent Humanitarian Aid experts: Karl Blanchet, James Brown and Danielle Deboutte

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Final Report
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List of abbreviations

EUCP EU Civil Protection
CDC Centre for Disease Control and Prevention
CP Civil Protection
DG Directorate-General
DG DEVCO Directorate-General for International Cooperation and Development
DG RTD Directorate-General for Research and Innovation
DG SANTE Directorate-General for Health and Food Safety
DRR Disaster Risk Reduction
EC European Commission
ECDC European Centre for Disease Prevention and Control
DG ECHO Directorate-General for Civil Protection and Humanitarian Aid Operations
EEAS European Union External Action Service
EET Emergency Toolbox
EMC European Medical Corps
EMT Emergency Medical Teams
ERCC Emergency Response Coordination Centre
ETU Ebola Treatment Unit
EU European Union
EUAV EU-added value
EUCPM EU Civil Protection Mechanism
EUD European Union Delegation
EUIBOAs European Union Institutions Bodies and Offices
ExAR External Assign Revenue
FATA Federally Administered Tribal Areas
FCA Index for Risk Management and Forgotten Crisis Assessment
FichOp Fiche opérationelle
GAVI Global Alliance for Vaccines and Immunisation
GHC Global Health Cluster
GHE Global Health Expert
HA Health Action
HDI Human Development Index
HIP Humanitarian Implementation Plan
HOPE The HOPE Database
HQ Head Quarters
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
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<tr>
<td>HSS</td>
<td>Humanitarian Settlement Services</td>
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<tr>
<td>IAF</td>
<td>Integrated Analysis Framework</td>
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<td>IDPs</td>
<td>Internally Displaced Persons</td>
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<td>IL</td>
<td>Intervention Logic</td>
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<td>INFORM</td>
<td>Index for Risk Management</td>
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<td>IRC</td>
<td>International Rescue Committee</td>
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<td>JRC</td>
<td>Join Research Centre</td>
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<td>LRRD</td>
<td>Linking Relief Rehabilitation and Development</td>
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<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
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<tr>
<td>MENA</td>
<td>Middle East and North African</td>
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<tr>
<td>MoH</td>
<td>Ministry of Health</td>
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<td>MoU</td>
<td>Memorandums of Understanding</td>
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<td>MS</td>
<td>Member State</td>
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<td>MSF</td>
<td>Médecins Sans Frontières</td>
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<td>NGOs</td>
<td>Non-Governmental Organisations</td>
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<tr>
<td>ODI</td>
<td>Overseas Development Institute</td>
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<td>OFDA</td>
<td>Office of U.S. Foreign Disaster Assistance</td>
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<tr>
<td>RHE</td>
<td>Regional Health Expert</td>
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<td>SARC</td>
<td>Search and Rescue Committee</td>
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<tr>
<td>TA</td>
<td>Technical Assistant</td>
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<td>UN</td>
<td>United Nations</td>
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<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<td>UNOCHA</td>
<td>United Nations Office for the Coordination of Humanitarian Affairs</td>
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<td>VAF</td>
<td>Vulnerability Assessment Framework</td>
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<td>VfM</td>
<td>Value for Money</td>
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<td>WASH</td>
<td>Water, Sanitation and Hygiene</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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Abstract
This evaluation provides an independent assessment of the European Commission's interventions in the humanitarian health sector during the period 2014 to 2016. The evaluation concludes that Commission-funded humanitarian health actions addressed important health needs and at output level, the majority of results were fully or partially achieved by funded actions. The Commission’s field network of Regional Health Experts (RHEs) was an important element of EU added value. However, shortcomings were identified in relation to the quality of needs assessments, level of collaboration with other actors, the sufficiency of budgets in some regions, awareness and use of the Commission’s consolidated humanitarian health guidelines, and, the level of monitoring and reporting of project results.

The evaluation provides the following recommendations to support future improvements in these areas: develop a strategic performance framework/logic model and ensure strategic priorities are reflected in needs assessment templates, partner proposals, the above-mentioned guidelines, and monitoring and final reports, to support clear alignment of strategic objectives with activities and project outcomes and reporting; develop a stakeholder engagement matrix to support early and comprehensive stakeholder engagement; better capitalise on RHE technical expertise; consider increasing the variety of funding mechanisms available; and, further expand and improve the Commission’s advocacy work.
Executive summary

This evaluation provides an independent assessment of the European Commission's Directorate-General for European Civil Protection and Humanitarian Aid Operations’ (DG ECHO’s) interventions in the humanitarian health sector during the period 2014 to 2016. The evaluation, launched by DG ECHO in November 2016, was carried out by ICF Consulting Services Ltd, with specialist inputs from humanitarian aid and health experts.

The purpose of the evaluation was to analyse DG ECHO’s portfolio of health interventions between 2014-2016, reporting findings against seven core evaluation criteria specified in the Terms of Reference (relevance, coherence, connectedness, effectiveness, efficiency, EU Added Value and sustainability), in order to provide conclusions and recommendations to inform DG ECHO’s future interventions in this area and feed into the comprehensive Humanitarian Aid evaluation currently being undertaken.

Evaluation data sources and methods

Findings presented in this report are based on analysis and triangulation of the following data sources:

- HOPE\(^1\) database records for all 553 DG ECHO-funded humanitarian health actions in Third Countries, reported between 2014-2016;
- Project reports and FicheOps\(^2\) from a sample of 100 projects;
- A sample of 52 Humanitarian Implementation Plans (HIPs);
- Background literature from 55 references;
- 44 semi-structured stakeholder interviews with DG ECHO officers and partners, international donors and development actors;
- An online survey gathering feedback from 32 DG ECHO partners (106 respondents);
- Three field visits (exploring the External Assigned Revenues – ExAR – programme in Ivory Coast, DG ECHO’s health interventions in Jordan in response to the Syrian conflict; and DG ECHO’s humanitarian health response in South Sudan); and
- A research-based case study on the global humanitarian response to the earthquake in Nepal in 2015.

Validity of evaluation results

As with any evaluation, limited data and data inconsistencies in some cases, along with the vested interests of different stakeholder groups may affect the quality and strength of findings.

It was not feasible to conduct a review of the full portfolio of health-focused actions, due to budget constraints, and given the high number of funded projects identified. A purposeful sample of 100 was therefore selected to capture the diversity of health-focused actions funded by DG ECHO and the diversity of contexts in which the intervention took place.

The HOPE Database was the principle source for extracting health-funded actions. A number of inaccuracies related to defining health sub-categories of actions were found when further analysing the data. Findings within this evaluation report reflect the data extracted from the database, however caution was applied when providing views on the amount of funding provided by DG ECHO to each of the pre-defined sub-categories, due to this inaccuracy.

\(^1\) DG ECHO’s humanitarian project database.
\(^2\) The FichOp is an ECHO internal file with all observations, comments, and initial appraisals, report of monitoring and final decision from Field and Desk staff.
For practical reasons such as time and budget available for the evaluation, as well as security concerns, it was not possible to randomly select sites for fieldwork. The approach to selection of sites for fieldwork was therefore both purposeful and convenient, involving DG ECHO regional health experts and Headquarters (HQ).

As far as possible, methodological limitations were overcome by using complementary research methods to enhance the reliability and validity of the data collected, and to provide the basis for cross-verification and triangulation of the evaluation results. Caution was exercised when interpreting data and reporting findings, and interests of different stakeholder groups were taken into account to address potential bias and to ensure objectivity. Input, review and validation with external thematic experts contributed to substantiate the validity of the evaluation results. However, in some cases it was not possible to make conclusive findings on the basis of existing evidence: where this was the case, it has been clearly highlighted in the report.

Main findings

This section provides summary findings from the descriptive analysis of actions, followed by in-depth analysis by evaluation theme. The final component of this section provides a summary of the main findings observed during the field visit to the ExAR Programme in Cote d’Ivoire.

Overview of DG ECHO’s response in 2014-2016

Between 2014 and 2016, DG ECHO funded 553 humanitarian health sector actions in third countries (equivalent to € 616.9 million of funding).

Most funded actions were multi-sectoral – although they had a health focus or health component – combining health activities with nutrition, food security and livelihoods and/or Water, Sanitation and Hygiene (WASH) activities. Breaking down health activities into health sub-sectors, the most common health sub-sectors covered by projects were primary health (67% of projects) followed by medical supplies (51%), reproductive health (48%), community outreach (47%), and, prevention and response to outbreaks/epidemics (42.5%). Just over a quarter of projects (27%) included Mental and Psycho-Social support.

Looking at funding breakdowns for country, partner and target group, South Sudan received the largest amount of humanitarian health funding over this period (€ 73 million or 11.4% of the total budget) while globally, the International Red Cross and Red Crescent Movement was the partner organisation receiving the largest amount of funding (€ 121 million, 18.9%). In relation to target groups for funding, the majority of funding (73%) was provided to support IDPs and refugees. Natural disaster-affected populations received the smallest amount of funding. Nearly three quarters (72%) of DG ECHO funding was provided to projects that incorporated preparedness and response activities to epidemics (equivalent to 42.5% of projects).

Relevance

DG ECHO’s humanitarian health actions have been relevant to a moderate extent, however better needs assessments would improve relevance of funded actions.

DG ECHO’s field network of Regional Health Experts (RHEs) were key in providing primary, up-to-date data, and, context-specific information to inform DG ECHO’s response strategies in the health sector. RHEs also engaged with DG ECHO implementing partners at design stage, by, for example, informing partners of thematic priorities and defining crisis-specific strategies. Evidence shows, however, that RHEs were not systematically consulted at the stage of the development of the HIPs or by DG ECHO TAs and partners on projects delivering health activities.
DG ECHO’s humanitarian health actions addressed important needs but it is not clear whether they systematically targeted the most affected and vulnerable populations and supported the most relevant interventions.

In relation to needs assessments, it was found that RHE’s did not conduct regular health-specific needs assessments to inform HIP development at the level of each crisis area of DG ECHO interventions or where they may have, this was not documented... The quality of health needs assessments was limited by issues inherent to humanitarian interventions which complicate the establishment of factors, often inter-related, that can lead to excess morbidity, mortality and disability. DG ECHO implementing partners’ capacity to conduct proper needs assessments to inform medical activities was also a determinant factor. Whilst some had sound capacity, others less so. The quality of these needs assessments influenced donor and partners’ understanding of the essential package of health services to be adopted in a given crisis and DG ECHO’s ability to ensure that funded projects supported the most vulnerable and most in need.

There is evidence that DG ECHO tailored its approach to address epidemics against recognised challenges and accessibility obstacles, yet harnessing available expertise, also outside DG ECHO, could have been better.

**Coherence**

DG ECHO’s humanitarian health actions recognised international standards and have been coherent, to some extent, with ECHO Consolidated Humanitarian Health Guidelines.

Coherence of DG ECHO funded health actions with DG ECHO principles, policies and Consolidated Humanitarian Health Guidelines was assessed, along with the extent to which these funded actions were consistent with global humanitarian health policies and standards. DG ECHO partners used a variety of international, national, and, internal guidelines dependant on the context of the crisis intervention, and DG ECHO staff played a role in disseminating such standards in the field.

The evaluation found that there was a lack of consistency in the use of DG ECHO’s Consolidated Humanitarian Health Guidelines by DG ECHO staff and partners: where they were used, the Decision Tree Annex was identified as useful for informing funding decisions. Furthermore, in practice, not all of DG ECHO funded health actions were in line with their Consolidated Humanitarian Health Guidelines. In some cases, only certain principles from the Guidelines were covered, while others were not.

**Connectedness and coordination**

DG ECHO’s humanitarian health actions have been designed and implemented in coordination with other relevant national and international actors, to varying degrees.

Overall, DG ECHO successfully coordinated its interventions with other actors in the humanitarian health sector. Good collaboration and coordination between actors was highlighted as essential for the success of actions, particularly in the early planning stage of projects. However, the context in which crises occurred affected DG ECHO’s ability to articulate and coordinate its response with other interventions and actors through national health clusters, and with other donors in certain regions. DG ECHO collaborated with the European Commission’s Directorate-General for International Cooperation and Development (DG DEVCO) and the European Centre for Disease Prevention and Control (ECDC) to a varying extent over the evaluation period. Collaboration with national authorities was, however, limited and differences in approaches and expectations led to unfruitful collaboration as the External Assigned Revenue (ExAR) experienced revealed in Côte d’Ivoire.
In the current early stage of deployment of the European Medical Corps (EMC)\(^3\), it is difficult to assess the extent to which the EMC can interact and coordinate with other DG ECHO actions.

**Effectiveness**

*Results (i.e. outputs) have been fully or partially achieved in most of the DG ECHO funded actions analysed, showing positive results in view of achieving effectiveness. However, the data available in partner reports and DG ECHO databases did not allow to assess the full extent to which DG ECHO's humanitarian health actions have been effective.*

It is to be noted that achievements depended greatly on the context and region, and results achieved do not necessarily imply quality of services, as quality of outputs and outcomes varied amongst DG ECHO partners. Confusion occurred between output and outcome indicators by partners during reporting (most data was reported at output level), and non-compulsory indicators were used that only partially captured intended results.

A number of facilitating factors were identified as promoting the effectiveness of DG ECHO actions: RHE expertise and close monitoring of projects, quality of drugs, existing health systems in place, DG ECHO partners’ health expertise, communication and collaboration with health stakeholders (in particular with the Ministry of Health), and sound knowledge of local communities, with a particular attention to cultural and gender sensitivity.

A number of obstacles were also identified as hindering the effectiveness of DG ECHO funded actions. At DG ECHO level, the main obstacles included the partner's availability, capacity and medical expertise, the choice of indicators by the partners and the availability of data affecting the monitoring of the actions, and timely provision of funding. At partner level, the major obstacles related to the procurement of drugs, lack of ability to deliver quality healthcare services, poor quality of referral level, low level of involvement and community participation in health-care activities, and increased insecurity and criminality. Further consultation of RHEs by DG ECHO TAs and partners for technical feedback and review of health projects and proposals was not sufficiently systematised.

**Efficiency**

*DG ECHO administrative mechanisms and systems were generally viewed as efficient. DG ECHO focused on funding action types that were already known to be good Value for Money (VfM). In most cases, the budget was sufficient to achieve the intended results, however, the data available, as well as the number, variety and complexity of interventions, did not allow to assess the extent to which DG ECHO’s humanitarian health actions have been efficient.*

In practice, due to methodological limitations, cost-effectiveness was not widely used by DG ECHO as a measure of efficiency. Efficiency was assessed more broadly as Value for Money (VfM) and the sufficiency of budgets to conduct required activities to a reasonable quality standard.

When selecting proposals, DG ECHO rarely conducted detailed efficiency analyses on new or innovative health projects. Instead they preferred to fund action types that were already known to be good VfM or where the largest percentage of funding was allocated to beneficiaries rather than to overhead costs.

Monitoring of projects and the provision of clear cost breakdowns by partners was essential for ensuring efficiency of projects and should be systematically incorporated in all projects. Coordination, streamlining and standardising of resources (particularly\(^3\) The EMC was set up in 2016 under the EU Civil Protection Mechanism to provide a rapid European response to emergencies with health consequences both inside and outside Europe.)
drug procurement) and training and capacity-building of existing local staff were also important factors improving efficiency.

DG ECHO administrative mechanisms and systems were generally viewed as efficient. However, the efficiency of funding mechanisms varied by type of crisis and mechanism: funding through geographical HIPs for follow-up actions and through the Epidemics Instrument was largely deemed efficient (with some exceptions), but other funding delivered through geographical HIPs was often too slow. In addition, efficiency could have been improved in the case of the ExAR in Côte d’Ivoire as DG ECHO’s cycles and systems were not adapted to multi-year provision. Other DG ECHO mechanisms exist to support efficiency e.g. DG ECHO’s funding of the Global Health Cluster (GHC), and coordination with other global actors. However, support for the GHC could be improved as well as DG ECHO’s deployment mechanisms for European public health agencies (e.g. ECDC) during crises.

Feedback regarding the sufficiency of budgets was very mixed, particularly for the Ebola response in West Africa. Impacts of budget insufficiencies on projects included withdrawal of interventions; reduced activities; and shortening the duration of actions.

DG ECHO staff had mixed views regarding the benefits of introducing longer-term funding mechanisms, however all partners noted preference for a two- to three-year funding period, which could allow better forward-planning to improve action effectiveness and efficiency.

**EU added value**

DG ECHO has drawn on its specific role and mandate to create an added value in the humanitarian health sector.

There is evidence that DG ECHO supported the provision of necessary health activities across the globe, in particular in forgotten crises. In addition, DG ECHO’s field network of RHEs was an important element of EU added value, bringing health and humanitarian expertise to DG ECHO’s responses. Team work between DG ECHO’s Health Team leader (policy) and Global Thematic Coordinator (policy), with support from RHEs and TAs, also contributed to important evolutions within the global discussion on humanitarian health aid.

The variety of inputs and tools available at EU level to contribute to an EU / DG ECHO humanitarian response (health system/public health development experts of DG DEVCO, assets under the EMC, research funding under the European Commission’s Directorate-General for Research and Innovation (DG RTD)) was also seen as an asset for DG ECHO as a donor, yet evidence suggests that the structuring of the different components could be further institutionalized and strengthened, to increase added value.

DG ECHO’s Consolidated Humanitarian Health Guidelines added value mainly to DG ECHO staff to inform funding decisions. Partners reported using them to some extent, but evidence suggests that this was somewhat superficial. Their added value would be improved if they were tied to a strategic performance framework (to meet DG ECHO’s strategic objectives) and against which RHE’s and country offices could measure progress made via their funding.

EU added value would be more easily traceable were DG ECHO to improve the measurement of the results of the projects it funds and the gaps it addresses. The absence of a strategic performance framework, tied to its strategic objectives in the health sector (as specified in DG ECHO’s Consolidated Humanitarian Health Guidelines), is a shortcoming. This idea is explored in more detail in the recommendations section below.
Sustainability and LRRD

A lack of consistent definition of sustainability means that the extent to which DG ECHO’s humanitarian health actions have been sustainable is inconclusive.

There was no consensus among stakeholders regarding definitions of sustainability or the extent to which sustainability can and should be a focus of humanitarian assistance. However, stakeholders felt that funding provided over a longer time period, rather than re-funding actions multiple times would better facilitate sustainability, and, allow better forward planning to improve effectiveness and efficiency. Multi-year funding, such as ExAR, were also identified as having significant potential to strengthening the link between humanitarian and development (i.e. LRRD) in a post-conflict environment. Although, in order to achieve successful implementation, ECHO would have to review its modus operandi to adapt it to such funding mechanism.

The sustainability of outcomes was not usually reported or measured. However, as a general outcome, almost all projects contained an aspect of capacity-building which can be a sustainable outcome (even if sustainability was not an initial objective). There is also no clear evidence of wider sustainable impacts: although a third of partners reported that DG ECHO-funded actions led to changes in government policies, no specific examples were identified.

The majority of DG ECHO funded actions were found to have been integrated into national programmes or systems and several examples of DG ECHO facilitating the handover of actions to national authorities were identified. However, the extent to which funding and/or actions were taken over by development actors was not clear: many handover difficulties were identified.

DG ECHO’s advocacy work was identified as a “game changer”, with evidence to suggest that it has influenced other actors to address gaps in their response, apply best practices and carry out follow-up actions.

Main findings from the ExAR Programme in Côte d’Ivoire

The table below provides a summary of the main findings observed during the field visit to the ExAR Programme in Côte d’Ivoire. This case study is of particular importance and interest, due to the innovative approach taken by DG ECHO in relation to funding of LRRD, drawing specific attention from within DG ECHO and externally. The full case study, in French, is available in Annex 8, which describes the context of this intervention, the main findings per evaluation theme, and provides a number of conclusions and recommendations. Furthermore, where relevant, these findings have been included as part of the main evaluation in this report.

Main findings from the ExAR Programme in Côte d’Ivoire

<table>
<thead>
<tr>
<th>Relevance</th>
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<tr>
<td>• Actions and activities respond to the major health needs of populations in primary health and barriers that prevent them from accessing services were addressed by the activities of the four partners.</td>
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<tr>
<td>• Women of reproductive age and children under the age of five were targeted by the interventions and are considered the most vulnerable groups.</td>
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<td>• Interventions meet priorities identified by ECHO in its financing decisions (HIPs).</td>
</tr>
<tr>
<td>• The involvement of stakeholders (regional and local authorities, community associations and caregivers) in the design and implementation of the activities varies between partners. The beneficiaries (women and children) have not been directly involved in the design.</td>
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</table>
Effectiveness
- There has been a general improvement in all aspects of interventions, even if the targets set through indicators have not all been met. The system is still fragile and needs are substantial.

Efficiency
- The budget available was considered appropriate to achieve or to move closer towards the majority of indicators set. However, significant needs remain unaddressed.
- DG ECHO mechanisms are considered to be effective with the exception of the contractual management, which is considered to be complex and not suitable to operations exceeding two years.

Connectivity and coordination
- Cooperation between ECHO and its four partners was strong and frequent (although the monthly meetings only started in 2015, one year after the beginning of the HSRA). The AFD and the MSHP were also invited to these meetings.
- The partners have collaborated closely with the national health programmes in the monitoring of standards and the training of health personnel.
- Cooperation between DG ECHO and the central level (UCP, Technical Secretariat of C2D and MSHP) was limited to sporadic exchanges and late information exchanges.
- The partners coordinated their activities with other humanitarian operators to avoid any overlaps; no duplication of actions was reported by the partners.
- The sectoral group represents a formal mechanism for exchanging experience between humanitarian donors (DG ECHO) and development actors.
- Cooperation between DG ECHO partners and regional and local authorities was regular and active. Their involvement in the design and sometimes in the implementation was, however, limited.

Sustainability
- Promotion and prevention aspects have been included by the four partners in their actions, which has made it possible to increase the number of good practices, as well as the use of its health centres.
- Different activities will be continued after the end of the project, especially in the area of governance, while other activities, in particular those requiring financial resources (such as the advanced strategies) need to be reviewed and adapted to continue without the support of their partners.
- The approach used by partners for promoting sustainability allows for ownership of the different tools and methodologies by the stakeholders, and allows for further involvement and training of various stakeholders (capacity-building COGES health personnel, and DD).
- There are a number of risks associated with maintaining sustainability of actions, such as staff turnover, lack of financing and durability of the equipment.
- There is a strong sense of motivation amongst the parties involved at district level, including within communities, associations, care givers and regional authorities.
- At the central level of the Ministry of Health, all stakeholders confirmed a lack of ownership taken by the UCP.

EU added value
- The elements which distinguish DG ECHO from other donors are mainly linked to its role as a strong humanitarian actor, transposed in a development context: rapid disbursement of funds, simplified procedures, flexibility, response capacity and experience and positioning on the ground, international recognition.
ExAR architecture

- A multi-annual approach is necessary and brings specific benefits, including strengthening of the link between the humanitarian sector and development sector (LRRD).
- DG ECHO has maintained its usual modus operandi for humanitarian interventions, although this was implemented in the context of LRRD: reporting procedures remained the same with some additional reporting requirements.
- The common framework as well as the regular meetings enabled common ideas and regular exchanges on what works well and what does not within this programme.
- Although the indicators are generally considered as good, they mostly measure the quantitative aspect of the results and they are not representative of the overall activities.
- There has been limited ownership and involvement of the UCP in the implementation and monitoring of the project.
- The differing approaches, visions and expectations of the two parties to the framework agreement of the PRSS (DG ECHO and the Government of Côte d’Ivoire) caused some tensions during the programme.

Conclusions and recommendations

Table 1, below, presents the five key strategic recommendations reported in section 4 of the main report. Each strategic-level recommendation is supported by a number of operational-level recommendations, and recommendations have been aligned with their relevant conclusions. A more extensive list of conclusions and recommendations, reported by project stage (design, implementation and follow-up) to support practical implementation, can be found in section 4 of the main report.
Table 1: Conclusions and recommendations

<table>
<thead>
<tr>
<th>Conclusions</th>
<th>Recommendations</th>
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<tr>
<td>Varying partner capacity to conduct needs assessments and lack of a</td>
<td>Develop a Strategic Performance Framework/logic model to support a more formal, systematised process for needs assessments, funding decision-making and the monitoring and evaluation of actions. Strategic priorities should be clarified and reflected in needs assessments templates, partner proposals, DG ECHO's Consolidated Humanitarian Health (CHH) guidelines and monitoring and final reports to support the clear alignment of strategic objectives with funded activities and action outcomes. More specifically:</td>
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<tr>
<td>standardised needs assessment process affected the extent to which DG</td>
<td>• DG ECHO should provide a specific needs assessment template to partners, in line with strategic priorities, which includes specific vulnerability criteria and appropriate guidance for completion;</td>
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<td>ECHO provided relevant support to crises.</td>
<td>• DG ECHO should promote the existing indicators (ECHO KRI’s in Annex B of the CHH guidelines), in particular those that capture the quality and timeliness of healthcare delivery. Indicators should also cover exit strategy/sustainability plans, expected health outcomes (not just outputs but formal health outcomes) and efficiency (clear cost breakdowns). Partners should also be supported by DG ECHO and the GHC to develop additional project-specific outcome indicators tailored to the context of the crisis, needs of the project and partner internal reporting systems;</td>
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<td>There was a general lack of awareness of DG ECHO’s Consolidated Humanitarian</td>
<td>• Compulsory indicators aligned with the strategic performance framework should be further promoted. Similarly, the use of these guidelines should be widely promoted among DG ECHO staff and partners to ensure indicators are included in partner proposals and funding decisions are made on the basis of these indicators. In cases where DG ECHO funds projects that do not clearly align with CHH guidelines and indicators, it is essential that reasons for funding are transparently reported;</td>
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<td>Health (CHH) guidelines, which were inconsistently used among partners and</td>
<td>• DG ECHO should support and promote, through the GHC, evaluation of actions against DG ECHO compulsory indicators and project-specific indicators, including promoting systematic collection of baseline data by partners, collection of</td>
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<td>other actors. However, when the guidelines were used, the Decision Tree</td>
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<td>Annex was identified as particularly useful for supporting funding decisions.</td>
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<td>In practice, not all actions were aligned with DG ECHO’s CHH guidelines:</td>
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<td>where actions were not aligned, no transparent explanation was provided as to why not.</td>
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<td>Monitoring of actions by DG ECHO staff and partners was not systematically</td>
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<td>done:</td>
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<tr>
<td>a) There was a lack of data (including baseline data) collected and</td>
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<td>reported;</td>
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<tr>
<td>b) There was confusion between output and outcome indicators by partners</td>
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<tr>
<td>during reporting (most data was reported at output level), and non-</td>
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<tr>
<td>compulsory indicators were used that only partially captured intended</td>
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<td>results;</td>
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<td>c) Reporting of budgets and spending was unclear in FicheOps and final</td>
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<td>reports;</td>
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**Evaluation of the European Commission's interventions in the humanitarian Health sector, 2014-2016**

<table>
<thead>
<tr>
<th><strong>d)</strong></th>
<th>There was a lack of clear consensus regarding the focus of DG ECHO actions on achieving sustainability.</th>
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<tr>
<td><strong>e)</strong></td>
<td>This limited the extent to which projects could be successfully evaluated.</td>
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</table>

- Good collaboration and coordination between 2. DG ECHO, partners and other actors, particularly in the early planning stage of projects, was highlighted as essential for the success of actions.
- In general, collaboration between DG ECHO and other actions was good although it was dependent on context. In some cases DG ECHO was not able to critically engage with relevant actors in national health clusters due to capacity issues or differences in favoured approach. Furthermore, collaboration with internal stakeholders (DEVCO, SANTE, EMC and the ECDC) could be improved.

**To support early and comprehensive stakeholder communication and engagement, ECHO should create, at the stage of HIP development, an engagement matrix for each country based on their principles of engagement, to clarify which stakeholders they can and should engage, and how.** Such a matrix would support a better understanding of the context within which DG ECHO operates, including the development actors (if any) present in the field and the specific actors involved in the national health cluster. This should help to facilitate:

- A better planning process between DG ECHO, national governments and development actors (where they exist) to share expertise and resources and better support sustainability;
- Improved collaboration with the Global Health Cluster (GHC) to ensure coordinated surge capacity which is integrated into local systems and staff hierarchies; and
- More coordinated and streamlined deployment of the EMC. Stakeholder mapping can support early assessment of the potential need for European Medical Team (EMT) deployment to allow early planning, as well as ensuring that EMT services and skills complement local capacity and needs and achieve cost-effectiveness and timely deployment.

- DG ECHO’s field presence through its network of 3. TAs and RHEs was key at improving the quality of needs assessments; facilitating and maintaining good coordination with stakeholders; disseminating international standards to the DG ECHO field network; and supporting advocacy work. RHE’s technical expertise, the trust relationships they

**RHE technical expertise should be better capitalised on (this may involve increasing RHE capacity):** RHEs and TAs should be further supported to play a greater role in stakeholder coordination. This includes:

- Ensuring a closer link between field staff and DG ECHO HQ. RHEs should systematically feed back into DG ECHO and JRC’s global needs assessments, and programming by DG ECHO HQ, including the HIP development process. TAs should also be encouraged to seek RHE technical advice more systematically.

established with partners and their monitoring of projects were seen as main contributing factors to the success of actions and RHEs were identified as a key area of DG ECHO’s added value.

- However RHEs were not systematically consulted and utilised: at crisis level although DG ECHO RHEs regularly gathered data on healthcare and emergency response needs and provided some input at HIP development stage, they did not conduct (or where they may have, this was not documented) formalised, well documented health-specific needs assessments to inform HIP development, and consultation of RHEs by DG ECHO TAs and partners for technical feedback and review of health projects and proposals was not sufficiently systematised.

- The efficiency of funding mechanisms varied by type of crisis and funding mechanism: funding through geographical HIPs for follow-up actions and through the Epidemics Instrument was, in most cases, deemed efficient, but other funding (for new projects and release of additional funds part-way through an action) delivered through geographical HIPs was deemed too slow.

- Views from DG ECHO staff, partners and other stakeholders on the benefits of longer-term funding periods were mixed: however all partners would prefer a two- to three-year funding period as they feel this would allow better forward-planning to improve effectiveness and efficiency, as well as better facilitate sustainability.

when making funding decisions;

More systematically supporting partner project design for health projects, for example, by promoting and enforcing the use of DG ECHO’s CHH guidelines to inform partner proposal design, promoting exchange of best practice and encouraging cooperation between partners and other actors at local level and more widely through the promotion of national and global health clusters;

- Promoting amongst partners, a better involvement of communities and service users in the planning, design and monitoring of actions to improve effectiveness, through participatory methods; and

- Supporting better engagement with internal departments. RHEs and TAs should play an even more active role in identifying opportunities where DG ECHO could utilise the expertise of NGOs, MS and various branches of EUIBOAs with health expertise, particularly more regular involvement of the ECDC in field-level needs assessments and utilisation of RTD research findings; and encouraging earlier and more sustained engagement with government departments and national and local health authorities through exploiting existing networks/contacts developed by DEVCO and other EU actors, where they exist.

4. Consider increasing the variety of funding mechanisms available for actions. While relevant to the health sector, this recommendation should be considered at a broader strategic level. More specifically:

- The process for funding first-time actions and releasing additional funds part-way through an action (through the geographical HIPs) needs to be revised to improve the speed of funding release. The Epidemics Instrument should be promoted as an effective tool to use for rapid funding release;

- A longer-term funding period of two years or more would be useful in some contexts (e.g. protracted crises, refugee camp settings) as it supports better planning and resource allocation to improve action effectiveness and efficiency. Longer-term funding such as the ExAR programme in Ivory Coast would also support LRRD and sustainability however better cost-spending transparency is required; and

- DG ECHO should consider introducing a two-tier funding structure: initial funding should be used to fund actions known to be effective, however sufficient
funding should be available to fund innovative projects on longer-term funding timescales; and
- DG ECHO could further elaborate on collaboration with EU Trust Funds to support the sustainability of successful actions.

- DG ECHO’s advocacy work was identified as a “game changer”, influencing other actors to address gaps in their response, apply best practice and carry out follow-up actions. Team work between DG ECHO’s Health Team leader (policy) and Global Thematic Coordinator (policy), with support from RHEs and the GHC, was identified as a key area of added value as they contributed to important evolutions within the global discussion on humanitarian health.

5. **Further expand and improve DG ECHO’s advocacy work.** DG ECHO should further maximise its influencing powers by identifying key issues to advocate for, and promote their views more widely across stakeholder groups (for example through organising thematic forums for debate) to drive engagement.
- DG ECHO should also focus on better documenting and promoting their existing good practice among other actors. This includes promoting their funding of innovative projects and approaches, for example, current collaborative work with DG DEVCO to look at the quality of medicines.
1 Introduction

This evaluation provides an independent assessment of the Directorate-General for European Civil Protection and Humanitarian Aid Operations’ (DG ECHO’s) interventions in the humanitarian health sector during the period 2014 to 2016. The evaluation was launched by DG ECHO in November 2016, and was carried out by ICF Consulting Services Ltd with specialist inputs from humanitarian aid and health experts.

This report details the work undertaken and provides a synthesis of the evidence collected within the framework of this evaluation: it sets out the main findings per evaluation theme and provides a series of conclusions and recommendations to inform DG ECHO’s future interventions in this area.

1.1 Purpose and scope of the evaluation

The purpose of this evaluation was to analyse DG ECHO’s portfolio of health interventions 2014-2016, investigating in-depth specific themes (see below), in order to provide conclusions and recommendations that will feed into the comprehensive Humanitarian Aid evaluation.

This evaluation aimed to assess the following issues:

- **Relevance** of DG ECHO actions in the Humanitarian Health sector, in particular the beneficiaries targeted and appropriateness of aid modalities used in the health sector;
- **Coherence** of DG ECHO health actions with core humanitarian principles, DG ECHO's policies, its Consolidated Humanitarian Health Guidelines (CHH), as well as with Global humanitarian health policies and standards;
- **Connectedness** between DG ECHO’s response and the interventions of actors in other areas addressing the same crisis;
- **Effectiveness** of DG ECHO health actions in achieving or contributing to DG ECHO’s overarching objectives (preventing excess preventable mortality, permanent disability, and disease associated with humanitarian crises);
- **Efficiency** of DG ECHO health actions;
- **EU added value** of such actions; and
- **Sustainability** of DG ECHO health actions and the opportunities for collaboration between humanitarian and development actors, notably through any Linking Relief Rehabilitation and Development (LRRD) interventions.

In addition, the following elements have been covered:

- DG ECHO’s Epidemics Instrument;
- Lessons learned from the Ebola crisis;
- The European Medical Corps (EMC) and the extent to which it has, so far, been used in a coherent manner with humanitarian health aid;
- Advantages and disadvantages of the plurennial transitional programme ‘External Assign Revenue’ (ExAR), which has been operating in Côte d'Ivoire since late 2013; and
- The influence of DG ECHO’s current policies and guidelines on health (notably DG ECHO’s Consolidated Humanitarian Health Guidelines) in promoting high quality projects and ensuring coherence within the overall portfolio of health projects.
1.2 Methodology

The evaluation was designed to respond to a specific set of evaluation issues and questions, as articulated in the Terms of Reference (ToR). A variety of data sources were used to build a rich and comprehensive evidence base for the evaluation, most notably:

- **Project portfolio analysis:**
  - A list of DG ECHO actions implemented in the health sector over the period 2014-2016 was extracted from the HOPE database and analysed, covering 573 actions;
  - A sample of a 100 actions within DG ECHO’s 2014-2016 health portfolio was created and reviewed in detail. This sample, representative of the composition of the portfolio, is included in Annex 2 of this report;
  - A sample of 52 Humanitarian Implementation Plans (HIPs) covering the period 2014 and 2016 were reviewed in order to determine links between strategic objectives made at policy and guidelines level and DG ECHO’s annual humanitarian response strategies. Key information extracted for analysis from each HIP include the stated health needs for each country or region, the target beneficiaries, details on the specific health responses provided by DG ECHO, as well as funding allocations, potential challenges and constraints, involvement of local/national actors, and exit scenarios;

- **Literature review:** 55 documents were reviewed to define key humanitarian health concepts, to capture information on best donor practice and on DG ECHO’s strategies and actions in certain areas (e.g. Ebola response);

- **Qualitative interviews:** 44 stakeholders were interviewed via semi-structured interviews, to explore each evaluation criteria and thematic area in more depth. Annex 3 provides a list of all interviewees, covering DG ECHO officers and partners, international donors and development actors;

- **Online survey of DG ECHO partners:** An online survey which gathered feedback from 32 DG ECHO partners\(^4\) (representing a total of 106 replies) who implemented health activities over the 2014-2016 evaluation period. The analysis of the survey responses has fed the evidence base and is presented in Annex 4;

- **Fieldwork in select countries:** Three field visits took place, exploring the ExAR programme in Côte d’Ivoire; DG ECHO’s health interventions in Jordan in response to the conflict in Syria; and DG ECHO’s humanitarian health response in South Sudan. A research-based case study was also produced on the global humanitarian response to the Earthquake in Nepal in 2015 (including deployment of foreign medical teams) and DG ECHO’s health response within it. All four case studies are provided in a separate annex to this report.

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\(^4\) The 32 partners that responded represent 58% of the partners involved in humanitarian health actions and 16.7% of the total funding.
1.3 Validity of the evaluation results

Complementary research methods were used to enhance the reliability and validity of the data collected and to provide the basis for cross-verification, corroboration and triangulation of the evaluation results. The vested interests of different stakeholder groups were taken into account to address potential bias and to ensure objectivity. However, as with any evaluation, there were limitations to the methodologies applied, which are summarised in Table 1 below. Given these methodological caveats and limitations, caution was exercised when interpreting data and producing findings.
### Table 1. Limitations to methodologies applied

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<th>Tasks</th>
<th>Issues encountered</th>
<th>Steps taken</th>
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| Project documentation        | Inconsistencies in type and amount of information available in partner reports.  
                              | Data mainly at output-level, less at outcome level.  
                              | Limited data to inform cost-effectiveness and efficiency and sustainability assessments.  
                              | Data inaccuracies within the HOPE Database in relation to defining health sub-categories of actions. | Data used with caution and triangulated with other data sources (interviews, survey, case studies, literature review) |
| Portfolio analysis           | Only received new, readymade portfolio at the draft final report stage which duplicated work initially undertaken.  
                              | Data not clear on number of beneficiaries. | Graphs automatically created through the HOPE dashboard were used and the Overview section was re-written on the basis of the new database. Beneficiaries’ results were not included in the analysis due to errors in the HOPE database. | Used exact title matches between projects to identify total number of refunded projects, however data was still inaccurate, therefore no analysis could be included on refunded projects. It is recommended that a marker is created in the HOPE database to allow for future identification and analysis of refunded projects. |
| Identification of refunded projects | No common marker to identify projects that have been funded more than once. | | | |
| Stakeholder interviews       | Diversity of interviewees consulted (DG ECHO representatives, DG ECHO partners, global standard setting organisations, etc.) with more or less informed knowledge of DG ECHO’s health interventions and some vested interests | A specific set of questions was developed for each category of interviewee to consult. During the analysis, the information collected was contextualised; the differences in the contexts and views were factored in. Data was cross-checked with other data sources. |
| Survey                       | Low response rate (106 out of 589 contacted)  
                              | Partners were also overly positive in their responses to some of their responses (possibly due to vested interest to send positive feedback) | To increase the response rate, several reminders were sent and the deadline has been extended. The evaluation team also answered any request by email encouraging partners to complete the survey or forward the request to the relevant person.  
                              | Data from the survey was handled with caution and triangulated with other data sources. |
1.4 This Report

The remainder of this document is structured as follows:

- Section 2 provides an overview of DG ECHO’s interventions in the health and medical sector during the period 2014-2016;
- Section 3 addresses the specific evaluation questions; and
- Section 4 sets out the conclusions and recommendations of the evaluation.

The main report is supplemented by Annexes which contain the detailed evidence base for the evaluation and is structured as follows:

- Annex 1: Supplementary information on DG ECHO’s response, including funding breakdown per country and partner;
- Annex 2: Details on how the evaluation sample was built;
- Annex 3: Breakdown of the stakeholder interviews conducted;
- Annex 4: Analysis of the DG ECHO partner survey conducted within this evaluation;
- Annex 5: Summary of key achievements of DG ECHO’s actions by region;
- Annex 6: Key findings on lessons learnt from the Ebola crisis;
- Annex 7: A bibliography of the literature reviewed for this evaluation;
- Annex 8: Four case studies relevant to DG ECHO interventions during the 2014-2016 period:
  - ExAR programme in the Côte d’Ivoire;
  - DG ECHO funded actions in Jordan, in response to the Syrian conflict;
  - DG ECHO’s humanitarian health response in South Sudan; and
  - The global humanitarian response to the Earthquake in Nepal in 2015, and DG ECHO’s health response within it.
- Annex 9: The Executive Summary, translated into French.
2 Overview of DG ECHO’s interventions in the health and medical sector

This section provides an overview of DG ECHO’s interventions in the health and medical sector, over the period 2014-2016, and is based on data extracted from the HOPE database.

2.1 Overview of DG ECHO’s response in 2014-2016

Over the period 2014-2016, DG ECHO funded 573 actions classified in the HOPE database under the health sector, out of which 553 were funded in third countries\(^5\). The total contracted amount of DG ECHO funding classified in HOPE under ‘health sector’ was €640.5 million, of which € 616.9 million was contracted in third countries.

The graphs (Figure 1, Figure 2, Figure 3) presented in this section have been automatically extracted from the HOPE dashboard, DG ECHO’s internal reporting tool. They therefore include funding provided to non-third countries.

Most actions were multi-sectoral, either with a health focus or with a health component. Most actions combined support to health activities with support to nutrition, food security and livelihoods and/or Water, Sanitation and Hygiene (WASH) activities. The remaining actions were fully dedicated to the health sector, for example strengthening essential primary and secondary healthcare services or improving access to healthcare for internally displaced persons (IDPs). The breakdown of health subsectors covered by funded projects is presented under section 2.2.

Funding increased steadily from 2014 to 2016 (Figure 1), with South Sudan receiving the largest amount of funding (€ 73 million) representing 11.4% of the total budget, over 2014-2016 (Figure 2). In terms of partners, the International Red Cross and Red Crescent Movement (BE, CH, DE, DK, FI, FR, LU, NL, NO) received the largest amount of funding (€ 121 million, 18.9%), as illustrated in Figure 3 below.

\(^5\) For purposes of this evaluation, only actions targeting third countries were analysed.

Figure 1. Annual amounts of contracted funding (excluding cash and vouchers) classified under the Health sector in HOPE, (2014-2016)

Figure 2. Top ten receiving countries (2014-2016) - Total amounts of contracted funding (including cash and vouchers) classified under the Health sector in HOPE (in € million)
The majority of funding was provided to **support IDPs and refugees**, including returnees and others (73%, 405 projects). A small number of funded projects (24) supported disabled populations. Furthermore, nearly three quarters (72%, € 455.5 million) of DG ECHO funding was provided to projects that incorporated prevention and response activities to outbreaks/epidemics, which included early warning and response actions. These actions focussed mainly on Ebola but also Cholera, Measles and Meningitis and included both prevention and response activities. Natural disaster-affected populations received the smallest amount of funding. A full breakdown of funding per country and partner can be found in Annex 1.

### 2.2 Overview of health subsectors covered by funded projects

The HOPE database classifies projects under various health subsectors, to show the breakdown of subsectors covered by their activities. Projects can be classified under more than one health subsector, reflecting the variety of health activities provided. The data per health subsector presented below covers the 553 projects funded in third countries only. Figure 4 presents the subsector coverage of those projects.

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6 The evaluation period includes projects that were granted funding in 2013 but started their work in 2014.
The most common health subsectors covered by projects were primary health (67% of projects) followed by medical supplies (51%), reproductive health (48%), community outreach (47%), and, prevention and response to outbreaks/epidemics (42.5%). Just over a quarter of projects (27%) included Mental and Psycho-Social support. Figure 5 presents the subsector coverage per region.

Figure 4. Projects’ coverage by health sub-sector, as reported in DG ECHO’s HOPE database (2014-2016)

Figure 6. Projects’ coverage by health subsector, by Region (2014-2016)
The MENA (Middle East and North African) and Asia regions had the lowest number of interventions focussed on prevention and/or response to epidemics. Reproductive health was also one of the top five health subsectors covered in MENA, Eastern Africa, Asia and Central Africa. In Latin America and the Caribbean, and, Western Africa, around a third of the projects covered reproductive health (29%, 9 out of 31 projects, and, 37%, 42 out of 112 projects respectively).

Focusing on mental and psychosocial support, the top five countries receiving interventions in were the Democratic Republic of Congo (15), Syrian Arab Republic (14), Iraq (13), Côte d’Ivoire (10) and Columbia (9), of which the International Red Cross and Red Crescent Movement (BE, CH, DE, DK, FI, FR, LU, NL, NO) and MSF (BE, CH, ES, FR, NL) were the most active partners (Annex 1, Table 6).

The Democratic Republic of Congo and South Sudan Republic had the greatest range of health sub-sectors covered. Focussing on partners, the International Medical Corps UK and Premiere Urgence Internationale have covered the largest range of health subsectors in projects they have conducted. A list of the top countries receiving interventions, top partners delivering interventions, and the countries that received no interventions per health subsector is presented in Annex 1 Table 6.
3 Evaluation findings

This section presents analysis and triangulation of the evidence collected in response to each evaluation criteria and the specific evaluation questions under each criteria.

3.1 Relevance

This section addresses the following evaluation questions:

- To what extent have DG ECHO humanitarian health actions (including the Geographical HIPs and Epidemics instrument) addressed the needs of the most affected population;
- To what extent have DG ECHO humanitarian health actions targeted the most vulnerable groups;
- To what extent have key stakeholders such as local, regional and national communities (including affected population) and authorities been consulted and participated in the design, implementation and follow-up of DG ECHO humanitarian health actions; and
- To what extent DG ECHO tailored its approach to addressing epidemics to recognise challenges (i.e. weak health system, scarcity of humanitarian partners) and accessibility obstacles (i.e. geographic, economic and socio-cultural)?

Relevance - main findings

- DG ECHO’s field network of RHEs, all medically trained doctors, were key in providing primary and up-to-date data and context-specific information to inform DG ECHO’s response strategies in the health sector. RHE’s also engaged with DG ECHO implementing partners at design stage, by, for example, informing partners of thematic priorities and defining crisis-specific strategies. They have not, however, conducted regular health-specific assessments to inform HIP development at the level of each crisis area of DG ECHO interventions, or where they may have, this was not documented. Evidence also shows that RHEs were not systematically consulted at the stage of the development of the HIPs nor by DG ECHO TAs and partners on projects delivering health activities.

- The quality of needs assessments in the health sector was limited by issues inherent to humanitarian interventions which complicate the establishment of factors, often inter-related, which influence risks leading to excess morbidity, mortality and disability. DG ECHO implementing partners’ capacity to conduct proper needs assessments to inform health-related activities was also a determinant factor. Whilst some had sound capacity, others less so.

- The quality of needs assessments in turn influenced donor and partners’ understanding of the essential package of health services to be adopted in a given crisis and DG ECHO’s ability to control that funded projects supported the most vulnerable and in need.

- DG ECHO’s humanitarian health actions addressed important needs but it is not clear whether they systematically targeted the most affected and vulnerable populations and supported the most relevant interventions.

- There is evidence that DG ECHO tailored its approach to address epidemics against recognised challenges and accessibility obstacles, yet harnessing available expertise, also outside DG ECHO, could have been better.
3.1.1 DG ECHO’s needs assessments in the health sector relied on Regional Health Experts (RHE’s) and partners’ work. They would benefit from harnessing expertise available elsewhere.

Quality needs assessments are essential to proper targeting of support. This in turn is key to achieve DG ECHO’s overarching objective in humanitarian health “to limit excess preventable mortality, permanent disability, and disease associated with humanitarian crises” (as mentioned in DG ECHO’s Consolidated Humanitarian Health Guidelines - CHH).

3.1.1.1 Needs assessments at global and crisis level

The development of DG ECHO’s crisis-level humanitarian responses, formalised in its annual HIPs (annual multi-sectoral humanitarian response strategies) - where funding decisions are also made - are based on multi-sectoral needs assessments. Those needs assessments draw on (1) a range of secondary sources (e.g. household surveys, government data, UN Office for the Coordination of Humanitarian Affairs’ (UNOCHA’s) Humanitarian Needs Overview, UNDP’s Human Development Index (HDI)), on (2) inputs from DG ECHO’s health experts, including those in the field (RHEs)8, as well as (3) discussions with implementing partners and DG ECHO staff in the field. They also draw on global needs and risk assessments on the basis of (1) the Index for Risk Management and Forgotten Crisis Assessment (FCA)9, (2) the Integrated Analysis Framework (IAF)10, and (3) the Index for Risk Management - INFORM, led by the Inter-Agency Standing Committee (IASC) and the Joint Research Centre (JRC), which includes some health-specific indicators. The need to improve DG ECHO’s needs assessments and resource allocation systems, based on the Index for Risk Management (INFORM), was however recognised11.

The evaluation found that DG ECHO’s humanitarian response strategies and needs assessments in the health sector have mainly relied on inputs provided by (1) DG ECHO’s field network of RHEs and by (2) DG ECHO’s implementing partners. However, whilst RHEs gathered data on healthcare and emergency response needs, capacities and policies on an ongoing basis for the countries they covered12, no formal, health-specific assessments at crisis level were regularly conducted by DG ECHO, or where they may have, this was not documented. In addition, the format of RHE reports was not aligned to DG ECHO’s Consolidated

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8 In October 2016, DG ECHO had a network of 7 RHEs covering DG ECHO’s operations in the following 7 regions: Central and Latin America, North and West Africa, Central Africa, the Great Lakes Region, the East and the Southern Africa Region, the Maskrek region and Central Asia, and the rest of Asia. They were in turn supported by a GHE and the Health Focal point at DG ECHO’s headquarters.

9 http://ec.europa.eu/DG ECHO/what/humanitarian-aid/needs-assessments_en

10 The IAF is an in-depth assessment carried out by the EC’s humanitarian experts, which consists of a qualitative assessment of humanitarian needs per single crisis, also taking into account the population affected and foreseeable trends https://ec.europa.eu/DG ECHO/what/humanitarian-aid/needs-assessments_en

11 At the time of writing (June 2017), an exercise to improve DG ECHO’s needs assessments and resource allocation systems, based on the Index for Risk Management (INFORM), was ongoing. A consultancy firm was contracted to develop sector-specific indicators to improve the identification of needs at sector level.

12 They consider, for instance, evolutions in the healthcare system ‘before-during-and after’ the crisis, e.g. level of destruction of health structures, the availability of health staff, the concentration of refugees/IDPs, differences in access to health services between the capital and rural areas, etc. When RHEs visit countries, activities conducted typically include the following: desk review and review of information provided by partners and relevant organisations; review of health related data/information at country level; field meetings with other donors (to identify gaps); meetings with the Ministry of Health (e.g. a specialist working on the areas related to DG ECHO-funded projects); meetings with operational actors (WHO, UNICEF, NGOs) and with one/two partners in the field; visits of health structures and facilities; monitoring of ongoing projects/health dimensions of ongoing crises; meeting with local authorities.
Humanitarian Health Guidelines or to the HIPs. This would have allowed linking the situation on the ground and progress (or lack of) made via DG ECHO-funded projects, with DG ECHO’s overarching humanitarian response and objectives, both at the level of a given crisis and at health sector level.

**RHEs’ field presence and contextual knowledge was nonetheless crucial** as they provided technical feedback to field office staff (e.g. DG ECHO Technical Assistants (TAs)) when assessing partners’ applications (e.g. proposed vaccine coverage, intervention areas) and making informed funding decisions. Indeed, gaps in the delivery of essential healthcare services varied greatly across regions in a given country, and healthcare systems’ capacity can be suddenly overwhelmed by the scale of needs, e.g. in Lebanon, the healthcare system could not absorb needs due to the massive and steady influx of Syrian refugees. Filling such gaps requires having up-to-date information from the field. In Nepal, between six and ten DG ECHO staff were in Kathmandu within the first two weeks of the crisis where they made six field visits to affected areas with implementing organisations. DG ECHO further relied on exchanges of information with potential implementing partners in the health sector and DG ECHO participated in daily donor meetings as well as relevant sector cluster meetings.

However, evidence shows that [RHEs were not systematically consulted at the stage of the development of the HIPs nor by DG ECHO TAs and partners on projects delivering health activities.](#) Considering their multi-country portfolio, their involvement has also been dependent on their capacity and availability, as well as on TAs and partners’ initiative in seeking their technical support. The survey amongst DG ECHO implementing partners conducted within this evaluation shows that DG ECHO RHEs were notably involved in the selection and proper delivery of interventions in the health sector and had added value. Out of 100 DG ECHO partners who responded to the survey, 33 declared that a DG ECHO RHE had been involved in the design of their action(s). This small number could be due to the lack of visibility of the RHEs’ inputs since partners interact with field office staff and are not necessarily aware of other inputs. Types of RHEs’ support, at design stage, reported by partners included: feedback on proposals and project strategies, sharing of information from secondary data (health indicators and reports) and field visits on the needs of the population and challenges in health service provision. For example, following a RHE report on a monitoring mission to Afar and Amhara resilience clusters in Ethiopia in 2014, which identified some weaknesses at project level, improvement recommendations were provided, which included, among others, to improve the targeting of vulnerable groups and achieve better coverage of preventive services. In the case of the two EMC deployments since its launch, the field presence and local knowledge of DG ECHO RHE’s were highlighted as key facilitating factors, notably with regards to knowledge of the capacity of local health actors.

**RHE’s role in coordinating health expertise and inputs from various branches of European Union Institutions Bodies and Offices (EUIBOAs) could be enhanced**, most notably with: the Directorate-General for International Cooperation and Development (DG DEVCO), the European Centre for Disease Prevention and Control (ECDC), the Civil Protection (CP) policy unit at DG ECHO, the Directorate-General for Health and Food Safety (DG SANTE) and the Directorate-General for Research and Innovation (DG RTD)). Considering their multi-country portfolio, this, in turn, is dependent on RHEs’ capacity and availability and on the application of modus operandi.

**Evidence gathered for this evaluation has also shown that the quality of needs assessments in the health sector, conducted by DG ECHO staff and its partners, was influenced by shortcomings in local data to quantify in a robust manner (1) the risk of excess morbidity/mortality and disability, and**

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13 (1) Deployment of a yellow fever outbreak assessment team in Angola in May 2016 and (2) the deployment of a German mobile laboratory in DRC to increase the local capacity to diagnose yellow fever.
understand the complexity of inter-related factors, and in turn (2) the capacity of local health systems to adequately absorb the humanitarian shock:

- At a conceptual level, a number of inter-related factors influenced risks leading to excess morbidity, mortality and disability and establishing the proper causality chain can be challenging\(^\text{14}\). These risks are higher in volatile humanitarian contexts and countries with low capacity health systems (e.g. DRC, CAR). In some instances, better coordination at the stage of needs assessment between partners and donors present in the field could improve the quality of such needs assessments.

- In certain contexts, reasons were more political: host governments that neglect a refugee situation or other state actors denied the existence of a crisis, e.g. in the Great Lakes Region. Amongst the most cited obstacles in the need assessment(s) phase, DG ECHO implementing partners, responding to this evaluation survey, highlighted security constraints (56%) and lack of access to sites (42%) to conduct needs assessments, e.g. due to risk of violence or conflict, or need to obtain authorities’ authorisation, or permission from armed groups controlling the area, as challenges for conducting needs assessments.

In such cases, needs assessments were done remotely, which in turn diminished data quality. The reported effect is that the quantification of excess preventable mortality were relatively weak and on par to estimates. This in turn influenced donor and partners’ understanding of the essential package of health services to be adopted in a given crisis and DG ECHO’s ability to identify the most vulnerable and most in need (see further below). **DG ECHO’s Consolidated Humanitarian Health guidelines in this regard, whilst helpful in providing orientations, were not specific enough – aside from the decision tree – to inform those types of decisions.**

### 3.1.1.2 Needs assessments at project level

Needs assessments were also conducted at project level by DG ECHO implementing partners, using a variety of data. More generally, secondary data, from, for example the Health Cluster and national actors, United Nations (UN) agencies and other donors or Non-Governmental Organisations (NGOs) was used.

In relation to primary data collection, some projects included the collection of baseline data at the start of an intervention, with others using participatory methodologies, involving beneficiaries, at project design stage. For example, within the project “Building resilience through integrated multi-sector interventions in drought prone areas of Liben zone of Somali Region” in Ethiopia (DG ECHO/-HF/BUD/2015/91034), the community and local government participated in various discussions on the drought problem and the current ways of addressing it. They identified weaknesses at community level and proposed possible solutions which informed the design of the project. Within two projects in Cameroon (DG ECHO/-AF/BUD/2016/92009 and DG ECHO/-CF/EDF/2014/01003) involving beneficiaries in the design of the action was a specific objective: the projects aimed to recruit and coordinate volunteers from the local communities and refugee population to collect local data to inform an accurate needs assessment. The latter approach can be considered as a good practice, also in view of the reference in DG ECHO’s Consolidated Humanitarian Health Guidelines of the importance of beneficiary participation at needs assessment and intervention design stages. The extent to which this was encouraged by DG ECHO staff and guided funding decisions is, however, not clear.

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DG ECHO implementing partners’ capacity to conduct proper needs assessments to inform health-related activities was a determinant factor of their quality. Some of DG ECHO’s partners in the health sector have strong standards and tools to conduct needs assessments and invest in abiding to quality standards, e.g. the ICRC needs assessments seek to be adapted to every context and to each phase of an emergency, and also to be accountable to beneficiaries; and the UNHCR reported using a standardized survey form, called the Heightened Risk Identification Tool (HRIT) to identify vulnerabilities amongst refugees which would require an intervention. The evaluation found however, that partners in the field often faced high staff turnover. Some partners were altogether absent from the field and conducted needs assessments remotely or purely based on secondary data; others had not been present for long. For example, one 2014 RHE report on the Afar and Amhara resilience clusters in Ethiopia highlighted that healthcare planning by partners was rather weak and carried out on the basis of insufficient knowledge of the local context. A 2016 monitoring report on Nigeria by a DG ECHO RHE indicated that DG ECHO partners had highlighted the lack of accurate information on needs, which limited their needs assessments; and they reported using general health indicators collected at regional/country level when feedback shows that more relevant indicators would have covered their specific geographical area of intervention.

The evaluation also found that attention to how needs evolved over the course of a project, and also across re-funded ones, varied, according to partner, context (level of volatility) and also according to DG ECHO staff. The South Sudan case study shows that partners should be encouraged to update their needs assessments when situations drastically change, affecting the implementation of planned activities or types of interventions. The evaluation found evidence of good practice in rapidly-evolving crises, for example, the project “Health response to humanitarian needs in the Syrian Arab Republic” (ECHO/SYR/BUD/2014/91031) reported using a consolidated needs assessment methodology based on an early warning system and a main document to report on using a variety of indicators (e.g. access to hospital, mapping of healthcare facilities and services and their level of functionality) and monthly data collection, by field staff, at the level of hospitals and health centres, which was then triangulated with data from other actors and donors.

More generally, the quality of needs assessment conducted by partners was also influenced by factors inherent to humanitarian contexts (shortcomings in existing data, security and access issues, need to react fast), which make establishing proper causality and designing interventions to address the correct factors of influence, complex. For example, within the project « Reponse Rapide aux Movements de Population (RRMP) (2014/01210) », the involvement of the different populations in the implementation of the actions was not sufficiently defined nor clarified, due to the urgent need to launch this action.

3.1.1.3 Evidence shows that DG ECHO humanitarian health actions addressed important needs in the health sector at global level

DG ECHO actions addressed important needs but it is not clear whether they systematically targeted the most affected and vulnerable populations and supported the most relevant interventions. This is mainly due to a lack of systematic, documented needs assessments at the level of each crisis.

The top ten receiving countries of actions classified under the health sector in HOPE database and implemented over the period 2014-2016 were South Sudan, Syria, Iraq, Lebanon, DRC, Mali, Turkey, Yemen, Afghanistan and Somalia (see Figure 1 in the overview section)). Primary health and medical supplies were the two most covered subsectors by DG ECHO funded projects (see Figure 4 in the overview section and Table 6 in Annex 1).

According to data collected in HOPE, most beneficiaries were refugees and/or IDPs. Within this group, the following were supported for example: women and children...
affected by malnutrition in Afghanistan; affected population caused by drought and food insecurity in Ethiopia; Afghan refugees in Iran and in Pakistan (particularly women and children); Rohingya refugees, Kutupalong Refugees, host communities and Undocumented Myanmar Nationals in Bangladesh; Central African Republic refugees in DRC and in Cameroon; DRC refugees in neighbouring countries; Sudanese refugees in Gambella region in Ethiopia.

The evaluation also found that support in the health sector, funded by DG ECHO, was targeted to relevant regions, as per UNOCHA’s needs metrics, as defined for example by the level of conflict severity and vulnerability. In DRC for example, DG ECHO funded a mix of dedicated health-related activities (Emergency health response, primary and secondary health care, psychosocial support, Sexual and Gender Based Violence (SGBV)-related health activities, malaria outbreak response and cholera vaccination activities) and multi-sectoral ones, linking health activities with WASH and/ or economic security and protection activities. It provided support mainly in the North Kivu, Katanga and the Equateur provinces. According to UNOCHA needs assessment for 2017, the first two provinces are amongst the six (out of 26) where 80% of humanitarian needs in DRC are concentrated (in 2017). In North Kivu, numerous armed groups operate, ethnic tensions are rife and the province currently hosts the largest share of IDPs and refugees in DRC. In Katanga (e.g. Kinkondja) military interventions occurred, the share of IDPs was high and there was a malaria outbreak response in 2014.

In Afghanistan, DG ECHO funded a mix of dedicated health projects (emergency health, trauma, physical rehabilitation services, psychosocial support and emergency preparedness activities) and combined health and nutrition projects. They targeted mainly refugees, women and children in the Kunar and Nangarhar Provinces. Those are provinces where, according to UN OCHA needs assessment for 2017, health facilities were closed as a direct result of conflict when health service capacities have been heavily overburdened by rapidly rising demands from a large number of IDPs and refugee returnees from Pakistan and following full-scale military operations from the North Waziristan Agency in June 2014. These are also provinces where in 2017 Global Acute Malnutrition prevalence was >15% above the emergency threshold.

There are a few instances where evidence suggested that gaps in DG ECHO’s humanitarian health response existed, for example the mental health needs had not been addressed at all in a region in CAR where a DG ECHO project had been implemented and this was highlighted by the RHE as an opportunity loss. The following health sub sectors have been the least covered, as reported in the HOPE database: health infrastructure rehabilitation (28% of projects, 155), Mental and Psycho-Social Support (27%, 152), Capacity Building (13%, 73) and HIV (0.7%, 43). Only four projects covered emergency health assistance and only two covered preventative and curative care.

The evaluation was however not able to establish whether DG ECHO and its implementing partners systematically targeted the most affected and vulnerable populations in a given crisis. Rather, it found that identifying the most affected and vulnerable populations within a crisis (beyond the common definition of vulnerable groups in conflict and displacement, i.e. women, children and the disabled) had been challenging for reasons already invoked under section 3.1.1. There are some

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16 Ibid

examples of efforts made by DG ECHO and its partners to identify the most affected and vulnerable, for example, a number of HIPs highlighted the higher risks for certain vulnerable groups or regions. In Iraq, there is evidence that attention was paid to give priority to out-of-refugee camp populations (over refugees and IDPs inside camps) in view of critical gaps in local health infrastructures to ensure essential service provision to them. In other cases, DG ECHO funded actions that aimed to identify the most vulnerable, as presented in the case study on DG ECHO’s response in the health sector to the Syrian crisis in Jordan, DG ECHO’s funded the ‘Vulnerability Assessment Framework’ (VAF) which identified and tracked the multi-sectoral vulnerabilities of Syrian non-camp based refugees registered with UNHCR in Jordan, which helped partners target the most vulnerable refugees in their project design and implementation\textsuperscript{18}. The tool was reported as a key source of information by the DG ECHO RHE.

Opportunities to improve the better targeting of vulnerable populations do however exist. For example, DG ECHO’s gender-age marker, introduced in 2014 to “make actions more sensitive to the different needs and capacities of women and men of different ages\textsuperscript{19}, was not always used consistently across funded actions. Also, in the case of responses to epidemics, DG ECHO staff reported that partners tended to target the whole population affected, when a more targeted response, in view of limited funding available, could have been more efficient. For example, within the support to the Afar and Amhara resilience clusters in Ethiopia in 2014, an exemption system for the poorest segments of the beneficiary population was applied. This was designed to safeguard their access to the health services supported.

The choice of how aid is delivered also has a bearing on how well it addressed the needs of populations. In the health sector, health services can be delivered directly (e.g. in refugee setting, DG ECHO implementing partner delivers health services directly and is 100% responsible for the services) or indirectly (by supporting existing health services and infrastructure). Approaches to aid delivery can be input-based, e.g. a partner supports existing health facilities by providing inputs such as drugs, training, managerial support, or it can be performance-based. Aid can also be delivered via cash transfers, in-kind material or vouchers, e.g. a partner refers a patient to a hospital and pays the medical bill, or pays for transport. Finally, delivering aid, including in the health sector, through the Békou Trust Fund in CAR (the first multi-donor European Trust Fund which was set up in 2014\textsuperscript{20}) was seen as relevant to the needs of a context characterised by a very long term crisis and weak institutions, this requiring a mixed development and emergency/life-saving approach. The evaluation found however little information in DG ECHO reporting documents on aid modalities used, an issue faced more widely in the humanitarian aid sector. This is consistent with method issues reported in the Evaluation of the use of different transfer modalities in DG ECHO humanitarian aid actions 2011-2014.

3.1.2 There is evidence that DG ECHO tailored its approach to address epidemics against recognised challenges and accessibility obstacles, yet improvements, notably in terms of harnessing expertise elsewhere, could be made

The review of the portfolio, on the basis of the HOPE database, shows that 235 actions addressed prevention and response to outbreaks/epidemics (which also covered including early warning and response actions), equating to 72% of the funding total. According to the classification of actions by subsectors, 208 were funded under geographical HIPs and 27 actions were funded under the Emergency Toolbox (EET)

\textsuperscript{18} For further information, see separate Annex on Case Studies for full Jordan case study report.


HIP. The review of the portfolio shows that they broadly supported similar projects. The 208 projects funded under geographical HIPs supported responses to outbreaks of *inter alia* cholera in Chad, DRC, Tanzania, South Sudan Republic, Nigeria, Kenya, Malawi; measles in Ethiopia, Chad, Niger, Guinea and Uganda; the plague in Madagascar; haemorrhagic fever in Guinea, Sierra Leone and Liberia; and malaria in DRC. It can be reasonably assumed that those projects were funded under the Epidemics instrument, which forms part of the EET, and Table 4 in Annex 1 provides an overview of the use made of this instrument. It shows that the Epidemics instrument was used in a variety of regions to address *inter alia* cholera, malaria, measles, meningitis, polio, Ebola, and haemorrhagic fever. Médecins Sans Frontières (MSF), United Nations Children’s Fund (UNICEF) and World Health Organisation (WHO) were the major implementing partners of actions funded under the Epidemics instrument.

An initial allocation to the Epidemics instrument is made at the start of the year which can be topped up as needs arise in the case of outbreaks and their rapid spread. This is the main added value of this instrument against the geographical HIPs for which allocation are made once a year, with the partner survey conducted as part of this evaluation showing that the nine respondents who applied for funding under this instrument did so due to the shorter time needed to release funds and the availability of the funding all year around.

With regard to Responses to Epidemics under the European Medical Corps, the EMC was set up, officially in February 2016, as part of the European Emergency Response Capacity, also known as the voluntary pool of assets of the EU Civil Protection Mechanism (EUCPM). It aimed to "significantly increase the availability of doctors and medical equipment in response to emergencies, and allow for better response planning and preparations." Both EMC responses since its official launch were in response to the yellow fever outbreak. Evidence shows that deployments in Angola (an assessment team sent in May 2016 in response to yellow fever outbreak) and DRC (deployment of a mobile laboratory in DRC in response to Yellow fever also) addressed needs but were considered more as trials than part of an integrated response with other DG ECHO-funded actions in country. Stakeholders agreed that further efforts were needed to better integrate assets available under the EMC and expertise of ECDC and DG ECHO staff and partners’ work in the field, e.g. providing epidemiological data, assets or expertise from EU Member States (MSs) to inform funding decision-making and support to DG ECHO partners.

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21 There are no ways to identify, within the HOPE database, projects funded under the Epidemics instrument specifically.

3.2 Coherence

This section addresses the following evaluation questions:

- To what extent DG ECHO health actions:
  - Recognised international standards (i.e. those endorsed and promoted by WHO, the GHC, the Sphere Project) and
  - Were consistent with DG ECHO principles and DG ECHO’s Consolidated Humanitarian Health Guidelines?
- To what extent the EMC design and setup is coherent with DG ECHO’s Consolidated Humanitarian Health Guidelines and other international standards and guidelines?

Coherence - main findings

- DG ECHO Partners used a variety of international, national, and, internal guidelines dependent on the context of the crisis intervention.
- DG ECHO staff played a role in disseminating international standards in the field.
- There was a lack of consistency in the use of DG ECHO’s Consolidated Humanitarian Health Guidelines by DG ECHO staff and partners: where they were used, the Decision Tree Annex was identified as useful for informing funding decisions.
- In practice, not all of DG ECHO’s actions were in line with the Consolidated Humanitarian Health Guidelines. In some cases, only certain principles from the Guidelines were covered, while others were not. Where actions were not aligned, no transparent explanation was provided as to why not.
- With the current data, it is difficult to assess the coherence of the EMC with guidelines and standards.
- DG ECHO needs to be clearer on how to use, monitor, and, promote their Consolidated Humanitarian Health Guidelines to ensure consistency across their actions.

In 2014 DG ECHO published its Consolidated Humanitarian Health Guidelines, with the aim of providing more clarity on what it should fund. Crucially, the Guidelines specify that ‘The overriding objective of DG DG ECHO’s health assistance is to limit excess preventable mortality, permanent disability, and disease associated with humanitarian crises.’

The Guidelines are based on the basic principles of humanitarian work outlined in international guidelines and standards and were formed through multiple stakeholder consultations and expert opinions. They are to be used, along with the technical annexes, by DG ECHO staff and partners to inform DG ECHO’s responses in the health sector and create a coherent set of interventions.

The following section highlights the use and awareness of international standards and DG ECHO’s Consolidated Humanitarian Health Guidelines by DG ECHO staff, partners, and international organisations. To further understand the extent to which these standards and guidelines were reflected in practice in DG ECHO’s health actions, the evaluation report sections on relevance, coordination and

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connectedness, efficiency, effectiveness, and, sustainability explore the key principles in detail.

3.2.1 DG ECHO partners used a variety of international, national, and internal guidelines dependant on the context of the crisis

DG ECHO partners used a variety of guidelines, depending on the relevance of certain guidelines to the action. Results from the partner survey (see Annex 4: Figure 13) showed that **WHO guidelines are the most referred to by partners when designing an action, yet in implementation, partners find their own internal guidelines most useful, as they may be more relevant on an operational level.** It is difficult to assess whether the partner's internal guidelines are in line with DG ECHO's Consolidated Humanitarian Health Guidelines, as no data was provided on the content of such internal guidelines. The use of national health guidelines varied the most depending on the context of the crisis. In some situations, such guidelines are not used because they are not consistent with international guidelines (for example on drug procurements), and/or, the Ministry of Health does not recognise a crisis due to political barriers resulting in a lack of guidelines (for example in Syria).

In the case of the Syrian crisis, the Jordan Response Plan (JRP) was developed by the Government to align all international actions being implemented in the country: Although the JRP is was not specifically referred to by DG ECHO field staff when talking about the health funding during the evaluation period and it is not mentioned in any of the internal documents presented to the evaluation team, the health interventions funded by DG ECHO between 2014-16 in Jordan were in line with two of the three main health strategies of the JRP.

**Flexibility in the use of national guidelines is in accordance with DG ECHO’s Consolidated Humanitarian Health Guidelines** where DG ECHO advocates that “if the most appropriate response to the humanitarian needs of the population requires an approach that differs from existing national recommendations, DG ECHO will endeavour to support those interventions that most closely adhere to [DG ECHO’s] principles”.

3.2.2 DG ECHO staff played a role in disseminating and advocating for international standards in the field

DG ECHO’s GHE and RHEs played a role in ensuring that global recommendations and standards are disseminated to the DG ECHO field officers and DG ECHO partners in their region. Interviews with DG ECHO staff highlighted that **DG ECHO continually aimed to consolidate other guidelines and recent developments in the health sector and translate latest information into knowledge and practical implementation on the ground through coordination with various actors.**

Furthermore, in some cases, **DG ECHO staff played an advocacy role, as highlighted in DG ECHO’s Consolidated Humanitarian Health Guidelines, through contributing to the creation and dissemination of new research, standards and guidelines; and new revisions to the SPHERE standards drawing upon DG ECHO’s Consolidated Humanitarian Health Guidelines**. Within Jordan, DG ECHO was clearly perceived by some of the informants to the evaluation to be at its best when facing urgent humanitarian challenges such as the humanitarian situation at the berm. DG ECHO acted as a very principled humanitarian donor and was seen by other donors and stakeholders to be the first to stand up for important humanitarian principles.

Other examples included collaboration between DG ECHO and the WHO in creating new guidelines as part of the health clusters; and, contributing to the creation of national Ebola treatment guidelines in Liberia.

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25 Interview with WHO representative
3.2.3 There was a lack of consistency in the use of DG ECHO’s Consolidated Humanitarian Health Guidelines by DG ECHO staff and partners

In practice, DG ECHO’s Consolidated Humanitarian Health Guidelines were used intermittently by DG ECHO staff and partners. Interviews with DG ECHO’s RHEs and TAs highlighted that sometimes DG ECHO TAs do not have time to read and rigorously adhere to the guidelines. This finding is reflected in the use of the guidelines by the partners, where only half of the respondents to the evaluation survey stated using the guidelines in practice. In the countries visited by the evaluation team26, DG ECHO’s Consolidated Humanitarian Health Guidelines were not consulted or used by DG ECHO staff or partners for project development and implementation. The lack of adaptability of the guidelines to certain contexts, and the use of other guidelines were the main reasons for discrepancies in the use of DG ECHO’s Consolidated Humanitarian Health Guidelines in DG ECHO’s actions. For example, the previous RHE for Latin America and the Caribbean stated DG ECHO’s Consolidated Humanitarian Health Guidelines were created with the focus on rural African settings, and so were less adapted to urban middle income settings.

When DG ECHO’s Consolidated Humanitarian Health Guidelines are used, they mainly act as a strategic benchmark for funding and designing health actions, where the technical annexes were highlighted as particularly useful. Out of the respondents to the ECHO partner survey, two fifths of respondents (36) used the guidelines in the design of their actions and a sixth (14) used the guidelines in the implementation. The large majority of respondents (72) found the technical annexes to be useful. DG ECHO TAs and RHEs predominantly used the guidelines for the assessment of project proposals to advise on funding decisions, as observed, for example in Jordan.

Not all actions funded were in line with DG ECHO’s Consolidated Humanitarian Health Guidelines. It was noted by RHEs that at times partners did not have the time or capacity to complete proposals which adhered to DG ECHO’s Consolidated Humanitarian Health Guidelines, leading to the partner’s reputation and previous work in the region acting as the main determining factors in the granting of funding. Table 2 below outlines key principles from DG ECHO’s Consolidated Humanitarian Health Guidelines and the extent to which these were reflected in DG ECHO’s actions. More detailed analysis and concrete examples are further discussed under other evaluation themes within this report.

26 Ivory Coast, Jordan, South Sudan.
Table 2. The extent to which DG ECHO’s actions were coherent with DG ECHO’s Consolidated Humanitarian Health Guidelines

**KEY:**

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<tr>
<th>Coherence Level</th>
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<tr>
<td>To a large extent</td>
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<td>To a moderate extent</td>
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<td>To a small extent</td>
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<tr>
<td>Not enough clear evidence</td>
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<table>
<thead>
<tr>
<th>Main principle in DG ECHO’s Consolidated health Guideline</th>
<th>Evidence collected from DG ECHO’s actions</th>
<th>Section in report for further information and examples</th>
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<tbody>
<tr>
<td>Independent monitoring of the projects</td>
<td>Evaluation, monitoring, and, audit are mentioned as essential to ensure efficiency – the majority of partners felt that DG ECHO was involved in the monitoring of projects.</td>
<td>Efficiency</td>
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<tr>
<td>Actions target the most vulnerable and in greatest need</td>
<td>DG ECHO actions addressed important needs but it is not clear whether the partners systematically managed to target the most affected, vulnerable populations.</td>
<td>Relevance</td>
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<tr>
<td>Needs assessments include quantitative assessments of health needs and the use of published reports on best practice</td>
<td>Needs assessments relied on RHE’s and partners work and quality varied. The extent to which this was systematically conducted and checked by DG ECHO staff in the field is however not clear.</td>
<td>Relevance</td>
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<tr>
<td>Building of capacities in healthcare services</td>
<td>A sample of projects worked with the local communities, MoHs, healthcare professionals, and, other partners in capacity building activities during and after the action.</td>
<td>Sustainability / Connectedness and Coordination</td>
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<tr>
<td>Transition from humanitarian to development interventions</td>
<td>Dependant on the context of the crisis. It is not clear the extent to which development actors took over funding from humanitarian actions.</td>
<td>Sustainability</td>
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<tr>
<td>Do no harm</td>
<td>RHE’s provide up to date information to inform response strategies and help decide funding decisions to ensure DG ECHO’s assistance ‘does no harm’. RhEs are however not involved in the review of all new funding decisions with health activities. Information provided by the GTC indicates that an agreement between DG ECHO FN and HQ exists, whereby all new actions are reviewed by sector experts.</td>
<td>Relevance</td>
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<tr>
<td>Exit strategies</td>
<td>There is no clear from the evidence gathered from partners what is meant by the term ‘exit strategy’ making it difficult to assess whether</td>
<td>Sustainability</td>
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Innovative actions that use new approaches, tools, and, methods

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<td>A few examples of innovative actions, such as multi-sectoral programs, and, research. Yet a number of projects were also funded and re-funded as they provided a ‘classical’ response from trusted partners. It is important to note that in certain cases such projects may have been the most appropriate (although not the most innovative).</td>
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<td>Connectedness and coordination / Effectiveness</td>
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Actions for all ages and gender

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<td></td>
<td>DG ECHO’s gender-age marker was not used consistently across funded actions, making it difficult to form a concrete conclusion.</td>
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<td>Relevance</td>
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Community participation

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<td>Examples of working with community and religious leaders in conducting needs assessments, project design and implementation, and project follow up. However, it is not clear how systematically this was done or monitored by DG ECHO staff.</td>
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<td>Connectedness and coordination / Relevance</td>
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Coordination with other parts of the EC and MSs

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<td>A few examples of working with EU MSs and other EC services, such as within the Ebola response. The depth and scope of coordination as well as responsibility could be improved.</td>
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<td></td>
<td>Connectedness and Coordination / Lessons learnt from Ebola</td>
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3.2.4 With the current data it is difficult to assess the coherence of the EMC with guidelines and standards

Due to the relatively recent development and deployment of the EMC, it was difficult to assess the coherence of the initiative with DG ECHO’s Consolidated Humanitarian Health Guidelines and other intentional standards. There is ongoing cooperation and coordination between ECDC, DG SANTE and DG ECHO in the setup and design of the EMC, as well as with the WHO, which aimed to align the EMC with EU and WHO standards, and, humanitarian principles. The EMC have positioned itself as an in-kind contribution to the overall global health emergency workflow that is led by the WHO, instead of developing completely separate responses. At the present stage it is difficult to assess whether EU and international principles and standards have been met in the two official and then pilot deployments of the EMC.

Tentative recommendations from interviews with stakeholders should be taken into early consideration when thinking about the role of the EMC and its coherence with DG ECHO’s Consolidated Humanitarian Health Guidelines and other international standards:

- Create a specialist public health expert team for EMC public health missions that would use ECDC experts and DG ECHO RHEs, and would be trained on DG ECHO’s Consolidated Humanitarian Health Guidelines which would result in the more effective targeting of the populations “with the greatest need and highest level of vulnerability” which is one of DG ECHO’s main principles;
- Create more internal guidelines and standards, that are in line with DG ECHO’s humanitarian principles and international standards, around clinical practice, medicine, and, security for mission staff to ensure consistency across health actions funded;
- Outline clearly how DG ECHO’s financing and the EMC are linked and should work together in future responses.
3.3 Connectedness and coordination

This section addresses the following evaluation questions:

- To what extent have DG ECHO’s crisis responses in humanitarian health been well articulated to, and coordinated with, interventions of actors in the areas addressing the same crisis (i.e. CP, Development, local authorities); and
- To what extent the EMC interacts and coordinate with other DG ECHO actions and EU instruments.

Connectedness and coordination - main findings

- Overall, DG ECHO successfully coordinated its interventions with other actors in the humanitarian health sector. Good collaboration and coordination between actors was highlighted as essential for the success of actions, particularly in the early planning stage of projects.

- However, the context of the crisis affected DG ECHO’s ability to articulate and coordinate its response with other interventions and actors through national health clusters, and with other donors in certain regions.

- DG ECHO collaborated with DG DEVCO and the ECDC to a varying extent over the evaluation period. Improved synergies between these institutions can greatly increase the impact of future DG ECHO actions.

- Collaboration with national authorities was limited and differences in approaches and expectation led to unfruitful collaboration.

- In the current early stage of deployment of the EMC, it is difficult to assess the extent to which the EMC can interact and coordinate with other DG ECHO actions.

3.3.1.1 Overall, DG ECHO successfully coordinated its interventions with other actors in the humanitarian health sector. However, the context of the crisis affects DG ECHO’s ability to articulate and coordinate its response with other interventions through global and national health clusters.

Global level

DG ECHO has been supporting the GHC both directly and indirectly (DG ECHO indirectly funds the GHC) over the past years. The GHC is the main international forum for coordinating humanitarian health assistance and is led by the WHO. The intention of the GHC is for partners and donors’ interventions to be aligned and the utilisation of existing resources to be optimised in order to maximise effectiveness. At the global level, DG ECHO’s relationship with the WHO has generally been strong. Global health cluster meetings have been regularly attended by DG ECHO’s GHE, relevant TAs and RHEs and other donors reported that regular coordination with DG ECHO occurred through GHC meetings. More specifically:

- DG ECHO was a good internal and external advocate during the WHO reform, supporting and contributing to the reform of the WHO’s Health Emergencies Programme27. They also helped to support the GHC agenda by encouraging better inter-cluster collaboration;

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27 Following the deliberations of the Executive Board in January 2016, the Director General, Deputy Director-General and Regional Directors of the World Health Organization (WHO) issued a statement committing to urgently reform the emergency work of WHO in a comprehensive way “through the establishment of one single Programme, with one workforce, one budget, one set of rules and processes and one clear line of authority” and “an independent mechanism of assessment and monitoring of the performance of the Organization, reporting to the governing bodies”. (Source:...
• GHE and RHEs have contributed to the development of the GHC multi-annual strategy, as well as to specific technical working groups, for example exploring the role of cash vouchers in the humanitarian health sector;

• DG ECHO participated in the development of essential health service packages to be used globally in which they have advocated for a more active role for and involvement of WHO; and

• RHEs also looked for policy coherence and complementarity with other global humanitarian health actors such as the Global Alliance for Vaccines and Immunisation (GAVI) and GFTAM. For example, DG ECHO collaborated with GAVI in actions involving immunisations in countries.

Finally, DG ECHO, together with the Office of U.S. Foreign Disaster Assistance (OFDA), has funded the NGO Consortium project led by Save the Children in order to provide rapid response staff on a short-term basis to support country Health Cluster capacity. However, DG ECHO's funding support for this GHC surge capacity could be improved.

**National level**

At national level, **DG ECHO country TAs and RHEs have been instrumental in ensuring coordination and complementarity with strategies developed by country health clusters and/or national and local authorities.** National health cluster meetings have been regularly attended by relevant TAs and RHEs and, in general, **all DG ECHO TAs were investing a substantial amount of time in coordination activities.** TAs successfully coordinated with other donors and humanitarian partners through national health clusters to ensure that interventions were not duplicated – in instances where actions overlap, DG ECHO proposed to partners to complement the action of a relevant health actor that was carrying out a similar intervention. In South Sudan and in Jordan, for example, DG ECHO organised their own weekly meetings with all humanitarian donors to share information and exchange on the implementation of its interventions. **More broadly, DG ECHO has sought to establish agreements with other partners (WHO, UNICEF, OCHA), as well as support multi-donor operations.** A relevant example is the EC resilience building programme in Ethiopia. It is an innovative initiative that brings together at an operational level DG ECHO and the EU Delegation in the field. The strategy consists of an integrated approach where different partners - working in close coordination - implement a multi-sectoral resilience program together with the local authorities.

However, **in some cases DG ECHO has not been able to critically engage with the relevant actors in the global and national health clusters due to capacity reasons and/or differences in favoured approaches. As a result, the extent of DG ECHO’s collaboration with national clusters varied by country.** For example in South Sudan, DG ECHO has rarely attended the health cluster. Similarly, the ExAR case study (Côte d’Ivoire) provided an example where DG ECHO staff on the ground attempted to engage the Ministry of Health through regular meetings and joint project visits. However, due to the different approaches and expectations, the cooperation ended up being limited to sporadic exchanges of information. This lack of communication was a cause for insufficient appropriation of the intervention by the national authorities and negatively affected interventions sustainability (as described in section 3.7). In Nepal, health coordination was initially limited due to shortages in partner human resources and high turnover of NGO staff attending coordination meetings, resulting in a lack of consistent dialogue for all actors in the region.

Furthermore, the different structure of donors’ organisations may have at times hampered effective communications. For example, DG ECHO health advisors are
located around the world, while some other donors have health experts in headquarters, making it challenging to find the right interlocutor within each region.

3.3.1.2 Project level

At project level, the analysis of the different data sources suggested that DG ECHO funded projects have been coordinated with other actors through multiple channels, with support from DG ECHO. It was common for DG ECHO partners to coordinate with the national Ministry of Health (MoH) and/or other relevant ministries, such as the Ministry of Education and Ministry of Social Development, as well as with local authorities and/or community and religious leaders.

The main methods of coordination were through direct liaison with other humanitarian actors and donors present in the region, as well as through the Health Cluster. Coordination activities with national or local actors were mainly centred on:

- **Project activities.** Partners mentioned collaboration with national ministries, local authorities (mainly health authorities), and sometimes community and religious leaders in conducting health needs assessments, project design, project implementation and follow up of the project’s progress. A number of projects also reported regular meetings and updates with the aforementioned stakeholders to monitor response and project outputs;

- **Coordination with other actors in the local area.** Partners acknowledged the role of national ministries and local authorities, in supporting the coordination of activities with other relevant actors, humanitarian or development, in the local area. A number of projects referred to cluster meetings (local, regional and/or global) in partnership with the MoH.

- **Funding and logistics.** Partners highlighted the role of national ministries and local authorities in supporting some project activities and helping with procurement and distribution of supplies (especially pharmaceutical products), both in equipment and workers. As within other humanitarian aid sectors, a number of partners working in the health sector mentioned having Memorandums of Understanding (MoUs) with the national government, for example in tax exemptions and working permits. Three projects assessed as part of this evaluation highlighted working with local/national security forces. For example, in Syria (DG ECHO/SYR/BUD/2015/91025), the partner reported cooperation with the SRAD community police who manage the refugee camp and security.

- **Capacity building.** A sample of partners mentioned capacity building activities with the MoH and local communities during the action. For example, one project (DG ECHO/WF/BUD/2015/91074) was working with local health management committees and village health committees to rebuild community structures. To ensure continuity of actions, a few projects had the intention for the MoH to continue operating the project after the partner left, however no further information was provided.

The majority of partners stated they were involved in a cluster (health cluster, nutrition cluster, logistics cluster - local and/or global) and participated in cluster meetings. For example, in South Sudan (DG ECHO/AF/BUD/2014/91020), IMC UK was a regular participant of the inter cluster working group on health and nutrition, and GBV protection sub cluster meetings. In Turkey (DG ECHO/SYR/BUD/2015/91034), the IMC UK Medical team was part of the health cluster and has participated in coordination meetings hosted by WHO in Gaziantep.

Evidence shows that DG ECHO promoted coordination amongst partners in the field to avoid overlapping of activities and ensure sharing of information. For instance, in the context of Côte d’Ivoire, DG ECHO and its partners held monthly meetings to exchange on progress, challenges, best practices, etc. Some projects'
documentation also demonstrated how partners on the ground had good relationships with other actors. For example, the Algerian Red Crescent (CRA) was acting as an agent to help MI obtain authorizations for the import of certain drugs (narcotics, dangerous goods) or with customs procedures (DG ECHO/NF/BUD/2016/91002).

3.3.2 DG ECHO collaborated with DG DEVCO and the ECDC, to a various extent, over the evaluation period

Collaboration with DG DEVCO existed formally with Director General meetings. In instances where both Directorate-Generals (DGs) were present during a crisis in a country (including epidemics or natural disasters), they should in theory consult and harness each other’s expertise. Nevertheless, **DG DEVCO did not contribute to DG ECHO’s HIPs development and DG ECHO was not always involved when DG DEVCO’s multiannual country strategies and annual country strategies were developed**.

**There have been examples where DG ECHO and DG DEVCO did coordinate responses, most notably during the Ebola outbreak.** A report from the European Court of Auditors stated that DG DEVCO were flexible in providing early additional humanitarian assistance to DG ECHO during the outbreak through the reallocation of funding from the EDF’s B-Reserve and the rapid deployment of DG DEVCO’s mobile CBRN laboratories. DG ECHO and DG DEVCO further coordinated closely in the High-Level Ebola conference in March 2015.

Furthermore, **DG ECHO and DG DEVCO collaborated on an advocacy and awareness level** to some extent through opening a dialogue on procurement and access to quality medicines in the health sector. **Over the evaluation period, actions of the two DGs were sometimes overlapping or closely linked, and so enhanced coordination at operational level could have improved outcomes.** For instance, in Côte d’Ivoire, DG ECHO and DG DEVCO funded similar interventions aiming at revitalizing the Ivorian health sector (i.e. ExAR and PARSSI, respectively). It was reported that NGOs working in the same area coordinated their activities through regular meetings such as IRC and Caritas in the Tonkpi region, but there were only limited exchanges between DG ECHO and DG DEVCO. The same was found during the Jordan field visit, with stakeholders in the field reporting very little interaction between the two institutions. DG ECHO was also involved in discussions in a regional Inter-service group on health with DG RTD, DG SANTE and DG DEVCO, which is a coordination forum to discuss policies, but meetings were not very frequent.

**Collaboration between DG ECHO and the ECDC has been ad-hoc, and could be strengthened in particular at the needs assessment stage, and more broadly at the strategic level.** For example, during the Ebola crisis, the ECDC was working in the same areas of many of the DG ECHO-funded NGOs and were able to develop collaborative partnerships with these NGOs. However, it relied on local arrangements and goodwill rather than any prior planning. DG ECHO was not permanently present in the field so they were not able to coordinate the operation. In the future, technical inputs from the ECDC could be requested more regularly as part of DG ECHO’s needs assessment, ensuring epidemiological expertise. An example of where the ECDC were involved in one needs assessment mission was in the response to Yellow Fever in Angola, under the EMC, where there was a public health / epidemiology component.

**3.3.3 In the current early stage of deployment of the EMC, it is difficult to assess the extent to which EMC can interact and coordinate with other DG ECHO actions**

The institutionalisation of cooperation and coordination in the deployment of the EMC between ECDC, DG SANTE and DG ECHO is ongoing. So far, the EMC public health teams have been formed on an ad-hoc basis. Only two EMC deployments in response to a Yellow fever outbreak in Angola and DRC have taken place since its official launch in 2016. Issues surrounding the mandates of players involved (such as
for ECDC) leave important questions for the years ahead in relation to connectedness, coordination and efficiency. For example, in specific outbreaks (such as Zika) finding the right experts and medical staff could be a challenge where a swift, EU response is warranted.

Going forward, cooperation with DG SANTE could be used to increase the health expertise of DG ECHO, through enhancing the health component in training of the teams. Additionally, a careful assessment on how best to deploy the medical teams prior to the intervention, under the EMC umbrella or as a health action (HA) needs assessment supported action, is needed.

Progress is being made to improve coordination and collaboration between DG ECHO and other European actors such as the ECDC. For example, the handover of the Epidemics Instrument to the Emergency Response Coordination Centre (ERCC) will have implications for future epidemic disease responses.
3.4 Effectiveness

This section addresses the following evaluation questions:

- To what extent have DG ECHO humanitarian health actions achieved the objectives set;
- To what extent have DG ECHO humanitarian health actions contributed to the achievement of DG ECHO objectives (i.e. preventing excess preventable, mortality, permanent disability, and disease associated with humanitarian crisis);
- To what extent has the Epidemics funding instrument provided timely and effective support and to what extent does it differ from - and offers potential benefits in comparison to - other tools (i.e. HIPs);
- What are the key achievements of DG ECHO humanitarian health actions; and
- What were the main factors limiting the success of the DG ECHO actions in the humanitarian health sector?

Effectiveness can be defined as the proportion of individuals who, having received the intervention, experience the intended positive health outcome or impact conditional on the achievement of the outputs. However, establishing whether an intervention has led to a given outcome or impact is challenging for several reasons:

- The quality of the narrative surrounding the definition of the results (i.e. whether outputs or outcomes) by DG ECHO partners in their reporting varies greatly and lacks consistency;
- Disaggregated data at community or regional level is scarce and fragmented and is rarely collected by DG ECHO partners across the project cycle;
- Changes in a health situation, as captured by indicators, might only be visible after a certain time, by which the intervention has ended;
- Determination of causal links and attribution of changes solely to DG ECHO’s health interventions is not feasible as numerous factors can influence changes in a health situation, as captured by indicators.

Therefore, in the context of this evaluation, the assessment of effectiveness was mainly undertaken at output and to some extent at outcome level reporting on positive results, it was however not possible to assess the scale of effects. In light of the above considerations, results should be taken with caution.

Effectiveness - main findings

- Baseline data varied from one project to another. Local pre-intervention baseline data may be unavailable when collation and analysis takes place at provincial or national level.
- Funded project objectives were measured as output (e.g. number of people reached by the intervention) rather than outcomes.
- Results (i.e. outputs) have been fully or partially achieved in most of the DG ECHO-funded actions analysed, showing positive results in view of achieving effectiveness.
- However, it is not possible with the data available in partner reports and DG ECHO databases to assess the effectiveness of DG ECHO actions and to demonstrate that DG ECHO is funding effective projects. DG ECHO are not leading by example although they are one of the biggest donors.
- It is to be noted that achievements depended greatly on the context and region, and results achieved do not necessarily imply quality of services, as quality of

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outputs and outcomes varied amongst DG ECHO partners.

- A number of facilitating factors were identified as promoting the effectiveness of DG ECHO actions and include: RHE expertise and close monitoring of projects, quality of drugs, existing health system, partners health expertise, communication and collaboration with health stakeholders in particular with the MoH, and sound knowledge of local communities with a particular attention to cultural and gender sensitivity.

- A number of obstacles were identified as hindering the effectiveness of DG ECHO actions. At DG ECHO level, the main obstacles include the partner’s availability, capacity and medical expertise, the choice of indicators by the partners and the availability of data affecting the monitoring of the actions, and timely provision of funding. At partner level, the major obstacles related to the procurement of drugs, lack of capacity to deliver quality healthcare services, poor quality of referral level, low level of involvement and community participation in health-care activities, and increased insecurity and criminality.

### 3.4.1 DG ECHO humanitarian health actions have contributed to the achievement of DG ECHO objectives, however no consistent monitoring of the impact of the interventions has been conducted by DG ECHO

Figure 7 below provides a reconstructed Intervention Logic (IL) on the basis of the evidence collected for this evaluation. The IL is based on projects that have been identified as successful (i.e. having achieved some or all of their intended results) and depicts the causal mechanisms or pathways through which the activities are thought to bring about the desired changes (i.e. the cause and effect linkages). The IL includes the following building blocks:

- Inputs representing the resources fed into the intervention;
- Actions which are the service delivery;
- Outputs representing the immediate results of the actions;
- Outcomes representing the short/medium-term results of the actions; and
- Impacts, which represent the expected long-term effects.

In addition, there are a number of factors that should be taken into account as they might contribute or limit the success of the interventions.
Figure 7. Reconstructed Intervention Logic for DG ECHO’s interventions in the humanitarian health sector.

- **Inputs**
  - ECHO’s health policies and humanitarian missions
  - Humanitarian health standards
- **Activities (553 projects)**
  - Technical training: 73% (2004-2016)
  - Reassessments: 6% (2004-2016)
  - Health infrastructure: 3% (2004-2016)
- **Outputs**
  - Beneficiaries are provided with primary healthcare services
  - Deaths in health facilities are reduced
  - Disease burdens are decreased
- **Outcomes**
  - Increased access to primary health care
  - Increased access to quality health services
  - Lower incidence of disabilities

- **Short term impacts**
  - Improved prevention, surveillance and containment of diseases
  - Improved health outcomes
  - Increased access to quality health services

- **Long term impacts**
  - Increased availability and access to quality healthcare
  - Improved health of communities
  - Lower mortality
  - Improved quality of life
  - Improved health of communities
  - Lower incidence of disabilities

**Reconstructed Intervention Logic**

- **Reconstructed Intervention Logic** for DG ECHO’s interventions in the humanitarian health sector.
Assessing the extent to which DG ECHO humanitarian health actions contributed to the achievement of DG ECHO objectives means measuring DG ECHO’s contribution to limiting excess preventable mortality, permanent disability and disease associated with humanitarian crises as defined in the DG ECHO’s Consolidated Humanitarian Health Guidelines (2014, p. 5).

Although a few DG ECHO partners reported a reduction in mortality rates, most partners did not evaluate their contribution to this impact-level objective. In addition, **DG ECHO did not monitor the impact of its intervention but rather sought to fund interventions that are known to have a positive outcome and impact, as specified in the DG ECHO Consolidated Humanitarian Health Guidelines:** “Health interventions are chosen on the basis of the best possible existing evidence of their effectiveness, as derived from published reports of research or of ‘best practices’. Those interventions that have the highest potential to save most lives in a timely manner will be given highest priority” (2014, p.8).

Impact assessments can be undertaken by partners such as the MSF research centre, or academic institutions. However, DG ECHO did not provide them with any prescriptive guidelines to do so. Therefore, **it appears that DG ECHO repeatedly funded interventions that report positive outcomes, but it did not monitor the impact of such funded action in the longer term.**

### 3.4.2 DG ECHO partners reported on their outcomes, however, at times with mixed consistency or lack of clear separation between outcomes and outputs

In their Logframe, DG ECHO partners defined a number of results to be achieved. The definition of results varied per partner, with some defining outputs to be achieved, such as ‘number of consultations’ (DG ECHO/SYR/BUD/2015/91020), others focused on outcomes to be achieved, such as ‘improved access to comprehensive primary health care services’ (DG ECHO/-HF/BUD/2015/91007), while some included a mix of outcomes and outputs. The narrative differed greatly with no consistency and clear separation of outputs and outcomes. In addition, some indicators seemed to only partially capture the intended result, whether outcomes or outputs. For instance, a project result (DG ECHO/SYR/BUD/2014/91025) was defined as “To improve health and wellbeing for conflict affected Syrians in Turkey” and the indicator was “Number of clients receiving physical rehabilitation”. The latter only partially captured the health and wellbeing of conflict-affected populations.

The analysis of the sample of 100 projects indicates that out of the projects for which information was available (closed projects), just under a third (28) of projects fully achieved the results set (i.e. reaching the indicators set) while just over a tenth (12) have partially achieved their results. Based on the sample, the sector with the highest proportion of results achieved appeared to be epidemics followed by secondary health and primary health. In terms of region, Asia, Eastern Africa, and Western Africa were found to have the highest proportion of projects, which have achieved their intended results while in Central Africa, the majority of project’s results have been only partially achieved and in MENA, there was an equal balance between projects’ results achieved and partially achieved. **Feedback from interviews with DG ECHO partners and staff further suggest that the results varied depending on the context and the country.** For instance, in Haiti, the results were achieved while that was not the case in Central America. Similarly, in the Middle East, where the focus was on providing basic services to refugees, it was...
reported, through project documentation, to be successful in some countries and less in others, based on the context.

DG ECHO emphasised the importance of providing high quality assistance (DG ECHO, 2014, p.8). Quality of health services was reported to vary greatly between partners but overall, partners believed quality has improved over time based on monitoring activities and beneficiaries feedback. This suggests that achieving the intended results does not necessarily imply quality of services. Although many partners mentioned quality of services in their objectives, available indicators rarely captured the quality component: measures of achieved quality or progress on quality is scarce in Single Forms. Monitoring of actions by DG ECHO field staff varied as there is no reported standard or uniform monitoring guideline to adhere to. In South Sudan for example, TAs only had an informal checklist to use which focused on partial elements of the health facility. In Jordan, TAs gathered their own information about projects, and used their own internal monitoring mechanisms, separate from the HOPE database.

Furthermore, it was found that monitoring requirements varied for different partners, with NGOs having more demanding requirements compared to UN agencies. Monitoring visits by RHEs considered quality of health services but this could be further strengthened if an appropriate checklist/guideline would be available to DG ECHO TAs, especially those without health expertise.

Similarly, timeliness was a key aspect highlighted throughout the DG ECHO Consolidated Humanitarian Health Guidelines. However, DG ECHO did not provide a definition of timeliness and only few partners defined what timely access meant in their Logframe, by setting indicators such as “Proportion of victims that received medical assistance within 72 hours”. Timely access was promoted through activities such as provision of transportation, coverage of expenses, training of medical staff, and awareness raising of communities. The majority of DG ECHO partners interviewed believed their actions provided timely access to health services. Likewise, feedback from DG ECHO staff further suggested that timely access was provided but depending on the region and context, timeliness could be affected by external factors that could not be controlled by the partners.

The vast majority of DG ECHO partners did not assess health outcomes using a formal mechanism, due to several reasons mainly related to the lack of health data in particular baseline data. Consequently, very limited evidence is available on the effectiveness of DG ECHO funded actions. Some evidence of positive outcomes have, however, been reported in project reports and through interviews with DG ECHO partners and DG ECHO staff, though it is not possible to judge the scale of effects on the basis of available evidence. Examples of key achievements resulting from DG ECHO funded actions in the area of health are presented below.

3.4.3 Despite limited evidence on the effectiveness of DG ECHO funded actions, key achievements were captured per region

Some examples of key achievements of DG ECHO humanitarian health actions were identified within each region (Annex 5). The interventions described below (Table 3) effectively addressed the specific needs of beneficiaries across the globe, as reported in project reports.
Table 3. Key achievements of DG ECHO’s response, and, the key health sectors covered by DG ECHO’s humanitarian health actions per region

<table>
<thead>
<tr>
<th>Region</th>
<th>DG ECHO’s response</th>
<th>Key health sectors covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>MENA</td>
<td>• Health-related support and aid through the establishment of strong partnerships with the few actors present on the ground³⁰</td>
<td>• Primary health; Medical supplies; Reproductive health; Community outreach</td>
</tr>
<tr>
<td>Central Africa</td>
<td>• Emergency response to populations affected by conflict (IDPs, refugees and host communities)</td>
<td>• Primary health; Epidemics; Reproductive health; Medical supplies; Interventions often combined with sanitation, WASH or nutrition activities</td>
</tr>
<tr>
<td>Western Africa</td>
<td>• Largely concentrated around epidemics</td>
<td>• Ebola was a predominant focus of response; Primary healthcare</td>
</tr>
<tr>
<td>Eastern Africa</td>
<td>• Region faces ongoing and sustained conflicts so responses have been focused on conflict-affected populations, refugees and IDPs</td>
<td>• Increased access to primary and secondary healthcare; Sexual and reproductive health; Epidemics; Nutrition services; Mental health was also integrated in some actions</td>
</tr>
<tr>
<td>Asia</td>
<td>• Region comprises of several mountainous countries with many hazards affecting their population, such as flash floods, landslides and earthquakes, leading to the majority of interventions being linked to the implementation of health-related activities with a Disaster Risk Reduction (DRR) focus</td>
<td>• Community outreach was a key component of the majority of the actions</td>
</tr>
</tbody>
</table>
| Latin America and the Caribbean | • Largely concentrated around epidemics  
• Haiti is the largest beneficiary in the region. DG ECHO has been one of the last humanitarian donors present in the country and has continued to address the prevalent humanitarian needs | • Needs associated with cholera outbreaks, emergency response, prevention, capacity building. |

³⁰ In Syria, for example, localisation of the vulnerable populations affected by the crisis, prioritisation of their needs and identification of beneficiaries is mostly undertaken by the Syrian Arab Red Crescent (SARC), supported locally by charities and communities.
3.4.4 The main factors influencing implementation and results of DG ECHO actions in the humanitarian health sector appeared at DG ECHO and at partner level

A series of factors influencing the success of DG ECHO actions were identified at two levels - DG ECHO level and partner level. While some factors are more general and could apply to any humanitarian actions, others are specific to health interventions. This section describes the major factors influencing DG ECHO actions focusing on the health specific ones.

3.4.4.1 Factors at DG ECHO’s level

Evidence collected suggests that one of the main factors affecting DG ECHO’s actions in the area of health related to the **partners selected, their availability, their capacity and expertise, and therefore the quality of their intervention**. In some countries, the number of partners was limited, and there seemed to be some reluctance from partners to move to areas with new conflicts, arrival of refugees or epidemics. In such countries, DG ECHO possesses a limited pool of potential partners who do not necessarily hold the required health expertise. It is recognised among RHEs that there is a clear gap in medical emergency care as a result of the lack of capacity to provide emergency health services, in particular in insecure/high conflict settings: this lack of capacity is further demonstrated in relation to secondary health services such as trauma, disabilities and mental health, although these issues are becoming more and more integrated in humanitarian conflict settings. Partner expertise and capacity varied largely by country, depending principally on the human resources they have been able to deploy. Some regions and crises are indeed more attractive to health practitioners and protracted crises for instance are often less attractive in comparison to new emergencies. The same applies to more stable areas, which are more appealing in comparison to volatile regions, or for crises that attract more media and political attention. It is therefore challenging to scale up humanitarian health interventions in areas of greatest need.

**Technical support by RHEs and TAs was considered a main contributing factor to the success of the actions by both partners and DG ECHO staff.** This included support in proposal development and implementation. Most respondents to this evaluation’s online survey reported that DG ECHO was involved in the definition of the strategy to a large (36%) or moderate (33%) extent and in the need assessments to a moderate (30%) or small (26%) extent. Frequent communication and regular meetings were reported as helpful, working groups allowed for exchange of information and best practice sharing. Partners reported DG ECHO to be particularly supportive and flexible, having a good understanding of the activities and the context. Furthermore, at DG ECHO level, inter-sectoral coordination and exchange among the RHEs and GHE were identified as contributing factors more efficient interventions.

However, **obstacles were identified by DG ECHO staff in terms of monitoring of funded projects.** On one hand, this was due to the lack of access to sites for monitoring visits, which makes a full evaluation difficult. This has been the case in Somalia and Iraq for instance, where it has not been deemed feasible for the majority of DG ECHO interventions in certain regions. On the other hand, the **indicators selected by the partners to assess their activities were not always appropriate** to the context, intervention and activity. Particularly when interventions focused on providing quality healthcare for instance, the quality was not captured within the existing DG ECHO compulsory criteria and additional indicators selected by the partners. In addition, given the nature of humanitarian aid, data collection was not always a priority for the partners; therefore, **baseline data were not always collected**, preventing any analysis of progress, in particular when an action is continued over time.
Furthermore, measuring results can be challenging as changes might only occur or be visible several months after an intervention. This is particularly difficult in conflict settings, where violence and moving populations prevent keeping track of health information. In addition, it was often difficult to attribute any changes in health indicators solely to DG ECHO’s health interventions as several health interventions might be ongoing in the same region and can be accompanied by other interventions such as WASH, nutrition, sanitation which inevitably contributed to improving the health of the population.

Timely access to funding was described as another factor affecting the results of the actions. Several examples were mentioned such as in Yemen, where it took six months to sign a contract or in Uganda where it took over a month to answer any questions related to funding. Feedback from the interviews suggested that the time taken from project acceptance to funding has increased over the years, moving from a decision taken within weeks, to months. However, based on partner’s feedback, DG ECHO remains quicker in comparison to other donors. While DG ECHO retrospectively funds actions, partners were reluctant to start their activities or simply did not have the funding to do so. Funding for follow-up projects tended to be disbursed quicker as partnerships have already been established and the actions are known by DG ECHO. Funding via the Epidemics instrument was also usually disbursed faster, however there were still some occasions where bureaucratic burdens led to funding not being released until an epidemic had reached its peak or was over.

Other factors, although not commonly reported, were also identified. These included coordination in the health sector and relations with the MoH. A last factor was reported in relation to the Ebola epidemics, where DG ECHO was funding some health actions but assistance was missing in other areas such as sanitation and transport, DG ECHO health experts emphasised the need for certain health actions to be accompanied by other interventions (e.g. WASH, nutrition, sanitation, etc.) to be effective.

3.4.4.2 Factors at partner level

One of the main factors affecting the effectiveness of the actions related to the procurement and quality of drugs. It can be challenging to import prescription drugs, for instance, importation is forbidden in Thailand. In other countries, severe delays were reported such as in Afghanistan and South Sudan where it took up to eight months to receive the consignments. Acquiring safe and effective medicine locally was also a challenge. DG ECHO guidelines include drug quality standards which limit the supply of unsafe drugs and in combination with import constraints this means that demand for safe and effective medicines is not always met. Alternatives are therefore sought; contingency stocks were mentioned as a solution to continue supplying medicine in cases of rupture or acquisition of drugs on the local market but that could represent a challenge. An RHE reported that some partners have bought local drugs of doubtful quality, which increased the need for DG ECHO to systematically check the drugs during visits. In this regard, the QUAMED initiative (DG ECHO/ERC/BUD/2014/91002) was developed by 11 DG ECHO partners with a mission to increase the access to quality medicines in low- and middle-income countries by gathering and sharing independent information, and create leverage on the pharmaceutical market. The project was reported a success in improving assurances of the quality of medicines used in humanitarian response, with all major medical partners now a member of QUAMED. It was also reported by partners that DG ECHO procedures have become more complicated and that it was difficult (i.e. modification request needed or special authorisation) to transfer drugs to a follow-up DG ECHO funded action. DG ECHO allows a threshold of 5 per cent of remaining drugs to be transferred to the next action; however, it might not be sufficient to bridge the gap while awaiting for new funding. Lastly, poor management
of drug supply by the partner and local medical staff further hindered the availability of necessary drugs.

**As highlighted by partners, the ability to deliver quality healthcare services was also key to the success of the actions and continues to be of concern** due to the lack of medical staff and in some cases in particular, the lack of female medical staff. This includes both, local and international staff, and is due to the lack of interest to work in certain regions/crises, the security risk, the lack of qualified personnel or specialists (e.g. obstetricians), the high turnover, the difficulties in obtaining visas and the low remuneration offered by certain INGOs.

**The referral mechanism is also an important factor affecting the interventions**, due mainly to the poor quality of referral level (i.e. hospitals and specialised services). For instance in Thailand, referrals are limited to some diseases only; in CAR, the RHE reported no referral capacity in the country to deal with psychological trauma or psychiatric conditions. In others, such as Côte d’Ivoire, referral was reported to exist but to be inefficient. This issue is linked to the overall weakness of national and local health systems in place, which often does not meet the quality requirements of humanitarian organisations. Partners reported several ways in which they have tackled the challenges linked to referrals, such as by providing ambulances, by setting up mechanisms following up on referrals, and through coordination with other relevant actors outside of DG ECHO funded actions.

Project partners also stressed the importance of establishing strong communication and collaboration with key stakeholders in the health system and a good level of coordination with the UN/other international organisations and cluster system. Furthermore, the establishment of strong links between project implementers and the MoH was mentioned as an important success factor to achieve effective and sustainable results. Partners having a positive track record of working with the health authorities were more prone to achieving successful results on the ground.

Another major factor identified related to the community involvement and participation in health-care activities. A sound knowledge of local communities was seen as crucial in order to facilitate the implementation of DG ECHO's actions on the ground. The involvement of community workers and leaders to promote community participation, especially of women and other vulnerable groups was seen as critical. It was reported as being a key element in building trust and maintaining good patient relationships to ensure beneficiary use of the facilities.

According to implementing partners, the most successful interventions were those conducted in a culturally sensitive manner as well as in a gender sensitive manner, for example having male and female outreach workers, or having a female doctor working in each clinic in order to facilitate women's access to the services provided. Cultural barriers, religious and cultural beliefs, attitudes and practices, but also low awareness can prevent community participation to the activities. For example, in many countries such as Somalia, women are required to stay indoors after birth, which decreases the access to maternal and child health services. Another example is the increase in the number of Ebola cases in Sierra Leone and Guinea due to insufficient awareness of the need to isolate and treat cases early on as well as resistance from local communities to health workers.

**The level of public investment in health is also an element to be taken into account.** Cuts in public funding allocated to the health sector have been witnessed across the different regions covered by DG ECHO. For instance, Uganda saw a decrease of government health expenditure of 8.6% between 2010 and 2014. In Mali, government health expenditure dropped by 6.6% in the same period, other examples
include Jordan with 5.8% decrease, Burkina Faso with 4.6%, and Cameroon with 4.3% drop in the period 2010-2014\textsuperscript{31}.

**National health standards** that did not respect international standards can create difficulties to operate, in particular when the health system is private and does not grant free access to services for individuals. The issue is further enhanced for refugees, who face difficulties to access health insurance or access national health services.

An increase in insecurity and criminality has led many NGOs as well as DG ECHO to review their ‘modus operandi’ and operational set-up. An increased number of attacks on hospitals and health workers have been reported recently. WHO reported 198 attacks on healthcare in the first three quarters of 2016 only accounting for 366 deaths and 468 injuries\textsuperscript{32}. In addition, some health structures are still occupied by armed groups and therefore inaccessible.

Some partners also pointed out the importance of data collection. Inadequate data collection and difficulties in accessing publicly collected health-related data/indicators (in particular data on mortality) can affect project effectiveness, especially in the design stage (baseline data) and for the monitoring of the activities (i.e. measuring results). In addition, some partners possessed limited capacity in analysing data to produce quantitative analysis.

Other common factors identified include difficulties in delivering aid in remote areas, such as in Nepal, climate conditions and the hostile natural environment, corruption, inconsistent and poorly understood regulatory framework governing the presence and work of international humanitarian NGOs, coordination with other actors and donors on the ground as well as in cooperating with local authorities, movement of population, lack of funding, and national regulation.


3.5 Efficiency

This section addresses the following evaluation questions:

- To what extent did DG ECHO humanitarian health strategy allow the delivery of assistance in a cost effective manner;
- To what extent are DG ECHO administrative and financial mechanisms and systems efficient; and
- What are the advantages and disadvantages of multi-year approach (i.e. ExAR) as opposed to implementing actions using DG ECHO standard programming cycle?

Cost-effectiveness and efficiency are important considerations for DG ECHO (as mentioned in Annex 1 of DG ECHO’s Consolidated Humanitarian Health Guidelines; the Commission’s General Guidelines on Operational Priorities for Humanitarian Aid for 2016 (DG ECHO 2015); and geographical HIPs). However no explicit definition of cost-effective or efficiency is provided by DG ECHO.

Furthermore, it is well understood by DG ECHO staff that the cost-effectiveness of health interventions is difficult to calculate and can be misleading for several reasons: it is often difficult to separate the health costs and benefits for beneficiaries from the costs and benefits of other forms of support they receive (for example, in some cases individuals will receive a holistic package of services including health, WASH and shelter support); cost-effectiveness is not synonymous with quality of actions; and the extent to which cost-effectiveness can be assessed often depends on the partner organisation as they usually undertake these calculations rather than DG ECHO. Importantly, the cost of delivering actions also varies by country and region because of varying fixed/overhead costs (for example, in Somalia 40% of funding is usually required just to ensure the security of workers) meaning that an assessment of cost-effectiveness is not particularly informative.

In practice, cost-effectiveness is therefore not usually used by DG ECHO as a proxy for efficiency and it has not been assessed in detail in this report due to the shortcomings highlighted above, as well as data limitations. Rather, this report focusses on a much broader definition of efficiency used by DG ECHO. It assesses:

- the extent to which DG ECHO has selected actions that have the best chance of saving the most people with the least money available (Value for Money (VfM));
- the extent to which budgets are perceived to have been sufficient to conduct the activities required to a reasonable quality standard; and
- The factors that enhance and limit the efficiency of actions.

Efficiency - main findings

- In practice, due to methodological limitations, cost-effectiveness was not widely used by DG ECHO as a measure of efficiency. Efficiency was assessed more broadly as VfM and the sufficiency of budgets to conduct required activities to a reasonable quality standard.

- When selecting proposals, DG ECHO rarely conducted detailed efficiency analyses on new or innovative health projects. Instead they preferred to fund action types that are already known to be good VfM, or where the largest percentage of funding was allocated to beneficiaries rather than to overhead costs.

- Feedback regarding the sufficiency of budgets was very mixed, particularly for the

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33 It has not been possible to link funding data to accurate or informative outcomes data, for example the number of beneficiaries supported by health actions.
Ebola response in West Africa. Impacts of budget insufficiencies on projects included withdrawal of interventions; reduced activities; and shortening the duration of actions.

- Monitoring of projects and the provision of clear cost breakdowns by partners was essential for ensuring efficiency and should be systematically incorporated in all projects. Coordination, streamlining and standardising of resources (particularly drug procurement) and training and capacity-building of existing local staff were also important factors improving efficiency.

- DG ECHO administrative mechanisms and systems were generally viewed as efficient. However the efficiency of funding mechanisms varied by type of crisis and mechanism: funding through geographical HIPs for follow-up actions and through the Epidemics Instrument was largely deemed efficient (with some exceptions), other funding delivered through geographical HIPs was often too slow.

- DG ECHO staff had mixed views regarding the benefits of introducing longer-term funding mechanisms, however all partners would prefer a two- to three-year funding period as they feel this would allow better forward-planning to improve action effectiveness and efficiency.

- Other DG ECHO mechanisms exist to support efficiency e.g. DG ECHO’s funding of the GHC, and coordination with other global actors. However support for the GHC could be improved as well as DG ECHO’s deployment mechanisms for European public health agencies (e.g. ECDC) during crises.

3.5.1 DG ECHO broadly assessed efficiency as VfM and the sufficiency of budgets to conduct required activities to a reasonable quality standard.

In all crises, funding decisions are made primarily on the basis of need: DG ECHO seeks to address the needs of the most vulnerable individuals facing a humanitarian crisis. However, most DG ECHO staff mentioned that VfM was usually broadly considered in all funding decisions: actions were designed to save the most people with the least money available. For example, in South Sudan it was found that DG ECHO TAs were promoting VfM during proposal development and throughout project implementation. DG ECHO partners were also well aware of the VfM requirements of DG ECHO.

However, in the majority of cases, DG ECHO did not directly assess/evaluate the efficiency of funded actions or the extent to which they were good VfM. Rather, DG ECHO tended to fund actions/methods that they knew had the potential to be effective, efficient and good VfM as identified by academic studies or evaluations. This may have affected the extent to which innovative projects were selected for funding.

Another proxy for efficiency used by DG ECHO was to select projects where the largest percentage of the budget went to beneficiaries rather than to cover overhead costs. However, in most cases this was used as a very rough proxy as average overhead costs varied by region depending on various factors (for example security costs to ensure the protection of humanitarian actors in conflict-affected areas will be higher than in other regions) – these variations in essential regional overhead costs should not inhibit funding in particular regions due to a perceived lack of VfM. Furthermore, in some regions, beneficiary costs were inevitably higher than in others: DG ECHO’s commitment is to provide a minimum package of services and in some areas where pre-existing healthcare provision was good, this package of services would be more comprehensive, and therefore more expensive to deliver.
3.5.2 A mixed result was found across regions when assessing DG ECHO’s budget appropriateness

Overall, most survey respondents (67% of 102) strongly agreed or agreed that the budget provided by DG ECHO was appropriate and sufficient for the scale and type of action(s) funded. However these findings contrast with the findings from interviews which showed a more mixed result. Looking at findings broken down by region, there were mixed perspectives on the appropriateness of budgets in all regions except Asia:

- **West Africa.** More broadly, over the period 2014-2016, funding was deemed to be sufficient in Burkina Faso but this may be due to the fact that there was a parallel government-run action being conducted in the country. Views on the efficiency of the Ebola response were mixed; and the stakeholder opinion was that because of weak health systems in the area, funding was generally insufficient to ensure the achievement of outcomes.

- **Central Africa.** On one hand, it was argued that constant conflict and disease outbreaks meant the budget was overall insufficient in the region, particularly the budget allocated for drugs. For example, in the DRC, the budget was deemed totally insufficient to address needs. However, in contrast, it was also argued that project underspending in this region was common due to budget miscalculations by partners.

- **East and Southern Africa.** Generally, the opinion was that due to cuts every year despite a high demand for funding, budgets were insufficient. However, funding for South Sudan was viewed as adequate.

- **Central America, Mexico and the Caribbean.** Generally, the budget for the region was insufficient, although it was argued that despite this, good VfM was achieved. The budget for the Haiti earthquake was viewed as sufficient.

- **MENA region.** Mixed responses in relation to budget sufficiency were found during the data collection. Budgets were deemed sufficient in Afghanistan. However budget cuts in Syria and Yemen despite increasing demand were viewed as particularly problematic and most RHE reports mentioned the need to focus on improving the efficiency/VfM of actions in the region. Budgets in Iraq and Lebanon were also viewed as insufficient, although there was mixed feedback in Jordan: case study findings suggested that the budget was too generous while other sources felt that increasing demand meant budgets were no longer sufficient.

In contrast, in Asia, although only feedback for Myanmar and Nepal (during the earthquake) was available, budgets here were deemed sufficient.

3.5.2.1 Partners worked to overcome budget limitations in certain cases, however withdrawal of interventions and reduced activities were reported

In cases where the budgets were not deemed sufficient, partners attempted to overcome budget limitations by: seeking support from other donors; shouldering the additional costs themselves; or applying for additional funding from DG ECHO (although this is usually difficult to obtain). **In some regions RHEs advocated internally for additional DG ECHO Head Quarters (HQ) funding.** In addition, while rare and difficult to do, if a partner is under-performing, it is possible for DG ECHO to ask the partner to return the funding to HQ and terminate the action. It was not clear whether or not this had actually been done in practice. Furthermore, RHEs/TAs have some flexibility (in consultation with DG ECHO HQ) to re-allocate health sector budgets between different partner organisations (this is also done under the Emergency Response Mechanism).
Nevertheless, in cases where budget limitations could not be overcome, impacts included:

- Withdrawal of interventions from certain areas/regions considered too high-cost in relation to the number of beneficiaries it was supporting (for example, the withdrawal of Handicap International from Balqaa Governorate in Jordan);
- Reduced activities or the prioritising of certain activities e.g. reducing medication provision; reducing the numbers of individuals being screened for disease; or in the case of CAR, stopping the mental health interventions; and/or
- Shortening the duration of an action.

3.5.2.2 Multiple factors promoting efficiency were identified

Factors promoting efficiency, as found through this evaluation are summarised below:

- **Evaluation, monitoring and audit** were mentioned as essential for ensuring efficiency. The evaluation survey results showed that 75% of partners felt that DG ECHO was involved in monitoring project implementation to a large or moderate extent, although no details were provided regarding the type of monitoring activities conducted or the quality of the monitoring;
- **Effective coordination and partnership working.** For example, the development of a local working group for mental health in the Yemen (DG ECHO/YEM/BUD/2016/91013) improved efficiency through facilitating a forum for information exchange between a variety of agencies concerning a range of technical challenges in the field;
- **Use of experienced implementing partners.** For example, findings from the Côte d’Ivoire highlighted that working with implementing partners that have been present in the intervention zone for years helped ensure efficiency due to their understanding and experience of the context and the links and relationships they had established over time;
- **Streamlining resources/administrative functions and standardising processes and protocols.** Examples include integrating and centralising project administrative offices (DG ECHO/SYR/BUD/2015/91025); and undertaking advocacy activities to recommend limiting the number of villages where refugees settle in order to help optimise the efficiency of the response (DG ECHO/DRF/BUD/2013/93014);
- **Better drug procurement and planning.** For example, using generic drugs sourced through partner central procurement mechanisms as local procurement is usually expensive; or, in the case of Iraq, procuring high quality medicines indirectly through the WHO; and bulk-buying resources (DG ECHO/SYR/BUD/2015/91025);
- **Use of local contractors/providers.** For example, sourcing locally-produced medical devices (meeting DG ECHO quality requirements) which were cheaper and easier to repair locally (DG ECHO/-AF/BUD/2016/91003); and recruiting local staff rather than international staff;
- **Tailoring standardised tools and resources.** For example, designing standardised lists of medical items e.g. drugs, consumables and equipment which can then be locally adapted to meet local requirements and resource availability (DG ECHO/SYR/BUD/2015/91020); and
- **Training and capacity-building of local implementing staff, such as training medical and paramedical staff to improve the efficiency of medical staff and streamline the flow of patients through the healthcare system (DG ECHO/SYR/BUD/2015/91020).**
3.5.2.3 At the same time, factors limiting efficiency were found, affecting the delivery of actions

Factors limiting the efficiency of funded actions included:

- **Poor monitoring of project spending.** A problem highlighted in several project reports was that partners did not contact DG ECHO to warn them of an expected project under-spend or over-spend or failed to justify expenditure. In addition, in many project reports and FicheOps, reporting on spending and budgets was poor: information was inconsistently reported and unclear. It was suggested that partners should be asked to provide more detailed budget breakdowns/financial plans so that DG ECHO could better monitor implementation and adjust the funding as required. Partners should also flag up any expenditure changes as early as possible and expenditure should be clearly reported in final reports and FicheOps;

- **Unexpected changes in the number of target beneficiaries.** Despite preparedness and contingency planning, it is often almost impossible to predict the number of target beneficiaries, particularly in areas with large migrant flows (e.g. Afghanistan), due to the unpredictable nature of crises. In the large majority of cases the numbers are under-estimated, however there are cases of over-estimation e.g. the Azraq hospital in Jordan received far fewer refugees than expected;

- **Lack of coordination of funding and actions** leading to inefficiencies or duplication of work by governments, donors, partners or other actors;

- **Poor local relationships**, for example between partners and local medical staff/actors/Ministries of Health;

- **Poor project management by the implementing partner** leading to delays, over-spends and limited outcomes;

- **Implementing partner procurement issues.** For example, drug procurement issues due to DG ECHO’s regulations around which procurement partners can be used; DG ECHO's rule that only 5% of drugs can be leftover at the end of an action; and delays or difficulties in importing drugs or vaccines;

- **Staffing.** Problems with using local staff included: difficulties recruiting enough local staff; issues with staff of different ethnicities working with certain beneficiary groups; or local staff lacking sufficient training. In the case of the EVD response in Liberia, the deployment of hundreds of international staff for 3-4 weeks caused a huge surge followed by rapid decrease in capacity which one RHE argued hampered efficiency;

- **Not enough funding provided to support work in complimentary sectors.** One partner mentioned that DG ECHO sometimes neglected funding for essential work in other sectors e.g. WASH activities for cholera projects. In many cases the efficiency of health projects is negatively impacted because partners must carry out these essential side-projects even if they were outside of original project scope; and

- **Additional country-specific implementing costs.** Implementation costs can be particularly high in some regions due to certain political contexts or requirements (e.g. high staff security costs).
3.5.3 The efficiency of DG ECHO administrative and financial mechanisms and systems varied

This section explores stakeholders’ views (expressed through the survey and interviews) on the efficiency of DG ECHO’s mechanisms and systems, and how they can be improved.

3.5.3.1 Funding applications, monitoring and reporting requirements

Overall, most stakeholders were happy with DG ECHO’s administrative mechanisms and systems. When asked to compare DG ECHO to other donors:

- the majority of survey respondents (81% of 103 respondents) agreed or strongly agreed that DG ECHO monitoring systems (including monitoring visits, Logframes, and reporting indicators) are easy to adhere to (only 9% disagreed);
- 76% of respondents agreed or strongly agreed that DG ECHO modification systems are easy to adhere to;
- The DG ECHO grant application process was perceived easy to use by 72% of respondents; and
- 55% agreed or strongly agreed that DG ECHO’s decision-making process is quick (21% disagreed or strongly disagreed).

More specifically, partners liked the single e-application form; the easy-to-understand guidelines for filling out proposal forms and understanding the funding mechanisms; and the e-reports. For those partners who were not happy with the mechanisms, the following suggestions for improvement were provided:

- The time between publishing the HIP and the deadline for submitting proposals should be extended (it is usually three months);
- Use of more innovative reporting mechanisms and less paperwork, especially for the funding application process and the e-single form;
- Removal of the character limits in forms to allow partners to provide more explanation;
- Enrichment of the indicator matrix for health interventions that partners must report against;
- Better understanding the inevitability of partner-side delays due to working in a humanitarian setting; and
- Improved communication between DG ECHO and partners.

3.5.3.2 The majority of partners found DG ECHO funding to be distributed swiftly, however it varied depending on the type of crisis and instrument

Results from this evaluation survey found that 65% of 103 respondents agreed or strongly agreed that DG ECHO funding is disbursed quickly (14% disagreed) and 37% of 101 partners applied to DG ECHO for funding because they viewed them as a flexible donor. However, findings from the interviews showed that the speed and efficiency at which funds were delivered to partners varied depending on the type of crisis and the type of funding instrument used. More specifically, evidence gathered shows that:

- For follow-up actions funded through geographical HIPs, DG ECHO was able to release funding relatively quickly and efficiently – the need to re-submit an application meant however that some activities had to be halted until release of new funding;
- For first-time actions delivered through geographical HIPs, especially actions responding to a particularly acute and urgent crisis and/or a new crisis situation, the process was relatively slow and could be improved. Although DG
ECHO does retro-actively fund partners, in most cases, partners do not have enough funding to start delivering an action prior to receipt of DG ECHO funding or are reluctant to start work without a contract;

- In the midst of a crisis, DG ECHO was found to often be quite slow at releasing additional funding when required; and
- In most cases this funding was used as part of a ‘funding package’ alongside HIP funding or funding from other donors to kick-start an action in response to an epidemic.

3.5.3.3 Views on longer-term funding mechanisms differed between DG ECHO staff and DG ECHO partners

DG ECHO staff were generally ambivalent with regards to whether they preferred a short-term (i.e. DG ECHO’s standard 6-18 month funding cycle) or longer-term funding period. Most felt that shorter-term funding was important for DG ECHO to maintain their reputation as a flexible donor, as DG ECHO allows actions to be changed/modified in response to changing contexts. Longer-term funding could lead to partners using too many funds in the first year, the fixing of funds in certain regions for longer than necessary, and the fear that longer-term funding turns the action more into a development action than humanitarian response.

In contrast to DG ECHO staff, while partners valued the flexibility of DG ECHO funding, all partners interviewed to date would prefer a longer funding period of two to three years because it allows for better forward-planning, development of a regional strategy and less service disruption due to funding gaps (particularly in protracted crises); is less administrative work (and cost) for partners because funding applications are written less frequently; and allows recovery from slow starts and allows outcomes to be achieved despite initial project delays. Furthermore, they argued that other emergency donors e.g. the German Ministry of Foreign Affairs, are already using this approach.

In the context of Côte d’Ivoire for instance, where the purpose was to strengthen the health system, such longer term funding was found relevant, appropriate and necessary, and provided DG ECHO partners with several advantages such as the possibility of creating a relationship with the parties involved, integrating activities into the national health system, or accompanying staff and monitoring their progress and achievements: activities which would have not been possible to put in place in 6 to 18 months. However, a key limitation of the ExAR programme in Côte d’Ivoire was that DG ECHO mechanisms and ways of working were not yet adapted to this longer-term funding structure. This needs to be addressed for future long-term funding initiatives.

3.5.3.4 Other DG ECHO mechanisms in place demonstrate efficiency, however improvements can be made

At global level, DG ECHO indirectly funds the GHC (led by the WHO) and in some countries, DG ECHO indirectly and directly funds regional health clusters (only in areas where they are seen to be functioning well). DG ECHO tried to promote better coordination of partners and other actors through this mechanism to improve efficiency and prevent the duplication of work. However, DG ECHO’s support could be improved: several times DG ECHO’s funding to the GHC was delayed by several months causing a funding gap which, along with other contributing factors such as poor partner performance and challenges with the WHO, led to the cluster’s inability to provide surge capacity. DG ECHO also tried to coordinate and optimise the utilisation of existing resources, for example in CAR and South Sudan, DG ECHO coordinated with GAVI to ensure that existing vaccination facilities were used efficiently. Finally, DG ECHO’s deployment mechanisms for EU organisations was viewed as problematic and leading to significant inefficiencies. During the
Ebola outbreak, existing DG ECHO mechanisms were not immediately able to deploy the ECDC, which resulted in delays and inefficiencies. Although discussions are currently being undertaken to develop a deployment mechanism for European public health professionals in future crises, this is an important area of improvement for DG ECHO.

### 3.6 EU added value

This section presents the EU-added value (EUAV) of DG ECHO’s actions in the health sector over 2014-2016, exploring factors such as changes, or contributions, which can reasonably be argued to have been due to EU intervention, rather than any other factors.

This section draws from the findings made under all other evaluation criteria, in order to answer the following evaluation question:

- How did DG ECHO draw on its specific role and mandate to create an added value in the humanitarian health sector, which would not be achieved by actions by individual EU MSs and other actors?

#### EU added value - main findings

- DG ECHO’s field network of RHEs was an important element of EU added value, bringing health and humanitarian expertise to DG ECHO’s responses.
- Team work between DG ECHO’s Health Team leader (policy) and Global Thematic Coordinator (policy), with support from RHEs and TAs, contributed to important evolutions within the global discussion on humanitarian health aid.
- There is evidence that DG ECHO supported the provision of necessary health activities in forgotten crises.
- The variety of inputs and tools available at EU level to contribute to an EU / DG ECHO humanitarian response (health system/public health development experts of DG DEVCO, assets under the European Medical Corps, research funding under DG RTD) was also an asset for DG ECHO as a donor, yet evidence suggests that the structuring of the different components could be further institutionalised and strengthened.
- DG ECHO’s Consolidated Humanitarian Health Guidelines added value mainly to DG ECHO RHEs to inform funding decisions. Partners reported using them to some extent, but evidence suggests that this was somewhat superficial. Their added value would be improved if they were tied to a strategic performance framework (to meet DG ECHO’s strategic objectives) and against which RHE’s and country offices could measure progress made via their funding.
- EU added value would be more easily traceable were DG ECHO to improve the measurement of the results of the projects it funds and the gaps it addresses. The absence of a strategic performance framework, tied to its strategic objectives in the health sector (as specified in DG ECHO’s Consolidated Humanitarian Health Guidelines), is a shortcoming. This idea is explored in more detail in the recommendations section below (Section 4).

DG ECHO’s health responses were built on its field network of RHEs and medical doctors (working as TAs in some countries), to provide technical and contextual inputs both to field TAs and staff at HQ, as well as feedback to partners.

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Evidence shows that they added value by being present in the field, which is not the case of all other donors. Their field presence and medical knowledge allowed an exchange with partners, as well as the gathering of up-to-date information on needs, and knowledge of local communities with a particular attention to cultural and gender sensitivity, evolutions in context and projects’ progress, as well as communication and collaboration with health stakeholders (e.g. the MoH, DG DEVCO and other donors).

Yet, the evaluation found that **DG ECHO RHEs were not systematically consulted** on projects which included health activities nor in the development of DG ECHO’s HIPs. This was dependent on TAs and partners’ level of initiative in seeking their technical support and also on RHEs’ capacity to do so, considering their large regional portfolio. Their role coordinating inputs from different NGOs at the stage of needs assessment and from various branches of EUIBOAs with health expertise (ECDC, CP policy unit at DG ECHO, DG DEVCO, DG SANTE, DG RTD) to structure different inputs (epidemiologic, research-focused, intra-EU etc.) within an emergency response in the health sector could also be further specified.

At global level, **DG ECHO’s contribution to global discussions on humanitarian health and its systems has been recognised**. It has supported the GHC by being an active participant and supporting better coordination across clusters and also amongst donors and actors. It has intervened in ways to optimise the utilisation of existing resources, for example by intervening in countries where Global Fund programmes were running and coordinating with GAVI so that vaccination facilities could be optimally used. **DG ECHO’s level of technical expertise has also allowed it to be influential, participating, for instance, in the discussions on the use of non-conditional cash for health, the development of essential health service packages**, or opening a dialogue on procurement and access to quality medicines. Furthermore, the role of RHE’s to feed into such global discussions can be highlighted, as information is passed on from the field into policy discussions at the GHC level.

There is evidence that **DG ECHO supported the provision of health activities in forgotten crises**, e.g. Yemen (€24m), Chad including Nigerian and CAR Refugees and Host Populations (€17m), Myanmar (€8.25m), Libya (€5.7m), Bangladesh (€4.6m), India (€3.6m), Saharawi refugees in Algeria (€2.75 m). DG ECHO plays a determinant role in the provision of humanitarian assistance in South Sudan, where the humanitarian situation is critical. In South Sudan DG ECHO’s partners work in geographical areas where the health needs of the populations are not covered by any other actor (including public services).

The **variety of tools and expertise available to DG ECHO to contribute to an EU humanitarian response was also an asset for DG ECHO as a donor**, yet evidence suggests that the structuring of the different components could be further institutionalized and strengthened. This has reportedly improved since the Ebola crisis and more recently the migration crisis faced in Europe, as well as discussions on Trust Funds such as the Bêkou fund in CAR, or the MADAD fund for Syria. For example, there could be more structured dialogue on countries of intervention between DG ECHO, DG DEVCO, and where relevant, ECDC, and EU MS. Delegation of clear roles of responsibility is further needed, for example on whether Directors at DG ECHO, or European Union External Action Service (EEAS) should coordinate external relations, or RHEs). Finally, **some legal and administrative hurdles existed and have prevented seamless transitions from DG ECHO to DG DEVCO funding or nesting the deployment of EMC assets within a larger DG ECHO HA response**. There have been signs that these issues are progressively being addressed. Considering the importance of DG ECHO as a donor and its proximity to DG DEVCO in

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certain contexts, their respective expertise would further add value to the EU’s humanitarian health aid response.

**DG ECHO’s Consolidated Humanitarian Health Guidelines added value mainly to DG ECHO RHEs to inform funding decisions.** Partners reported using the guidelines to some extent, in particular Annex A and its technical annexes, but evidence suggests that this was somewhat superficial. Some further elements could also be added with more detail, e.g. necessary steps in needs assessments (e.g. beneficiary participation) and designing a response, based on the identification of causal factors; steps to coordinate inputs from various EU actors with humanitarian health expertise or assets, e.g. engaging European Union Delegations (EUDs) to engage with institutional actors to unblock certain administrative/political issues impeding on humanitarian responses.

**EU added value would be more easily traceable were DG ECHO to improve the measurement of results from the projects it funds and the gaps it has addressed.** This would imply changing the reporting requirements from partners, and mission / monitoring reports from RHEs so that they focus on outputs and outcomes, and also involve direct beneficiaries and any actors involved in follow-up actions. **DG ECHO’s added value would also be more easily measured if reporting systems were based on a strategic performance measurement framework, specific to the health sector, and tied to DG ECHO’s strategic objectives (as specified in DG ECHO’s Consolidated Humanitarian Health Guidelines ).** The GHC, RHEs and country offices could then measure progress made by the actions funded against this overarching strategic performance framework.
3.7 Sustainability and LRRD

This section addresses the following evaluation questions:

- The extent to which the DG ECHO humanitarian health actions have provided sustainable results including the extent to which:
  - benefits from the intervention were likely to continue after termination of the intervention;
  - DG ECHO’s engagement into a pluri-annual action has been an effective and efficient way of promoting LRRD for Health sector programmes in a post-conflict environment;
  - DG ECHO has been collaborating and coordinating actions with development actors;
  - DG ECHO played a role in strengthening national and regional government’s long-term policies and practices in the health sector and integrating DG ECHO actions into national systems;
  - DG ECHO contributed to integrated prevention, preparedness and DRR in their responses;
- What could further be done to increase the uptake of results and lessons learnt from relief projects into development planning and programming; and
- How successful DG ECHO has been, through advocacy, in influencing other actors to address gaps in response, applying best practices, and carry out follow-up action.

An important limitation of this evaluation was the general lack of monitoring/reporting of sustainability by partners and DG ECHO staff. It is not clear whether this is due to poor reporting; because sustainability was not an objective of the action; and/or because the term was not clearly defined, and therefore it was not measured or focussed on.

Our research found that definitions of sustainability and opinions regarding the extent to which sustainability can and should be achieved by DG ECHO-funded humanitarian health actions varied greatly among DG ECHO staff, partners and humanitarian and development actors:

- A small number of DG ECHO staff felt that sustainability should always be considered in the design and implementation of actions, while others reported that sustainability was not within the remit of humanitarian assistance. In general, partners seemed to place a greater focus on sustainability than DG ECHO, with the majority (87%) of partners reporting that they considered long-term health strategies to a large, moderate or small extent, in the design and implementation of their actions, with sustainability often being part of their core principles; however
- In line with DG ECHO’s Consolidated Humanitarian Health Guidelines, in many cases sustainability was not deemed possible due to the severity of the crisis, the acute/protracted nature of the crisis, the specific context of a country/region (e.g. the fragility of the existing health systems or government corruption), and/or funding limitations, and was therefore not considered.

For the purpose of this evaluation, a very broad definition of sustainability was therefore used, namely the extent to which results have been maintained at a certain rate or level three to six months after the end of the DG ECHO funding period. Sustainability was assessed at four different levels: the sustainability of funding, project activities, and project outcomes (such as increased knowledge and skills of healthcare professionals); as well as the evidence of wider project impacts.
**Sustainability and LRRD - main findings**

- There was no consensus among stakeholders regarding definitions of sustainability or the extent to which sustainability can and should be a focus of humanitarian assistance.

- Stakeholders felt that funding provided over a longer time period (e.g. ExAR), rather than re-funding actions multiple times would better facilitate sustainability, and, allow better forward planning to improve effectiveness and efficiency.

- Multi-year funding, such as ExAR, were identified as having significant potential to strengthening LRRD in a post-conflict environment. Although, in order to achieve successful implementation, DG ECHO would have to review its modus operandi to adapt it to such funding mechanism.

- The majority of DG ECHO-funded actions were integrated into national programmes or systems and several examples of DG ECHO facilitating the handover of actions to national authorities were identified. However the extent to which funding and/or actions were taken over by development actors was not clear: many handover difficulties were identified.

- In order to facilitate better update of results and lessons learnt from relief projects into development planning and LRRD, humanitarian actors should engage with political and development stakeholders earlier in the process; develop health-specific LRRD guidelines/standards; and improve coordination and discussion with development actors.

- The sustainability of outcomes was not usually reported or measured. However, as a general outcome, almost all projects contained an aspect of capacity-building which can be a sustainable outcome (even if sustainability was not an initial objective). There is also no clear evidence of wider sustainable impacts: although a third of partners reported that DG ECHO-funded actions led to changes in government policies, no specific examples were identified.

- DRR activities were usually considered in the design and implementation of actions, with some projects specifically funded to improve response preparedness.

- DG ECHO’s advocacy work was identified as a “game changer”, with evidence to suggest that it has influenced other actors to address gaps in their response, apply best practices and carry out follow-up actions.

3.7.1 The extent to which DG ECHO humanitarian health actions were sustainable varied depending on the duration of funding and how actions were handed over to other development actors, or national/local authorities

This section discusses, in turn, the extent to which project funding, actions, outcomes and project impacts have been sustained.

**3.7.1.1 Sustainability of funding**

There were mixed views regarding whether or not repeated funding can facilitate sustainability. **Recurrent funding was mentioned by partners as important in ensuring sustainability, along with DG ECHO’s support in planning for**

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36 The evaluation team was not able to establish how many actions, out of the 573 actions in the health sector implemented from 2014 to 2016, were refunded (due to the lack of a common marker in the HOPE database)
**sustainable actions and phasing out strategies.** This being said, it was difficult for partners to predict whether or not re-funding would be granted and whether funding would be available to continue an existing action in the following year.

**Funding provided over an extended time period (i.e. ExAR) was seen as a better way to facilitate sustainability in certain contexts** (e.g. post-conflict) and for certain types of interventions (e.g. health system strengthening, capacity building), as it allows for better forward planning and implementation of a stronger exit strategy by giving partners more time and funding/resources to negotiate with local authorities and the MoH to ensure sustainable handover.

For example, in the case of ExAR in the Côte d’Ivoire, the multi-year funding approach allowed the programme to strengthen and stabilise health structures and the promotion of health activities. At district and regional level, ExAR strengthened the capacities of government officials and ‘normalised’ the health activities in the region. However, the central level was neglected in the design and implementation of activities. As a result, the central level judged that they did not have the necessary financial information to continue the activities implemented by DG ECHO partners once over and sustainability was not assured.

**The extent to which development actors took over the funding of humanitarian actions was unclear.** However, findings from this evaluation highlighted that the handover of funding to development actors was very difficult to achieve for the following reasons: compared to humanitarian funding, there are more restrictions on how development funding in the health sector can be spent since those have to be aligned with government strategy; they have different strategic funding targets (i.e. funding MoH mid-level structures, staff and processes rather than life-saving funding for the most vulnerable groups); and longer planning cycles. Furthermore the relationship between humanitarian funding and development funding is not linear: countries can move from crisis response phase to development stage and then back to crisis response, meaning the handover criteria for funding can be complex. More stringent administrative processes and rigid frameworks also mean that development funding often takes a long time to be released which can lead to funding gaps between humanitarian and development funding. **Although there were funds available to bridge this gap i.e. the EC’s Instrument Contributing to Stability and Peace**[^37], they were little known among field staff.

### 3.7.1.2 Sustainability of activities

**Handover of actions to national actors/alignment with national policies and strategies**

Survey respondents noted that ensuring handover to national actors was a key component of effective exit strategies facilitating lasting effects of actions. More specifically, 90% reported that their actions were integrated into existing national programmes and systems to a large, moderate or small extent at the end of the funding period. As far as possible, **DG ECHO and partners aimed to integrate humanitarian health provision into existing MoH health frameworks or systems** (as opposed to creating parallel systems) so they can easily be taken over by national actors at the end of the funding period.

[^37]: The IcSP is an EU instrument used to support security initiatives and peace-building activities in partner countries. Part of the EU’s new generation of instruments for the financing of external action, it focusses on crisis response, preparedness, conflict prevention and peace-building. More information can be found at: [http://ec.europa.eu/dgs/fpi/what-we-do/instrument_contributing_to_stability_and_peace_en.htm](http://ec.europa.eu/dgs/fpi/what-we-do/instrument_contributing_to_stability_and_peace_en.htm).
The wider evidence provides several examples of where DG ECHO and its implementing partners have worked closely with MoH and other national stakeholders to facilitate the handover of project actions to national authorities. For example, handing over the medical and nutritional activities of programmes to local district staff; and reabsorbing staff used for the funded action into the existing health system at the end of the action with support from local NGOs. In South Sudan, for example, DG ECHO partners have put in place strategies to ensure continuation of services by employing local staff (even from refugee camps), giving responsibility to local health communities, and, promoting task shifting. Facilitating factors for project handover identified by stakeholders include:

- **Designing and discussing the exit plan with local authorities and other actors, including the MoH, in advance and involving them in all stages of the project to develop a sense of local ownership and ensure they possess the necessary information and knowledge to continue the activities. For example, early and gradual involvement of medical staff in the planning and early implementation of activities to ensure gradual handover of roles and responsibilities;**
- **Implementing actions through local partners;**
- **Provision of technical support** by the partner organisation to national actors;
- **Advocacy to promote the uptake of projects by national governments;** and,
- **Aligning actions with national policies and strategies** (92% of survey respondents stated that their actions were aligned with national policies and strategies and approximately one third of projects reported evidence of, or the aim of, aligning DG ECHO’s interventions with national and local policies, strategies and/or programmes).

However, the fragility of local healthcare systems and lack of MoH capacity to maintain the same standard of activities as the partner organisation were seen as key limiting factors for facilitating sustainability in some contexts, for example in Syria, DRC, Chad, Cameroon, CAR, Nigeria and South Sudan. Furthermore, while it is necessary to think about handover actions from the start of a crisis, it must also be ensured that emergency healthcare is readily available if there is a re-occurrence of a crisis situation: this balance is particularly difficult to achieve in some crises-affected areas due to the unpredictability of future developments.

**Handover of actions to development actors**

DG ECHO’s Consolidated Humanitarian Health Guidelines state that “wherever possible, Partners are expected to co-ordinate with development partners, from different sectors and at different levels (e.g. local and national), and to ensure their interventions contribute to, or lay the foundations for, longer term strategies to reduce future humanitarian health needs” (DG ECHO 2014, p.16). Collaboration includes seeking the best transitional solutions, avoiding isolated humanitarian actions without sustainability and participating in priority setting for research with great potential impact on humanitarian needs.

However, in general, handover and collaboration with development actors did **not occur**. Although most projects mentioned that they collaborated with development actors in the field, in most cases this collaboration did not continue after the end of the action. **14 projects explicitly mentioned that follow-up actions with development actors occurred, and half of survey respondents declared that their actions were not followed up by a development intervention** (only 17% of respondents declared that all or most of their actions were followed up by a development intervention).
This is likely due to the difficulties of handing humanitarian actions over to development actors including: a lack of development funding in certain contexts compared to humanitarian funding; a time-lag between funding provision; and differing priorities and varying degrees of risk adversity of actors. Due to differences between development theory (which focusses on the broader task of developing/strengthening healthcare systems based on equity of access) and humanitarian response objectives (which focus on providing targeted, immediate, life-saving support to the most vulnerable members of populations), development actors are often reluctant to support humanitarian actions that have not been developed in collaboration with development actors.

In order to increase the uptake of results and lessons learnt from relief projects into development planning and programming and facilitate resilience building and LRRD, stakeholders argued that it is essential that humanitarian, political and development actors engage with each other from the outset of a crisis and in a more formalised way. This would ensure the establishment of joint and complimentary priorities and the sharing of responsibility which can facilitate the handover of humanitarian actions to development actors at the end of a humanitarian response.

Stakeholders also mentioned the importance of improving coordination and discussion with development actors, including: summarising learnings from DG ECHO-funded actions and sharing them in a more standardised way; developing standards to share with stakeholders involved in the transition between humanitarian activities and development activities; developing some health-specific guidelines to support best-practice LRRD processes in the health sector; and improving the quality of DG ECHO project documentation. Finally, having the option of a longer duration of transition funding (beyond 24 months) was also seen as important in facilitating LRRD and the takeover of humanitarian actions by development actors.

3.7.1.3 Sustainability of outcomes

As discussed above, DG ECHO and partners do not systematically report project outcomes and, as a result, in most cases there is no information on the sustainability of outcomes. This section therefore focusses on more generic outcomes, particularly the extent to which capacity-building has been achieved.

In line with DG ECHO’s Consolidated Humanitarian Health Guidelines which stress the importance of considering capacity-building that will reduce future humanitarian health needs, all survey respondents reported building capacity of local staff, and the majority (97%) believed that actions also built capacity of communities/beneficiaries. Nevertheless, it remains unclear whether capacity-building was undertaken with the aim of facilitating sustainability or sustainability was a side effect of capacity-building activities to rapidly achieve a minimum acceptable quality of service.

Finally, there was very limited evidence that DG ECHO-funded actions had an impact on Government policies and processes. While approximately a third of survey respondents (32 out of 102) reported that DG ECHO-funded actions did have an impact, no concrete examples were identified over the evaluation period.

3.7.1.4 DG ECHO’s contribution to integrated prevention, preparedness and DRR in response

DG ECHO’s Consolidated Humanitarian Health Guidelines state that: “DRR, disaster preparedness and resilience are relevant in every aspect of a health sector humanitarian response. DG ECHO requires that all humanitarian action it supports be based on a sound assessment of risk and the intervention should seek to reduce immediate and future risks” (DG ECHO 2014, p.16). This was reflected in findings
from DG ECHO staff who reiterated that during every crisis, all partners should be involved in contributing to early warning alerts for epidemics outbreaks.

The evaluation partner survey found that **the large majority (86%) of 103 respondents integrated DRR activities into the design and implementation of their health actions** (only 3% of declared that DRR activities were not integrated in their actions) and 13% of sample projects were specifically aimed at improving the response preparedness of health systems and/or populations.

**DRR activities included:**

- Reinforcing national disease surveillance mechanisms and building surveillance capacity;
- Training staff on emergency health situations and how to monitor and report a crisis;
- Strengthening the capacity of the Ministries of Health, local authorities and institutions to respond to epidemic outbreaks efficiently and effectively;
- Creating and testing Rapid Response Team capacity to respond to future disease outbreaks; and
- As is protocol for some partner organisations e.g. International Rescue Committee (IRC), including DRR, local capacity building and sustainability components within programmes wherever possible.

### 3.7.2 DG ECHO’s advocacy work

DG ECHO has been described as “influential” and a “game changer” in facilitating systems change through their advocacy work. 80% of survey respondents stated that DG ECHO was involved in advocacy work during project implementation and evidence was found to suggest that DG ECHO’s advocacy work – both at project level and more widely – has influenced other actors to address gaps in their response, apply best practices and carry out follow-up actions. For example, DG ECHO’s advocacy for better access to remote areas to address current gaps in the humanitarian response and their funding contribution to large-scale polio campaigns in the Horn of Africa and Syria were identified as examples of successful advocacy.

Furthermore, through DG ECHO’s involvement in the GHC they have: challenged WHO on the response to Ebola and on WHO’s internal reform; participated in the development of essential health service packages, as well as advancing the discussion on cash for health. Other achievements through the GHC included the opening of a dialogue on procurement and access to quality medicines, advocating for WHO to be more involved; contributing to wider technical debates and country-level support initiatives, including support to improve the quality of health cluster coordinators; and supporting health cluster meetings which bring together partners to conduct gap analyses and develop coordinated strategic priorities.

Other examples of advocacy work conducted, as highlighted by DG ECHO, included discussions and implementation work on increasing access to quality of medicines (through funding of the QUAMED initiative- DG ECHO/ERC/BUD/2014/91002); and work towards adapting processes/procedures of global health actors in fragile settings.
4 Conclusions and Recommendations

This section brings together the findings under each evaluation criteria and provides strategic and operational level recommendations based on these findings. Conclusions and recommendations have been structured temporally, by project stage (design, implementation and follow-up) to support their more practical application by DG ECHO. As far as possible, recommendations have been clearly identified as health-sector specific or broader cross-sectoral, and aimed at DG ECHO or their implementing partners/other stakeholders.

4.1 Conclusions

4.1.1 Action planning and design

- **DG ECHO’s field presence through its network of TAs, and its network of RHEs was key in improving the quality of needs assessments at both crisis and project level.** In general, RHEs and TAs were identified as key components of ECHO’s added value. However, **DG ECHO RHEs were not systematically consulted and utilised** and the quality of health-specific needs assessments was often limited by a lack of available local data from the field. This reduced the accuracy of information to inform funding decisions and ensure the relevant targeting and monitoring of support. Furthermore, at **crisis level,** although ECHO RHEs regularly gathered data on healthcare and emergency response needs and provided some input at HIP development stage, they did not regularly conduct **formalised, well documented** health-specific needs assessments to inform HIP development, and consultation of RHEs by DG ECHO TAs and partners for technical feedback and review of health projects and proposals was not sufficiently systematised.

- **At individual project level, the quality of health needs assessments varied based on partners’ capacity** (in addition to the inherent barriers faced when conducting assessments in humanitarian settings). The lack of a standardised partner needs assessment process affected the extent to which DG ECHO provided relevant support to crises. **In cases where needs assessments were based on weak data and/or estimations, DG ECHO’s humanitarian health guidelines were not specific enough to inform funding decisions.**

- **Good collaboration and coordination between DG ECHO, partners and other actors, particularly in the early planning stages of projects, was highlighted as essential to support quality needs assessments and planning** to: ensure the better targeting of aid; avoid the inadvertent exclusion of vulnerable groups; improve the effectiveness and efficiency of actions; increase EU Added Value; and ensure sustainability. As mentioned in the implementation section below, **in general, collaboration between DG ECHO and other actors was good, although it was dependent on context.** The recommendations below highlight where collaboration opportunities could be further improved during early planning stages (at global, region/country and project level).

- **DG ECHO administrative systems were generally viewed as efficient** by its staff and partners, although improvements could be made, particularly regarding reducing administrative burden.

- **The efficiency of funding mechanisms varied by type of crisis and funding mechanism:** funding through geographical HIPs for **follow-up actions** and through the Epidemics Instrument was, in most cases, deemed efficient, but other funding (for new projects and release of additional funds part-way through an action) delivered through geographical HIPs was often too slow. Furthermore, views on the benefits of longer-term funding periods were mixed: while DG ECHO staff identified a number of limitations of extended funding, all
partners would prefer a two- to three-year funding period as they feel this would allow better forward-planning to improve effectiveness and efficiency, as well as better facilitate sustainability.

- **DRR activities**, particularly epidemics monitoring and preparedness, were identified as an essential part of humanitarian responses in the health sector. In line with this expectation, DRR activities were usually considered in the design and implementation of actions by partners, with some projects specifically funded by DG ECHO to improve response preparedness.

### 4.1.2 Implementation

- Between 2014 and 2016, **DG ECHO funded 573 actions in the health sector (553 funded actions in third countries)**. Primary health was the most commonly funded health sub-sector, although actions also covered sub-sectors such as reproductive health and/or mental and psycho-social support. The total amount of DG ECHO funding provided for these projects was €640.5 million, out of which €616.9 million was provided to third countries.

- **Overall, DG ECHO-funded actions responded to health needs and successfully targeted the most affected geographical areas.** However, it was not clear whether they systematically reached the most vulnerable populations in each geographical area and supported the most relevant interventions. Attention to how needs evolved over the course of the project also varied by partner, context and DG ECHO staff. More specifically, for epidemics, there is evidence that DG ECHO tailored its approach to address recognised challenges and accessibility obstacles, yet harnessing available expertise, including external expertise, could have been better. The evaluation identified DG ECHO’s support for the provision of health activities in forgotten crises as a key area of added value.

- **DG ECHO-funded actions were generally well coordinated with other actors and interventions at various levels (national and local authorities, humanitarian actors and donors), through DG ECHO’s engagement with global and national health clusters.** TAs and RHEs played an important role in facilitating and maintaining good coordination.

- **However, the extent to which coordination and collaboration was achieved was context-dependent.** In some cases DG ECHO was not able to critically engage with relevant actors in national health clusters (for example Ministries of Health) due to capacity issues or differences in favoured approaches. Furthermore, although several examples of collaboration with internal stakeholders (DEVCO, SANTE, EMC and the ECDC) were identified, they were generally ad-hoc and could be improved (particularly during the Ebola outbreak). During the Ebola outbreak the ECDC link was ad-hoc and reliant on goodwill and local arrangements rather than prior planning and ECDC deployment through ECHO, while preferred, was not possible. Similarly, although institutionalisation of cooperation and collaboration between ECDC, ECHO and SANTE during the deployment of the EMC was ongoing, so far teams have been deployed only on an ad-hoc basis.

- **Overall, there was a general lack of awareness and use of DG ECHO’s Consolidated Humanitarian Health Guidelines among partners and other actors and, in practice, not all of DG ECHO’s actions were in line with these guidelines** and where actions were not aligned, no transparent explanation was provided as to why not. Where DG ECHO’s CHH Guidelines

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38 These sub-sectors are not mutually exclusive. – single projects were often categorised as falling within multiple sub-sectors.
were used, they acted as a strategic benchmark for funding and implementation: the Decision Tree was identified as particularly useful for supporting funding decisions. More broadly, DG ECHO staff played an important role in disseminating international standards to the DG ECHO field network. Due to the relatively recent development and deployment of the EMC, it is difficult to assess the coherence of the EMC with ECHO guidelines and various international standards.

- The monitoring of actions by DG ECHO staff and partners was seen as key to ensuring efficient and effective actions, however it was not systematically done. Lack of data (including the availability of baseline data) collected and reported, confusion between output and outcome indicators by partners during reporting (most data was reported at output level), choice of non-compulsory indicators that only partially captured intended results and the lack of clear standards or monitoring guidelines for ECHO staff affected the effectiveness of actions in many cases. Similarly, the inconsistent/unclear reporting of cost data by partners and ad-hoc monitoring of spending by DG ECHO staff affected efficiency, often leading to potentially avoidable project over- or under-spends. Furthermore, DG ECHO did not sufficiently promote or encourage partners to set aside a proportion of their funding for project evaluation. In most cases, the effectiveness of actions was measured by reporting against output indicators rather than outcomes. As a result, it was not possible with the data available to assess the effectiveness of DG ECHO actions and to prove that DG ECHO is funding effective projects.

- A number of facilitating factors were identified as promoting the effectiveness of DG ECHO actions and include: RHE expertise and close monitoring of projects, quality of drugs, existing health system, partners health expertise, communication and collaboration with health stakeholders in particular with the MoH, and sound knowledge of local communities with particular attention to cultural and gender sensitivity.

- Within each geographical region, feedback on the sufficiency of budgets was very mixed and varied by country. Insufficient budgets led to withdrawal of interventions, reduced activities and/or the shortening of the duration of actions in some cases. Timely provision of funding was identified as important in ensuring the effectiveness and efficiency of actions. Factors improving the efficiency of projects also included the streamlining and standardising of resources (particularly drug procurement) and training and capacity-building of existing local staff.

- In general, results (i.e. outputs) have been fully or partially achieved in most of the ECHO-funded actions analysed. Yet, achievements depended greatly on the context and region. Furthermore, achievement of results does not necessarily imply a good quality of service, as quality varied among ECHO partners. Most partners and ECHO staff considered the technical support and expertise of RHEs and TAs and trust relationships established with partners as main contributing factors to the success of actions. Other contributing factors included: drug quality and procurement; existing health systems, partner availability, expertise and capacity, and functioning referral mechanisms.

4.1.3 Action follow-up and sustainability

- There was no consensus among stakeholders regarding definitions of sustainability or the extent to which sustainability can and should be a focus of humanitarian health assistance. Furthermore, monitoring of sustainability was not usually conducted.
• In general, there was little evidence of coordination and handover of funding or actions to development actors in the field: many difficulties with such handovers were identified.

• The majority of actions were integrated into national programmes or systems, with several examples of DG ECHO facilitating the handover of actions to national authorities were identified.

• The sustainability of outcomes was not usually reported or measured. Nevertheless, almost all projects contained an aspect of capacity-building which can lead to a sustainable outcome (even if sustainability was not an initial objective). There was no evidence of wider sustainable impacts, and although a third of partners reported that DG ECHO-funded actions led to changes in government policies, no concrete examples were identified.

• ECHO’s advocacy work was identified as a “game changer”, with evidence to suggest that it has influenced other actors to address gaps in their response, apply best practices and carry out follow-up actions. In particular, team work between DG ECHO’s Health Team leader (policy) and Global Thematic Coordinator (policy), with support from RHEs and the GHC, was identified as a key area of added value as they contributed to important evolutions within the global discussion on humanitarian health.

4.2 Recommendations

As an overarching recommendation that spans planning, design, implementation and monitoring, and follow-up, DG ECHO should consider developing a strategic performance framework/logic model to support a more formal and systemised process for needs assessments, funding decision making and the monitoring and evaluation of actions. Strategic priorities mapped in the framework should:

• Feed back into HIPs, aligning strategic and thematic priorities with funded activities and action outcomes; and

• Be clearly clarified and reflected in DG ECHO’s Consolidated Humanitarian Health Guidelines (including in the indicators in the funding Decision Tree) to ensure they provide a framework and a set of key indicators to inform proposal design (for partners) and funding decisions. The same core indicators should provide a clear structure for DG ECHO staff and partner reporting (monitoring reports, final reports and FicheOps).

The remainder of recommendations from this evaluation are structured by project stage (planning and design, implementation and follow-up) to support their more practical application by DG ECHO.

4.2.1 Action planning and design

4.2.1.1 Stakeholder coordination and engagement

• To support early and comprehensive stakeholder communication and engagement, ECHO should create, at the stage of HIP development, an engagement matrix for each country based on their principles of engagement, to clarify which stakeholders they can and should engage, and how. This matrix could align with the strategic performance framework proposed above. Such a matrix would support a better understanding of the context within which DG ECHO operates, including the development actors (if any) present in the field and the specific actors involved in the national health cluster. This should help to facilitate:

  - A better planning process between DG ECHO, national governments and development actors (where they exist), in order to share expertise and better support project sustainability and the uptake of results and
lessons learnt from relief projects into development planning and LRRD. Strategic-level engagement between DG ECHO and DG DEVCO should be more formalised/less ad-hoc and they should systematically support the development of, and integration of, strategic programming where possible. Communication channels with national governments should be opened early on to ensure alignment with national policies: good practices exist such as joint humanitarian-development strategic planning. DG ECHO, with support from the GHC, could also support the development of health-specific LRRD guidelines or standards; as well as strengthen relations with UN agencies such as UNICEF and WHO that cover the spectrum from relief to development;

- **More coordinated and streamlined deployment of the EMC** to ensure that EMT services and skills complement local capacity, are cost effective and deployed in a timely manner. Alongside an engagement matrix, ECHO should promote the development of common EU-level and internal public health standards that outline clearly how humanitarian and civil protection (EMC) streams should collaborate. Needs assessments should also identify whether timely deployment of EMTs to an intervention is possible; and surgical trauma teams (which appear most effective) should receive advanced logistical support. Due to the need for rapid deployment, it may be useful for ECHO to conduct scenario planning prior to disasters to assess in which countries and for which types of disasters EMT deployment can be most useful.

- **ECHO should continue its work to improve the deployment mechanisms for EU organisations**, in particular work to support the development of a deployment mechanism for European Public Health professionals in future crises.

- **RHE’s should be further supported to play a greater role in stakeholder coordination.** This includes:
  - **Ensuring a closer link between field staff and ECHO HQ.** RHEs should systematically feed back into ECHO and JRC’s global needs assessments, and programming by ECHO HQ, including the HIP development process. Formalised input into HIP development could be achieved through the submission of a standardised comments form by RHEs. Capacity-dependent, TAs should also be encouraged to seek RHEs technical advice more systematically when making funding decisions to support evidence-based project selection.;
  
  - **Promoting amongst partners, better involvement of communities and service users** in the planning, design and monitoring of actions to improve effectiveness. RHEs should also support the exchange and dissemination of best practice (for project implementation and evaluation) to partners; and encourage cooperation between partners and other actors at local level and more widely through the promotion of national and global health clusters;

  - **Supporting better engagement with internal departments.** To further maximise the added value of RHEs and TAs and the variety of tools and expertise available within the EU, RHEs and TAs should play an even more active role in identifying opportunities where DG ECHO could utilise the expertise of NGOs, MS and various branches of EUIBOA with health expertise (DEVCO, ECDC, CP policy unit at DG ECHO, DG SANTE, DG RTD) to:

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○ Improve the provision of epidemiological and research data for needs assessments (for example, through more regular involvement of the ECDC in field-level needs assessments; and integration of RTD research results into DG ECHO Needs Assessments and programming cycles);
○ Support DG ECHO partners (for example, partners could benefit from CP logistical capacity); and
○ Encourage earlier and more sustained engagement with government departments, representatives and national and local health authorities through exploiting existing networks/contacts developed by DEVCO and other EU actors.

4.2.1.2 Needs assessments

• DG ECHO should further encourage needs assessments to be conducted within projects, and for them to be updated when contexts change. ECHO could also promote (through the GHC) the development of a health-specific course to train partners in needs assessment methodology. Acting on those recommendations would contribute to meeting DG ECHO’s commitment to improving needs assessments, made at the World Humanitarian Summit (“The Grand Bargain”).

• DG ECHO should improve the existing tools and information systems for needs assessments by:
  - Providing a specific health needs assessment template and appropriate guidance to complete it;
  - Developing specific vulnerability criteria at or before the onset of a crisis. Those criteria should be included in the needs assessment and could form part of a checklist when assessing partner proposals for relevance;
  - Updating information systems used to collect needs assessment and monitoring data to allow disaggregation of data by vulnerable group; and
  - Revising the methodology for the Integrated Analysis Framework (IAF) to include a Health-specific assessment.

4.2.1.3 Proposal development and assessment

• DG ECHO should continue to maintain its high quality administrative mechanisms and systems. However, concrete improvements can be made in the following areas: extending the time between HIP publication and the deadline for proposal submission; further reducing levels of paperwork and bureaucracy; removing character limits in e-forms; being more flexible in the face of partner-side delays; and ensuring clear channels of communication between ECHO and partners during proposal completion.

• To improve action quality, DG ECHO should ask partners, in their proposal, to highlight which actors they intend to cooperate with; and demonstrate the capacity of all potential service providers to deliver an action, as well as their capacity (and budget) to collect baseline data and conduct evaluation and monitoring activities. Funding should not be provided if this information is not available.

• DG ECHO must promote and enforce (via RHEs and TAs) the systematic use of its CHH guidelines (particularly the Decision Tree) among partners: it should be promoted as a strategic document to inform proposal design for ECHO funding. Partners should also receive additional support/training on how to better align their proposals with ECHO’s strategic priorities. As part of its function as a strategic document, ECHO should update the Guidelines to provide clarification regarding the extent to which sustainability should be a focus of health sector actions, clearly define
cost-effectiveness (and how to measure it) and ensure a consistent understanding across partners.

- In order to achieve strategic coherence, use of the Decision Tree in Annex A of ECHO’s CHH Guidelines also needs to be enforced among TAs. Alongside this, training could be provided to ECHO staff in how to best use the Decision Tree, particularly for new or innovative projects, or those that use new aid modalities, as well as how to interpret and implement HIPs and ensure funding decisions are aligned. In cases where ECHO funds projects that do not clearly align with CHH guidelines, it is essential that the reasons for funding are transparently reported.

- In line with the strategic framework highlighted above, DG ECHO should promote the existing indicators (ECHO KRI’s in Annex B of the CHH guidelines), in particular those that capture the quality and timeliness of healthcare delivery, which would form part of the assessment criteria for funding. These indicators should also cover exit strategy/sustainability plans, expected health outcomes (not just outputs but formal health outcomes), and efficiency (clear cost breakdowns). Realistic and comprehensive targets against these agreed indicators should be evidenced and agreed from the start and partners and DG ECHO staff should be clearly briefed on how to report against these indicators during implementation i.e. in project reports and FicheOps.

- In addition to DG ECHO’s compulsory indicators, partners should be supported to develop additional project-specific outcome indicators tailored to the needs of the project and partner internal reporting systems. Partners should be supported, through the GHC, to better understand output and outcome indicators and select the most informative ones to ensure project outcomes and impacts are effectively captured.

4.2.1.4 Funding

The following recommendations for funding, while relevant for health actions, should be considered as part of a wider evaluation and revision of DG ECHO-funding structures.

- The process for funding first-time actions and releasing additional funds part-way through a crisis (through the geographical HIPs) needs to be revised to improve the speed of funding release. The Epidemics Instrument should be promoted as an effective tool to use for rapid funding release.

- A longer-term funding period of two years or more would be useful in some contexts (e.g. protracted crises, refugee camp settings) as it supports better planning and resource allocation to improve action effectiveness and efficiency. Longer-term funding such as the ExAR programme in Côte d’Ivoire would also support LRRD and sustainability as it provides a better chance of transitional continuity than LRRD built into short-term relief contracts. This would also tie in with the Grand Bargain commitment. However, to facilitate this, better tools are required to enable DG ECHO’s management of funds as a recipient of ExAR funding. DG ECHO should also ensure transparent and detailed financial reporting to governmental counterparts on expenditure of project funds to allow governments to better understand the costs of maintaining the service.

- Where short-term funding arrangements are in place, DG ECHO should support partners to ensure that there are no gaps in funding for essential services when the relief phase ends and projects are transferred to other actors. DG ECHO should encourage partners to seek support through the GHC/NHCs to identify potential alternative sources of funding to prevent funding gaps.
• **ECHO should consider implementing a two-tier funding structure.** Initial funding should be used to fund actions known to be effective, however some funding should be available to fund innovative projects or longer-term funding timescales. It is essential that these innovative projects provide quality baseline and clear monitoring plans before funding is provided. **ECHO could also explore other funding approaches (for example looking at other donors) and excluding partners from funding until they can prove that they provide a quality service which meets the stated outcomes.**

• **ECHO could further elaborate on its collaboration with EU Trust Funds,** as a way of sustaining actions that address the health needs of targeted populations and report concrete outcomes. Cooperation between ECHO and the EU-MADAD trust fund could be used as a pilot, within the context of the ongoing Syria Crisis.

4.2.2 Implementation

• **It is essential that the monitoring of projects against agreed indicators (see above) is improved and that all outcomes are clearly reported:**

  - **DG ECHO should promote, through the GHC, the systematic collection of baseline data by partners.** If quantitative information is lacking at local level, estimates need to be established and reviewed for validity. The engagement matrix mentioned above could help to improve communication with relevant government departments and agencies that hold baseline and monitoring information. Monitoring against good quality baseline data will also support DRR and reduce response delays.

  - **Partners should be better encouraged and supported by DG ECHO and the GHC to collect both qualitative and quantitative data.** Data could be collected from exit interviews on user satisfaction and questions included in Post Disaster Needs Assessments. All data should be disaggregated by age and gender. DG ECHO should also promote data sharing by supporting: collaboration with national authorities to access existing data; innovative ways to gather data where access is limited; external project-level evaluations; capacity-building of partners to conduct M&E activities; joint assessment/evaluation between partners; and exchange of data, good practice and tools (for example, training curriculums, health promotion tools and clinical protocols) by ECHO partners at crisis and global level.

  - **ECHO needs to ensure partners more systematically report their spending to DG ECHO and flag up any funding issues as early as possible.**

  - **ECHO staff need to ensure that evaluation data is clearly reported in Fichops, and not just rely on partner reporting.** This may involve delivering training for internal staff on how to clearly report output and outcomes data.

  - **The content of the HOPE database should be improved.** This includes better-defining existing health sub-categories for the identification and analysis of health actions in the HOPE database; ensuring that information held in the database is accurate and up-to-date (this may involve training of ECHO staff in how to accurately use the database); adding an indicator to identify projects that have been re-funded (and why); and better reporting data to allow aggregation at country and regional level.

• **Collaboration with stakeholders was generally good.** However, accepting the reality of humanitarian settings and the barriers that exist to coordination (for example with development actors), as far as possible, DG ECHO should use the engagement matrix mentioned above to:
- **Strengthen its collaboration with the Cluster system at national and sub-national level** to support DG ECHO’s continued advocacy work; improve financial support to the global health cluster to prevent funding delays as far as possible; and improve collaboration with the Health Cluster Lead Agency (usually WHO supporting the MoH) to ensure coordinated surge capacity that is integrated into local systems and staff hierarchies;

- **Continue to collaborate with internal EU institutions and MS partners** (as above) during implementation;

- **Better support and coordinate with work in other overlapping sectors** (such as WASH); **Ensure continued collaboration with development actors** to ensure all plans for sustainability and handover are developed prior to the end of project closure; and

- **Promote in-country collaboration between all DG ECHO partners** through the coordination of annual or bi-annual meetings with all DG ECHO partners in each country to improve efficiency and outcomes of DG ECHO-funded actions.

- Capacity-building was a component of almost all projects. DG ECHO should further capitalise on existing work by exploring how capacity-building exercises can be improved/made more effective, and by sharing good practices across its network.

- ECHO could improve the efficiency of procurement of equipment and supplies by: providing a checklist of essential biomedical equipment and supplies for verification at the start of a project to ensure resources are in place; and consider allowing flexibility in their drug procurement regulations under some circumstances, particularly in relation to the 5% rule, to facilitate better drug procurement and forward planning.

### 4.2.3 Follow-up and sustainability

- **It is essential that DG ECHO is clear on its strategic approach to sustainability and that ECHO field staff, partners and wider actors are informed of sustainability objectives.** This will support an improvement in all phases of project design and implementation, as well as successful handover/integration of well-functioning actions.

- **As an overarching principle, it is vital that sustainability and follow-up of projects are discussed in early planning and implementation stages, in collaboration with other relevant stakeholders, and that a clear and concrete exit strategy or sustainability plan is articulated in funding proposals.**

- **DG ECHO should continue to build on its existing advocacy work.** DG ECHO should further maximise its significant influencing powers by identifying key issues to advocate for, and promote their views more widely across stakeholder groups (for example through organising thematic forums for debate) to drive engagement. DG ECHO should also focus on better documenting and promoting their existing good practice among other actors. This includes promoting their funding of innovative projects and approaches, for example, current collaborative work with DG DEVCO to look at the quality of medicines.
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