Avenir Analytics

Independent Evaluation of WHO's Whole of Syria Response

FINAL REPORT

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Avenir Analytics
Columba House, Lakeshore Drive,
Airside Retail Park, Swords,
Co. Dublin, K67 R2Y9, Ireland
Tel. +31.653.76.16.81
info@aveniranalytics.com

Acknowledgements

Introduction

Purpose and scope. This report presents the findings, analysis, and recommendations of the independent evaluation of WHO's Whole of Syria response. The evaluation was commissioned by the WHO Eastern Mediterranean Regional Office (EMRO), with support from the WHO Evaluation Office in Geneva, to generate comprehensive learning regarding WHO's operations and performance in Syria, while offering an impartial perspective on the Response for key stakeholders. It informs WHO's humanitarian work in emergency contexts elsewhere, the policy and practice of WHO Health Emergencies Programme, and WHO's ambition to 'better protect one billion more people from health emergencies' as articulated in the 13th General Programme of Work. The evaluation fulfils WHO's commitment to provide the United Kingdom Foreign, Commonwealth, and Development Office with an independent assessment of the Organization's overall response in Syria. Ultimately, the evaluation seeks to benefit people affected by conflict in Syria by aiding WHO in the improvement of its ongoing response in the country.

The evaluation covers WHO response activities within Syria from 2016-2020, including operations conducted through the main office in Damascus and sub-offices within Syria, cross border operations from Gaziantep, previous cross-border work from Erbil and Amman, Whole of Syria Health Cluster coordination from Amman, and support and coordination with Regional Offices (EMRO and EURO) and WHO headquarters. The key lines of inquiry covered by the evaluation are framed according to the UNEG evaluation criteria of relevance, effectiveness, coverage, and efficiency. This includes the explanatory factors influencing WHO's ability to respond and perform according to planned objectives.

Limitations. A number of limitations reduced the level of detail provided in the evaluation findings and recommendations. Limitations included the wide evaluation scope in terms of timeframe under review, breadth of programming, and geographic focus coupled with constrained evaluation resources, compressed timing for evaluation activity, and the remote conduct of data collection as a result of COVID-19 travel restrictions. Critical data gaps on the experiences of the affected population, results and financial performance figures, and the cross-border operations from Amman and Erbil also affected the depth of analysis across evaluation questions. The impact of these gaps is described in the presentation of relevant findings and assessed in the 'Evidence strength score sheet' presented in Appendix 4.

Intended audience. The principal audience of the evaluation includes WHO senior management (EMRO and EURO Regional Directors, WHO Health Emergencies Programme, and the Director-General), the heads of the WHO country and field offices active in the Response, and the Whole of Syria operational staff. Secondary users include external stakeholders such as FCDO and other donors, government authorities, and agencies within the UN-coordinated Whole of Syria Strategic Steering Group.

Methodology

Evaluation approach. Research was conducted between October 2020 and March 2021 across five distinct phases: Preparation, Inception, Data Collection, Analysis, and Reporting. The evaluation takes a theory-based approach, utilizing an inferred Theory of Change to organize the logic of the Response and clarify how WHO's Whole of Syria (WoS) operational approach and the delivery of critical functions work together towards the Organization's objectives for Syria during the 5-year period under review. The Theory of Change (see full report, Diagram 1) was developed by the evaluation team and approved by WHO during the inception phase.

Data collection and analysis. Based on the lines of inquiry presented in the evaluation Terms of Reference and finalized in the evaluation Inception Report, a full evaluation matrix was developed to specify indicators linked with each question and corresponding methods for data collection and analysis (see Appendix 1). The evaluation adopted a mixed methods approach, employing qualitative and quantitative data collection and analysis techniques to provide a robust evaluation evidence base. Data collection methodologies were selected according to their appropriateness for the evaluation scope and questions, with consideration for limitations in available time and resources, the logistical constraints of remote evaluation management, and recognition of the wide evaluation scope. Together, the selected methodologies provide a combination of verifiable, objective data points with a capitalization of experience and participatory learning across a range of response activities, locations, and stakeholders. Vulnerability, gender, disability, equity, and human rights are addressed through an integrated analysis across evaluation questions. Methodological triangulation was used to ensure the validity of findings and target the recommendations.

Data collection activities included the review and analysis of over 340 organizational documents and secondary analysis of WHO data on results, beneficiary feedback, funding and financial allocations, and Value for Money reports. Key informant interviews were conducted with 77 individuals, including 10 members of the Evaluation Reference Group and 67 internal and external stakeholders. Three workshops were conducted with a total of 25 WHO staff with teams in Gaziantep, Damascus, and EMRO/EURO. This included staff formerly involved in the Amman and Erbil cross-border operations. Drawing from the data gathered through document review and stakeholder interviews, two localization learning profiles were developed covering activities identified by WHO as areas where the Organization can maximize learning for future capacity building initiatives.

Country and Operational Context

Syria crisis and health situation. The evaluation is situated in the political and health-related dynamics of the Syria crisis. This complex, protracted humanitarian emergency entered its tenth year and continues to pose numerous health challenges to more than 12 million people, including 6 million IDPs and over 5.6 million refugees. Syria's health system has been severely impacted by a decade of conflict and the health needs of the affected population are multifaceted. This includes limited access to basic and emergency care, lack of medicine, overwhelmed health facilities, reduced protection against communicable diseases, and the prevalence of trauma and extensive needs for disability care. Mental health issues are also prevalent. The increase in the incidence of communicable disease and risk of dying from treatable non-communicable disease is exacerbated by displacement and overall poor living conditions. There is a severe shortage of qualified health care workers in the country and a little over half of the public hospitals and primary health care centers were fully functional leading into 2020. With limited capacity to address an additional crisis, Syria currently faces increasing rates of COVID-19 infections and related deaths. Resources for a comprehensive approach to the pandemic are stretched, compounded by a spiraling economic crisis that doubled the cost of food and witnessed a staggering decline in the value of the Syrian Pound.

WHO response structure in Syria. The WHO response structure for Syria aligns with the UN approach and architecture for the Whole of Syria response as defined by the Whole of Syria Strategic Steering Group. The Organization implements the Response through a main office in Damascus and five sub-offices within Syria, complemented by cross-border operations from Gaziantep in Turkey. Previous cross-border work for northeast and southwest Syria was conducted from Erbil (Iraq) and Amman (Jordan), respectively. Cross-border activity from Jordan stopped in July 2018. In January 2020, the renewed cross-border Security Council Resolution 2504 removed authorization for the Yaroubiya crossing from Iraq into northeast Syria, leading to the closure of the Erbil hub and shift to fully provide humanitarian assistance to the area through cross-line access from Damascus. Access points from Turkey into northwest Syria were reduced from two to one under Security Council Resolution 2533 in July 2020. This expires and comes under review again in July 2021.

The Response is organized under two WHO Regional Offices: EMRO (Eastern Mediterranean) and EURO (Europe). Within this structure, EMRO coordinates donor involvement, grant management, and reporting functions. The Senior Emergency Officer position in Geneva ensures the alignment of the bi-regional response and mobilizes support from headquarters as required. Additional responsibilities for global advocacy on policy and access reside with the WHO Director General and are supported through WHO's involvement in the International Syria Support Group / Humanitarian Task Force at regional and global levels.

WHO programming in Syria. The Organization's work in Syria is framed within WHO's Emergency Response Framework (2017) and the 'critical functions' it outlines for WHO action in emergency response. Within these functions, WHO aims to ensure the availability and equitable provision of health services in Syria and to progressively expand access to care. Towards this goal, it provides coordination for the Health Cluster. In addition to serving as the sectoral lead for health in emergencies and coordination of health partners, WHO's areas of work include health information services, health operations and technical expertise, and operations support and logistics. WHO coordinates with the Humanitarian Coordinators and OCHA to secure access to populations in need and works closely with local health actors and NGOs as implementing partners in the delivery of healthcare services across conflict lines and borders.

The Response targets Syrians affected by conflict (including displaced populations and returnees), with a particular focus on reaching the most vulnerable and tailoring services according to gender, age, and disability considerations. Additionally, the Response reaches local health actors and civil society, healthcare workers and institutions, government agencies, and the member organizations of the Syria Health Cluster as part of the population served by WHO programs and functions. As the conflict and consequent humanitarian needs evolve, WHO aims to continue its focus on life-saving assistance in Syria with growing attention on rebuilding the country's health system as part of the recovery transition.

Response stakeholders. Stakeholder analysis exercises conducted during the evaluation workshops with WHO staff identified five main categories of stakeholders shaping the Response with high levels of influence. This included WHO response actors, WHO global and support functions, local government and authorities, global governments and diplomatic forums, and humanitarian actors in the form of the Office of the Special Envoy, the Humanitarian Task Force / International Syria Support Group, donor agencies, the Red Crescent societies, and other UN agencies active in Syria. Within each category, the level of interest in the Response varied according to specific stakeholders and their relationship to the Response as a whole or to particular response hubs. Details from each stakeholder mapping were documented in in workshop reports as a learning output of the evaluation for the Response.

Response timeline. The evaluation identified a timeline of critical moments in the Response (see full report, Diagram 2) and three distinct phases of WHO engagement in Syria and the structure of the Organization's response model. The phases include:

- **Phase 1: 2012-2015 -** Establishing the scope of WHO involvement in Syria.
- **Phase 2: 2016-2017 -** Defining and consolidating WHO's Whole of Syria approach and operational model.
- **Phase 3: 2018-2020 -** Dynamic application of WHO's Whole of Syria approach in an evolving context.

Two characteristics of the Response and the context of its operations are evident across the timeline: the politicized environment of crisis and the consistent need for operational adaptation to address access constraints or respond to access opportunities.

Evaluation Findings

Evaluation findings are organized according to the five evaluation questions of relevance, effectiveness, coverage, efficiency, and explanatory factors. Within each section, evidence is presented against 17 associated sub-questions as posed in the evaluation Terms of Reference and finalized in the Inception Report.

Evaluation Question 1: Relevance

How well aligned has WHO's response to the Syria crisis been during the years under review with the stated needs of the Government, the specific needs of the affected population, and with WHO's broad approach to humanitarian action and health emergencies?

- *Finding 1:* WHO provided an increasingly relevant response in a context marked with conflicting interests between the central Government of Syria, WHO's Member States and funding partners, the wider UN and humanitarian community, and the evolving – sometimes rapidly shifting – needs of the population.

- *Finding 2:* WHO's operational structure enabled flexibility and adaptation to fluctuating lines of control, while participating in the UN WoS approach and its governing frameworks.

- *Finding 3:* WHO's critical functions, including Coordination, Health Information, Health Operations and Technical Expertise, and Operations Support and Logistics, filled an essential role for the humanitarian community and for the affected population in Syria.

- *Finding 4:* The Response aligns with WHO's broad approach to humanitarian action, at times revealing gaps in the extent of global priorities, investments, or guidance for protracted crises and conflict settings.

Evaluation Question 2: Effectiveness

What results has WHO achieved in the Syria Response during the years under review, whether intended or unintended?

- *Finding 1:* WHO was broadly effective in its objectives across its critical functions, with varying levels of achievement over time, locations, and program objectives.

- *Finding 2:* WHO has not consistently measured progress against targets for response level indicators or sufficiently disaggregated data to monitor equitable results across vulnerable populations.

- *Finding 3:* Data collected from the affected population through Third Party Monitoring shows a high rate of general satisfaction, with critique on the selection and distribution of needed medicines.

- *Finding 4:* While there is limited evidence of significant unintended outcomes (positive or negative) in the affected population, workshops with WHO staff and WHO documents highlight the positive, unexpected impact of the Organization's early investment in Syrian civil society.

Evaluation Question 3: Coverage

To what extent has WHO's interventions reached all segments of the affected population, including the most vulnerable, during the years under review?

- **Finding 1**: While WHO invested considerable efforts to reach all segments of the affected population, it faced access, funding, and logistical constraints. Programming modalities and the operational model supported coverage in hard-to-reach locations and improved access to health on culturally sensitive issues.

- **Finding 2**: While the Response follows a clear process for identifying needs at country and sub-district levels, the evaluation was not able to identify consistent use or evidence of field-level procedures for targeting services by vulnerability and ensuring their reach across vulnerable groups.

- **Finding 3**: Response-level data is limited on coverage according to sex, age, disability, displacement status, or location by severity scale classification and response hub. This signals reduced capacity to ensure coverage and access to services across all segments of the population.

- **Finding 4:** WHO applied several strategic and operational strategies to address the political and access challenges of ensuring coverage across geographic locations and conflict lines. While these efforts were broadly successful, questions remain about current reach into key locations of the country.

- **Finding 5:** As a trend, data suggest increasing reach in central Syria in a context otherwise marked by a decline or stasis in the volume of services provided by the Syria Country Office in southern Syria, northwest Syria, and northeast Syria. In recent years (2019-2020), the Syria Country Office received proportionally less funding for its level of required contributions compared to the Gaziantep Field Office.

Evaluation Question 4: Efficiency

How efficiently has WHO used the resources at its disposal to achieve maximum results in the Syria crisis in the timeliest and most efficient manner possible during the years under review?

- *Finding 1:* The degree to which WHO efficiently used its resources to reach its objectives varies by program design, partnerships, human resourcing, financial resourcing, and response model dynamics.

- *Finding 2:* There are many examples of efficient program designs and modalities used across the Response, with particular emphasis on health services. Performance is mixed on its supply chain and logistics function.

- *Finding 3:* While working with implementing partners and strong partner networks enabled more efficient program designs and modalities, short contracts and gaps between contract renewals with partners contributed to unnecessary delays in service delivery and reduced sustainability in investments like staff training and partner capacity building.

- *Finding 4:* Frequent and prolonged staff vacancies, contract gaps, and short staff contracts affected response efficiency and contributed to delays in service delivery.

- *Finding 5:* Financial analysis reveals a trend of decreasing flexible funds. There are also indications of increasing costs-per-treatment and higher operating costs in the Gaziantep Field Office compared to the Damascus hub. Data available to the evaluation team do not allow for a meaningful assessment on trends for cost-per-treatment / service costs and variable operating costs between response offices.

- **Finding 6:** The structure for and level of internal coordination in response operations evolved during the years under review. Reforms and progress made from the end of 2017 improved response efficiency, while aspects of response governance and accountability lines remain under-defined.

- **Finding 7:** WHO's initial Value for Money analysis of response operations revealed that 75% of assessed activities provided high impact at a low level of investment. Additional analysis is needed to assess trends over time. There is limited evidence that Value for Money monitoring is integrated into WHO operations.

Evaluation Question 5: Explanatory Factors

What have been the main internal and external factors influencing WHO's ability to respond during the years under review?

- **Finding 1**: Access challenges and the heavily politicized operating environment of the Response are the leading inhibiting factors, while the ability of the WHO response model to continuously adapt as a way to meet these challenges is the most cited example of the Organization's enabling factors.

- **Finding 2:** Internal and external inhibiting factors affected WHO's ability to ensure gender and beneficiary feedback systems and recruitment of sufficient, flexible human resources. Successes in these areas depended on the professionalism of WHO staff and implementing partners.

- **Finding 3:** The Response uses a number of approaches to generate learning and reflection. Improvements could be made on response-level systems for performance monitoring, evaluation, financial monitoring, and the exchange of learning or promising practice between staff, cluster members, and implementing partners.

Learning from the Response

The evaluation presents key lessons learned that contributed to the positive evolution of the Response during the years under review. It identifies useful learning to apply in future responses that adapt a multi-hub response structure, as well as a summary of learning applicable for work in Syria going forward.

Learning for future multi-hub responses. Three points feature across evaluation findings on how the Response positively developed, adapted, and shaped its operational model to address the access and political constraints of the Syria context. They are applicable in other operations that adopt a multi-hub structure:

- **Formulate criteria for the selection of a decentralized or centralized response model:** In future multi-hub responses, WHO should deliberately consider the relative benefits and costs of different levels of structural centralization, planning for the particular challenges that come with either choice.

- **Establish clear mechanisms for inter-hub coordination and decision-making authorities**: In future multi-hub responses, coordination mechanisms to facilitate decision making between hubs and/or regions should be developed and utilized from the start, along with clearly defined roles and responsibilities across the different levels of the Response.

- **Determine a transparent process for funding allocations based on needs:** In future multi-hub responses, decisions on an acceptable evidence base for needs and procedures for determining funding allocation should be established at the start. The severity scale approached in the Response for needs identification and prioritization is a promising practice for areas of the Organization where it is not already in use.

Learning for Syria, localization going forward. Two localization activities were identified to profile learning on future capacity building or partnership initiatives. They included Leishmaniasis control in northwest Syria (Gaziantep Office, 2018-2020) and mental health training in Aleppo and Al Hol (Syria Country Office, 2019 and 2020). The consolidated achievements, challenges, and lessons learned experienced in these activities include:

▪ **Achievements:** Provision of relevant and effective services targeting in- and out-of-camp populations, community healthcare workers, and frontline humanitarians; all trainees showed improved levels of awareness, knowledge, and motivation.

▪ **Challenges:** Delayed start to activities connected with WHO contracting and financing procedures, as well as limited availability of WHO staff; limited resources of partner agencies to expand services according to the level of need or continue services when the WHO partnership ends.

▪ **Lessons learned:** Effectiveness requires the combined inputs and expertise of WHO and partners; the community health worker modality is important for developing referral networks and locally accessible expertise; supporting frontline humanitarian actors and community health workers is necessary to create and sustain needed services; it is critical to consider the particular vulnerabilities of target populations when designing services and service delivery modalities.

Learning for Syria, challenges and opportunities going forward. WHO staff mapped challenges and opportunities for the Response going forward during the evaluation workshops. The exercise covered themes of strategic direction, operational environment and programming, and human and financial resources:

Learning area	Challenges	Opportunities
Strategic direction	- No post-conflict country strategy and the impact of protracted emergency on planning. - Concerns regarding national policies. - Accessing hard to reach areas remains difficult. - The unpredictability of continued access to northwest Syria from Gaziantep impacts WHO's ability to secure extended coverage of the country and raises questions about the future operations of NGOs in the area.	- Health diplomacy efforts. - Response adaptability to evolving context. - Current and potential advocacy with the Government of Syria on mental health policy, role of civil society, and health information digitalization. - NGOs in northwest Syria expected to continue operations irrespective of the UN cross-border resolution. Potential to work with partners internationally and advocate for their ability to work in other areas of Syria.
Operational environment and programming	- Limitations on cross-line support to northeast Syria. Same challenges expected for northwest Syria if access from Turkey is closed. - Difficult to secure and deliver COVID-19 equipment. Anticipated difficulties in COVID-19 immunization. - Delayed approvals, closed borders, sanctions, and inflation impede importing and delivering medical supplies and medicines. - Depleted healthcare workforce. Lack of funding to rebuild human resources.	- Recent successes in cross-line efforts and opportunities to build relationships in COVID-19 response. Use of remote communication platforms. - Ability to receive some supplies from Jordan, Dubai, and WHO headquarters. - Building the health system through the emergency response and funds for healthcare facility rehabilitation. - NGO and partner network prepared to provide health services to community and returnees.
Human and financial resources	- Ensuring wellbeing of staff, e.g., evacuation. - Donors lose interest when areas move to GoS control. Needs in these locations remain high. - Funding is static while needs are increasing. Difficult to convey / message this to funders. - Lack of non-humanitarian funding instruments.	- Credibility, technical expertise and coordinating power of WHO. Staff capacity inside Syria. - Creation of the Mental Health Gap national core team and Family Wellbeing Centres. - COVID-19 highlighted need for additional funding instruments. NEXUS and 'health for peace' dividends.

Conclusions

Evaluation questions. WHO provided an increasingly relevant and broadly effective response in Syria, delivering on its critical functions within a difficult operating environment marked by significant access constraints and politicization of health in humanitarian aid. The early decision to work with implementing partners supported the coverage of services and reach to vulnerable populations. Integrated services across partner networks and investments in response-level systems and internal coordination mechanisms from the end of 2017 into 2018 increased the efficiency of its operations. The Whole of Syria operational model enabled a high degree of responsiveness across geographic locations and changing lines of control. This has been achieved in an overall context of shrinking levels of flexible funding, the uncertain continuity of cross-border authorization, and the devastation caused to national health systems and the health workforce by the violent and protracted nature of the crisis.

Response-level systems and protocols remain under-developed. This appears to be the cause of insufficient institutional policies and procedures to respond to a complex, protracted humanitarian emergency, as well as the difficulty in justifying significant investments in harmonizing multi-hub systems without the certain authorization of cross-border operations. This has contributed to issues in staff recruitment, contracting, and prolonged vacancies, as well as an overall diminished information environment on the performance, coverage, and efficiency of the response. It has also impacted the durability of partnerships, leading to gaps in critical services. Questions remain on the extent of WHO's reach in northeast Syria, southern Syria, and Turkish-controlled areas of northern Syria. Without more transparent communication and protocols for establishing the true extent of services in sensitive areas, it will be difficult for response leadership to internally agree on gaps in these locations, how to best address them, and how to message challenges to external stakeholders.

Learning from the Response. Several lessons from the Response are applicable for WHO going forward. They include learning on the application and structure of multi-hub operations, the benefits of and approaches to localization in health services, and the challenges and opportunities for the Response going forward.

Success factors and areas for improvement. Response success factors and areas for improvement identified under each evaluation question (see full report, Table 13) informs the recommendations and action items provided to WHO.

Recommendations

The evaluation provides WHO recommendations and action items on the areas of: strategy and positioning, programming, and operations. They target the global, regional, and hub-levels of the Organization.

Strategy / Positioning – Global Recommendations.

Recommendation	Description
Recommendation 1: Consolidate humanitarian / armed conflict response framework for the WHO Health Emergency Programme.	Consider global review on WHO's adherence to and operational interpretation of the humanitarian principles in conflict-setting emergencies. Future revisions of the Emergency Response Framework should include: - Distinctions between armed conflict and complex emergencies from other types of health emergencies. - Guidance on the contextualization of humanitarian principles for WHO in situations of armed conflict. - Clarification on the scope of WHO operations and service provision in protracted crisis.

Recommendation	Description
Recommendation 2: Review – and possibly renew – level of institutional investment in cluster coordination capacity, program monitoring and evaluation, and Value for Money analysis.	Consider current levels of WHO global investment against institutional commitments at field level. Include focus on the development and retention of highly capacitated staff in coordination and M&E functions.

Strategy / Positioning – Regional and Country Recommendations.

Recommendation	Description
Recommendation 3: Enhance conflict analysis to ensure conflict sensitive programming at response and regional/district-levels.	Consider developing systematic conflict analysis that will feed strategic, programmatic, and operational decision making. Mainstream conflict analysis and conflict sensitivity through adopted tools and staff capacity building.
Recommendation 4: Maintain critical Whole of Syria structures, including the role of the EMRO office and the Whole of Syria Cluster Coordinator based in Amman.	Neutrally positioned roles in EMRO and Amman should be maintained until the Damascus office is able to provide equitable levels of services to all areas of the country without obstruction or threat to operational space.
Recommendation 5: Review opportunities for collective UN approach to constraints in northeast Syria.	Consider opportunities to convene other UN agencies facing access constraints and identify a collective risk and/or advocacy approach. Strategically engage the Resident Coordinator in this effort.

Programming – Regional and Country Recommendations.

Recommendation	Description
Recommendation 6: Improve use and documentation of gender and vulnerability analysis.	Map current practice and gaps, including tools in use and when or how they are deployed. Develop coherent approach and SOPs for gender and vulnerability in program design, partner selection, targeting, and addressing barriers to health. Integrate SOPs into existing program cycle modalities.
Recommendation 7: Improve protocols for field-level needs analysis and service targeting according to needs.	Map current practice, including the tools in use and when and how they are deployed. Develop coherent approach on service targeting in partner selection, partner monitoring, training and capacity building efforts, and the distribution of medicine and medical supplies.
Recommendation 8: Enhance response-level M&E system.	Create a dedicated unit for response-wide M&E. This function should not be layered into responsibilities for health cluster information management. Invest in a more robust and regular approach to outcome monitoring and accountability to affected populations, harmonized across each hub. Review current levels of understanding on reporting requirements and support staff training as needed. Improve disaggregation of indicators along key variables of location, severity scale, sex, and displacement status. Develop protocol to review performance data during or ahead of the operational review meetings or other hub-level management meetings.
Recommendation 9: Develop guidelines for hub closure or transfer of responsibilities between hubs.	Develop guidelines for hub closure or the transfer of hub responsibilities, including expectations for knowledge transfer and lessons learned exercises, important provisions for information security, and how to best approach the re-allocation of assets to other hubs. Review experiences from Amman and replicate learning.

Recommendation	Description
Recommendation 10: Re-assess Value for Money approach for sustainability.	Consider whether the approach developed for measuring Value for Money is sustainable in the context of the Response, including staff turn-over, demands on staff time, and the maturity of response-level information and reporting systems. If the approach remains applicable, re-assess current Value for Money performance to compare against the 2019 baseline.
Recommendation 11: Review and enhance progress on COVID-19.	Review the degree to which the COVID-19 strategy for Syria is sufficiently unified across geographic locations (including northeast Syria), identifying areas for improvement as needed or lessons for the future. Enhance communications with partners and authorities in areas outside Government control. Sustain advocacy with the Government on vaccine access in northeast Syria.

Operations – Regional and Country Recommendations.

Recommendation	Description
Recommendation 12: Adapt staff contract clauses to the challenges of the cross-border operating environment.	Consider longer staff contracts for the Gaziantep office with stipulations for deployments elsewhere in the EURO region or through the global surge deployment capacity if the post closes due to removal of cross-border authorization. Review successful examples of this approach used previously in the Organization.
Recommendation 13: Strengthen knowledge management in the Response.	Improve information sharing and availability of key documents across response offices, with particular attention to common tools and templates for program operations. Demarcate what type of information should or should not be accessible across response offices. Consider formally documenting the Response 'ways of working', including a specified organigram within the Response, articulated roles and responsibilities between response leaders at regional vs. hub levels, and a short explanation of the key protocols used to support inter-hub coordination.
Recommendation 14: Review and explore improvements for contracting implementing partners.	Proactively assess and pursue opportunities to create longer and a fewer number of contracts. Conduct an internal review on the cause of gaps between contract breaks and the extent to which WHO can plan or organize for them in advance. Consider standardizing the administrative approaches used with partners between the Syria Country Office and the Gaziantep Field Office (e.g., proposal templates, monitoring requirements).
Recommendation 15: Conduct a response-level financial review.	Review and collectively interpret the financial data presented in the evaluation, including funding allocations between hubs, the increasing cost-per-treatment trend, and the differences in spending per person in need in the Syria Country Office and the Gaziantep Field Office. Review the drivers of funding allocations between hubs. Consider the extent to which flexible funds are used to cover needs in areas that are not prioritized in earmarked funding. Continue to advocate with donors on the funding requirements for the Syria Country Office, while exploring a shift to development donors.

Table of Contents

List of Acronyms

Acronym	Full Title
4Ws	Who does What, Where and When
AAP	Accountability to Affected Populations
CCPM	Cluster Coordination Performance Monitoring
CCS	Country Cooperation Strategy
CFE	Contingency Fund for Emergencies
CHW	Community Health Worker
CSO	Civil society organization
DFID	Department for International Development (United Kingdom)
DPT	Diphtheria Pertussis and Tetanus (vaccine)
ECHO	European Civil Protection and Humanitarian Aid Operations
EM	Evaluation Manager
EMRO	Eastern Mediterranean Regional Office
EO	Evaluation Office
EPI	Expanded Programme on Immunization
EQ	Evaluation Question
ERF	Emergency Response Framework
ERG	Evaluation Reference Group
EURO	European Regional Office
EWARS/N	Early Warning Alert and Response System / Network
FCDO	Foreign, Commonwealth, and Development Office (United Kingdom)
FENSA	Framework of Engagement with Non-State Actors
GBV	Gender Based Violence
GoS	Government of Syria
GPW13	General Program of Work 13
HeRAMS	Health Resources and Services Availability Mapping System
HNO	Humanitarian Needs Overview
HQ	Headquarters
HRP	Humanitarian Response Plan
IASC	Inter-Agency Standing Committee
IDP	Internally Displaced Person
IEC	Information, Education and Communication
IHL	International Humanitarian Law
IP	Implementing Partner
IPC	Infection Prevention and Control

Acronym	Full Title
ISIS/ISIL	Islamic State of Iraq and Syria / Islamic State of Iraq and the Levant
JOP	Joint Operational Plan
KPI	Key Performance Indicator
M&E	Monitoring and Evaluation
MHPSS	Mental Health and Psychosocial Services
MoH	Ministry of Health
NES	Northeast Syria
(I)NGO	(International) Non-governmental Organization
NWS	Northwest Syria
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
PCR	Polymerase Chain Reaction
PPE	Personal Protective Equipment
RCCE	Risk Communication and Community Engagement
SA	Self-Administration (Kurdish)
SDG	Sustainable Development Goals
SOP	Standard Operating Procedures
SSA	Surveillance System of Attacks on Healthcare
ToC	Theory of Change
ToR	Terms of Reference
TPM	Third Party Monitoring
UN	United Nations
UNCT	United Nations Country Team
UNEG	United Nations Evaluation Group
UNSC	United States Security Council
UNSF	United Nations Strategic Framework
USAID/OFDA	United States Agency for International Development / Office of Foreign Disaster Assistance
USD	United States Dollar
VfM	Value for Money
WCO	WHO Country Office
WHE	WHO Health Emergencies Programme
WHO	World Health Organization
WoS	Whole of Syria

1. Introduction

This report presents the findings, analysis, and recommendations of the independent evaluation of WHO's Whole of Syria response. The evaluation was commissioned by the WHO Eastern Mediterranean Regional Office (EMRO), with support from the WHO Evaluation Office in Geneva, to generate learning and support accountability in the Organization's humanitarian efforts in Syria. It informs WHO's humanitarian work in emergency contexts elsewhere, the policy and practice of WHO Health Emergencies Programme, and WHO's strategic ambitions as articulated in the 13th General Programme of Work (GPW13). The evaluation covers WHO's response activities within Syria from 2016-2020, anticipating a continuation of the Response according to the evolution of the context.

The content of this report follows the requirements of the evaluation Terms of Reference (Appendix 5) and the methodology articulated in the evaluation Inception Report. It embeds organizational learning throughout its eight sections, reflecting the evolution of the Response over time. The evaluation purpose, objectives, scope, and methodology are outlined in Sections 2 and 3, accounting for limitations on the available time and resources for the evaluation. An overview of the country and operational context is provided in Section 4, including contributions from WHO staff provided during the workshops conducted as part of the evaluation. Findings for each of the evaluation questions (EQs) are detailed in Section 5, with key learnings from the Response summarized in Section 6. Conclusions and Recommendations are presented in Sections 7 and 8.

2. Evaluation purpose, objectives, and scope

2.1 Purpose and objectives

The evaluation aims to generate comprehensive learning regarding WHO's operations and performance in Syria, while offering an impartial perspective on the Response for key stakeholders. With dual learning and accountability objectives, the evaluation supports WHO's continued work in Syria and informs WHO's humanitarian work in emergency contexts elsewhere, the policy and practice of the WHO Health Emergencies Programme, and WHO's strategic ambition to 'better protect one billion more people from health emergencies' as articulated in the GPW13. This ambition reflects both WHO's intended organizational results for 2019-2023 and a vision for how it will drive contributions to the achievement of the Sustainable Development Goals (SDGs). The evaluation fulfils WHO's commitment to provide the United Kingdom Foreign, Commonwealth, and Development Office (FCDO)[1] with an independent assessment of the Organization's overall response in Syria. It also reflects WHO's institutional commitment to evaluation in humanitarian and emergency settings, acknowledging the substantial mobilization of financial and human resources in the Response[2] and the strategic interest to objectively review the achievements and risks of associated activities. Ultimately, the evaluation seeks to benefit people affected by conflict in Syria by aiding WHO in the improvement of its ongoing response in the country.

The key lines of inquiry covered by the evaluation are framed according to the UNEG evaluation criteria of relevance, effectiveness, coverage, and efficiency. This includes the explanatory factors influencing WHO's ability to respond and perform according to planned objectives. These topics are addressed through five overarching evaluation questions and their 17 associated sub-questions as organized in the evaluation ToR and refined in the evaluation Inception Report.

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[1] Formerly the Department for International Development (DFID). DFID was replaced by the Foreign, Commonwealth, and Development Office (FCDO) following a merger of the DFID and Foreign and Commonwealth Offices in 2020.
[2] WHO mobilized over USD 302 million for the Response from 2016-2020.

Table 1: Evaluation questions.

Evaluation Question	Sub-Questions
EQ 1: Relevance How well aligned has WHO's response to the Syria crisis been during the years under review (2016-2020) with the stated needs of the Government, the specific needs of the affected population, and with WHO's broad approach to humanitarian action and health emergencies in light of the GPW13 and the SDGs as well as its normative guidance on health emergencies?	1.1 How well aligned has WHO's response to the Syria crisis been with the stated needs of the Government and with other local authorities and local health actors? 1.2 How well aligned has WHO's response to the Syria crisis been with the specific needs of the affected population? 1.3 To what extent has WHO's response to the Syria crisis been aligned with WHO's broad approach to humanitarian action and health emergencies in light of the GPW13 and the SDGs as well as its normative guidance on health emergencies? 1.4 How has the situation changed over time, and in different areas of the country, and how well has WHO adapted its response to rapidly changing needs and conditions? 1.5 To what extent has WHO's Syria response been explicitly informed by gender analysis and undertaken in a gender-sensitive manner and their geographic locations?
EQ2: Effectiveness What results has WHO achieved in the Syria response during the years under review (2016-2020), whether intended or unintended?	2.1 To what extent have the planned objectives and outcomes been achieved by WHO's Syria response? 2.2 To what extent has WHO's Syria response produced unintended outcomes (positive or negative) and how has it managed these? 2.3 Are there any differential results across various vulnerable groups?
EQ3: Coverage To what extent has WHO's interventions reached all segments of the affected population, including the most vulnerable, during the years under review (2016-2020)?	3.1 To what extent has WHO's interventions reached all of the most vulnerable groups in Syria (e.g., those displaced, women, children, persons with disabilities, healthcare and aid workers, and other sub-segments of the population)? 3.2 Are there any gaps in terms of the coverage vis-à-vis needs (geographical reach, gender, persons with disabilities and other sub-segments of the population)?
EQ4: Efficiency How efficiently has WHO used the resources at its disposal (including financial, human, physical, intellectual, organizational and political capital, as well as partnership) to achieve maximum results in the Syria crisis in the timeliest and most efficient manner possible during the years under review (2016-2020)?	4.1 How successfully has WHO been able to deliver services in a timely manner? 4.2 How well has WHO used the financial, human, physical, intellectual, organizational and political capital at its disposal, as well as its partnerships, to achieve results? 4.3 What have been areas of particularly higher and lower efficiency (factoring in issues of opportunity cost as well as standard resource use)? 4.4 How well has WHO addressed the unique challenges of delivering humanitarian aid through cross border and cross line operation?
EQ5: Explanatory Factors What have been the main internal and external factors influencing WHO's ability to respond in the most relevant, effective, efficient and equitable manner possible during the years under review (2016-2020)?	5.1 What have been the main internal factors enabling and inhibiting WHO's ability to respond in the most relevant manner possible? 5.2 What have been the main external factors enabling and inhibiting WHO's ability to respond in the most effective manner possible? 5.3 To what extent has WHO monitored its performance and the factors affecting it, learned from this information and knowledge, and fed these sources of learning into its on-going response?

The evaluation questions originally posed in the ToR were adjusted during the inception phase, incorporating feedback from the Evaluation Reference Group (ERG) to clarify the timing covered under the questions and the intention for the evaluation to consider the particular performance and operating context of each year under review. Table 1 reflects these revisions. A full evaluation matrix further detailing the indicators linked with each question is provided in Appendix 1. The indicators reflect inclusion of a light review on Value for Money (VfM) and input from the ERG to integrate questions related to WHO's targeting strategy and reach across vulnerable groups under "Effectiveness" and "Coverage" criteria.

2.2 Evaluation scope

The evaluation covers all WHO response activities within Syria from 2016-2020, including operations conducted through the main office in Damascus and sub-offices within Syria, cross border operations from Gaziantep, previous cross-border work from Erbil and Amman, Whole of Syria Health Cluster coordination from Amman, and support and coordination with Regional Offices (EMRO and EURO) and WHO headquarters. Due to the turnover of staff and consequent limited information available from the closed Erbil and Amman operations, the focus is on the Response as a whole and the currently active operations within Syria and from Gaziantep. This scope comprises activities funded by a range of donors, inclusive of but not limited to FCDO.

The principal audience of the evaluation includes WHO senior management (EMRO and EURO Regional Directors, WHO Health Emergencies Programme, and the Director-General), the heads of the WHO country and field offices active in the Response, and the Whole of Syria operational staff. Secondary users include external stakeholders such as FCDO and other donors, government authorities, and agencies within the UN-coordinated Whole of Syria Strategic Steering Group. The wider humanitarian sector is part of the audience through report publication.

2.3 Evaluation limitations

A number of conditions reduced the level of detail provided in the evaluation findings and recommendations. Limitations included the wide evaluation scope in terms of timeframe under review, breadth of programming, and geographic focus coupled with constrained evaluation resources, compressed timing for evaluation activity, and the remote conduct of data collection as a result of COVID-19 travel restrictions. As anticipated in the evaluation Inception Report, the depth of analysis across evaluation questions varies due to these foreseen challenges and a number of critical data gaps. The impact of these data gaps on the evaluation evidence base is further described in Section 3 (Methodology), the presentation of relevant findings, and assessed in the 'Evidence strength score sheet' presented in Appendix 4.

To address these limitations, the report highlights questions raised by the data that are outside the capacity of the evaluation to address under the 'points for further inquiry' presented as part of the Recommendations (Section 8). These points are areas of learning for WHO to explore internally to extend the evaluation's utility.

3. Methodology

3.1 Evaluation phases

Research was conducted between October 2020 and March 2021 across five distinct phases: Preparation, Inception, Data Collection, Analysis, and Reporting. Each phase included a set of evaluation activities and deliverables guided and approved by the WHO Evaluation Manager in EMRO with technical support from the WHO Evaluation Office in Geneva and input from the Evaluation Reference Group.

Table 2: Deliverables and activities per evaluation phase.

Evaluation Phase	Key Deliverables and Activities
1. Preparation	Deliverable: Rapid Feasibility Review Activities: Background consultation with the WHO Evaluation Manager and WHO Evaluation Office (Geneva)
2. Inception	Deliverable: Inception Report (production and approval) Activities: Initial document gathering and review, background consultations with the ERG, presentation to the ERG on the Inception Report
3. Data collection	Deliverable: WHO Staff Workshop Reports Activities: Execution of data collection activities and further document gathering through engaged stakeholders
4. Analysis	Deliverable: Summary Findings Report Activities: Evaluation team analysis workshops, data coding, cleaning, and triangulation, determination of key findings, conclusions and recommendations
5. Reporting	Deliverable: Final Evaluation Report, Presentation of Final Report Activities: Draft report review by WHO Evaluation Management, submission of revised draft report to the ERG for review, submission of final report to WHO Evaluation Management for approval, presentation of final report to EMRO / EURO

Further details on the structure for evaluation management and the agreed deliverables is provided in Appendix 5 (Evaluation ToR) and the evaluation Inception Report.

3.2 Evaluation approach

The evaluation takes a theory-based approach, utilizing an inferred Theory of Change (ToC) to organize the logic of the Response and clarify how WHO's Whole of Syria (WoS) operational approach and the delivery of critical functions work together towards the Organization's objectives for Syria during the 5-year period under review. It provides a framework to describe and define the parameters of interest for key findings and to prioritize the recommendations most likely to impact WHO's work in Syria and other emergencies (see criteria listed below Diagram 1 and the evaluation matrix in Appendix 1). The inferred ToC assumes a dynamic humanitarian context, within which WHO navigated and adapted its operational and programmatic approach. As such, the evaluation approach is not designed to test the validity of the ToC[3]. Additionally, the inferred ToC is not designed to articulate a result chain against which the Response is benchmarked or measured.
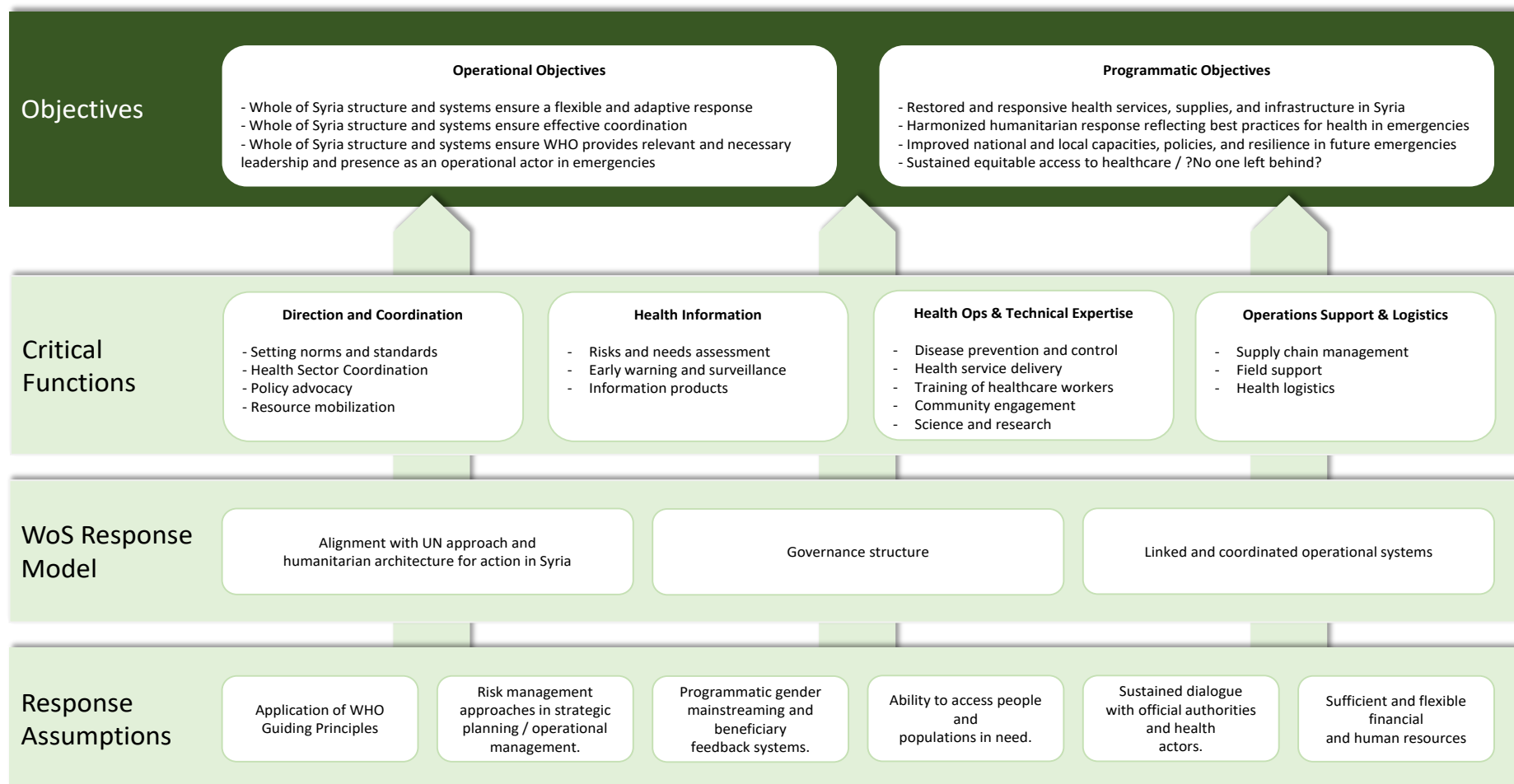
The Response ToC (Diagram 1) was developed by the evaluation team and approved by WHO during the inception phase[4]. It covers the duration of the 2016-2020 evaluation timeframe and draws from WHO's Emergency Response Framework (2nd edition 2017) (ERF), the FCDO business case, and other strategic documents[5].

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[3] Theory-based approaches that 'test' the ToC to address evaluation questions (such as contribution analysis) require a pre-agreed ToC against which to benchmark achievement. This approach was discussed with WHO and agreed to not be feasible during the inception phase and noted in the inception Report.

[4] The term "Direction" presented in the inferred ToC does not appear in the ERF framing of WHO critical functions in an emergency. It was added to the inferred ToC during the inception phase discussions with WHO staff, who requested the inclusion of WHO's work in "setting norms and standards" for the health sector response in Syria (an area of work that is not explicitly mentioned in the ERF categories). The ERF area of "Leadership" in the framing of the critical functions was intentionally not included in the inferred ToC as it relates to areas of work that are outside the scope of the evaluation.

[5] Country Cooperation Strategy (2016-2017, 2018), Syrian Arab Republic Biennium Country Plan (2016-2017, 2018-2019), Whole of Syria Operation Directions for 2019, Whole of Syria Operations in 2020 – Vision and Approach, Humanitarian Response Plans (2016-2020), WHO Whole of Syria Extension of the WHO/DFID Project (FCDO Bridge Funding, April 2020).

Diagram 1: Inferred Theory of Change for the WHO WoS response in Syria.

Objectives

Operational Objectives

- Whole of Syria structure and systems ensure a flexible and adaptive response
- Whole of Syria structure and systems ensure effective coordination
- Whole of Syria structure and systems ensure WHO provides relevant and necessary leadership and presence as an operational actor in emergencies

Programmatic Objectives

- Restored and responsive health services, supplies, and infrastructure in Syria
- Harmonized humanitarian response reflecting best practices for health in emergencies
- Improved national and local capacities, policies, and resilience in future emergencies
- Sustained equitable access to healthcare / ?No one left behind?

Critical Functions

Direction and Coordination

- Setting norms and standards
- Health Sector Coordination
- Policy advocacy
- Resource mobilization

Health Information

- Risks and needs assessment
- Early warning and surveillance
- Information products

Health Ops & Technical Expertise

- Disease prevention and control
- Health service delivery
- Training of healthcare workers
- Community engagement
- Science and research

Operations Support & Logistics

- Supply chain management
- Field support
- Health logistics

WoS Response Model

Alignment with UN approach and humanitarian architecture for action in Syria

Governance structure

Linked and coordinated operational systems

Response Assumptions

Application of WHO Guiding Principles

Risk management approaches in strategic planning / operational management.

Programmatic gender mainstreaming and beneficiary feedback systems.

Ability to access people and populations in need.

Sustained dialogue with official authorities and health actors.

Sufficient and flexible financial and human resources

As it relates to the evaluation criteria, the ToC highlights the relationship between the Response assumptions, operational structure, design and delivery of critical functions, and the achievement of objectives as follows:

- **Relevance:** Alignment of the WoS model, critical functions, and objectives with the needs and priorities of the affected population, government and humanitarian stakeholders, and WHO's strategic direction.
- **Effectiveness:** Delivery and achievements of the critical functions and objectives.
- **Coverage:** Adaptability of the WoS model and reach of critical functions to ensure equitable achievement of and progress towards response objectives according to the humanitarian context and needs.
- **Efficiency:** Utilization of the operational and institutional resources within the WoS structure to deliver timely, relevant, equitable, and effective critical functions
- **Explanatory factors:** Relationship of key response assumptions and other internal and external dynamics in WHO's ability to provide an effective, relevant, effective, and equitable response

3.3 Data collection and analysis

An evaluation matrix was developed to specify indicators linked with each evaluation question and corresponding methods for data collection and analysis (Appendix 1). The evaluation adopted a mixed methods approach, employing qualitative and quantitative data collection and analysis techniques to provide a robust evidence base. Data collection methodologies were selected according to their appropriateness for the evaluation scope and questions, with consideration for the limitations highlighted in Section 2. They provide a combination of verifiable, objective data points with a capitalization of experience across response activities, locations, and stakeholders. Vulnerability, gender, disability, equity, and human rights are addressed through an integrated analysis across evaluation questions. Methodological triangulation was used to ensure the validity of findings and target the recommendations. This included the use of tailored analysis frameworks that consolidated different data sources against the evaluation matrix. Reported practice was checked through documentary verification. Opinions and experiences were compared across stakeholder groups and assessed for consistency or divergence. Table 3 provides an overview of the evaluation data collection activities.

Table 3: Data collection activity overview.

Activity	Description
Document Review	Gathered and reviewed over 340 organizational policies, strategy papers, annual reports, donor meeting presentations and memos, funding agreements and reports, needs analysis and identification reports, internal and external status reports, monitoring dashboards and collated data, financial documents, and other sources of information on organization and program approach and performance. Avenir assembled an evaluation document library based on the material provided by WHO. Information was extracted and recorded in a standardized Avenir template for document review, organized by evaluation questions. Data needs were reviewed to identify and address gaps throughout the evaluation phases. A list of the key documents reviewed in the evaluation is provided in Appendix 3.
Secondary data analysis	Analysis of WHO data on results, beneficiary feedback, funding and financial allocations, and VfM according to documents provided by WHO. Explanatory details on the data and the systems underlying their production were provided by key stakeholders across response hubs and supporting regional teams, as well as by implementing partners, cluster members, and Third-Party Monitoring contractors. Information provided by WHO for the results and financial analysis was extracted from key documents, mapped, and re-organized in tailored analysis frameworks according to the evaluation questions and indicators listed in the evaluation matrix (Appendix 1). Information gaps are noted in the report findings.
Key informant interviews	Interviewed 10 ERG members and 67 stakeholders across categories of WHO global, regional, and country staff, donor representatives, UN representatives, implementing partners, health cluster members and co-coordinators, and other humanitarian actors. Interviews explored individual experiences, perceptions, and knowledge about the effectiveness, relevance, coverage, and efficiency of the Response, tracing critical adaptations over the 2016-2020 timeframe.

Activity	Description
	Interviews also explored significant achievements, challenges, and opinions about the leading issues for the Response going forward. Key informants were selected by the evaluation team according to purposive sampling from a list of stakeholders provided by WHO. Selection criteria included: representation of diverse stakeholder groups and positionality, type of experience with the Response, depth of perspective, and extent of knowledge on areas covered by the evaluation questions. Additional key informants were identified during the data collection phase according to stakeholder recommendations and requirements to address data gaps. All interviews were conducted remotely using a semi-structured interview guide, tailored to the stakeholder. While the questionnaires were not pre-tested due to limited time, the translation was cross-examined by two Arabic speakers within the Avenir team to determine the best terminology and phrasing. The questionnaires were additionally shared in advance with the Evaluation Manager with a request for input, as required, on phrasing. A summarized list of interviewed stakeholders is provided in Appendix 2.
WHO staff workshops	Three workshops with a total of 25 WHO staff were remotely conducted with teams in Gaziantep, Damascus, and EMRO/EURO. Workshops included staff formerly involved in the Amman and Erbil cross-border operations. Workshops facilitated participatory mapping of: the critical moments of the Response and their implications, stakeholders and their levels of interest in or influence on the Response, and perspectives on the challenges and opportunities for the Response going forward. Workshop participants were selected by the evaluation team in coordination with WHO focal points according to purposive sampling from a list of stakeholders provided by WHO. Selection criteria included: participant experience with the Response, depth of perspective, and extent of knowledge on the stakeholder environment. Tools used for workshop facilitation, data capture, and reporting were based on vetted Avenir templates and approaches for the workshop design, tailored for the requirements of the evaluation scope, criteria, and questions. Details on the workshop outputs are included in the workshop reports.
Localization learning profile	Two localization activities were collaboratively identified with WHO, covering mental health trainings with frontline humanitarian actors and community health workers (CHWs) in Aleppo and Al Hol (2019 and 2020) and use of CHWs in Leishmaniasis control in Gaziantep (2018 - 2020). Activities were selected for areas where WHO can maximize learning for future capacity building initiatives across health programming. Data gathering for the profiles included document review and stakeholder interviews with WHO and partner focal points. Key findings are integrated into the evaluation report, with emphasis in Section 6 (Learning from the Response).

Table 4 highlights the operational hubs covered by each data collection activity ('X' indicates that the method was used for that location).

Table 4: Operational evidence base.

WHO Operational Base	Document Review	Secondary Analysis	Key Informant Interviews	WHO Workshops	Localization Case Study
Geneva / HQ	X		X		
EMRO	X	X	X	X	
EURO	X		X	X	
Damascus + sub-offices	X	X	X	X	X
Gaziantep	X	X	X	X	X
Amman	X	X	X*	X	
Erbil	X	X	X*	X	

*Performance and results analysis only. Financial data was not available in a comparable format.

3.4 Evaluation ethics and quality control

The evaluation followed the UNEG Code of Conduct for Evaluation, the UNEG Norms and Standards for Evaluation (including standard 3.2 on ethics), and UNEG Ethical Guidelines for evaluations. Ethical standards integrated across every evaluation phase include informed consent, voluntary participation, and anonymity and confidentiality. Maintaining the standard of anonymity and confidentiality, the evaluation team and the Evaluation Manager agreed to produce a summarized key informant list (Appendix 2) that removes identifying information of interviewed stakeholders. This was supported by the WHO Evaluation Office.

The evaluation team applied quality control tools and an internal quality assurance mechanism across evaluation activities and deliverables. This included engaging with the WHO Evaluation Manager as the first line of quality assurance and approval on information requests, adjustments in the evaluation team and timeline, and the process to follow for evaluation decision making and review of evaluation products. The WHO Evaluation Office in Geneva provided a second line of quality assurance through participation in regular meetings, facilitation of the evaluation process, and review of key evaluation deliverables. Tools used for data analysis and data triangulation were based on vetted Avenir templates, tailored for the requirements of the evaluation. See the Inception Report for details on the ethical and quality control protocols of the evaluation.

3.5 Constraints and limitations

Identification of evaluation limitations and risks during the preparation and inception phases helped mitigate a range of constraints to ensure a credible evidence base for the evaluation. The following limitations apply to the evaluation evidence base and consequent depth of analysis possible in the evaluation report:

- **Remotely conducted evaluation:** Due to the risks and travel restrictions presented by COVID-19, the evaluation was remotely conducted. It required the evaluation team to conduct all interviews virtually, which led to challenges in connectivity and ease of scheduling with targeted stakeholders based inside Syria. It also limited the available data for analysis on the experiences and perspectives of Syrians affected by conflict (see point below) and prevented independent observation of activities. This restricts the depth of analysis possible for the evaluation findings, conclusions, and recommendations.

- **Limited data on the experience of affected populations**: WHO and the evaluation team agreed during the preparation and inception phases that it was not possible to conduct direct interviews with the affected population within the allotted resources and timeframe for the evaluation, as well as in regard to COVID-related travel restrictions and ethical constraints associated with remote data capture in the Syrian context[6]. To adapt, the evaluation relied on beneficiary feedback and monitoring data to gauge the experiences of the affected population. While WHO has a number of mechanisms for collecting data from the affected population, none were consistently applied across the evaluation timeframe or across response hubs. The quality of the raw data varied considerably within the Organization's systems for beneficiary engagement, constraining the evaluation to solely utilize the Third-Party Monitoring (TPM) data shared by the Gaziantep Field Office for northwest Syria. There was no equivalent data for the WCO Syria in terms of quality or comprehensiveness. Information directly collected from affected populations was not available for the Amman or Erbil hubs. This restricts the analysis possible for evaluation questions, especially indicators included in the Evaluation Matrix for "Effectiveness" and "Coverage." It may also influence the evaluation's contribution towards WHO's accountability to affected populations.

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[6] Ethical considerations include risks associated with data security challenges in Syria and the likelihood of significant bias in any dataset that only involves individuals who are able and willing to respond despite the data security risk. Additionally, there was not sufficient time available within the evaluation deadlines to convene an ethical review board and secure their approval on direct engagement with conflict affected populations in Syria as required by WHO's contract stipulations.

- **Unavailable external stakeholders:** Government and partner stakeholders demonstrated reticence and refusal to participate. In the case of partners, one Implementing Partner (IP) contacted for the Gaziantep hub and representatives for the Red Crescent Movement did not respond to invitations to participate in interviews. Data for representatives from the Government of Syria (GoS) is scarce, with three of the four targeted GoS representatives declining to participate without authorization from the Ministry of Health (MoH), which was not possible to organize within the timeframe of the evaluation. This restricts the analysis possible by key external stakeholders, most notably on the perspectives of the GoS on WHO's relevance and effectiveness.

- **Incomplete WHO staff workshop participation:** Three stakeholders invited to join the staff workshops were unable to participate or could only participate for a limited time. It was also noted during the EMRO/EURO workshop that the Senior Emergency Officer in Geneva should have been included. This stakeholder was not requested to join due to a procedural oversight during participant selection. In all cases, the draft workshop reports were shared with the affected stakeholders, who were invited to input on the report before finalization. While there are no significant data gaps in the workshop findings, the incomplete workshop participation limited the depth of discussion during the workshop sessions.

- **Cancelled focus groups with IPs:** Due to delays in coordinating the notification of external stakeholders on their requested participation in the evaluation, the implementing partner focus group discussions were cancelled to ensure the completion of the evaluation within a reasonable timeframe. To address the consequent information gaps, additional IPs were included in the schedule of key informant interviews. A total of seven IPs were interviewed (three for the Gaziantep Field Office and four for the WCO Syria), compared to four originally planned. While no significant data gaps resulted from this decision, reducing the number of participatory methodologies may limit the lessons learned identified in the evaluation.

- **Absent and inconsistent data available for financial and results analysis**: This includes documentation for key areas of analysis that do not exist or could not be found, information that is not consistently available across the evaluation scope (i.e., years, geographic hubs), and information that exists but was not available for use by the evaluation team. The implications of these gaps on the range and depth of the evaluation analysis are highlighted under the relevant evaluation findings in Section 5. Notable impacts include limited ability to disaggregate data by significant variables (e.g., response hub, severity scale prioritization, and gender) where relevant.

To address the variation of data quality and availability across evaluation questions, a score sheet for the relative strength of available evidence against evaluation findings is included in Appendix 4. Additionally, the report highlights questions raised by the data that are outside the capacity of the evaluation to address under 'points for further inquiry' in the evaluation recommendations (Section 8).

4. Country and Operational Context

4.1 The Syria crisis and health situation

The evaluation is situated in the political and health-related dynamics of the Syria crisis. This complex, protracted humanitarian emergency entered its tenth year and continues to pose numerous health challenges to more than 12 million people, including 6 million IDPs and over 5.6 million refugees. The situation in northwest Syria remains acute, with over 2.8 million people dependent on humanitarian assistance supplied from cross-border operations from southern Turkey. Population movements are expected to continue for the foreseeable future.

Syria's health system has been severely impacted by a decade of conflict and the health needs of the affected population are multifaceted. This includes limited access to basic and emergency care, lack of medicine, overwhelmed health facilities, reduced protection against communicable diseases, and the prevalence of trauma and extensive needs for disability care. Additionally, large portions of the population cannot access safe drinking water, in particular in northeast Syria. Mental health issues are prevalent, affecting an estimated range of 22 to 38% of the target population, depending on the nature of the disorder and the location of the population[7]. The consequent increase in the incidence of communicable disease and risk of dying from treatable non-communicable disease is further exacerbated by displacement and overall poor living conditions. Leading into 2020, only 53% of public hospitals and 51% of primary health care centers were fully functional[8] and there is a severe shortage of qualified health care workers, many of whom have left the country.

With limited capacity to address an additional crisis, Syria currently faces increasing rates of COVID-19 infections and related deaths. Testing rates are the third lowest in the region (199/100,000) and approximately 10% of all positive cases across the country are among health workers. Although government authorities are promoting a comprehensive approach, resources are stretched. This is compounded by a spiraling economic crisis that has doubled the cost of food compared to 2019 and witnessed a staggering decline in the value of the Syrian Pound. Social distancing and adhering to adequate sanitation precautions is especially difficult to impossible in camp settings, increasing the risk for an already vulnerable displaced population.

EMRO's mission to Syria in late October identified testing capacity, case management, infection prevention and control, and behavior change as suboptimal, especially in northeast Syria[9]. The COVID-19 response plan targets the following "pillars" as areas for WHO support and action: Leadership and coordination, surveillance and testing strategy, laboratory, infection prevention and control, case management, points of entry, risk communication and community engagement, continuity of care, and the health supply chain.[10]

4.2 WHO Whole of Syria response structure

The WHO response structure for Syria aligns with the UN approach and architecture for the WoS response as defined by the WoS Strategic Steering Group. The Response centers on joint Whole of Syria planning, including access to and presence in geographic areas, governing structures, and determining health needs and funding prioritization. The Organization implements the Response through a main office in Damascus and five sub-offices within Syria (WCO Syria), complemented by cross-border operations from Gaziantep in Turkey. Northwest Syria (NWS) is reached by sub-offices in Aleppo, Homs, and the Gaziantep Field Office. WCO Syria currently leads operations in the northeast (NES), through the sub-office in Qamishli. Southwest and central Syria, as well as rural Damascus, are also served by WCO Syria.

Previous cross-border work for northeast and southwest Syria was conducted from Erbil (Iraq) and Amman (Jordan), respectively. Cross-border activity from Jordan stopped in July 2018, following the shift of control over the area by government forces. In January 2020, the renewed cross-border Security Council Resolution 2504 removed authorization for the Yaroubiya crossing from Iraq into northeast Syria, leading to the closure of cross-border shipments from Erbil and the shift to fully provide humanitarian assistance to the area through cross-line operations from Damascus.

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[7] Evaluation ToR - The 38% figure references Syrian refugees living in Iraq, while the 22% figure reflects the global estimate for mental health issues in populations affected by conflict.
[8] WHO Whole of Syria Operations in 2020 – Vision and Approach, p. 4
[9] Regional mission to Syria, draft report.
[10] Syrian Arab Republic WHO Country Office – COVID-19 Response Plan – Presentation on the implementation of EMRO Mission Recommendations, 19/08/2020, Whole of Syria Coordination Meeting.

This shift raises a number of political and operational implications for WHO. The de facto governance structure in northeast Syria, the Kurdish Self-Administration (SA), is not recognized by the Syrian Government and official communication and coordination channels between the two areas are considerably restricted. Later in July 2020, the Security Council authorized an additional year of cross-border activity from Turkey into northwest Syria and reduced the related crossings from two to one access points under Resolution 2533. This expires and comes under review again in July 2021.

The Response is organized under two WHO Regional Offices: EMRO (Eastern Mediterranean) and EURO (Europe). Within this structure, EMRO coordinates donor involvement, grant management, and reporting functions. The Senior Emergency Officer position in Geneva ensures the alignment of the bi-regional response and mobilizes support from headquarters as required. Additional responsibilities for global advocacy on policy and access reside with the WHO Director General and are supported through WHO's involvement in the International Syria Support Group / Humanitarian Task Force at regional and global levels.

4.3 WHO programming in Syria

The Organization's work in Syria is framed within WHO's Emergency Response Framework (2017) and the 'critical functions'[11] it outlines for WHO action in emergency response. Within these functions, WHO aims to ensure the availability and provision of health services in Syria and to progressively expand access to care. Towards this goal, it provides coordination for the Health Cluster. Under the WoS model, this includes presence in Amman as the Whole of Syria Cluster Coordinator (co-coordinated by the International Rescue Committee), leadership in Gaziantep for the cluster response in northwest Syria, leadership in Damascus for the health sector response to government-controlled areas of Syria, and technical support from the Whole of Syria Cluster Coordinator in Amman to the NES Forum and the NES Health Working Group. In this capacity, WHO provides technical leadership, responsibility for setting standards and contextualization for the health response, harmonizing practice, and advocating on policy, access, and resource mobilization. It also provides monitoring to ensure standards for health in emergencies are upheld.

In addition to serving as the sectoral lead for health in emergencies and coordination of health partners, WHO's areas of work include health information services, health operations and technical expertise, and operations support and logistics. Key response initiatives within these categories are:

- **Health information services**: Risks and needs assessments through WHO's Health Resources and Services Availability Monitoring System (HeRAMS), early warning and disease surveillance through WHO's Early Warning Alert and Response System / Network (EWARS/N), development and dissemination of information products (e.g. the Health Cluster Bulletin), monthly situation reports, annual activity reports, and monitoring and verification of attacks on health care (including advocating for the protection of health care and respect for IHL).

- **Health operations and technical expertise**: Disease prevention and control, support to medical procedures / treatment courses, support to primary and secondary health care, support to health services in camp settings and informal settlements, support to trauma preparedness and response, support to the national immunization program operated by the MoH and supporting immunization in northwest Syria through the Syrian Immunization Group, community awareness and public health campaigns, provision of technical guidance and expertise to local and national health authorities and health actors, and capacity building and training on psychological care and mental health services. WHO is the sole supporter of secondary care, referral services, trauma care, and blood services in Syria.

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[11] WHO Emergency Response Framework (2017), page 9 and Chapter 3.

- **Operations support and logistics**: Leadership on supply chain management, including procurement and logistics for critical medical supplies and medicines and ongoing field support to partners. WHO supplies up to 40% of medical supplies and equipment in the country.

While WHO directly implements its coordination, health information, technical expertise, and operations support and logistics functions, it works closely with local health actors and NGOs as IPs in the delivery of healthcare services across conflict lines and borders. WHO's relationship with IPs involves capacity building with a view towards longer-term benefits for the health system and an investment in conflict resilience and peacebuilding. WHO coordinates with the Humanitarian Coordinators and OCHA to secure access to populations in need. This includes finding solutions for reaching target populations in light of changes to cross-border authorizations and navigating the political and security challenges of cross-line operations.

The Response targets Syrians affected by conflict (including displaced populations and returnees), with a particular focus on reaching the most vulnerable and tailoring services according to gender, age, and disability considerations. In addition to vulnerable Syrians, the Response reaches local health actors and civil society, healthcare workers and institutions, government agencies, and the member organizations of the Syria Health Cluster as part of the population served by WHO programs and functions. As the conflict and consequent humanitarian needs evolve, WHO aims to balance the divergent needs of this varied target population. As articulated in WHO's 'Vision and Directions for 2020' paper, this involves continued focus on life-saving assistance in Syria with growing attention on rebuilding the country's health system as part of the recovery transition.

4.4 Response stakeholders and stakeholder analysis

Stakeholder analysis conducted during the evaluation workshops with WHO staff (see Section 3, Methodology) identified five main categories of stakeholders shaping the Response with high levels of influence. Within each category, the level of interest in the Response varied according to specific stakeholders and their relationship to the Response as a whole or to particular response hubs. This includes:

- **WHO response actors**: This group displays a high level of both influence and interest. It includes the WoS focal point in the Health Emergencies Program in Geneva (Senior Emergency Officer), EMRO, WCO Syria, and the Gaziantep Field Office. Teams noted that the interest and influence of the EURO office shifted over time, depending on leadership priorities and timing of the Response. Reflecting its management structure and operational context, the team in Gaziantep identified a higher and more consistent level of interest and influence of the WHO Turkey Country Office compared to the other workshop groups. There were different perspectives on the level of interest of the WoS Health Cluster, with the team in Damascus experiencing a higher degree of interest from the stakeholder compared to the Gaziantep office.

- **WHO global and support functions**: This group displays a high level of influence, with varying levels of interest over the years under review. It includes the broad level of WHO Headquarters, the office of the Director General, and the Dubai logistics hub. Teams noted that the interest and influence of the Emergency Programme in Geneva shifted over time, depending on leadership priorities.

- **Local government and authorities:** This group displays high levels of both influence and interest. It includes the Government of Syria, the authorities of Syria and Turkey (e.g., Ministry of Health, Ministry of Foreign Affairs, Turkish health directorates in Afrin and north Aleppo, etc.), the de facto health authorities operating in areas controlled by other parties to the conflict, and the direct and non-direct IPs in northwest Syria. The placement of the 'parties to conflict' stakeholder on the spectrum of interest and influence depended on the specific actors, their size, and roles across the timing of the conflict.

- **Global governments and diplomatic forums**: This group displays a high level of both influence and interest. It includes regional governments (Iran, Saudi Arabia, and Egypt), Member States, and the UN Security Council. Every workshop noted that the level of influence and interest of Member States and their diplomatic entities depended greatly on the state.

- **Humanitarian Actors**: This group displays a high level of both influence and interest. It includes the Office of the Special Envoy, the Humanitarian Task Force / International Syria Support Group, other UN agencies active in Syria (depending on the extent of their mandate, relationship to health, and locations of operation), donor agencies, and the Red Crescent societies. Workshop participants described the interest and influence of the Red Crescent movement actors as "distinct and situational", depending on the WHO office and specific Red Crescent actor involved in that location.

The consolidated outcome of this stakeholder mapping informs the evaluation analysis and interpretation of key events in the Response (see Diagram 2 below). Details from each stakeholder mapping were documented in workshop reports as a learning output of the evaluation for the Response.

4.5 Response timeline

The evaluation covers the period of 2016-2020, with a focus on identifying how the Response evolved and performed in relation to shifting humanitarian needs during this time. Based on key stakeholder interviews, WHO staff workshops, and document review[12], there are three distinct phases of WHO engagement in Syria and the structure of the Organization's WoS response model:

- **Phase 1: 2012-2015 -** *Establishing the scope of WHO involvement in Syria*. This includes debating and clarifying the parameters of WHO's operational response versus advisory role in the crisis and the degree of interest in the Organization for launching an active cross-border presence. Response hubs in Damascus, Gaziantep, Amman, and Erbil are established.

- **Phase 2: 2016-2017 -** *Defining and consolidating WHO's Whole of Syria approach and operational model*. This includes further articulation of the response governance structure, roles and responsibilities, and ways of working across response hubs. The approach to resource allocation, joint operational reviews and planning, and further agreement on reporting lines are agreed and put into effect across the Response. This phase is also marked by an expansion in cross-border operations, the escalation of violence in the crisis, and initial access negotiations into besieged areas.

- **Phase 3: 2018-2020 -** *Dynamic application of WHO's Whole of Syria approach in an evolving context*. This includes adapting the focus of the Response, expanding activities, and re-organizing geographic responsibilities across response hubs as lines of control and authorizations for cross-border operations shift. This phase is marked by further investment in response-level systems (e.g., harmonized reporting platforms, VfM approaches, etc.), closure of the Amman and Erbil hubs, closure of cross-border access points and consequent demand for increased cross-line access, continuation of violence then followed by the reduction of GoS-led offensives, mass population displacements, and the emergence of COVID-19.

Diagram 2 presents a summary of the critical moments of the Response, including external and internal events.

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[12] In particular WHO Annual Reports, the 2016-2019 Humanitarian Needs Overviews, the 2020 Humanitarian Needs Overview Health Chapter (draft), the 2016-2020 Humanitarian Response Plans, and the 2017-2019 Humanitarian Response Plan End of Year Reports and Mid-year Monitoring Reports.

Diagram 2: Response timeline.
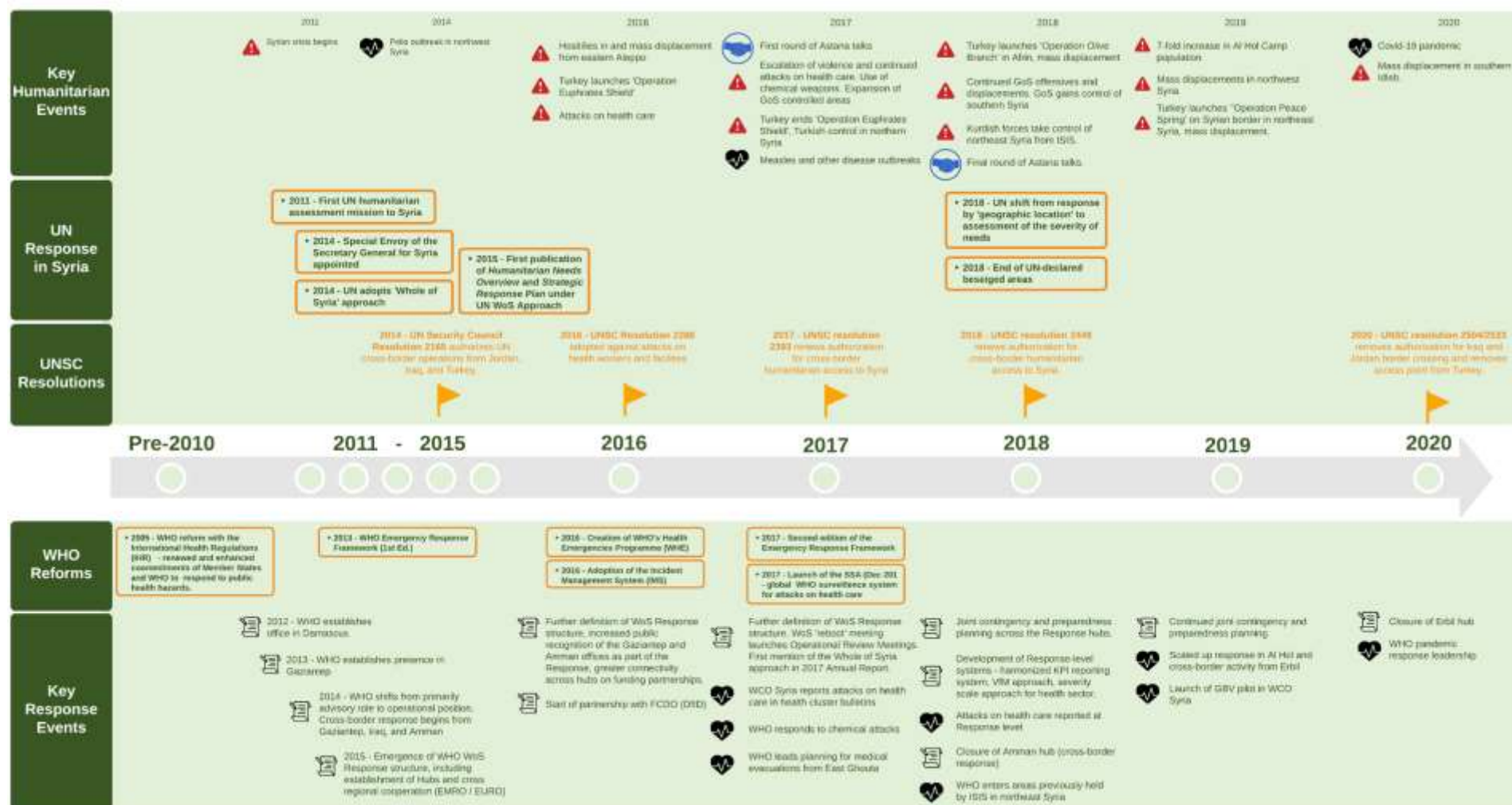
5. Evaluation Findings

Evaluation findings are organized according to the five evaluation questions of relevance, effectiveness, coverage, efficiency, and explanatory factors (see Section 2). Within each question, evidence is presented against 17 associated sub-questions as posed in the evaluation Terms of Reference and finalized in the Inception Report. Key lessons learned, the success factors of the Response, and areas for improvement across the findings are summarized under Sections 6 (Learning from the Response) and Section 7 (Conclusions). Points for further WHO inquiry identified through the evaluation analysis (as described under the 'limitations' paragraphs in Sections 2 and 3) are presented in Section 8 (Recommendations).

5.1 EQ1: Relevance

How well aligned has WHO's response to the Syria crisis been during the years under review with the stated needs of the Government, the specific needs of the affected population, and with WHO's broad approach to humanitarian action and health emergencies?

Key Findings:

- *Finding 1:* WHO provided an increasingly relevant response in a context marked with conflicting interests between the central Government of Syria, WHO's Member States and funding partners, the wider UN and humanitarian community, and the evolving – sometimes rapidly shifting – needs of the population.

- *Finding 2:* WHO's operational structure enabled flexibility and adaptation to fluctuating lines of control, while participating in the UN WoS approach and its governing frameworks.

- *Finding 3:* WHO's critical functions[13], including Direction and Coordination, Health Information, Health Operations and Technical Expertise, and Operations Support and Logistics, filled an essential role for the humanitarian community and for the affected population in Syria.

- *Finding 4:* The Response aligns with WHO's broad approach to humanitarian action, at times revealing gaps in the extent of global priorities, investments, or guidance for protracted crises and conflict settings.

Findings for this section are presented according to the topics of: alignment of the Response with the needs of the affected population, alignment of the Response with the priorities of the Government and other local authorities, alignment of the Response, and alignment of the Response with WHO's humanitarian strategy.

Alignment of the Response with the needs of the affected population
The evaluation explored the reported and documented approach of the Response to determining health needs in Syria and the extent to which WHO's critical functions align with those needs.

WHO's approach to determining and prioritizing needs shifted as population needs changed during the 2016-2020 timeframe. The end of 2016 through the middle of 2018 was marked by escalating violence and mass population displacements. For WHO, as well as the wider UN WoS response, the early years of this time were characterized by an initial distrust and friction between response hubs in how to best determine needs and prioritize response services. As one stakeholder described it, *"there were two WHOs sitting in opposing positions concerning the needs in Syria."* According to a wide range of WHO staff and external observers, the distrust between the Damascus and Gaziantep hubs reflected the political dynamic of the conflict, as well as tensions regarding decision-making authority and resource distribution between geographic areas.

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[13] As presented in the inferred ToC, Section 3.2. This includes the word "Direction" to encompass WHO's work in setting norms and standards, which is not present in the ERF framing of WHO's critical functions. The inferred ToC and this finding do not include the ERF critical function of "Leadership", as that function is beyond the scope of evaluation inquiry.

From the end of 2017 and into 2018, the Response considerably invested in building relationships and fostering collaboration across hubs. This included efforts made at the hub and regional levels, as well as support from Geneva in aligning the bi-regional response through the creation of SOPs and agreeing on a formula for unearmarked funding. Improved coordination led to clearer decision-making protocols on how to transparently identify health needs and establish their level of prioritization between geographic locations. This culminated in a series of joint contingency planning exercises in 2018 as lines of control rapidly shifted in ways that affected the geographic and consequent programmatic scope of the Damascus, Gaziantep, and Amman hubs. While mid-2018 and 2019 were less violent compared to earlier years, the trend of mass displacements and shifting lines of control continued. During this period, the Response strengthened its approach to needs identification through the application of a multi-factorial severity scale developed by the IASC Humanitarian Program Cycle Steering Group and adapted by the Health Cluster. This moved the organization from prioritizing needs according to population levels in the geographic areas under each response hub, to one that better accounts for health service availability, service accessibility, and population vulnerabilities within a sub-district[14]. This approach continued into 2020, with technical improvements to the severity scale methodology and the additional focus on needs analysis in the COVID-19 pandemic.

The Humanitarian Needs Overview (HNO) and the Humanitarian Response Plan (HRP), under OCHA's overall responsibility, are the primary mechanisms through which WHO determines humanitarian needs and prioritized areas of intervention on an annual basis. Through the WoS Health Cluster Coordinator, each response hub and its corresponding health cluster contributes to the HNO analysis. A range of tools are used to collect data, including information from the Multi-Sector Needs Assessment coordinated by OCHA to identify needs at a community level, sector-specific assessments conducted by WHO and health cluster members, the HeRAMS, EWARS/N, WHO's Surveillance System of Attacks on Healthcare (SSA), the cluster 4Ws and key performance indicator (KPI) reports, and networked information of partners and WHO 'focal points' across areas of operation. During interviews, stakeholders consistently affirmed the relevance of WHO's critical functions (Direction and Coordination, Health Information, Health Operations and Technical Expertise, and Operations Support and Logistics) in responding to the identified needs and in filling an essential humanitarian role for the affected population. The decision to develop and apply a severity scale approach tailored to the needs of the health sector was noted across stakeholders as a particularly welcome shift in providing a more relevant, needs-based response.

Due to insufficient data collected from the affected population in WHO's monitoring systems, it is not possible to determine whether people in need of health services agree with the organization's prioritization of support. Likewise, while the information sources WHO relies on to determine needs at a community level appear well triangulated and representative across target populations, there is limited evidence of systematic needs analysis at the field level. This includes regularly applied tools for: identifying barriers to health access according to gender or other vulnerabilities, prioritization of needs across facilities within a sub-district, and routinely used protocols for beneficiary consultation during field-level needs assessments. Instances of independent, field-level needs assessments that WHO quickly launched following an emergency event (e.g., Turkish incursion on the Syrian border or growth of Al Hol camp in 2019 following the offensive in Deir ez Zor) or in response to expanded access into an area (e.g., Ar-Raqqa in 2017) were well received by partners and bolstered WHO's credibility with donors and local health actors. The rapid needs assessments conducted by WHO in Ar-Raqqa and Al-Hasakeh in 2017 are a prime example of this cited across WHO internal and external reports, donor communications, and cluster documents. Stakeholders highlighted the belief that while WHO is both uniquely positioned to conduct quality field-level needs assessments due to its technical expertise in data systems, it is not routinely deploying this capacity. This may be attributed to limited access to areas where WHO is reliant on IPs or the Organization's focus on supporting health services primarily through systems established at the community level.

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[14] See "Health Severity Scale HPC 2020", Whole of Syria Health Cluster.

Gender is considered across WHO's critical functions, primarily through its training packages, public health priorities (i.e., reproductive health, mental health, and the more recent GBV program pilot), and normative guidance. Under WHO's leadership, the Health Sector works with the GBV sub-cluster and Protection Cluster and gender markers are utilized for project proposals submitted by cluster members in the health section of the HRP. It regularly considers women's specific health needs as part of its strategic and contingency planning and a Protection Risk Analysis is updated annually by the WoS Health Cluster for use by partners in developing projects. There is, however, limited evidence of more comprehensive gender analysis and mainstreaming within WHO's health services or in support of its IPs. This includes an absence of gender assessments that consider the distinct priorities or protection concerns experienced by women, men, boys, and girls as a result of their gender. Across interviews, stakeholders struggled to provide concrete examples of gender-assessment tools or partner selection criteria that incorporated gender criteria. Cluster members noted that field-level operational challenges related to gender are rarely discussed in meetings and generally the issue is difficult to openly address in Syria. WHO staff described an organizational culture that frequently assumes that targeting children, youth, or women with specific health services is equivalent to humanitarian gender analysis and program mainstreaming. While there are global, regional, and country level initiatives to develop and mainstream GBV expertise in WHO's operations, this work is rarely adequately resourced or staffed by dedicated GBV experts. In WCO Syria, it now sits within a strong mental health program that takes an integrated approach to introducing GBV services through more community based "Family Wellbeing Centres". Other program teams, however, have been slower to mainstream GBV into their operations.

Alignment of Response with the priorities of the Government and other local authorities
The evaluation explored the documented and reported level of WHO's engagement with the Government of Syria, as well as reported practice on providing technical support to the Self-Administration and Turkish authorities.

Alignment with the priorities of the Government of Syria: The frameworks through which WHO and other UN agencies coordinate priorities with the Syrian Government include the UN Strategic Framework (UNSF), the Government's agreement on the HRP, and WHO Country Cooperation Strategies (CCSs). The UNSF advocates for improved synergy between humanitarian action and recovery planning (especially in stable areas with high numbers of IDPs) and emphasizes capacity development, support to institutions, and restoring or expanding essential services and their infrastructure (including health facilities). These priorities are reflected in WHO's program portfolio and strategy papers, from 2016 through 2020, with growing focus from 2019. WHO's investment in civil society demonstrates a commitment to capacity development, while its work with local Health Directorates has included delivery of essential supplies, training, and light rehabilitation of health infrastructure. This approach is likewise reflected in aspects of the HRP and in the WHO CCSs finalized for 2016-2017 and 2018. WHO paused the development of its CCS in Syria after 2018, citing the prolonged absence of a National 2030 Strategy and a degree of uncertainty over when the UNSF would be renewed. At this time, the function of the CCS to establish agreed priorities with the host government was arguably covered under the UNSF extensions in 2019 and 2020.

While there is procedural alignment between WHO's involvement in the mechanisms securing the Government's support for the UN's presence in the country, there are frequent instances of the Government actively impeding WHO from implementing its part of the HRP and overlapping sections of the UNSF, or not adhering to its own agreements. This is highlighted in the HRP Mid-Year and End of Year Reports, WHO Annual Reports, and the minutes from health cluster meetings, as well as expressed across interviews with internal and external stakeholders.

In 2017 and 2018, the Government removed humanitarian supplies from approved convoys, blocked medical evacuations that were negotiated and agreed across conflict lines, denied issues with vaccination coverage in locations with demonstrably low rates of childhood immunization, and refused road delivery of aid to northeast Syria while this same route was used by other agencies. In 2019 and 2020, the challenges became largely bureaucratic, such as slowing approvals on shipments or the year-long delay for signing off on the 2020 HRP. From 2020, the effects of sanctions more significantly impacted programming, which shifted towards longer-term investments over immediate response activities. It was also noted by WHO staff that the Government did not engage the Organization in the development of its recently published health policy. Despite these obstacles, WHO diligently -and often successfully - advocated with the Government for access and pursued collaboration on areas of shared interest. This includes a range of technical support services for local Health Directorates, support on the country's COVID-19 response, initiatives towards conducting joint assessments, and continued diplomatic communication on the importance of sustaining independent and impartial humanitarian services across the country's conflict lines.

To understand the relevance of WHO's current approach with the stated priorities of the Government going forward, the evaluation compared WHO's program portfolio with the National Health Policy (2020-2024) and Strategic Plan "Syria 2030", published by the Directorate of Planning and International Cooperation Commission of the Government. Both Government documents underline a 'reconstruction' agenda that is significantly broader than WHO's present services or prioritization of delivering services to areas with the most pressing humanitarian needs. Importantly, reconstruction is excluded for UN funding under the UN Parameters and Principles in Syria, impacting WHO and other UN agencies' scope for engagement in this area. WHO has, however, highlighted the imperative for a longer-term approach to Syria and aspects of recovery planning across its strategy documents and key presentations dating from 2018 through 2020. This is likewise described as part of the UNSF objectives, which WHO actively supports. Beyond the narrative on reconstruction, there are several points of complementarity between WHO's focus areas and government objectives. These include: securing comprehensive coverage of basic health services, expanding access to primary health care (including the use of mobile clinics), increasing awareness and prevention of communicable diseases, improving the quality of health services and the re-building the health care workforce, building up mental health and disability services, and establishing heath management information systems.

Other local authorities: The evaluation interpreted this question to include the degree of relevant coordination or engagement with the Self-Administration in northeast Syria, Turkish authorities in northern Syria, and non-state actors in northwest Syria**.** Outside the UN Security Council resolutions authorizing cross-border operations and the recognition in the HRP that the UN works in areas outside GoS control, there is little to no procedural structure for UN agencies to coordinate plans with de facto authorities in these locations. Through interviews with WHO staff and partners, it is largely understood that the Response ensures a relevant package of health services and presence in these areas through its work in cluster and sector coordination, needs assessments through IPs and the HeRAMs and EWARS/N surveillance systems, and through independent communication channels focused on technical coordination established from EMRO and the WoS Health Cluster Coordinator post in Amman. As part of its cross-border authorization, the Gaziantep Field Office does coordinate with and secure approvals from the Turkish authorities. While this has largely secured an aligned and appreciated health response in these locations, WHO has faced situations where authorities removed humanitarian supplies from approved convoys or declined to secure safe passage for cross-line or cross-border shipments after committing to do so under ceasefire or other political agreements. Stakeholders involved with or observing the situation in northeast Syria, noted that restrictions on WHO's engagement with the Self-Administration has reduced the Organization's impact in the area throughout the 2016-2020 timeframe. There are, however, indications that the level of engagement is improving in 2020, aided by WHO's decision to expand response capacity to the area. Addressing the current vacancy and maintaining the position of the WoS Health Cluster Coordinator in Amman is also expected to support this improvement.

Alignment of Response with WHO's humanitarian strategy
The evaluation explored the documented and reported alignment of the Response against three areas of WHO's approach to humanitarian action and health emergencies: (i) organizational strategy and policies, (ii) coordination and role within the wider UN architecture for humanitarian action in Syria, and (iii) consideration and application of humanitarian principles.

Organizational strategies and policies: As specified in the ToR, the evaluation assessed alignment against the current organizational strategy applicable to the Response, the Thirteenth General Programme of Work (2019-2023). While the GPW13 is not applicable to the full span of years under review, notably 2016 through 2018[15], it provides the most appropriate reference for WHO's global ambitions for work in health emergencies and contexts like Syria. The evaluation also assessed alignment against WHO's 2nd edition of the Emergency Response Framework (2017) (ERF)[16] as the most appropriate version for the Response, most notably for its inclusion of the WHO Health Emergencies Programme (WHE) created in 2016 and the sections delineating WHO's guiding principles for emergency response, 'no regrets policy', and expanded set of critical functions that distinctly includes partner coordination.

Against the GPW13, the response program portfolio is especially aligned in the following areas:

- *Health Emergencies*: Strengthening capacity of local communities, building networks based on essential public health functions (including mental health and psychosocial support and nutrition), continued efforts to prevent and respond to disease outbreaks (including EWARS/N, vaccination campaigns, and leadership on the COVID-19 response), and focus on preventing system collapse and maintenance of critical services. The response program priorities are also broadly consistent with the GPW13 results framework for the WHE.

- *Universal Health Coverage*: In addition to the GPW13's priorities for health emergencies, the Response is active under the Universal Health Coverage objectives listed in the strategy. In particular, efforts to capacitate the health workforce, ensure access to medicines and other health products, expand service availability, and develop health information systems (e.g., EWARS/N and HeRAMS, as well as the SSA in a crisis context).

- *Healthier Populations*: The Response contributes to this objective through its efforts on improving reproductive health in a crisis (Platform 1), technical support and service delivery on non-communicable diseases and mental health (Platform 2), and its continued attention on sustained vaccination "even in the most inaccessible areas"[17], including polio as a key priority.

Alignment is more variable against the organizational shifts highlighted at the end of the strategy[18]. In most cases this points to a gap between WHO's global strategy and the degree to which the Organization has prioritized field level improvements. As a result of limited global-level guidance or investment in the targeted strategic shifts that primarily occur at the field level, country operations struggle to reach the expectations set forth in the GPW13. Key trends in this regard include insufficient global investment in cluster coordination capacity (primarily in available coordinators), performance monitoring capacity, and VfM capacity. There are also challenges associated with WHO's role as the 'provider of last resort' in the context of protracted crises. These areas are discussed in more detail under findings for "Efficiency" (EQ4).

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[15] These years are covered under the Twelfth General Programme of Work 2014-2019, which was developed prior to the creation of the WHO Health Emergencies Programme in 2016 and does not explicitly address health emergencies.
[16] At the time of this report, two editions of the ERF were published by WHO: 1st edition of the ERF, published in 2012, and the 2nd edition of the ERF, published in 2017.
[17] GPW13 p. 13.
[18] Ibid, p. 33-48.

A similar trend is apparent in assessing the Response against the ERF. As with the GPW13, the response program portfolio is well aligned with the 'critical functions' listed in the ERF. Likewise, it is broadly aligned with WHO's ten core commitments in emergency response[19], with some adaptation based on the length of time the Response has been in place and its particular coordination structure (e.g., the language of commitments 1, 2, and 3 is oriented to the initial crisis response). The regional and country WHE functions operate in close coordination with the global WHE focal point for Syria and there has been an active application of the 'no regrets policy' across funding streams (e.g., activation of CFE support in 2017 and 2020) and through surge deployments. There are, however, limitations to the applicability of the ERF to the Syria context. This is primarily seen in the lack of direction for protracted emergencies. These issues are discussed in more detail under the findings for "Efficiency" (EQ 4).

Coordination and role within the UN architecture for humanitarian action in Syria: UN agencies in Syria work under the umbrella of two main coordination frameworks: (i) the Whole of Syria mechanism governing the humanitarian agenda (including all hubs, UN agencies, and humanitarian organizations responding to the Syrian crisis), and (ii) the UN Country Team (UNCT) governing the development agenda (strictly focused on GoS-controlled areas of Syria and UN agencies working in those locations). The Whole of Syria response is framed by the HNO and the HRP. Within this framework, WHO is the lead agency for the Health Cluster. Typically, the work of the UNCT occurs under the Cooperation Framework that is developed together with the host government. It is multi-year in perspective and aligned with the Global 2030 Agenda and the SDGs. In Syria, the "Cooperation Framework" was replaced with the "Strategic Framework" (UNSF), initially developed in 2015 to cover 2016-2018 and subsequently extended in 2019 and 2020. A draft UNSF for 2021-2023 is currently under review and negotiation. Within this framework, WHO is the UN lead agency for the Institutional Capacity Development pillar. While the UNSF and the HRP are separate frameworks, there has been substantial overlap across their activities. The midterm review of the UNSF in 2017 found that "about 70% of activities under the UNSF are also covered by the HRP", including funding through the HRP mechanisms. That report also found that "the UN and government partners agree that the intersections between the HRP and the UNSF have to be accepted in the current situation."[20] According to interviews, that overlap continued through the 2019 and 2020 extensions.

Through these structures, WHO made significant efforts from the start of the Response to collaborate with UN agencies and coordinate across humanitarian health partners, while operating within the legal frameworks for the Organization's presence in Damascus and engagement in cross-border activities. WHO's "collaborative spirit" towards the UN approach to Syria was highlighted by external stakeholders as critical to navigating the complex political context and solidifying the UN's advocacy on key topics such as attacks on health care. The strength of WHO Health Cluster Coordinators at pivotable moments of the crisis positioned the Organization as a leading advocate within the UN response for humanitarian access in besieged and hard to reach areas, as well as in bridging divides between the UN Damascus and cross-border operations.

> *"Between WHO and OCHA there was very close collaboration. In the UNCT, everyone was very conscious - and WHO more than anyone else - that in Syria you don't go it alone."* – UN Stakeholder

Across external interviews, however, stakeholders perceived decreasing levels of collaboration and transparency in the relationship of WCO Syria with other UN agencies in recent years. These concerns were noted in 87% of the interviews conducted with external stakeholders engaging with WHO operations at the WoS or WCO Syria levels, including donors, UN actors, and humanitarian agencies (not including IPs). Stakeholders primarily highlighted issues in information sharing, collaborative approaches to addressing access challenges, and a perceived decline in WHO's commitment to the "One UN" approach in Syria.

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[19] WHO Emergency Response Framework (2nd edition 2017), p. 10-11.
[20] Whole of Syria Review, Draft Report (2016) (covering UN WoS Approach), page 5.

While reflecting on this, interviews also consistently provided positive feedback on the expansion of the Qamishli office, improving relationships with the NES Forum, and progress on securing and sharing information on the humanitarian gaps and needs in northeast Syria. WHO staff affirmed their commitment to inter-agency collaboration and coordination, while noting instances where inter-agency approaches lost WHO convoy access it would have otherwise secured if operating alone. Several staff emphasized difficulties with securing reliable, verified data in sensitive locations, pointing to a context where challenges in information sharing and transparency are primarily related to data availability and data protection.

Consideration and application of humanitarian principles: The ERF affirms the centrality of the humanitarian principles in WHO's emergency work.[21] This is reiterated across response strategy papers, presentations, proposals, and was consistently affirmed in interviews with current and previous response staff and leadership. Yet, while WHO emphasized the principled nature of its work in Syria, the Organization faced questions and criticism from the media, health activists, cluster members, donors, and Member States over the years about its impartiality, neutrality, and independence. This critique was most acute early in the Response (2015-2016) and through the years of active armed conflict when all UN agencies struggled with access from Damascus into besieged areas (2017-2018). In return, WHO redoubled its efforts at humanitarian diplomacy, communication, and provision of evidence-based accounts of its work across conflict lines. It also invested in strengthening its WoS approach through joint contingency planning and systematic, face-to-face operational review meetings in an effort to mobilize services between response hubs during mass displacements and to ensure impartial coverage of its presence. It has achieved this without sacrificing its operational space in Damascus largely through the legal protection granted by the UNSC cross-border resolutions, careful diplomacy with GoS authorities, and proactive efforts at building independent response hubs and cross-line communication channels through the WoS Health Cluster Coordinator position in Amman and the WHE team in EMRO.

> *"From the perspective of project objectives, there hasn't been any sort of discrimination or distinction between Syrian, Iraqi, or any other nationality. From design to execution, WHO supports anyone in need of emergency medical aid."* – Implementing Partner

Interviews with WHO revealed that while adhering to humanitarian principles remains a priority for the Response, interpretations of how to practically apply them in Syria and within the mandate of the Organization are inconsistent. This includes different positions between response staff on the appropriate level of WHO's relationship with and proximity to the Government in the context of WHO's mandated relationship with Member States and working modalities with national governments versus its continued emphasis on neutrality and independence[22]. In Syria, this is additionally complicated by the need to sustain humanitarian services in areas where access is controlled by that Member State. The ERF does not provide a unifying interpretation of the humanitarian principles and their applicability in the context of WHO's mandate. This is reflected by the absence of distinct guidance for operations in conflict settings within the ERF[23], which does not distinguish situations in which an emergency occurs or their impact on WHO's approach to the emergency (i.e., natural disaster vs. armed conflict). Armed conflict usually implies a "complex emergency", with characteristics that differ[24] from other emergencies like pandemics or natural disasters.

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[21] See ERF 2017, p. 11.

[22] This discrepancy is reflected when comparing OCHA's definition of independence: *"humanitarian action must be autonomous from the political, economic, military or other objectives that any actor may hold with regard to areas where humanitarian action is implemented"* with the ERF's description of WHO's operational response: *"An "operational response" consists of WHO emergency actions that exceed the usual country-level cooperation that the WHO Country Office has with the Member State."* and *"WHO's core commitments in emergency response are…undertaken in support of national health authorities and… in close collaboration with national and international partners."*

[23] The ERF defines 'emergency' as a *"a situation impacting the lives and well-being of a large number of people or a significant percentage of a population and requiring substantial multi-sectoral assistance. For a WHO response, there must be a clear public health consequence"* (ERF 2017, p. 3).

[24] See the IASC 'Definition of Complex Emergency' (1994), such as *"large number of civilian casualties, populations who are besieged or displaced quickly in large numbers"*, *"humanitarian assistance is seriously impeded, delayed, or prevented by politically or conflict-motivated constraints"*, and *"international and cross-border dimensions that require political mediation and coordination"*.

Humanitarian responses in armed conflicts need to account for these characteristics to ensure they fulfill the humanitarian principles, in particular those of neutrality and independence. While WHO can ascribe to humanity and impartiality without question under its mandate, as a member state organization it must secure government permission to establish operations and access areas that agencies with different mandates may not require. Interpreting the application of neutrality and independence, in this context, requires continuous conflict analysis and clear institutional parameters for how these principles are understood within the mandate of the Organization. Notably, a range of stakeholders identified 'weak conflict analysis' as a specific challenge within the Response, notwithstanding efforts made on this in the FCDO partnership.

5.2 EQ2: Effectiveness

What results has WHO achieved in the Syria Response during the years under review, whether intended or unintended?

Key Findings:

- *Finding 1:* WHO was broadly effective in its objectives across its critical functions, with varying levels of achievement over time, locations, and program objectives.

- *Finding 2:* WHO has not consistently measured progress against targets for response level indicators or sufficiently disaggregated data to monitor equitable results across vulnerable populations.

- *Finding 3:* Data collected from the affected population through Third Party Monitoring shows a high rate of general satisfaction, with critique on the selection and distribution of needed medicines.

- *Finding 4:* While there is limited evidence of significant unintended outcomes (positive or negative) in the affected population, workshops with WHO staff and WHO documents highlight the positive, unexpected impact of the Organization's early investment in Syrian civil society.

Findings for this section are presented according to the topics of: achievement of planned activities and outcomes, differential results across vulnerable groups, and positive or negative unintended outcomes.

Achievement of planned objectives and outcomes
The evaluation explored response achievements against three sources of information: (i) significant achievements and areas for improvement reported or highlighted by WHO and external stakeholders in interviews and workshops, triangulated with information found in key documents, (ii) WHO's performance against key response indicators, and (iii) perspectives of the affected population on response services and quality.

Significant achievements and areas for improvement. Interviews with stakeholders and WHO staff workshops highlight a range of WHO achievements within the design and delivery of its critical functions, as well as in the operational model of the Response's Whole of Syria approach, as summarized in Table 5 by stakeholder group.

Table 5: Stakeholder perspectives on key achievements, by critical functions and WoS operational model.

Stakeholder	Critical Functions	WoS Operational Model
WHO Staff	▪ **Partnerships** – primary and secondary healthcare provision, referral networks, re-building local capacity to ensure sustainability and continuity of care. ▪ **Cluster coordination and leadership** – bridging actors, cohesive response. ▪ **Provision of technical assistance** – reached partners and local authorities, quality of training packages. ▪ **Surveillance systems** – HeRAMS, EWARN/S, active use in disease control (e.g., response to wild Polio outbreak). ▪ **Immunization campaigns** – coordination with parties to conflict to secure polio vaccination, maintenance of polio immunization in ISIS controlled areas, scale up of EPI vaccination posts in northwest Syria. ▪ **Mental health** – training, mental healthcare facilities, integration into primacy healthcare services. ▪ **Supply distribution** – quantity, quality, and coverage of delivered medical supplies and medicine.	▪ **Partnerships** – working with Syrian civil society and local health authorities to secure access and service delivery. Highlight: Reach into ISIS controlled areas. ▪ **Inter-hub coordination** - continuity of care between hubs for IDPs, planning and pre-positioning for changed lines of control, cross-line referral support (e.g., from Idleb to Hama hospital). ▪ **Access negotiations** – reach into besieged areas and securing humanitarian corridors, cross-border and cross-line coordination with authorities to guarantee distribution of supplies.
Partners (including IPs, cluster members, GoS)	▪ **Partnerships** – hospital support on trauma response, referral networks, support on malnutrition treatment, support on the operational costs of health facilities. ▪ **Cluster coordination and leadership** – technical working groups, networking between health actors. ▪ **Provision of technical assistance** – courses developed on malnutrition and mental health, responsiveness to partner training requests, unified curriculum in NWS. ▪ **Mobile clinics and provision of free services** – enabling partners to reach vulnerable people. ▪ **Supply distribution** – supply of medications required for surgeries, provision of ambulances and equipment.	▪ **Communication lines provided by EMRO and Amman WoS Cluster Coordinator** – strategic discussions with UN WoS, technical support to NES Health Forum / Self-Administration, bridging Qamishli / Damascus.
UN	▪ **Partnerships** – diligence on WHO responsibilities within UN inter-agency partnerships (e.g., vaccination). ▪ **Cluster coordination and leadership** – medical evacuations, information sharing to cover gaps and avoid duplication of services. ▪ **Provision of technical assistance** – medical expertise of WHO staff contributing to strategic discussions. ▪ **Immunization campaigns** – response to and stopping of polio outbreak in 2017, maintenance of polio immunization in ISIS controlled areas, response to and stopping of measles outbreaks, appreciation from GoS.	▪ **Partnerships** – working with Syrian civil society and local health authorities to secure cross-border service delivery, WHO's leadership in building cross-border NGO network and capacity. ▪ **Inter-hub coordination** – coordinated reach into besieged areas from Damascus and Gaziantep hubs, complementarity between response hubs entering northeast Syria after the anti-ISIL operation. ▪ **Access negotiations** – UN inter-agency partnership on convoy negotiations into besieged areas (e.g., Aleppo), WHO's protection of humanitarian principles, life efforts to ensure WHO delivered cross-border and cross-line.

Stakeholder	Critical Functions	WoS Operational Model
	▪ **COVID-19 response** – WHO leadership and communication with UN offices on information for messaging with ministries / UNSC, securing PPE from Turkish authorities for northwest Syria. ▪ **Rehabilitation** – cross-UN collaboration, COVID-19 isolation centers, guidelines for "light rehabilitation".	▪ **Communication lines provided by EMRO and Amman WoS Cluster Coordinator** – strategic discussions with UN WoS, technical support to NES Health Forum / Self-Administration, bridging Qamishli / Damascus.
Donors	▪ **Partnerships** – provision of healthcare services. ▪ **Cluster coordination and leadership** – leadership of health response and working with a large number of local NGOs in northwest Syria. ▪ **Surveillance systems** - critical information source for donor and humanitarian community in Syria. ▪ **COVID-19 response** – strategic and technical leadership, supply lines for PPE. ▪ **Supply distribution** – lead actor providing medical supplies from international procurements.	▪ **Communication lines provided by EMRO** – strategic discussions with donors at WoS level, coordination and streamlining communication between response hubs, maintenance of WoS approach.

Reflecting on these achievements in interviews, representatives from every stakeholder group highlighted the importance of WHO's work in cluster coordination. This is shown in the Cluster Coordination Performance Monitoring results for the Damascus (2016, 2018, 2020), Gaziantep (2018 and draft 2020), and Amman hubs (2018), which report that the health clusters have fulfilled 80 to 90% of their duties in a "good" or "satisfactory manner". Despite a history of distrust between humanitarian actors in Damascus and cross-border operations, stakeholders credited WHO with creating a coordination system that drove a more effective humanitarian health response. While examples were provided from across the evaluation timeline, most focus was placed on the role of WHO's cluster coordinators during the escalation of fighting and shifting lines of control in 2017 – 2019 and leadership in the COVID-19 response in 2020. Attention was also given to the appreciated impact of the WoS Health Cluster Coordination in Amman in supporting the NES Health Working Group in Kurdish-controlled areas of northeast Syria and linking their work to the wider Cluster from 2018 through 2020, until the post became vacant.

In addition to WHO's leadership of the Health Cluster, stakeholders credited WHO's success in Syria to its adaptability and approach to inter-hub coordination, the technical expertise and dedication of WHO staff, the Organization's early support to the newly emerging Syrian civil society through its approach to partnership and work with IPs (including the institution of an application process for IPs in 2017), and WHO's active negotiation for access to hard to reach areas during critical points of the crisis.

Stakeholders also noted challenges and areas for improvement. These concerns consistently fell under "Coverage", "Efficiency", or "Explanatory Factors" categories and are integrated into the findings for those questions. The primary challenges impacting or undermining the effectiveness of the Response included recurring staff vacancies in critical positions, the short duration of IP contracts, and gaps between IP contract renewals. Additional areas for improvement noted by stakeholders included the lack of WHO supervision on the quality of care provided by IPs in contracted arrangements for provision of health services. Frustrations about how medicines and medical supplies are selected and targeted for distribution, as well as the degree to which WHO is able or willing to address the issue, were also raised. Both points are further elaborated below in this section.

Performance against key indicators[25]. Analysis of WHO's performance on key indicators consists of (i) results data on the number of treatment courses provided from 2018-2020 and (ii) two target variance analysis case studies on FCDO-funded activities from 2016 to 2020 and COVID-19 activities between April and December 2020. Based on its prominence in WHO documents and through discussions with stakeholders in WCO Syria and the Gaziantep Field Office regarding available data, the evaluation team analyzed performance on the indicator "number of treatment courses provided."[26] Beyond this, the evaluation team identified additional indicators that provide insight into the WHO's level of service distribution within sub-offices covered by WCO Syria. This analysis is presented under findings for "Coverage" (EQ3). WHO's available data for the "number of treatment courses" indicator was not tracked or disaggregated by sex and other vulnerability criteria.

Number of Treatment Courses
From 2016 to 2020, the Response provided a total of 60,734,564 treatment courses. For the cross-border operations, there was an overall increase in the number of treatment courses provided between 2016 and 2019 before a slight decrease in 2020. For WCO Syria, there has been an 25% overall decrease in the number of treatment courses provided from 11,000,000 in 2017 to 8,206,402 in 2020. The peak number of treatment courses for the Response was in 2017, at 14 million.

Figure 1: Number of treatment courses provided by year for WCO Syria and Cross Border Operations.
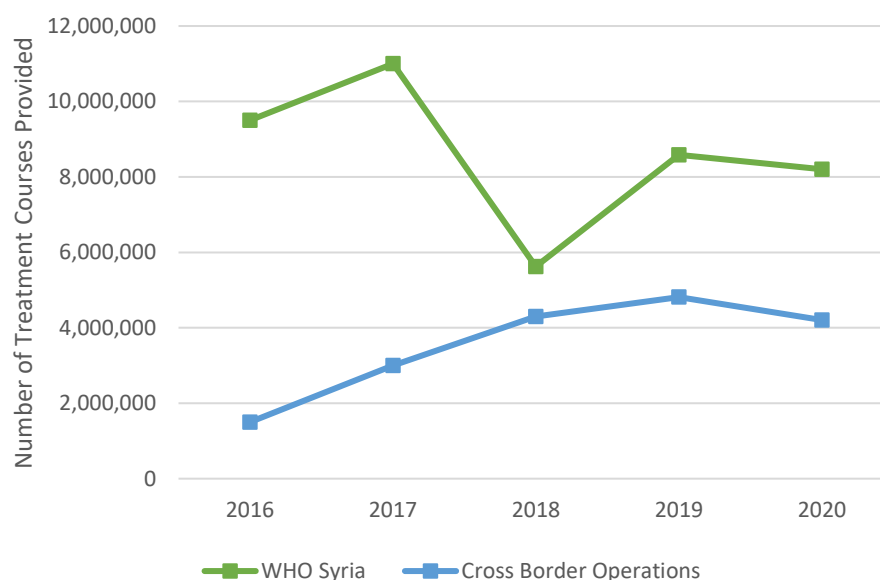
The evaluation team was not able to identify a clear explanation for the recent drop in treatment courses in the Response or the jump in levels from 2017, 2018, and 2019 in WCO Syria. Possible reasons include: supply chain challenges, issues in securing permissions for treatment distribution and delivery, access constraints, the closure of the Erbil cross-border access into northeast Syria and the elimination of one cross-border point for Turkey in 2020. Funding levels were largely steady between 2017 and 2019, but a decrease in non-COVID funding in 2020 may contribute to the drop seen in this year. Additional analysis on funding allocation is provided under findings for "Coverage" (EQ3).

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[25] WCO Syria Health Information Management Unit provided KPI dashboards of the Response-wide Harmonized Indicator Reporting for years 2019 and 2020. Data from KPI dashboards in 2018 was provided for WCO Syria only. The data for WCO Syria was disaggregated by region. Data on the provision of treatment courses was obtained from Annual Reports in 2016 and 2017 and from KPI dashboards from 2018-2020. Raw data in Excel format was additionally provided for these dashboards for years 2018 to 2020 (WoS covered only in 2020).
[26] To explore change over time, the evaluation focused analysis on datasets covering at least three or more years of operation. The Response started collecting harmonized WoS performance data from 2019 and in some cases only reported figures for 2020. As a result, data relating to both WCO Syria and cross-border operations was restricted to this indicator, which was consistently used in WHO's Annual Reports dating back to 2016.

While it is difficult to interpret the success of these numbers without a benchmark on total need for 'treatment courses' or WHO's committed level of coverage for treatment courses (i.e., WHO-specific response-level targets for the indicator – see point immediately below), a number of internal and external stakeholders noted their belief that WHO performed above expectations for this indicator. In many instances, stakeholders reflected on this as evidence of WHO's commitment to save lives and reach people across all lines of conflict, despite enormous bureaucratic, political, and security obstacles.

Target variance analysis case studies

WHO has not consistently measured progress against targets for response level indicators[27]. As a result, the evaluation selected FCDO-funded activities as a case study for target variance analysis based on the significance of FCDO funding (~25% of the Response), the quality and regularity of FCDO reporting, and application of the available data for the evaluation timeframe. Performance on 2020 COVID-19 indicators was also analyzed, as the only other available dataset with uniform application of performance targets.

In the case study analysis of FCDO indicators and targets, WHO consistently exceeded targets, with increasing performance across the years (e.g., from 12% of the target for improved primary health care and outreach health services in 2016 to 319% in 2020). This is evidenced at output, outcome, and impact level indicators.

Impact-level performance. WHO reported on two impact indicators for FCDO:
▪ Number of outpatient consultations in Syria
▪ Percentage of health facilities that are accessible

WHO exceeded its agreed targets on the number of outpatient consultations every year, with a peak in 2018. WHO also exceeded its agreed targets around the accessibility of health facilities, from 103 to 110% achievement of targets across the years of implementation.

Figure 2: Percentage of targets achieved by WHO for impact indicators between 2016 and 2019.

Number of supported outpatient consultations

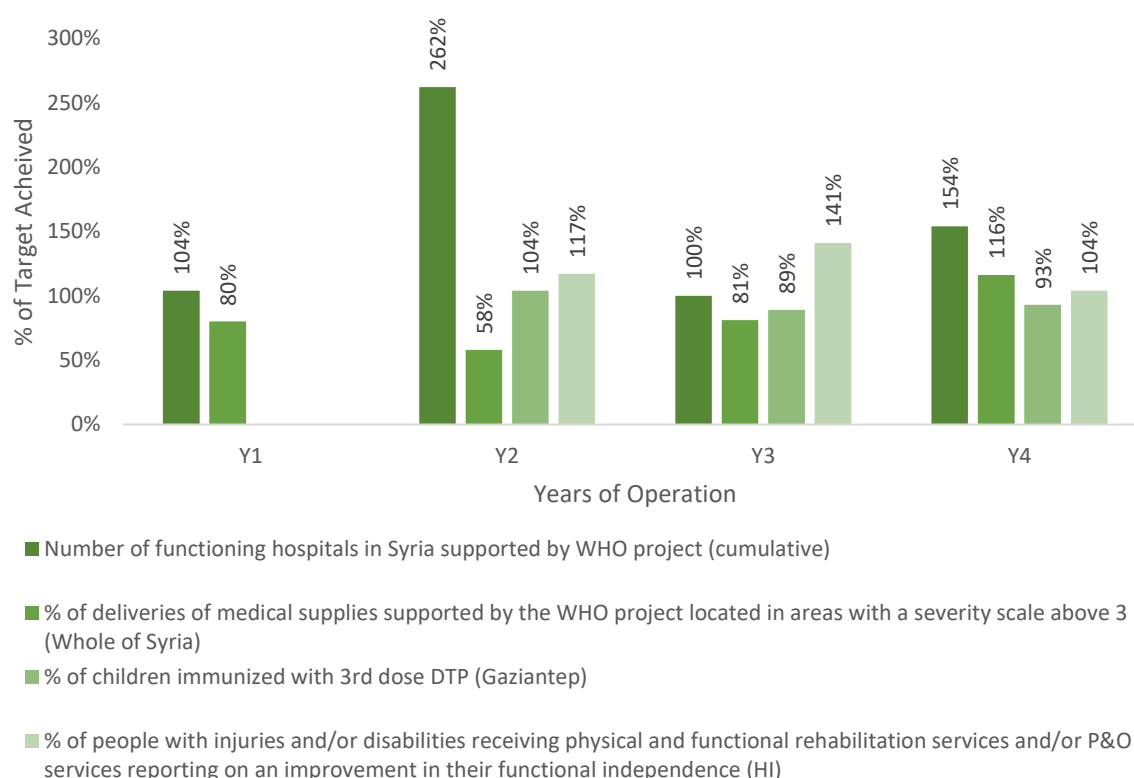Percentage of health facilities in Syria that are accessible (whole of Syria)

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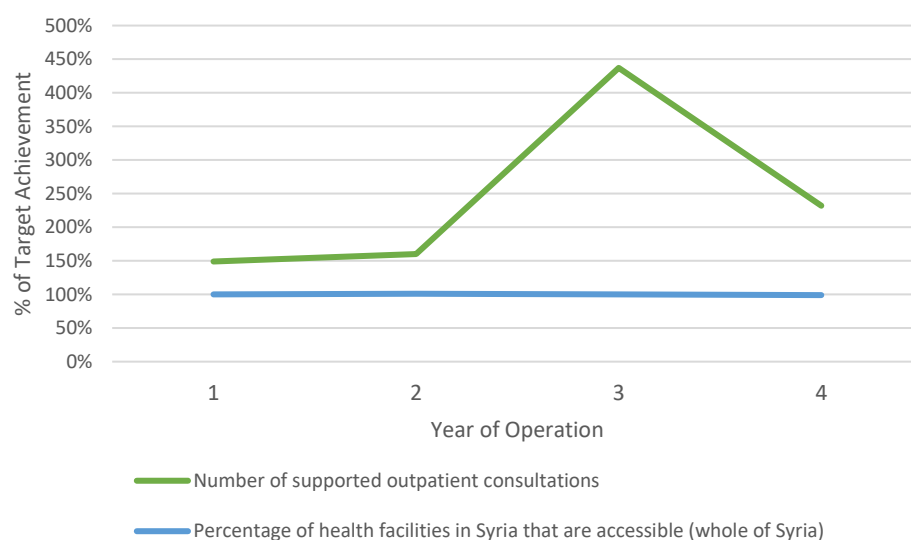
[27] The Response historically established targets in individual donor contracts, rather than across the harmonized KPIs. As of 2021, the response will now establish its own broader targets across key performance indicators.

FCDO outcome-level performance: WHO reported on four outcome indicators for FCDO:

▪ Number of functioning hospitals in Syria supported by WHO
▪ Percentage of deliveries of medical supplies supported by WHO in areas with a severity scale above 3
▪ Percentage of children immunized with 3rd dose DTP (Gaziantep)
▪ Percentage of people with injuries and/or disabilities receiving physical and functional rehabilitation services and/or P&O services reporting an improvement in their functional independence

The latter two indicators did not report on achievements until 2017. Results varied across 2016-2020 without any strong trends of progression or regression, aside from the percentage of targets achieved for the rate of children immunized (achieving 58% of the target in 2017 and 116% of the target in 2020). The highest achievement of targets is on the number of functioning hospitals, which peaked at 262% of the target in 2017.

Figure 3: Percentage of targets achieved by WHO for outcome indicators between 2016 and 2020.

■ Number of functioning hospitals in Syria supported by WHO project (cumulative)

■ % of deliveries of medical supplies supported by the WHO project located in areas with a severity scale above 3 (Whole of Syria)

■ % of children immunized with 3rd dose DTP (Gaziantep)

■ % of people with injuries and/or disabilities receiving physical and functional rehabilitation services and/or P&O services reporting on an improvement in their functional independence (HI)

Output-level performance: Over the partnership, WHO reported on a number of output indicators for FCDO, with adjustments made to the logframe each year. Five consistently reported indicators include:

▪ Output 1: Improved primary health care and outreach health services
▪ Output 2: Secondary care services strengthened
▪ Output 3: 3a) EWARS/N for improved public health surveillance/monitoring priority public health diseases is strengthened + 3b) The Health Information System (HIS) for emergency [using HeRAMS and/or DHIS2] for regular, timely and accurate collection and dissemination of data is further strengthened
▪ Output 4: Ameliorated service provision to people in need of mental health and psychosocial services (MHPSS)
▪ Output 5: Strengthened level of preparedness for management of trauma including physical rehabilitation

Target achievement varied across the years of operations, with peaks in the strengthening of secondary care in 2018 and in the provision on MHPSS services in 2019. Output 1 saw sustained improvements from 12% of targets achieved in 2016 to 319% of targets achieved in 2019. All output indicators saw some level of increasing performance against the targets across 2016-2020 other than Output 3, in which achievement against targets decrease from 129% to 103% across the years (though it should be noted that this target remained not only achieved but surpassed throughout).

Figure 4: Percentage of targets achieved by WHO for output indicators between 2016 and 2020.
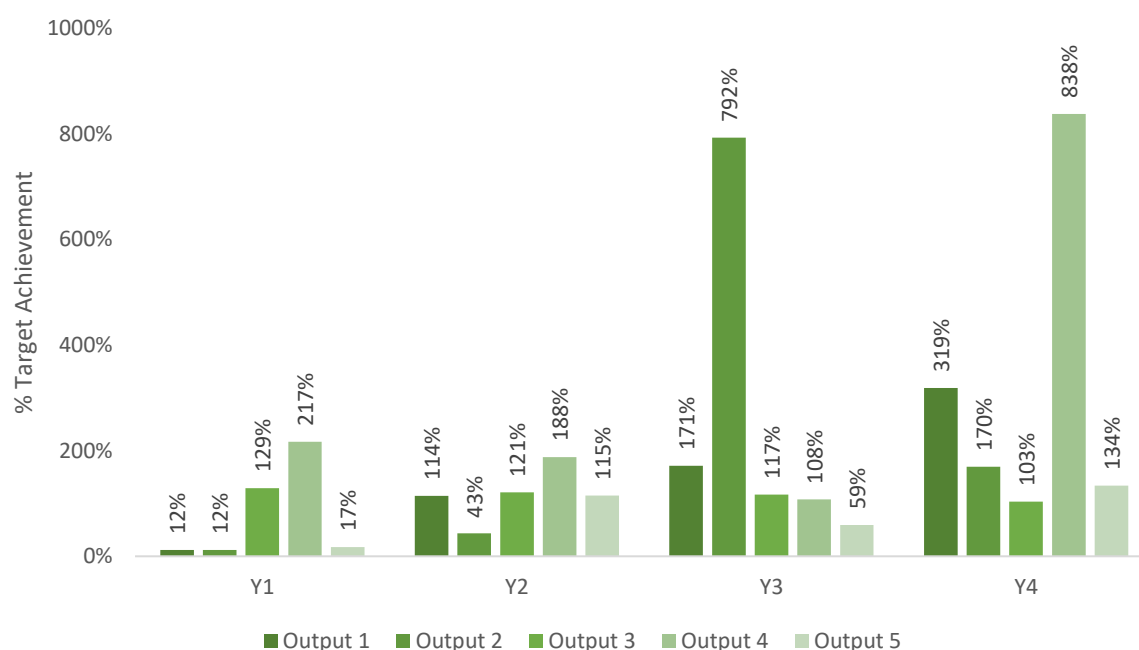
While over-performance on targets is generally a positive trend, it can reflect situations where WHO has not adequately anticipated needs, its capacity to address those needs, or the full reach of the requested budget during the proposal process. Challenges with target setting are raised as an issue across exchanges between WHO and FCDO, primarily focusing on the methodological difficulties of determining meaningful targets in a context characterized by unpredictable, mass population displacements.[28]

In contrast to FCDO, performance against targets for COVID-19 indicators is more mixed. Table 6 shows a heatmap where red represents <50% of target achieved, yellow represents 50-99% of target achieved, and green represents ≥100% of target achieved. The presented data cover results for April 1st to December 31st, 2020.

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[28] See PowerPoint from the DFID Q4 Meeting on Logframe Targets (March 2018).

Table 6: Percentage of targets achieved by WHO for COVID-19 indicators, 2020.

Indicator	Target	Result	% Target Achieved
# of PPE distributed among humanitarian personnel (health workers, warehouse employees, third party monitors and private contractors)	13,000,000	18,067,062	139%
# of humanitarian personnel (health workers, warehouse employees, third party monitors and private contractors) trained on IPC	3,326	4,354	131%
# of laboratory tests conducted	75000	84000	112%
% of suspected COVID-19 cases reported through surveillance system and investigated within 24-48 hours	90	99.9	111%
# of health workers trained on case management	3000	3320	111%
# of humanitarian personnel trained on MHPSS	6000	6429	107%
# of COVID-19 RCCE plans developed	1	1	100%
# of PoEs equipped with appropriate levels of staffing, PPE and other necessary COVID-19 supplies, including ambulances	13	13	100%
# of isolation centers established at governorate level and equipped with life-saving essentials such as ventilators, oxygenators and monitors	26	22	85%
# of people reached through COVID-19 IEC materials (developed, printed and distributed), social media, WhatsApp, radio & TV channels, and community engagement (sent and issued)	15,000,000	12,500,000	83%
# of women, girls, men and boys participating in awareness raising sessions	350,000	255,480	73%
# of non-COVID-19 health facilities (mobile medical units, medical teams and ambulances) supported in order to continue providing health services	350	240	69%
# of COVID-19 humanitarian updates produced and disseminated	36	22	61%
# of RRT team members trained on COVID-19 in all governorates	850	507	60%
# of laboratory technicians trained on PCR, bio- safety, technical procedures and reporting formats*	100	56	56%
# of laboratories established to test COVID-19	14	6	43%
Testing rate per day/100,000 population	5	0.97	19%

While this data represents performance across the health sector, it reflects WHO's overall leadership and individual areas of responsibility for the Syria COVID-19 strategy. The greatest success with regards to the achievements of targets is in the provision of PPE equipment (139% of target relating to # of PPE distributed to humanitarian personnel was met) and the number of humanitarian personnel trained on infection prevention and control (IPC, 131% of target). The indicators with the lowest proportion of targets met includes testing rates (19% of target) and, correspondingly, the number of laboratories established to test COVID-19 (43% of target).

In interviews, stakeholders noted the continued challenge with securing COVID-19 supplies for Syria during a global pandemic that affected the world's supply chain on related materials. In many cases, stakeholders perceived WHO as initially slow to respond, with increasing levels of strategic leadership and success on securing PPE and delivering training to healthcare workers. Laboratory equipment and testing was confirmed as an issue during interviews, largely linked to sanctions, bureaucratic delays, compromised equipment quality, and the challenge of securing this equipment in a highly competitive and expensive global market for COVID-19 testing equipment.

Perspectives of the affected population. Data on the perspectives of the affected population is limited. The Response does not apply a consistent approach to securing beneficiary feedback on their use or satisfaction with the type and quality of provided services.

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Additionally, the evaluation was not able to locate a common framework for accountability to affected populations – including the importance of beneficiary-oriented outcome monitoring and feedback systems - that is applied across the Response or the health sector under WHO's cluster leadership. As a result of quality issues in the beneficiary feedback data provided by WCO Syria, the evaluation restricted its analysis on the perspectives of the affected population to the Third-Party Monitoring (TPM) data provided by the Gaziantep Field Office[29]. The data used for the case study was collected between October and November 2019 (two supply lines), between January and February 2020 (11 supply lines), and from February to April 2020 (11 supply lines). For this analysis, 'beneficiaries' is defined both as patients and as healthcare workers/facility managers who receive support for their work from WHO.

While it is limited in its geographic scope (only covering the areas of northwest Syria reached by the Gaziantep hub), the case study of Gaziantep's TPM data provides a useful account of the perspectives of the affected population reached by WHO's efforts at supply distribution. For the period under review, it primarily shows a high rate of general satisfaction, with critique on the selection and distribution of needed medicines (e.g., over-supply in some locations, under-supply in others). Key findings from the analysis include:

- *Varied access to prescribed drugs*. 49% of respondents were able to access all drugs prescribed during their visit, while 47% reported that the prescribed drugs were unavailable (the remaining 4% responded 'Don't Know'). The most commonly cited unavailable drugs included antibiotics, pain relief, aspirin, anti-inflammatories and cough medicine. Drug availability did not differ by age or gender but did differ by location (see Figure 6), with patients in Afrin having the highest access to the drugs they were prescribed (77%) and patients in Jebel Saman having the lowest access (18%).

Figure 5: Patients whose needed medicines were available when they visited the health facility.
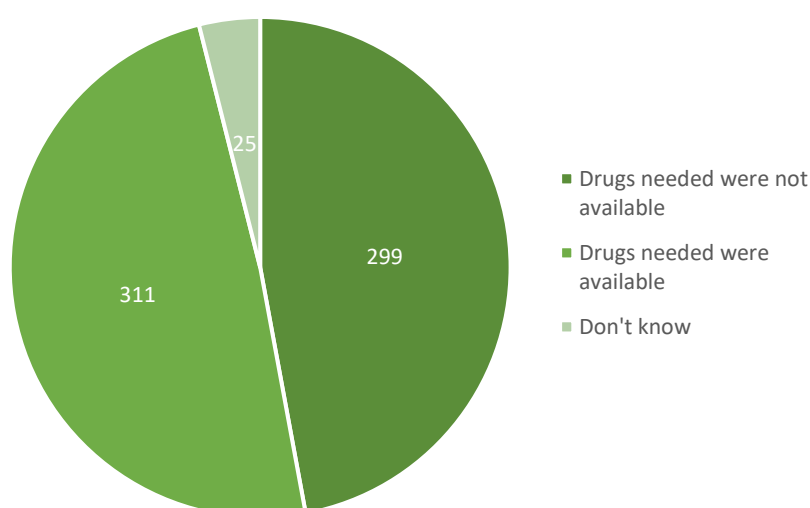
Figure 6: Percentage of patients whose prescribed drugs were available by district.
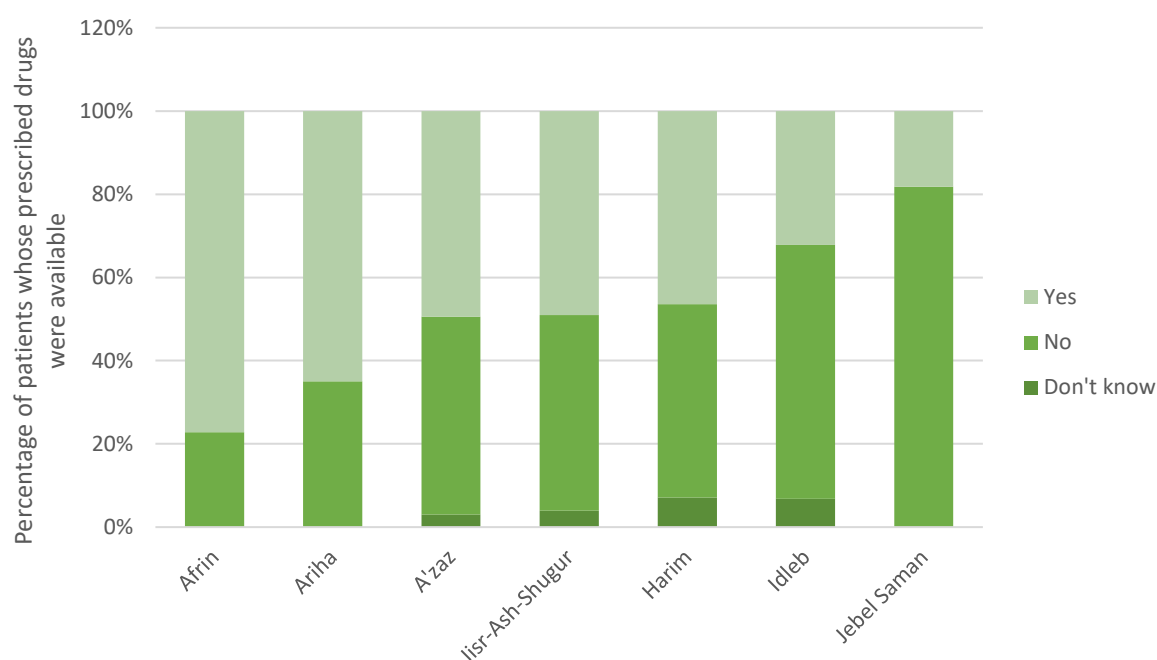
- *High levels of patient satisfaction with the health facilities.* In terms of overall satisfaction, 100% of respondents reported that they received the care they needed during their visit to the health facility. 93% responded that they would visit the health facility again, while 1% said they would not and 6% responded that they did not know. 98% of patients said that they would recommend the health facility to a family member, with a further 2% responding 'Don't know'.

- *Patients offered a variety of suggestions for improvements to health facilities, particularly relating to the provision of medicines.* The most common suggestions for improvements included the provision of needed medicines (40% of respondents), followed by the need for specialized medical staff (10% of respondents). Other suggestions for improvements included a greater availability of specialized departments, an on-site laboratory for medical testing, and the provision of labor rooms.

- *Pharmacists offered positive feedback around the supply of medicines from WHO, with suggestions for improvement.* Pharmacists cited many positive aspects of WHO's support, including the timely provision of needed medicines, the reliability of the supply chain, and the effective packaging of kits and medicines. Two main areas of improvement suggested by pharmacists included increasing the supply of medicines to match the needs of patients (particularly in areas that had seen large influxes of displaced persons), and a greater alignment between the types of medicines provided and the needs of the patients.

These findings are consistent with points raised by external humanitarian health actors and IPs in interviews conducted with stakeholders across response hubs. As described, IPs will often re-distribute kits within their network to ensure items do not spoil if the contents are not needed by their facilities or services. This is done without WHO direct support or guidance. The issue of over or under supply of medicine and supply distribution is further discussed under findings for "Coverage" (EQ3) and "Efficiency" (EQ4).

Differential results across vulnerable groups

As noted above for the data analysis on indicator performance, performance indicator data shared by WHO were not disaggregated by sex or other vulnerability criteria. As a result, the evaluation is not able to fully address this question. Based on interviews and a review of the raw data behind the harmonized KPI dashboards, however, the evaluation found several indications of weak or inadequate systems for ensuring equitable results across vulnerable groups:

- WHO has not sufficiently disaggregated data to monitor equitable results across vulnerable populations, therefore limiting its ability to detect issues and respond accordingly.
- There remains limited contact with affected populations or inquiry into the quality of care received by partner agencies. This impacts the extent to which WHO is able to determine the outcomes of its work across vulnerable groups.
- Although WHO worked to expand available health services, there is less evidence on the extent to which the Organization supported utilization of services, with an understanding of how this is impacted by gender, age, disability, or affiliations within the conflict.

Positive or negative unintended outcomes

According to donor reports and internal donor memos, the biggest question concerning unintended outcomes in WHO's WoS Response relate to the potential support given to the parties of conflict through the delivery of aid. This includes the possibility of implicit political legitimization provided by an aid response, security or information breaches created by a multi-hub approach (e.g. teams in one location provide information about the operations of another team to governing authorities), and the provision of financial resources to parties of conflict through aid diversion (including the removal or seizure of aid supplies from convoys and warehouses) or financial contributions made to affiliated groups through partnership modalities. As it relates to Syria, these concerns extend beyond WHO and are reflected across all UN and NGO operations.

Due to the time, resource, and remote-management limitations of this evaluation, these questions were beyond the capacity of the evaluation team to meaningfully or comprehensively investigate. Documents confirm that WHO has been under regular review from donors and internal compliance mechanisms on these issues and no major breach has been detected in the 2016-2020 timeframe. As noted under "Relevance" (EQ1), however, the absence of robust conflict analysis across the Response may hinder the Organization's understanding of these risks and ability to address them in a consistent or systematic manner.

On the positive side, several WHO documents and workshop participants noted the benefits of WHO's approach to working with IPs and Syrian civil society. While WHO initially developed and invested in its partner network to support the delivery of essential healthcare services across conflict lines and borders, the Organization sees long-term opportunities for formalizing and expanding the role of civil society.[30] One internal stakeholder described it as an "organic evolution" that, while not necessarily planned from the start, is an important lesson and innovation in response modalities for the Organization going forward.

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[30] WoS Vision and Approach, 2020, p. 11.

5.3 EQ3: Coverage

To what extent has WHO's interventions reached all segments of the affected population, including the most vulnerable, during the years under review?

Key Findings:

- **Finding 1**: While WHO invested considerable efforts to reach all segments of the affected population, it faced access, funding, and logistical constraints. Programming modalities and the WoS operational model supported coverage in hard-to-reach locations and improved access to health on culturally sensitive issues.

- **Finding 2**: While the Response follows a clear process for identifying needs at country and sub-district levels, the evaluation was not able to identify consistent use or evidence of field-level procedures for targeting services by vulnerability and ensuring their reach across vulnerable groups.

- **Finding 3**: Response-level data is limited on coverage according to sex, age, disability, displacement status, or location by severity scale classification and response hub. This signals reduced capacity to ensure coverage and access to services across all segments of the population.

- **Finding 4:** WHO applied several strategic and operational strategies to address the political and access challenges of ensuring coverage across geographic locations and conflict lines. While these efforts were broadly successful, questions remain about current reach into key locations of the country.

- **Finding 5:** As a trend, data suggest increasing reach in central Syria in a context otherwise marked by a decline or stasis in the volume of services provided by WCO Syria in southern Syria, northwest Syria, and northeast Syria. In recent years (2019-2020), WCO Syria received proportionally less funding for its level of required contributions compared to the Gaziantep Field Office.

Findings for this section are presented according to the topics of: coverage according to population vulnerabilities and geographic coverage and reach across conflict lines.

Coverage according to population vulnerabilities
The evaluation explored response coverage according to population vulnerabilities against three sources of information: (i) significant efforts at or challenges experienced in securing equitable coverage of services according to WHO and external stakeholders in interviews or highlighted in key documents, (ii) reported and documented systems, SOPs, guidelines, tools, and other procedures for targeting services by vulnerability and ensuring their reach by prioritized vulnerable groups, and (iii) reviewing WHO performance data for reach of services across dis-aggregations by sex, age, disabilities, and displacement status.

In this analysis, population vulnerabilities are based on the definitions most frequently used in WHO documents and publications from the Health Cluster in Syria: women (including pregnant and nursing women), children (with particular emphasis on children under the age of 5), the elderly, persons with disabilities, and displacement status (including whether displaced persons are residing in camps or outside of camps).

Significant efforts at or challenges experienced in securing equitable coverage of services. Interviews with stakeholders and internal and external documents highlight a range of efforts and challenges towards securing equitable coverage of services according to identified population vulnerabilities. Table 7 outlines these perspectives, summarized by stakeholder group.

Table 7: Stakeholder perspectives on coverage efforts and challenges.

Stakeholder Group	Efforts towards securing equitable coverage	Challenges towards securing equitable coverage
WHO Staff	▪ **Partnerships** – working with partners specialized on issues of disability, mental health and GBV, and reproductive care; excellent collaboration with UNICEF and Syria Immunization Group; partner application protocol is aligned with needs. ▪ **Cluster coordination and leadership** – technical working groups and workshops provided on issues of GBV and reproductive health; 4Ws review to ensure sector coverage on health services. ▪ **Targeted health services** – focus on supporting the primary and secondary health services particularly needed by women, children, and disabled people (e.g., reproductive health care, childhood vaccines, physical rehabilitation, GBV and mental health services). ▪ **Health service mainstreaming** – integration of health services covering sensitive issues (mental health and GBV) into accepted networks or referral approaches. ▪ **Development and use of severity scale prioritization** – needs-based analysis on how to prioritize funding allocations that accounts for specific population vulnerabilities (in addition to gaps in health services).	▪ **Partnerships** – challenges in 2016-2017 transitioning to application process; difficulty encouraging partners to expand activities to cover targeted services for vulnerable populations in "risky locations". ▪ **Cluster coordination and leadership** – inconsistent reporting on 4Ws from partners and partner participation in coordination structures. ▪ **Remote management** – inability to directly access locations to ensure equitable delivery of services across targeted population groups; reliance on Third Party Monitoring contractors and IPs to provide quality data. ▪ **Information gaps** – sections of Syria remain difficult to access and partners in those areas lack data on vulnerabilities; limited response-level data from 2016-2018 and continued data gaps reach by vulnerabilities. ▪ **Resource gaps** – insufficient levels of funding and staffing to adequately address all needs and operation often forced to prioritize assistance according to urgency (e.g., saving a life immediately) over specialized care (e.g., mental health and physical rehabilitation); diminished healthcare workforce over years of conflict.
Partners (including IPs, cluster members, GoS)	▪ **Partnerships** – referral networks between camps and hospital facilities in Al Hol, strength of IP local knowledge on vulnerabilities (in particular as it relates to gender and women's access to health); partner application protocol requires IPs to describe service reach by gender and age. ▪ **Cluster coordination and leadership** – technical working groups and workshops on GBV. ▪ **Provision of technical assistance** – courses developed for partners on childhood malnutrition and mental health, training on reproductive health. ▪ **Provision of free services and mobile clinics** – expanded reach of services for people with disabilities and women; covering or eliminating the costs of transport for a second person to accompany women. ▪ **Quality of care guidelines** – clear guidelines to maintain privacy during service delivery. ▪ **Targeted health services** – birth and delivery points established in IDP and refugee camps. ▪ **Supply distribution** – health kits are suitable for all ages and account for women's particular health needs.	▪ **Partnerships** – limited discussion during partner meetings on issues IP face in reaching vulnerable groups; expectation that IP will ensure equitable access across vulnerabilities. ▪ **Cluster coordination and leadership** – limited discussion or focus within the cluster on coverage or service reach according to population vulnerabilities. ▪ **Quality assurance** – limited focus on or creation of beneficiary feedback systems and monitoring on quality of care - impacting reach across vulnerable groups. ▪ **Information gaps** – EWARS/N system does not adequately cover northeast Syria – limiting abilities of the system to detect outbreaks of childhood diseases. ▪ **Resource gaps** – frequent and long contract gaps for IPs – impacting availability of specialized or free-of-charge services for vulnerable groups. ▪ **Supply distribution** – health kits and medicines are not always well targeted or distributed according to need – potentially impacting availability for vulnerable groups utilizing affected facilities.

Stakeholder Group	Efforts towards securing equitable coverage	Challenges towards securing equitable coverage
UN	**Partnerships** – creation of joint operational plan (JOP) within UN inter-agency partnerships (e.g., nutrition, rehabilitation, vaccination); regular meetings to review and report on the JOP. **Cluster coordination and leadership** – information sharing to cover gaps in health services targeted for vulnerable groups.	**Partnerships** – inconsistent use of JOP process and plan in final determination of who does what between UN agencies – potentially creating gaps or duplications in specialized services for vulnerable groups. **Resource gaps** – insufficient funds available for health response in Syria – WHO forced to prioritize assistance according to urgency (e.g., saving a life) over specialized care (e.g., mental health and physical rehabilitation). **Development and use of severity scale prioritization** – severity scale does not adequately mobilize programming or resources for the smaller number of very acute needs of vulnerable populations in less-densely populated locations or areas with overall fewer gaps in healthcare services. **Access into IDP camps** – access and service provision in the IDP camps of northeast Syria is not guaranteed; challenge to consistently reach IDPs in the camps with adequate services and supplies due road closures, withholding of permissions, and security concerns.
Donors	**Partnerships** – reach to vulnerable IDPs (in and out of camps) through selection and contracting of IPs. **Health service mainstreaming** – integration of health services covering sensitive issues (mental health and GBV) into existing and accepted networks of primary health care or referral approaches. **Development and use of severity scale prioritization** – needs-based analysis on how to prioritize funding allocations that accounts for specific population vulnerabilities (in addition to gaps in health services).	**Information gaps** – inconsistent picture of reach across vulnerable groups (including, in particular, northeast Syria) and lack of a demonstrated strategy for targeting services according to the needs of vulnerable groups (vs. according to gaps in health services).

Reflecting on the question of coverage and reach across vulnerable groups, stakeholders consistently noted the absence of any known or clearly evident service gap according to sex or age. There was less knowledge or emphasis in the discussions regarding disability care, beyond mental health work. The overall perspective is that WHO is aware, invested in, and working towards reaching vulnerable people with relevant and accessible services. Examples of promising or appreciated practice in this regard included the mainstreaming approaches to mental health and GBV in a challenging social context for these services, support to IPs and health facilities to provide services free of charge, and support for and use of mobile clinics. Most stakeholders also believed that the transparency and quality of service prioritization in respect to vulnerabilities was improved through the introduction of the severity scale analysis.

Stakeholders highlighted concerns regarding challenges or weaknesses in WHO's ability to ensure that vulnerable groups utilized or accessed available care, prioritization of services across a large population in a context of decreasing funding and securing or communicating information on the rate of service reach or utilization across vulnerable groups. Partners and cluster members noted that there is limited discussion in cluster meetings or in IP implementation meetings with WHO on the obstacles partners face trying to reach vulnerable people.

Stakeholders also raised general issues in service coverage, distinct from the focus on vulnerabilities. The most frequently raised concerns included procurement or supply line bottlenecks (e.g. delays at the border, waiting for approvals), the removal of critical supplies from convoys by authorities (particularly problematic from 2016 through 2018), poorly targeted kit or health supply distribution (e.g. under or over supply of items compared to the needs of individual health facilities), the scale of needs compared to the level of resources available to meet that need, and difficulties in reaching poorer, less educated communities. The short duration of and frequent delays between IP contracts was frequently noted as limiting continuity of care for critical services and important modalities for reaching remote populations or in-camp IDPs (e.g., mobile units, referrals to out-of-camp hospitals).

Systems and procedures for targeting and reaching vulnerable groups. The evaluation looked for evidence of systems, SOPs, guidelines, tools, and other procedures used by the Response for service targeting by vulnerability and ensuring reach by prioritized vulnerable groups. Across interviews with WHO staff, the most cited approaches to targeting services was the needs identification that occurs during the annual HNO and HRP process described under "Relevance" (EQ1) and the severity scale approach used to determine the allocation of resources by sub-district (accounting for population vulnerabilities in those locations).

Once programs are identified and resourced, WHO engages partners in an application process that requires information on intended service reach by gender and age and a review of previous performance on the same metrics if applicable to the partner. Response staff across hubs described using 4W reporting in the Health Cluster to identify critical gaps where WHO may be required to step in as the 'provider of last resort.'[31] Information from HeRAMS and EWARS/N are also frequently applied in targeting services, including those specifically designed for women and children or required by in- and out-of-camp IDPs.

The evaluation, however, found limited evidence of documented or commonly referenced SOPs, guidelines, or tools applied at field-level for targeting or ensuring the accessibility of health services, training, or supply distribution for different vulnerable groups beyond the process described above. Based on the documentation requests and the information received from WHO, key gaps include:

- Response and hub-level targeting strategies applicable within specific program areas that account for utilization and barriers to access according to vulnerabilities.
- Response and/or hub-level SOPs for reviewing partner selection or performance according to targeting and reach of vulnerable populations.
- Response and/or hub-level SOPs in targeting facilities or partners for health trainings and supply delivery according to their reach or utilization by vulnerable populations.
- Partner mapping by area of expertise according to tailored services by sex, age, and disability
- Consistent requirements for IP reporting across response hubs on reach by sex, age, and disability.
- M&E SOPs and protocol for required KPI reporting by vulnerability criteria (including the use of actual figures vs. population estimates).
- Consistent disaggregation of response and hub-level coverage data by vulnerable groups and according to location and program area.
- Consistent disaggregation of response and hub-level coverage data according to severity scale classification.

The lack of evidence on field-level SOPs, guidelines, tools, or analysis tailored for use within distinct programming areas (e.g., training vs. supply distribution vs. mental health or trauma services) that are typically available in a humanitarian operation of prolonged duration indicates a weakened ability to program for and guarantee coverage of services across vulnerable groups.

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[31] GPW13, p.37: "WHO may, exceptionally and for short periods, have to serve as provider of last resort as more robust solutions are established."

Data on service reach by targeted vulnerabilities. As described above, there is no response-level data on programming coverage according to sex, age, or disabilities. Hub-level data on vulnerabilities is not coherently available across services or location. Where found, information occurs in isolated pockets such as donor or grant-specific reporting or within singular data collection exercises such as surveys conducted through TPM contractors on supply distributions. As a result, the evaluation constrained its analysis to implementation rates across severity scale classifications, which are based on vulnerability metrics within a sub-district. This information was only available for WCO Syria in 2019 and 2020[32]. Comparable data on severity scale coverage for cross-border activity in the same years was not shared with the evaluation team and could not be located in documents reflecting WHO's performance metrics.

According to this information, the majority of treatment courses in WCO Syria were provided in areas with a severity scale *less than or equal to three* in 2019 and 2020. While this was a small majority in 2019 (55.5%), it increased in 2020 (67.3%). It is unclear whether other services in WCO Syria were prioritized to areas of greater severity (with preference for treatment courses in more accessible locations, for example) or how the total distribution of WCO Syria's work is allocated according to areas of greater or less severity.

Figure 7: Proportion of treatment courses provided by severity scales classification to three.

The evaluation team noted inconsistencies between WHO's description of its prioritization approach and the data available in its response-level KPI dashboards. According to stakeholders, HRP documents, and WHO Annual Reports, the Organization prioritizes services for severity scale locations *greater than or equal to three*. The inclusion of severity scale level three in the 'less than' coverage metric reduces clarity on the true coverage of WCO Syria's coverage according to need. Without better data disaggregation on service coverage according to severity scale, it is impossible to conclude whether the volume and range of WHO's work is prioritized according to vulnerability as defined in its own systems. This reduces WHO's ability to ensure equitable targeting and coverage of healthcare services.

Geographic coverage and reach across conflict lines
The evaluation explored geographic coverage and reach across conflict lines against three sources of information: (i) significant efforts at or challenges experienced in securing geographic coverage of services according to WHO and external stakeholders in interviews or highlighted in key documents, (ii) reviewing WHO performance data for reach of services across sub-offices, and (iii) reviewing funding allocations across response hub.

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[32] Data extracted from the KPI dashboards of the Response-wide Harmonized Indicator Reporting for years 2019 and 2020. Information was shared by the WCO Syria M&E team.

Significant efforts at or challenges experienced in securing geographic coverage of services. Interviews with stakeholders and internal and external documents highlight a range of efforts and challenges towards securing geographic coverage of services. Themes were consistent across stakeholder groups and types of documents.

Access is the leading issue in terms of geographic coverage, including legal or otherwise authorized permissions to move into or openly operate within a location, security risks and guarantees, and the unimpeded transport of health goods and services across borders and lines of conflict. In the early years of the Response (pre-2016), access concerns were dominated by discussions of whether and how to establish cross-border operations. From 2016 through 2018, the focus expanded to include hard-to-reach and besieged areas, violent attacks on convoys or healthcare facilities, and the routine removal of medicines and medical supplies from authorized convoys. From 2019 to the end of 2020, access concerns increasingly shifted to the challenges of ensuring cross-line service delivery into areas under GoS or Kurdish control. Going forward, stakeholders worry that authorized cross-border access into northwest Syria will be removed entirely by the UN Security Council. If this happens, there is no available cross-line corridor into the area.

The politicized environment in Syria is the second most frequently cited issue in terms of decisions and challenges faced by WHO in prioritizing, funding, and operating across all geographic areas according to need. As described in WHO staff workshops, "*Syria is the most politicized humanitarian context in which WHO operates. Due to its immediacy and life-saving nature, health is often at the leading edge of political efforts to instrumentalize humanitarian aid.*" Despite these constraints, WHO pushed to provide services in all locations of the country without discrimination according to national, ethnic, or political affiliation.

In response to these two related issues, WHO applied several operational strategies. Those noted as most important and successful by stakeholders included: adaptation of the WHO WoS response model to the changing dynamics of the conflict, WHO's decision to work with a range of IPs with different connections to health facilities across conflict lines, developing neutral and evidence-based metrics for identifying needs across geographic locations (including the establishment and use of health information and surveillance systems), establishing independent lines of communication from Amman and EMRO to health actors in geographic regions of Syria that could not be engaged by Damascus, and the development of internally coherent advocacy at local and international levels. Transparency on funding allocations also improved through the introduction of the severity scale index.

Perceptions on the degree to which WHO secured and sustained access into critical locations varied between external and internal stakeholders, as well as between response staff. While acknowledging WHO's clear presence across all geographic regions of Syria, external stakeholders raised questions about WHO's current coverage and level of activity in southern Syria, northeast Syria, and the Turkish-controlled 'Peace Spring' area in northern Syria. In previous years, it was noted that while WHO worked to reach besieged areas, it often failed to secure access for convoys into these locations or stop authorities from removing critical health supplies and medicines (as experienced by all UN agencies at the time). Outside of some success on vaccination, WHO – like other humanitarian agencies - did not enter large areas of northeast Syria until after the shift of territorial control from ISIS to GoS or Kurdish SA authorities.

Gaps in northeast Syria were the most frequently raised issue by external stakeholders, including representatives from the UN, donors, and humanitarian partners or cluster members. From 2016 through the end of 2019, this area was reached through a combination of cross-border access from Erbil, independent communication lines and support from the WoS Health Cluster Coordinator in Amman and the EMRO WHE team, and air lifts or convoys of supplies to and through the WCO Syria sub-office in Qamishli.

In January 2020, the cross-border authorization for access through Erbil was revoked. Later that year, the WoS Health Cluster Coordinator in Amman left their post and it remained vacant until the time of this evaluation (Spring 2021). These changes increased demands on WCO Syria to secure access into the area, while requiring additional engagement from the EMRO office on technical support to the Kurdish SA and the Health Working Group of the NES Forum. Reflecting on 2020, external stakeholders questioned the degree to which WHO reached the area compared to its reported successes. They also raised concerns about the strategy to rely on cross-line delivery of COVID-19 vaccinations in 2021 and the level of investment in a vaccine humanitarian buffer for northeast Syria. Generally, stakeholders noted a lack of clarity, consistent engagement, or information from WHO on the challenges in reaching northeast Syria and support the Response may need from partners in terms of advocacy or messaging to Member States about their commitment to secure cross-line access for UN agencies from Damascus. There was also positive feedback on the expansion of the Qamishli office and increased activity as a result.

Internal descriptions about the extent of WHO's work the Turkish-controlled 'Peace Spring' area, southern Syria, and northeast Syria varied considerably, indicating the Organization needs to more clearly define how its operations in sensitive locations are documented, verified, and shared within the Response and with relevant external partners. It may also indicate different understandings of what is needed from WHO in these locations and the level of urgency required by the Organization to push for increased access or service delivery.

Reach of services by WCO sub-office. As noted under "Effectiveness" (EQ2), coherent data on service distribution across sub-offices and geographic locations was limited to WCO Syria. Based on WHO documents[33] and through discussions with WHO staff, the evaluation team analyzed three leading indicators on the level of service distribution across WCO Syria sub-offices:
- Number of treatment courses provided
- Immunization percentage rate
- Total number of healthcare providers trained

To explore change over time, the evaluation focused analysis on datasets covering at least three or more years of operation. As the Response started publishing harmonized WoS performance data from 2019[34], sub-office level data relating to both WCO Syria and cross-border operations were not available for these indicators. While the analysis in this section only reflects the performance of WCO Syria, it is included to explore coverage during a period of growing operational responsibility for this hub.

Indicator 1: Number of Treatment Courses
In WCO Syria, a total of 22.5 million treatment courses were provided between 2018 and 2020, with a peak of 8.6 million in 2019. The highest number of treatment courses provided were in Central Syria (8.8 million), followed by northeast Syria (7.3 million). Southern Syria had the lowest number of treatment courses provided with 1.08 million courses over three years.

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[33] WHO Annual Reports, donor reports, strategy papers, and HNO and HRP reports.
[34] Based on the data shared from WHO and interviews with WHO staff, the decision to collect harmonized reporting on KPIs was made in 2018 and publication of the data started in 2019. No harmonized data are available prior 2019.
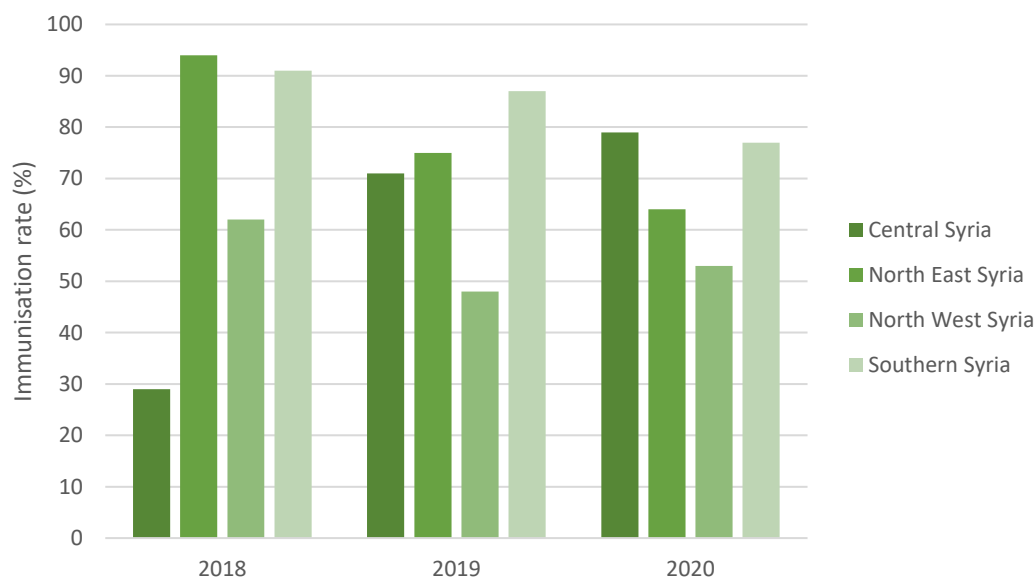
Figure 8: Number of treatment courses provided per year by region.
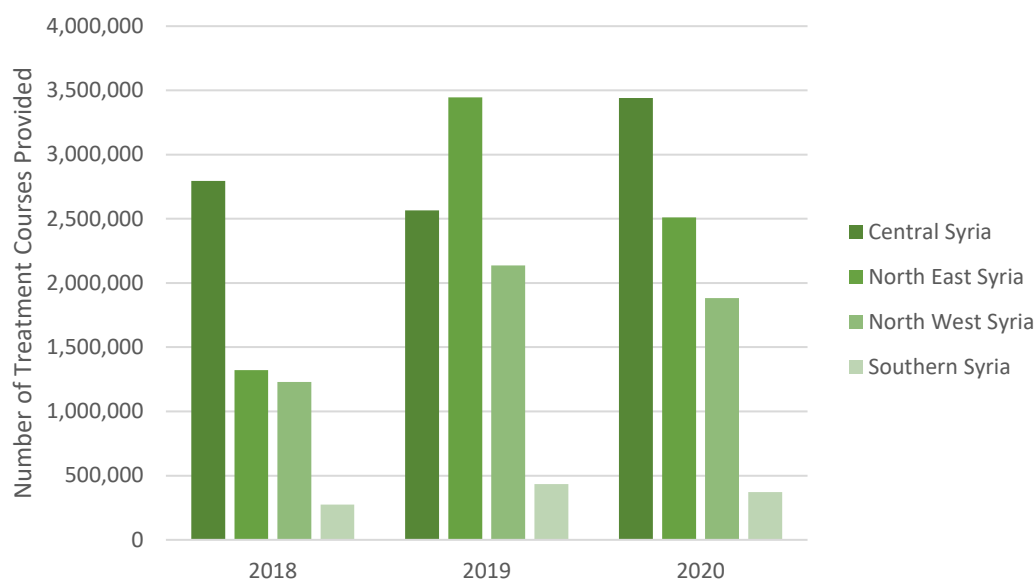
Indicator 2: Immunization Percentage Rate

This indicator covers the average immunization percentage rate, with aggregate results for DPT3 (under 1 year), Measles 2 (1-2 years), and Polio 3 (Under 1 year).

**Figure 9**: Immunization rate (%) per year by WCO Syria covered region.

Immunization rates varied over the three years with steady decreases in southern Syria and northeast Syria. Results for central Syria increased by 172%. The evaluation team was not able to identify a clear explanation for reduced activity. Possible reasons include: shift in prioritization of regions due to changing population needs and supply chain challenges. The drop in immunization for southern Syria directly corresponds with the closure of the Amman hub and WCO Syria's increased responsibility in this region after the Government of Syria regained control over the area.

It indicates expanded demands on the response office from 2019 for this location alongside continued access constraints, assuming the numbers for each year only reflect WCO Syria activity. A similar trend may explain rates in northeast Syria from 2019 to 2020 but does not account for the decline from 2018 to 2019.

Indicator 3: Trained healthcare providers

From 2018-2020, WCO Syria supported the training of 48,744 healthcare providers in Syria. The numbers of healthcare workers trained significantly varied by region. Central Syria accounted for the highest total number of healthcare providers trained (n=32,019), while southern Syria accounts for the lowest number of healthcare providers trained (n=3857).

**Figure 10:** Number of healthcare providers trained per year by region.
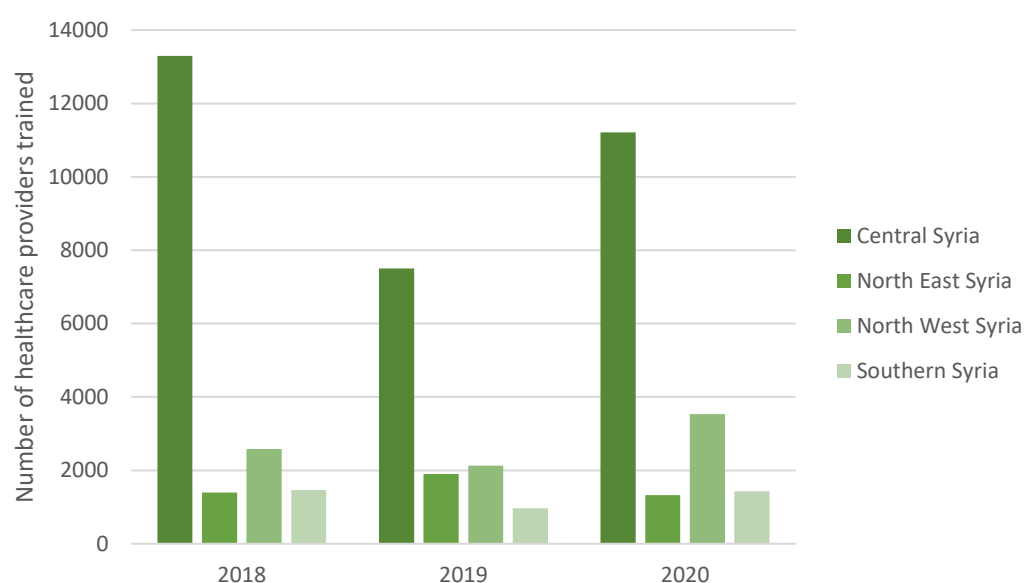
Without better data on the range of WHO services provided over time, including longer trend analysis at the WoS level and the estimated level of need in the population for each service by sub-office, the evaluation cannot provide a full account for the variable level of service distribution over time or by sub-office. As a trend, however, the data suggest increasing achievement in central Syria in a situation of an overall decline or stasis in the level of service delivery for other regions under WCO Syria responsibility from 2018 to 2020. As an exception, training numbers for healthcare providers are relatively steady, with slight decreases in central Syria offset by a slight increase in northwest Syria.

Funding allocation by response hub. Donor contributions[35] against needs varied significantly in the early years of the response, reaching stability in 2017. From 2017 to 2019, donors contributed around 6.30 USD annually per person in need of health assistance. This amount increased to 7.30 USD in 2020 due to additional funds for the COVID-19 pandemic response.

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[35] Data sources include the "WoS Funding Status 2020-12122020" Excel file shared by EMRO and HNO figures on the number of people in need per year. Funding from WHO's Contingency Fund for Emergencies (CFE) function was not included in the data sources provided by WHO and, therefore, not reflected in this analysis. Donor contributions in 2020 do not include pledges. Donor contributions in 2020 include both HRP and COVID-19 funding.

Figure 11. Evolution of funds contributed per person in need of health assistance.
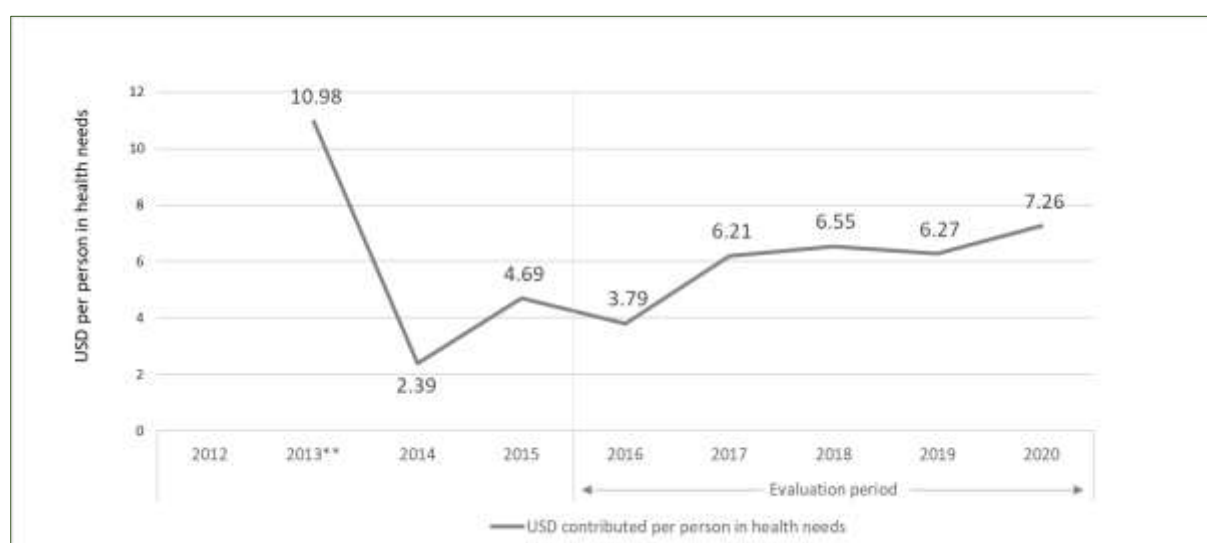
Looking at financial records between 2018 and 2020[36], the required funding according to needs[37] is steadily distributed between Damascus and Gaziantep, with 65-70% of requested contributions allocated to Damascus and 25-35% of requested contributions allocated to Gaziantep. However, the distribution of funding actually contributed by donors is variable, with Damascus receiving from 53 to 75% and Gaziantep receiving from 19 to 46% of total annual contributions from 2018-2020.

Figure 12. Distribution of funding requirements and actual contributions.
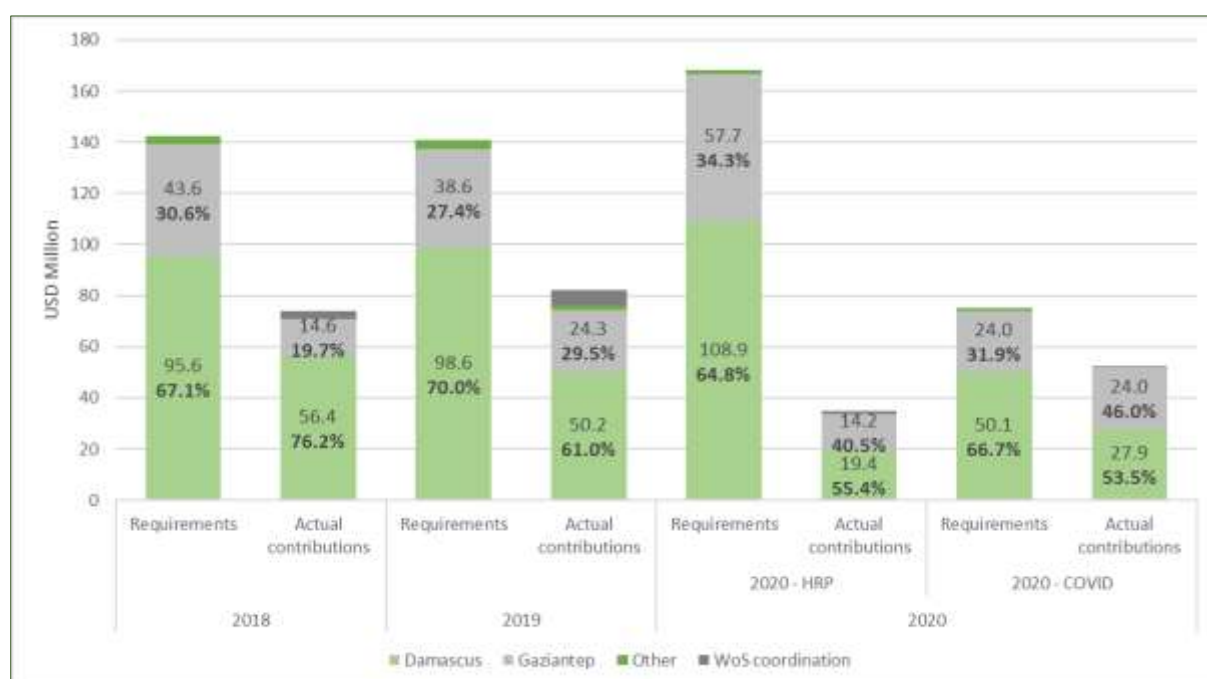
In 2019 and 2020 the funding requirements for WCO Syria as presented in WHO's Annual Reports were less covered by donor contributions than the Gaziantep hub. The funding gap for WCO Syria in 2019 was 48% compared to 14% in Gaziantep.

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[36] Data extracted from HRP appeal documents and the "WoS Funding Status 2020 – 15122020" Excel file shared by EMRO. Funding requirements extracted from Annual Reports. Donor contributions in 2020 include pledges.

[37] This refers to the level of funding WHO requested in donor contributions to meet the population health needs under its responsibility.

In 2020, WHO launched an additional appeal to respond to COVID-19. 100% of the Gaziantep appeal was met compared to 56% of the Damascus portion. Gaziantep requirements were also better covered in the 2020 HRP appeal, although not as significantly. For this allocation, 29% of Gaziantep's required funding was covered compared to 23% in Damascus. In 2018, however, the situation was reversed, with Gaziantep receiving a considerably lower amount of funding against requirements compared to Damascus.

The evaluation team was not able to locate or secure the overall actual budgets for WCO Syria and cross-border hubs for every year under review. Funding data disaggregated by response hub was not provided prior to 2018. The information that was shared excluded allocations for the Amman hub in 2018 and the Erbil hub in 2018-2019. Without better data on funding allocations according to severity scale classifications, the evaluation cannot definitively conclude whether the final distribution of funds aligned with Organizational priorities. However, assuming the funding requirements listed for each response hub in the Annual Reports for 2018 through 2020 are a reflection of the severity scale prioritization, the data suggest an overall decreasing level of actual, required funding for WCO Syria in a context of expanding geographic responsibilities. This corresponds with the decreasing levels of service provision in WCO Syria sub-offices from 2018 through 2020. It does not, however, account for the expanded activity in central Syria compared to other regions. That likely reflects additional access or political constraints in addition to the resource limitations.

5.4 EQ4: Efficiency

How efficiently has WHO used the resources at its disposal to achieve maximum results in the Syria crisis in the timeliest and most efficient manner possible during the years under review?

Key Findings:

- *Finding 1:* The degree to which WHO efficiently used its resources to reach its objectives varies by program design, partnerships, human resourcing, financial resourcing, and response model dynamics.

- *Finding 2:* There are many examples of efficient program designs and modalities used across the Response, with particular emphasis on health services. Performance is mixed on its supply chain and logistics function.

- *Finding 3:* While working with IPs and strong partner networks enabled more efficient program designs and modalities, short IP contracts and gaps between contract renewals contributed to unnecessary delays in service delivery and reduced sustainability in investments like IP staff training and capacity building.

- *Finding 4:* Frequent and prolonged staff vacancies, contract gaps, and short staff contracts affected response efficiency and contributed to delays in service delivery.

- *Finding 5:* Financial analysis reveals a trend of decreasing flexible funds. There are also indications of increasing costs-per-treatment and higher operating costs in the Gaziantep Field Office compared to the Damascus hub. Data available to the evaluation team do not allow for a meaningful assessment on trends for cost-per-treatment / service costs and variable operating costs between response offices.

- *Finding 6:* The structure for and level of internal coordination in response operations evolved during the years under review. Reforms and progress made from the end of 2017 improved response efficiency, while aspects of response governance and accountability lines remain under-defined.

- *Finding 7:* WHO's initial VfM analysis of response operations revealed that 75% of assessed activities provided high impact at a low level of investment. Additional VfM analysis is needed to assess trends over time. There is limited evidence that VfM monitoring is integrated into WHO operations.

Findings for this section are presented according to the significant themes and trends identified across data sources on the subject of efficiency in WHO's WoS Response: program design, partnerships, human resources and contracting, funding modalities and cost-efficiency, the WoS response model, and WHO's approach to and use of VfM analysis. The evaluation sub-questions are integrated within each theme, including the topics of timeliness, areas of higher or lower efficiency, and the challenges of cross-border and cross-line operations.

Program design
Efficiency in WHO's program design was explored according to the perceptions and examples provided by response stakeholders, triangulated with information found in key documents. WHO does not currently have sufficient programming data to determine timeliness through performance metrics, including the systematic tracking of progress against agreed milestones or benchmarks.

Reflecting on the question of efficiency in program design, WHO workshop participants and interviewed stakeholders emphasized several important health responses and program expansions that were built through existing networks. Examples of this include utilizing networks established for polio vaccination campaigns to re-build and scale the delivery of primary care services in northeast and northwest Syria in 2017 and 2018, as well as using the network of primary care services to introduce and integrate mental health capacity into initial points of patient care. Referral pathways connecting in-camp populations with out-of-camp secondary health care providers developed from the Raqqa response were also highlighted as an illustration of this strategy.

The approach reduced duplication, increased the speed at which patients could receive care by improving facilities that are known by the community and eliminating the need for multiple trips to different care providers, and enabled a faster scale up of services to address growing needs or respond to expanded access (e.g., as experienced in northeast Syria, following the anti-ISIL campaigns). The development of the Essential Health Services Package and regional referral networks in northwest Syria also represent a unique operational adaptation of WHO to the Syrian context, where the cross-border health cluster had to function like a de facto health authority due to the scarcity of functioning facilities and active healthcare workers in the region. WHO staff also remarked that the shift to online training in 2020 due to COVID-19 provided opportunities to expand participation with reduced costs to the Organization and participants.

Stakeholders had mixed perspectives on inefficiencies within WHO's program design or modalities. It was repeatedly noted across interviews that air shipments in northeast Syria were particularly expensive. The cost, however, was countered by the life-saving urgency of the supply provision and the fact that no other option was available for delivery after authorization for cross-line road access to Qamishli from Damascus was repeatedly denied by the Government. Donors remarked that this eventually ended after concerted advocacy on the part of the WCO Syria Representative.

WHO's role in securing the supply line of critical medicines and medical equipment with economies of scale was consistently viewed as a way in which the Organization supports the cost-efficiency of the wider humanitarian response, as well as its own operations. Interviews with humanitarian agencies in northeast Syria especially emphasized the impact of losing the UN's cross-border authorization in Erbil on the cost and delays of moving supplies into the region through comparatively smaller, less efficiently positioned INGOs. WHO staff noted the importance of using pre-packaged kits (vs. supply lists) and pre-positioned buffer stock to increase the readiness of the supply line and the timeliness of delivery. However, issues of medicine availability and delays in procurement were identified by a range of external stakeholders, who observed situations where medicine did not arrive until after the time in which it was needed. This is reflected in the patient satisfaction surveys for northwest Syria presented under "Effectiveness" (EQ2), in which nearly half (47%) of the respondents reported that the drugs prescribed to them during that visit were not available. Stakeholders also indicated concerns about the timeliness of COVID-19 vaccine distribution in the months ahead.

While acknowledging the considerable challenges faced by WHO in leading the medical equipment and medicines supply line for the humanitarian response in Syria, there was a sense from external and internal stakeholders that a *"more creative approach"* is required in the Organization to solve the delays in procurement and distribution. Interviews suggest that while pre-packaged kits improved the speed of distributing medical supplies, their contents are not consistently targeted at the field level for maximum usefulness (e.g., primary care facilities receiving medicine for complex cancer treatment, while tertiary hospitals are under-supplied on these items). This signals a potentially larger weakness in how supplies are targeted, versus an efficiency gap in their procurement.

Looking at the full trajectory of the Response across the 2016-2020 timeframe, it is clear from interviews and program documentation that the Operations Support and Logistics function of the Organization has steadily improved over time. At present, WHO provides up to 40% of the humanitarian medical supply needs in Syria with minimal resources and in a context with considerable logistics challenges. It is also clear from the Organization's funding data and HRP commitments, that the Response is not capacitated to fully cover the remaining and significant gaps in health supplies across the country. This includes limited available funding for logistics positions, which are essential to WHO's work in operations support and supply chain management.

Partnerships

Efficiency in WHO's partnerships was explored according to the perceptions and examples provided by response stakeholders during interviews and staff workshops, triangulated for consistency across stakeholder groups and as reflected in WHO's internal planning documents.

Under the question of efficiency, the primary reflection for partnership centered on the contracting arrangements with IPs, which often consist of short (1-3 months or 4-6 months) project agreements that are often renewed over the years with considerable gaps between new contracts. According to the provided examples, this led to situations where partners had to suspend critical services or led to outdated needs assessments. It was felt that the cause of delays between contracts was predictable and, therefore, should have been addressed in WHO's planning and contracting procedures.

> *"The process of contract renewal took so much time that often the contracts would come to an end and there would be a 2 or sometimes 3 months gap until the new contract is signed. During those times, we would still be receiving cases with emergency needs who needed support and there would be no partner NGO or anyone else lined up to help. This might have to do with bureaucracy from the Government's side – for example delays on their approvals - but WHO already knew these delays would happen. They should have started to work on the renewal process months before, considering that delays were inevitable."* – Implementing Partner

Short contracts and contract delays reportedly drove staff turnover in IP organizations, compromising the sustainability of capacity building efforts and undermining service quality. As partners explained:

- *"We start losing staff on the ground because of the long interruption between projects. If it takes two months to renew a contract, staff have to choose between finding a new job or working voluntarily."*
- *"We trained staff for a long time – financial resources were spent for them to become qualified. With gaps between contracts, people leave for other organizations."*
- *"Organizations with longer projects attract our staff – the staff we invested in through training. Only 20 to 30% of our trained staff stay with us and the rest find other jobs. Then, we have to train again."*

Within WHO, the issue of short contracts was often associated during interviews with the Gaziantep Field Office and the inability to guarantee longer contracts under the ongoing potential of losing cross-border authorization. The issues noted above, however, were common across IPs interviewed for Damascus and Gaziantep.

While WHO response staff interviewed during the evaluation frequently cited the GPW13 description of WHO as the 'provider of last resort'[38] as an explanation for its practice of issuing short contracts with IPs, many IPs worked with WHO during the whole evaluation period with gaps between projects. In several instances, partners expressed an implicit expectation from WHO that they would continue operating during the breaks with the understanding – but no guarantee – of contract renewal. This indicates a misalignment between the short-term perspective of the Organization's self-description as the 'provider of last resort' in an emergency compared to a protracted crisis where the population remains heavily dependent on sustained WHO services and funding over a number of years. A range of response documents[39] highlight the need for longer-term programming and longer contract periods for implementing partners where WHO acts as either the direct service provider or the critical source of funding and resources for partners. This signals a strategic need in the Organization to assess its 'last resort' role and the adequacy of its IP contracting structures in protracted crises.

The length of IP contracts was also associated with short-term donor funding and the limitations of the funding instruments available in humanitarian settings. Reviewing the donor agreements, however, it appears that the majority of WHO's funding in Syria was allocated in year-long grants or, in the case of FCDO, multi-year grants that required review and renewal on an annual basis. This likely contributed to shorter horizons within program design and implementation periods but cannot account for IP contracts established in one- to six-month timeframes. Delays caused by counter-terrorism screening and other requirements in the partner approval process with donors more likely explain the length and frequency of IP contract gaps, contributing to shorter final contracts when spending is fixed within one-year increments. WHO staff also highlighted the role of administrative delays as a driver of prolonged contract gaps, noting that the process for establishing partner contracts is unnecessarily lengthy, inefficient, and requires a significant level of follow up from staff.

Human resources and staffing in WHO
Efficiency in WHO's partnerships was explored according to the perceptions and examples provided by response stakeholders during interviews and staff workshops, triangulated for consistency across stakeholder groups and as reflected in WHO's internal planning documents.

The persistence of WHO's highly dedicated staff "in spite of challenging internal systems" was a recurrent theme across interviews under the question of efficiency. The "challenging systems" involved issues in recruitment and contracting, including frequent and prolonged vacancies, contract gaps, or short contracts, that led to the "double or triple hatting" of responsibilities on existing staff. This contributed to unnecessary delays in service delivery, as well as a level of exhaustion and stress that some internal stakeholders said contributed to mental health concerns. Vacancies and short contracts undermined longer-term programming goals and required a continuous effort on administrative activities to address.

While these challenges were identified across a range of response positions, they are especially pronounced in WHO's role in the Health Cluster. For example, the Health Information Management Unit in Damascus is currently serving the Damascus health cluster, while also managing the harmonized reporting system for response-specific programming and providing the M&E capacity for WCO Syria. Similarly, the Amman hub Health Cluster had to "borrow" a percentage of time from the information management officer assigned to the WoS Health Cluster during its operation, with consequent impact on the cluster performance rating in the Jordan Cluster Coordination Performance Monitoring survey published in 2018. The WoS Cluster Coordinator post for Amman and the WHO Cluster Coordinator position for Gaziantep are currently vacant, with the WoS position vacant for six months at the time of this report (Spring 2021).

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[38] Ibid, p.37: "WHO may, exceptionally and for short periods, have to serve as provider of last resort as more robust solutions are established."

[39] In particular, see: WoS Vision and Approach, 2020; WoS Futures, 2019; Longer term options + New Directions for 2019 (PPT); and the WHO SAR Humanitarian Response Plan 2018. According to members of the ERG, the Country Functional Review also recommends longer term contracts for protracted crisis settings.

While helpful, the role provided by the NGO cluster co-coordinators is not sufficient to address gaps caused by WHO vacancies nor is it their mandated responsibility to hold that position for an extended period. At points, these issues reduced the Response's overall coordination capacity, effectiveness, and coverage. While the GPW13 states the Organization's commitment to building its cluster coordination capacity in emergencies[40], the challenges faced in the Response with recruitment and retention of highly capacitated cluster coordinators suggests larger questions on the level of WHO's institutional investment in this function.

As mentioned under "Relevance" (EQ1), the ERF provides for surge deployments under the 'no regrets policy.' While the evaluation was not able to conclude on the number of requests for surge support submitted by the Response and the speed of their fulfillment, it is evident the Response benefited from this deployment capacity based on the number of references to surge support made during interviews. This capacity, however, did not entirely prevent important contract gaps or the consequences of extended vacancies.

The evaluation was not able to identify a consistent reason for the short-term contracting modality in staffing, including why or when it is selected. At times, short-term contracts were attributed to the length of donor funding for a particular project. Other stakeholders attributed them to uncertainties of how long response hubs would be in operation. For example, once the Amman hub secured funding for a dedicated information management officer, it anticipated the hub would close following the expected government offensive that would transition the area back to GoS control. As a result, the office could only offer a six-month contract for the post, which led to recruitment challenges. Ultimately the hub closed without filling the position. The Gaziantep Field Office also notably struggled with short staff contracts, leading to slower recruitments, high levels of staff turn-over, and challenges in recruiting sufficiently senior level individuals to critical positions. This is largely seen by staff as a result of the hub's operating environment and the uncertainty of losing cross-border authorization during the annual reviews of previous UNSC resolutions. For positions that become vacant or are offered to candidates within a six-month window of the UNSC review, there is a reluctance to create longer contracts without knowing if the hub will continue operating.

Funding modalities and cost-efficiency
Cost-efficiency was explored analyzing WHO funding and budget utilization data, including (i) an overview on the level of flexible funding available to the Response, (ii) the proportionality of donor contributions to delivered treatment courses, and (iii) budget utilization across the Damascus and Gaziantep response hubs.

Availability of flexible funding. Response donors during the 2016-2020[41] timeframe largely consisted of USAID/OFDA, FDCO, Japan, Norway, ECHO, UNOCHA, Kuwait, and Sweden. While most donors earmarked funding, contributions by Norway, Kuwait, and Sweden were flexible allocations. This translated into variable levels of proportionate flexible funding from 2016-2020, ranging from 8 to 24% of total contributions. In 2020, flexible funding was especially scarce, accounting for only 8% of contributed funds.

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[40] GPW13, p. 37, see the "Service delivery coordinator" section under the "Strategic Shifts" chapter of the strategy.
[41] Calculations include donor contributions in 2020 for both the HRP and COVID-19 appeals. They do not include pledges in 2020. Funding from WHO's Contingency Fund for Emergencies (CFE) is excluded from the analysis. This can lead to inconsistencies with other data sources on response funding levels that do include CFE contributions, either totally or in part. Data used for this analysis is sourced from the "WoS Funding Status 2020 – 15122020" Excel file shared by EMRO.

**Figure 13.** Flexibility of donor contributions.
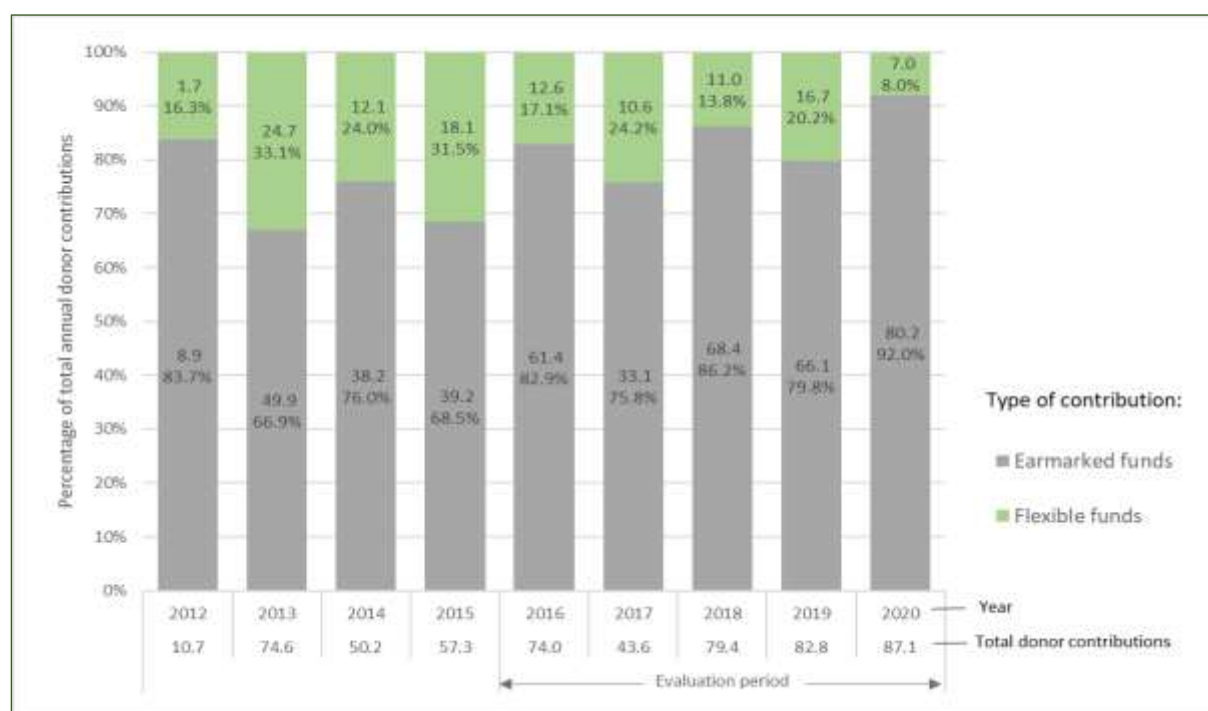
A driving assumption underlying the success of the Response in strategy document and donor proposals was "sufficient flexible financial resources." The significant levels of earmarked funding also represented a culture change in the Organization, which historically relied primarily on Member State contributions that allowed for a wider degree of flexibility, while not sufficiently covering the needs of a large scale, operational humanitarian response. Stakeholder interviews indicate that this funding environment primarily affected WHO's ability to direct funds according to the required contributions for each response hub. In many cases, earmarked contributions were tied to cross-border operations or specific geographic locations in Syria, rather than programmatic areas or according to WHO's critical functions. In terms of emergency response capacity, the majority of interviewed stakeholders confirmed that donors allowed re-programming and a level of flexibility to address emergency needs.

Donor contribution per delivered treatment courses.[42] While the amount of funds contributed per person in need remained stable through the evaluation timeframe (see EQ3, "Coverage") at around 6.30 USD per person from 2017 through 2020, analysis of available data reveals an increasing trend in the contribution cost per treatment, from 3.97 USD in 2016 to 6.19 USD in 2019 and 11.53 USD in 2020.

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[42] Analysis based on data from the "WoS Funding Status 2020 – 15122020" Excel file shared by EMRO and WHO Annual Reports for the numbers of delivered treatments per year.

Figure 14. Funds contributed per delivered treatment.
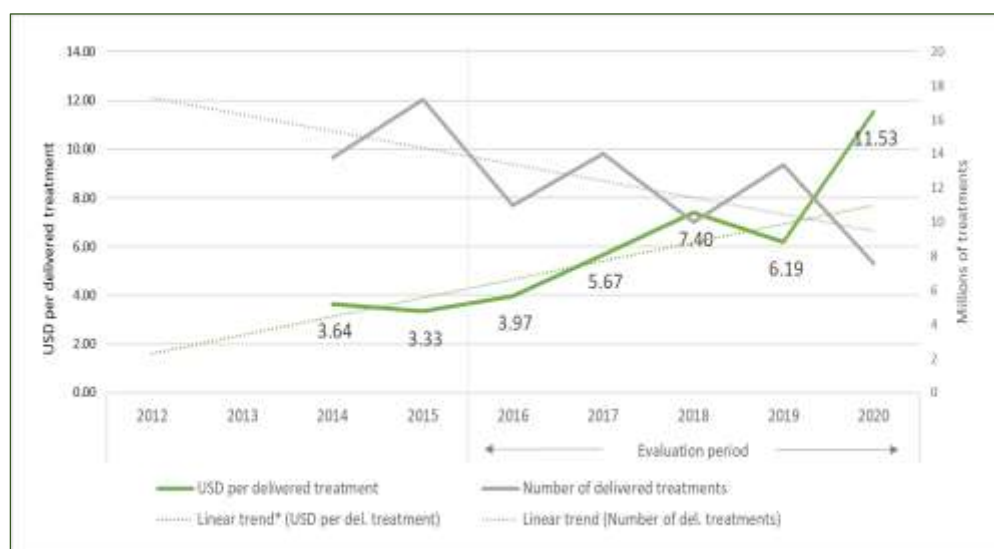

* Linear trend line for USD per treatment does not include 2020 – funding levels for COVID-19 response make it an outlier.

While it is unclear from available information what is driving this upward trend, it correlates with a reduction in the total number of delivered treatments even while funding increased. The increased cost per treatment may reflect a shift towards delivering more expensive treatments (e.g., expanding capacity for addressing non-communicable diseases compared to cheaper interventions), a shift towards other areas of programming not captured in this indicator, or the rising costs associated with cross-border or cross-line delivery modalities. There may also be a COVID-19 related driver to the increase in 2020. Available data did not allow for a disaggregation of trends by target group, response hub, sub-office, or severity scale classifications.

Budget utilization. The evaluation team struggled to find financial data on budget utilization across response hubs for the years under review. It did eventually secure separate financial documents from each hub that were sufficiently comprehensive for an analysis of the 2018-2019 biennium for the Damascus and Gaziantep offices. There was not, however, adequate information to run the same analysis for the preceding years or in 2020. Information was missing for the Amman and Erbil hubs.

Figure 15 displays utilized budgets as a percentage of contributed donor funds for the 2018-2019 biennium. During this period, Gaziantep utilized more funds than it received (104% if utilized funds is expressed as a percentage of received donor contributions), while Damascus utilized less (79%).

Figure 15. Budget utilization against donor contributions by hub (Biennium 2018-19).
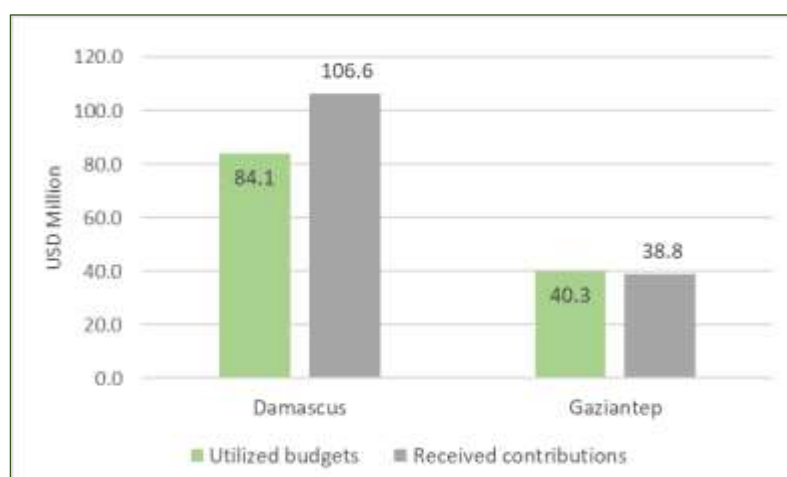
The lower rate of budget utilization in WCO Syria could indicate challenges with absorption capacity or other difficulties in spending funds due to the changing population needs or access constraints experienced during this period. Data were insufficient to conclude whether this was a unique situation to the 2018-2019 biennium or an indicator of a more stable trend from 2016 through 2020.

In terms of budget utilization per person "in need"[43], the Gaziantep Field Office spent nearly twice as much per person "in need" compared to WCO Syria during the 2018-2019 biennium. This is shown below, in Figure 16.

Figure 16. USD utilized per person "in need" by hub (Biennium 2018-19).
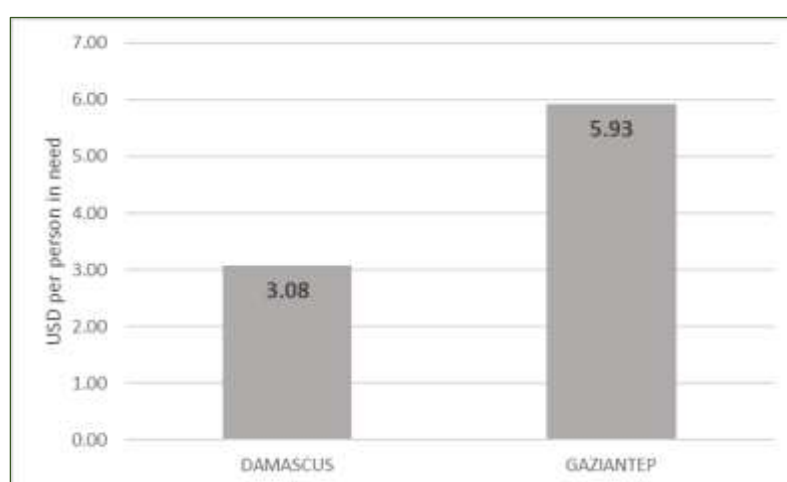
Available data were insufficient to determine whether this was a unique situation to the 2018-2019 biennium or an indicator of a stable trend from 2016-2020. Based on interviews, the higher level of spending per person in Gaziantep reflects costs associated with the partnership modalities used in northwest Syria compared to other parts of the country. In particular, while Damascus largely supports health facilities funded by the government, WHO's cross-border partners fully cover the cost of every aspect of health delivery and require a higher level of financial support. Cross-border operations may also face additional security and transport costs.

WoS Response Model
Efficiency in the WoS response model was explored according to the perceptions and examples provided by response stakeholders during interviews and staff workshops, triangulated for consistency across stakeholder groups and as reflected in WHO's internal planning documents.

The structure of WoS response operations evolved during the years under review. In 2016, it was mostly characterized by disparate hubs focused on their geographic areas of responsibility. There was little effort at harmonization between offices. In 2017, this shifted, and response hubs increasingly worked towards improved dialogue. Operationally, however, roles and responsibilities between hubs and regions remained difficult for staff to navigate. The overall efficiency of the Response improved following the WoS 're-boot' meeting at the end of 2017 and the institutionalization of systematic operational review meetings. This increased internal coordination, resource planning, and the speed of decision making.

The benefits of this approach on operational efficiency included coherent approaches to needs analysis and program prioritization, streamlined communications with donors and external stakeholders, and linked up contingency planning during the years of rapidly moving lines of control.

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[43] "People in need" were calculated using figures presented in the WHO Annual Reports, considering the percent of the population falling under each hub's geographic area as the "people in need" in that location. This is justified based on the decision of the Response to largely determine allocations between hubs based on the population size of each hubs' geographic area during this time period.

In one frequently cited example, coordination within the Response enabled a more agile re-distribution of the Amman hub's medical stock to the Erbil and Gaziantep hubs when the office closed in late 2018. After an initial attempt to locate a centralized WoS "command and control" function for the Response in Amman, the model settled into a decentralized "coordination" approach that largely positioned operational decision-making within the response-areas of each hub. This strengthened relationship building and advocacy with relevant authorities, as well as located decision-making power in closer proximity to affected populations – an objective of the GPW13.[44]

While stakeholders confirmed the appropriateness of the decentralized "coordination" approach used in the Response, WHO faced and continues to grapple with accountability structures within the model. As described, roles and responsibilities lacked clarity in 2016 and 2017, especially regarding regional level authority on response-wide issues (e.g., EMRO vs. EURO), inter-hub responsibilities (e.g., decisions between the Damascus, Amman, and Gaziantep offices on funding allocations), and response-level accountabilities (e.g., reporting line differences between the hubs). Following the re-boot meeting in 2017, the situation improved through a more formalized approach to decision making, as well as further defining the response governance structure. Still, stakeholders noted issues from 2018 through 2020 on the imbalance in the reporting lines reflected in each hub. For example, WCO Syria is led by a Representative with a reporting line to the Regional Director, while the Gaziantep office is led by a Head of Office with a reporting line to the WCO Turkey Representative who reports to a different Regional Director. The Amman and Erbil hubs had fluctuating reporting lines, with offices eventually coming under the respective WCO Representatives in Jordan and Iraq.

In the absence of a singular, centralized focal point for response leadership, WHO and external stakeholders noted consequent challenges for and limitations on the depth and consistency of support, direction, and representation available for the Response. The shifting lines of responsibility between hubs additionally created situations for external stakeholders where messaging and communication from the Response was inconsistent, amplified by the absence of a singular Response leader. The realities of organizational culture created leadership imbalances across different position-level and reporting-line hierarchies, which WHO staff noted made it difficult for smaller hubs to secure representation in higher-level discussions or equivalent consideration during internal meetings on challenging topics like resource requirements or the urgency to speak publicly on politically sensitive matters (e.g., attacks on health care). These imbalances were observed by external stakeholders who engaged with the Response at different points from 2016 through 2020.

While Response reporting lines settled into an agreed structure with consequent accountabilities, the governance structure was never formalized in a guiding SOP document, organigram, or other articulated and approved set of procedures, creating room for misunderstandings. Workshop participants highlighted the challenge of relying on the institutional memory of key response staff and "good will" during significant changes in critical roles (such as leadership positions or cluster coordination posts) to ensure the values transfer for new team members, particularly in regard to the history and reasoning of the WoS approach. The guidance for accountabilities and reporting lines provided in the ERF apply to emergencies that are more neatly contained within WHO's typical country organigram than is implemented in Syria. In the Syrian context, response leaders at all levels of the Organization had to adapt WHO's standard management structure without clear organizational parameters or previous institutional experience. As described in a workshop, this had the effect of "building the Response while implementing it." It required significant investment in developing a shared vision and acceptance of the structure between response leaders at regional, country, and hub levels, as well as across two different response regions (EMRO and EURO). While largely successful in this regard, a number of stakeholders highlighted delays this caused in terms of sustained momentum and noted the level of time and energy expended by staff on managing internal expectations and relationships.
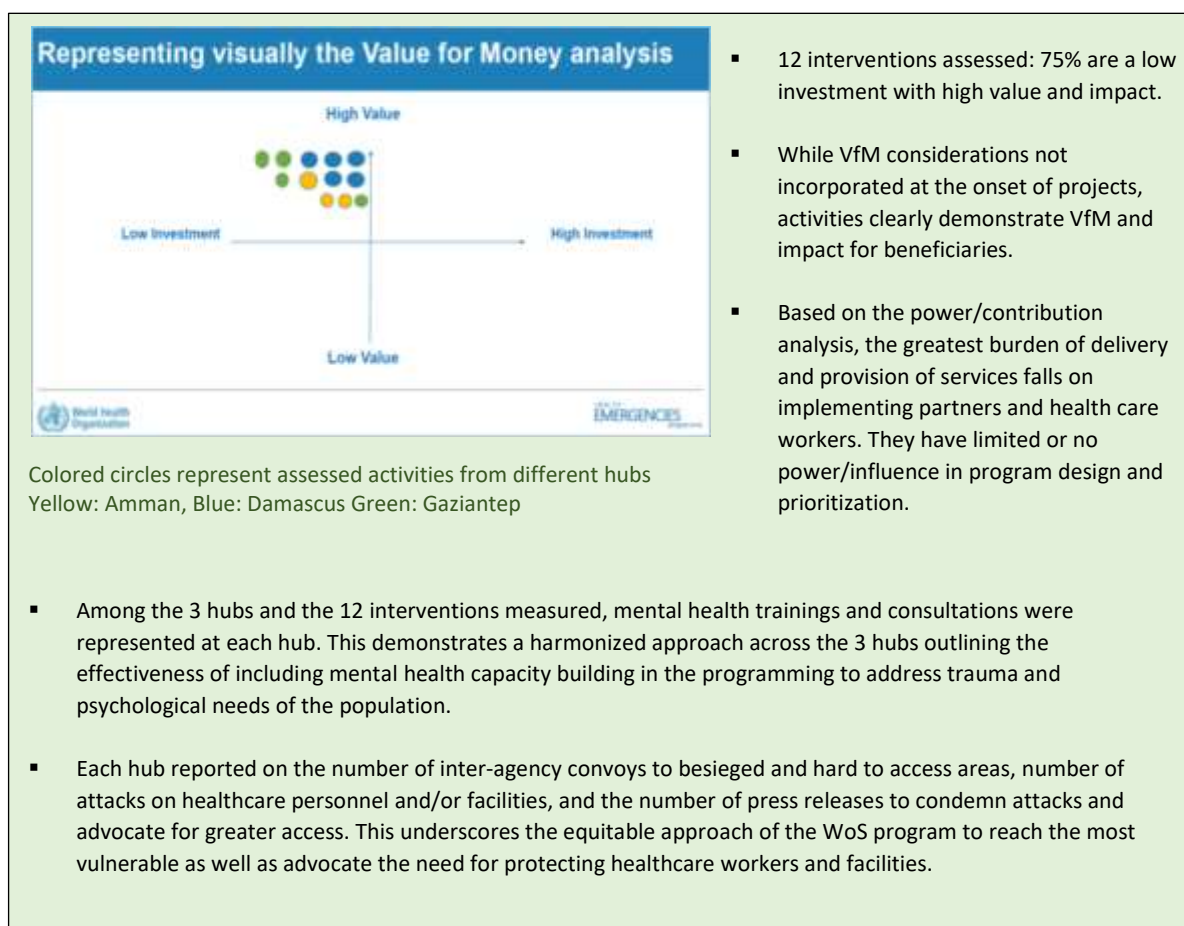
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[44] See GPW13, p.45, section "Reshape the operating model to drive country, regional, and global impact", in particular the last line on key priorities: *"redistributing resources – particularly technical expertise – geographically close to where impact matters."*

Value for Money

The evaluation included a light review of WHO's performance against FCDO expectations for VfM monitoring and reporting. Due to the limited time and resources available for data gathering and analysis, it was not possible to conclusively assess whether WHO did, in fact, provide value for money.

As part of WHO's partner agreement with FCDO, a VfM strategy was created in 2018 and tested in 2019, retroactively collecting baseline data for 2018. The findings from the analysis are presented in Box 1.

Box 1. Findings from WHO's VfM baseline analysis (March 2019).

Colored circles represent assessed activities from different hubs
Yellow: Amman, Blue: Damascus Green: Gaziantep

- 12 interventions assessed: 75% are a low investment with high value and impact.

- While VfM considerations not incorporated at the onset of projects, activities clearly demonstrate VfM and impact for beneficiaries.

- Based on the power/contribution analysis, the greatest burden of delivery and provision of services falls on implementing partners and health care workers. They have limited or no power/influence in program design and prioritization.

- Among the 3 hubs and the 12 interventions measured, mental health trainings and consultations were represented at each hub. This demonstrates a harmonized approach across the 3 hubs outlining the effectiveness of including mental health capacity building in the programming to address trauma and psychological needs of the population.

- Each hub reported on the number of inter-agency convoys to besieged and hard to access areas, number of attacks on healthcare personnel and/or facilities, and the number of press releases to condemn attacks and advocate for greater access. This underscores the equitable approach of the WoS program to reach the most vulnerable as well as advocate the need for protecting healthcare workers and facilities.

The VfM strategy consisted of training and data collection activities over a 12 month-period, to strengthen the analytical capacity of teams on evidence-based impact assessment and to support program managers on maximizing impact. All response hubs were engaged in this process and provided feedback on relevant indicators to use for the analysis. A focal point was appointed to help articulate program costs and results.

In March 2019, after 12 months of VfM strategy implementation and VfM data consolidation, a baseline analysis was performed at a regional level with participatory feedback by all hubs. The baseline was established against the 4E's: Economy, "Getting the right price"; Efficiency, "Doing things in the right way"; Effectiveness, "Doing the right things"; and Equity, "Not leaving anybody behind". A VfM implementation update was produced as part of the WHO-FCDO Whole of Syria Annual Review Meeting in June 2019[45]. Since this exercise, the topic of VfM was raised again in the WHO-FCDO Annual Review Meeting in 2020, confirming WHO's commitment to integrate the VfM approach in its TPM activities, develop metrics for identifying cost savings in procurement, assess opportunities to improve efficiency through enhanced coordination with other agencies, and to develop indicators to measure the effectiveness and added value of WHO interventions.

Despite the initial enthusiasm and significant effort put into the VfM baseline analysis, WHO has not repeated the exercise as required to assess progress over time or ensure the utilization of VfM approaches in response management. Due to high rates of staff turn-over and "organizational mobility" (as described by WHO), however, the majority of the response staff trained in 2018 had either left the Organization or been re-assigned elsewhere. This undermined the continuity of VfM knowledge and investments towards staff capacity and ownership on the VfM approach adopted by the Response.

Reviewing available documents, VfM does not appear mainstreamed into response operations in a systematic manner. In particular:

- **Training needs remain unaddressed**. The turnover affecting the sustainability of the initial training was identified as a challenge in the 2019 Annual Review. This was reportedly going to be addressed through further trainings. However further trainings are not confirmed or verified in subsequent donor updates.

- **VfM progress tracking is missing from key donor updates**. 2020 updates[46] omit data collection activities and VfM assessments. They highlight the adoption of VfM in TPM visits as a "result", but they do not show any progress tracking against VfM indicators or metrics. During interviews with TPM contractors and reviewing their data, the evaluation team could not identify any clearly marked approach to VfM data collection.

The GPW13 describes VfM assessment as part of the way WHO will "succeed in driving a measurable improvement in the health of people at the country level."[47] In Syria, the VfM strategy received significant attention from 2018, in keeping with this commitment. Speaking with response stakeholders and reviewing background documentation, however, the evaluation was not able to identify global capacity support or direction on VfM that was available for response teams following their initial investment and subsequent challenges in pursuing additional rounds of VfM training, data collection, or analysis. This signals a gap in the global support available to regional and country teams in fulfilling not only their donor commitments, but in supporting the organizational shift towards stronger VfM and performance measurement systems.

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[45] Source: 8. Value for Money / Y3- VFM Update.
[46] (1) "2.7 Draft FCDO WHO Annual Review 2020_WHOcomments" and (2) "Email Thread: Re_ Value for Money - any input from Hub level_ - deadline 12 Oct (15 September to 13 October 2020)".
[47] IBID, p. 43.

5.5 EQ5: Explanatory factors

What have been the main internal and external factors influencing WHO's ability to respond during the years under review?

Key Findings:

- ▪ ***Finding 1****:* Access challenges and the heavily politicized operating environment of the Response are the leading inhibiting factors, while the ability of the WHO response model to continuously adapt as a way to meet these challenges is the most cited example of the Organization's enabling factors.

- ▪ ***Finding 2:*** Internal and external inhibiting factors affected WHO's ability to ensure gender and beneficiary feedback systems and recruitment of sufficient, flexible human resources. Successes in these areas depended on the professionalism of WHO staff and IPs.

- ▪ ***Finding 3:*** The Response uses a number of approaches to generate learning and reflection. Improvements could be made on response-level systems for M&E, financial monitoring, and the exchange of learning or promising practice between staff, cluster members, and IPs.

Findings for this section are presented according to the topics of: inhibiting and enabling factors (internal and external) and the role of learning and reflection in response adaptation.

Inhibiting and enabling factors

The evaluation explored inhibiting and enabling factors through an embedded analysis across evaluation questions. They were further categorized into external versus internal factors and summarized in Table 8.

Table 8: Explanatory factors.

External Factors – Inhibiting	External Factors – Enabling
- Political environment - Security - Access - Inability to work on the ground – remote management - Annual renewal of the UNSC cross-border resolution - Closure of cross-border access points under UNSC - Increasingly conditional funding / short-term funding - Delayed or denied approvals from authorities - Population mobility /surge in population movement - Shortage in locally available healthcare workers - Contextual sensitivies to / censorship of gender issues - Currency fluctuation / devaluation	- UNSC authorizations for cross-border operations and UNSF framework for UN operations in Syria - Inclusion of aligned health priorities in GoS Syria 2030 strategy - Donor partnership approach and support to WHO - UN-wide WoS approach - Availability and engagement of other UN agencies in coordinated service delivery (e.g., UNICEF / vaccines) - Dedicated IPs and partner networks, representing a range of health services and areas of expertise
Internal Factors – Inhibiting	**Internal Factors – Enabling**
- GPW13 / ERF do not fully align with protracted emergencies - Inconsistent interpretation of humanitarian principles for the context or WHO globally - Insufficient conflict analysis - Inconsistent development of response-wide, inter-hub, and hub-level systems and protocols - Bureaucracy of WoS regional split - Lack of SOPs or documented protocol on response roles, responsibilities, and governance structure - Incomplete response-level data (M&E and finances) - Staffing turnover / vacancies	- Aligned priorities with GPW13 and 'no regrets policy' in the ERF - Agreed importance of the humanitarian principles - Flexible and decentralized WoS response model - Routine system for Operational Review Meetings - Strength and role of WHO Health Cluster Coordinators - Adoption of health sector specific severity scale approach to needs identification and prioritization - Institutional and individual technical expertise - Staff dedication

Once mapped, the evaluation contextualized the enabling and inhibiting factors against the 'Response Assumptions' presented in the WoS Theory of Change (ToC) (Section 3). Significant themes across interviews, workshops, and documents were extracted to best understand key learnings for the Response and the applicability of the explanatory factors in fostering or hindering response relevance, effectiveness, coverage, and efficiency.

Of the inhibiting and enabling factors, stakeholders and WHO documents placed most emphasis on the inhibiting access challenges faced throughout the duration of the Response and its heavily politicized operating environment. Access challenges and the politicized operating environment undermined several of the core assumptions of the Response for what was required to achieve its objectives through its WoS model and critical functions, as reflected in the ToC presented in Section 3. This includes assumptions on the 'ability to access people and populations in need', 'sustained dialogue with official authorities and health actors,' and 'sufficient, flexible financial resources.' Based on the findings presented in earlier sections, access constraints and politics have primarily affected aspects of the relevance, coverage, and efficiency of the Response.

The ability of the WHO response model to continuously adapt as a way to meet these challenges was the most cited example of the Organization's enabling factors. Conversely, it supported several of the underlying assumptions of the Response challenged by access constraints and politics, including 'ability to access people and populations in need' through cross-border operations and moving responsibilities between hubs as lines of control or populations shifted and 'sustained dialogue with official authorities and health actors' by creating independent communication lines and areas of responsibility within an internally coordinated operational approach. Based on findings presented under earlier sections, this primarily bolstered aspects of the relevance, effectiveness, and coverage of the Response. The adaptability of the WoS response model, however, has not been matched by the external funding environment, which is reflected in the differential levels of funding coverage against required contributions between WCO Syria and Gaziantep in recent years. While the financial analysis in the evaluation is limited by incomplete data, the presented case studies suggest that this may affect aspects of response coverage and effectiveness.

The inferred response ToC highlights the importance of 'programmatic gender mainstreaming and beneficiary feedback systems' and 'sufficient, flexible human resources' as underlying assumptions for the success of the Response. As shown in Table 8, the evaluation found external and internal forces that weakened these areas:

▪ **Gender and beneficiary feedback:** Contextual sensitivities to / censorship of gender issues; inconsistent development of hub-level systems and protocols for gender assessments, needs analysis, M&E reporting SOPs, and Accountability to Affected Populations; and incomplete response-level M&E data.

▪ **Human resources:** Shortage in locally available healthcare workers; perpetual uncertainty of cross-border authorization; short-term funding; staffing turnover / vacancies within WHO and IPs.

Successes under both assumptions primarily depended on the enabling factors of the dedication and professionalism of WHO staff and IPs in responding to gaps in protocol or resources.

The evaluation did not identify any major issues with the remaining assumptions listed in the ToC - 'application of WHO Guiding Principles' and 'risk management approaches in strategic planning and operational management'. However, three of the inhibiting internal factors listed in Table 8 could be understood as potentially reducing the presence and applicability of these assumptions in the success of the Response. This includes: insufficient conflict analysis, inconsistent interpretation of the humanitarian principles for the context or WHO globally, and the lack of SOPs or documented protocol on response roles, responsibilities, and governance structure.

Learning and reflection in response adaptation

The evaluation identified active mechanisms that support learning, reflection, and response adaptation. This was triangulated against interviews and workshops to explore their significance to response staff, including the importance of each mechanism behind actions taken during the years under review.

The Response generated learning and reflection through a number of approaches. Those most frequently cited during interviews and across documents as contributing to learning and adaptation include:

- **Operational review meeting:** Routinely held[48] meetings between response office leadership to review and discuss operational strategy, challenges, and requirements for inter-hub coordination. Operational review meetings constituted an important part of implementing WHO's corporate strategies and policies. Meetings are typically held in person, which has strengthened relationships and communication.

- **Strategic donor review meetings:** Quarterly meetings between WHO response leadership and FCDO representatives, eventually expanded to include participation from other donors such as ECHO and OFDA.

- **Cluster coordination performance monitoring survey:** Annual survey of cluster members conducted for each response hub, including sections for interpretation of results and action items.

- **Third party monitoring:** Independent monitoring of WHO activities, including supply distribution and services provided by IPs. Methodology is active in both the Damascus and Gaziantep offices.

A range of singular learning and reflection exercises also contributed to response adaptation:

- **Internal audit and independent missions**: Internal 'integrated audits' of the Response in 2017 and 2019, the Turkey Mission Report (2019) of the Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme.

- **Evaluations**: Initial evaluation of FENSA (2019) and Independent Review of Cross-Border Operations from Jordan into Syria (UN-wide) (2019).

- **Response missions**: Regional mission to Syria (2020).

- **Closure reports**: Amman Cross-Border Health Sector Working Group – Summary and Closure Report.

- **Value for Money**: Methodology development and baseline assessment on response VfM.

While progress has been made from 2016 through 2020 on the available platforms to monitor the Response and support learning and adaptation, several areas could use improvement:

- **WoS harmonized KPI reporting**: The development of a harmonized approach to WoS KPI reporting was an important step towards consolidating a systematic approach to response monitoring. As noted through the evaluation findings, however, there is limited evidence that the current data collected and available through this system is consistently reviewed for program learning, reflection, or adaptation.

- **Financial reviews**: While each hub has tools and procedures for tracking their funding, the evaluation was unable to locate a singular document or tool used to track response-level expenditures or allocations within critical functions, such as would be required for reflection on budget coverage or operational efficiency at the leadership level. It is unclear whether the Response considers operational costs, opportunities for efficiency gains, or utilization rates when making allocation decisions between hubs or across critical functions.

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[48] Meetings were originally held on a monthly basis, then shifted to bi-monthly or quarterly from October 2020.

- **Closure reports**: The evaluation was not able to identify programmatic or operational closure reports or lessons learned activities for the Erbil or Amman hubs. It was unclear whether lessons learned or closure reports were produced by Gaziantep for WCO Syria for the locations that shifted between the hubs.

- **Value for Money**: The exercise has not been repeated as originally planned, reducing the impact and utility of the initial exercise for ongoing decision making or management purposes.

Finally, the evaluation was not able to identify a mechanism to support the exchange of promising or innovative practice between programmatic staff. Cluster members also shared that the cluster rarely creates platforms for discussion on learning or useful reflections on performance data, beyond reviews of coverage gaps through the 4Ws process. Knowledge management systems, broadly, appear fragmented. The Response does not have an identifiable repository for critical documents across response hubs or a clearly defined policy on what types of documents should be available across hubs to support learning, versus those which should remain internal to the hubs for information security purposes. The consequence is continued fragmentation between offices on information that, if better linked, could enhance learning and coordination.

6. Learning from the Response

This section presents key lessons learned that contributed to the positive evolution of the Response during the years under review. It identifies useful learning to apply in future responses that adopt a multi-hub response structure, as well as a summary of the learning applicable for work in Syria going forward. This includes highlighted lessons from the localization learning profiles and the key challenges and opportunities facing the Response as mapped during the evaluation workshops with WHO staff.

6.1 Learning for future multi-hub responses

Three points feature across evaluation findings on how the Response positively developed, adapted, and shaped its operational model to address the access and political constraints of the Syria context. They are applicable in other operations that adopt a multi-hub structure:

- **Formulate criteria for the selection of a decentralized or centralized response model:** Over the years of implementation, the Response attempted different levels of centralization, eventually settling into a largely decentralized structure that retained key WHO reporting lines (e.g., Erbil hub reporting to WCO Iraq) while establishing mechanisms for inter-hub coordination and clearer parameters on the levels of authority for key decisions (e.g., what decisions rest with the hubs versus EMRO). The decentralized approach allowed greater proximity between hub operations and the relevant authorities and affected population. In the political context of Syria, it also enabled independent operations and lines of communication within contested or non-government held areas. The approach, however, did require considerable coordination efforts to sustain and many systems or protocols that should exist at a response level remain under-developed. The absence of singular, centralized leadership limited the depth and consistency of support, direction, and representation available for the Response, including situations where external messaging was inconsistent. In future multi-hub responses, WHO should deliberately consider the relative benefits and costs of different levels of structural centralization, planning for the particular challenges that come with either choice.

- **Establish clear mechanisms for inter-hub coordination and decision-making authorities**: During interviews and staff workshops, the importance of the 2017 "re-boot" meeting was stressed as a turning point for the Response. This meeting set into motion the structure for face-to-face operational review meetings and stronger parameters around what decision authorities belonged to each level of the Response (region, WCO-Syria, cross-border hubs). In future multi-hub responses, similar coordination mechanisms to facilitate decision making between hubs and/or regions should be developed and utilized from the start, along with clearly defined roles and responsibilities across different levels of the Response.

- **Determine a transparent process for funding allocations based on needs:** In the early years of the Response, tension existed between hubs on the level of need in the geographic areas of each office and the consequent allocation of required contributions for their activities. This eased considerably after an agreement was reached to proportionally allocate contributions largely according to population size. The introduction of the severity scale index to assess needs according to health service availability, service accessibility, and population vulnerabilities at the sub-district level created further transparency and relevance to the process. In future multi-hub responses, decisions on an acceptable evidence base for needs and procedures for determining funding allocation should be established at the start.

6.2 Learning for Syria, localization going forward

The Organization strategically engaged with IPs from the start of the Response. Initially, the approach was oriented towards equitable service access and coverage, especially into hard-to-reach locations or in the context of cross-border programming. In a conflict that witnessed the loss of over half of its health facilities and workforce by 2020[49], WHO's investment in local partners creates pathways for civil society to develop a sustainable level of equitable and accessible health services in all areas of the country going forward.

As part of the evaluation approach (see Section 3, 'Methodology'), two localization activities were identified with WHO to profile learning on future capacity building or partnership initiatives. They included engaging community health workers (CHWs) in Leishmaniasis control in northwest Syria (Gaziantep Office, 2018-2020) and mental health training for frontline humanitarian actors and community health workers in Aleppo and Al Hol (WCO Syria, 2019 and 2020). While the main outputs from these 'deep dives' on localization are integrated into the evaluation findings presented in Section 5, the consolidated achievements, challenges, and lessons learned experienced in these activities include:

- **Achievements:** Provision of relevant and effective services targeting in- and out-of-camp populations, community healthcare workers, and frontline humanitarians; all trainees showed improved levels of awareness, knowledge, and motivation.

- **Challenges:** Delayed start to activities connected with WHO contracting and financing procedures, as well as limited availability of WHO staff; limited resources of partner agencies to expand services according to the level of need or continue services when the WHO partnership ends.

- **Lessons Learned:** Effective response requires the combined inputs and expertise of WHO and partners (i.e. WHO supervision or continued coaching, WHO provision of medicines or mobile units); the community health worker modality is important for developing referral networks and locally accessible expertise; supporting frontline humanitarian actors and community health workers is necessary to create and sustain needed services; it is critical to consider the particular vulnerabilities of target populations when designing services and service delivery modalities.

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[49] See HNO and HRP tracking of this figure from 2016 through 2020 reports.

Table 9 features the achievements, challenges, and lessons learned experienced in each of these activities.

Table 9: Summarized learning from localization profiles.

Activity	Achievements	Challenges	Lessons Learned
Leishmaniasis control in Gaziantep with MENTOR	- Effectively responded to massive outbreaks primarily affecting children in camps. - Large reach across IDPs as targeted vulnerable group. - Established protocol for monitoring activities, including beneficiary feedback system and data. disaggregation by sex, age, and displacement status. - All CHW trainees showed improved knowledge on training topics and good or high level of satisfaction with training.	- Delayed start to activities – international procurements and transfer of funds delayed. - COVID-19 limited ability to conduct trainings in 2020. - The needs in northwest Syria are large – program needs to expand the number of CHWs to address the scope of it. - Resurgence of cases from January 2021. - EWARN/S not available or used across all partnering facilities reporting cases – created data discrepancies be HeRAMS and EWARN/S. - Lack of funding to renew partnership will create service gaps.	- Collaboration with the health cluster "vital" to securing community support. - CHW modality key for early detection and treatment, which reduces transmission. - Lack of medical centers addressed through CHWs but need to expand number of CHWs to address scope of problem. - WHO only actor supplying medicine. Continue this support. - CHWs trained in and out of camp settings. Important for developing referral networks and knowledge. - CHW network able to address range of issues, efficient approach. - Mobile clinics are also important, CHWs cannot cover all locations. - Multiple years of WHO partnership: strong relationship. - Sustained funding required to continue program.
Mental health training in Aleppo and Al Hol (WCO Syria) – frontline humanitarians and community health workers	- Created awareness in trainees about mental health in the workplace and target population. - Supported trainees with the tools needed to advocate for the importance of mental health. - Supported trainees to better understand importance of mental health programming and provide care or referral for cases. - Training successfully tailored to the needs of the organization.	- One trainee organization discussed training with WHO for a year before organized. - Limited resources of trainees to expand mental health programming. - Trainees require additional support on updating curriculum, re-organizing teams to take on expanded mental health response, ensuring quality of care. - Limited targeting for vulnerable people – trainees want to focus on needs of elderly, youth, and other groups experiencing mental health crises.	- Important to tailor training for the needs of participants. - Innovative and practical facilitation encouraged participation in the training and motivation provide expanded services. - Frontline healthcare workers need mental health support to sustain efforts. - Supporting frontline healthcare workers to understand the importance of mental health in their own work helps expand awareness on the importance of mental health services for the communities they reach. - Critical to consider vulnerabilities for mental health services. - Peer support groups may help with difficult cases. - Continued follow up from WHO through online support welcome to encourage uptake of training.

6.3 Learning for Syria, challenges and opportunities going forward

As described in Section 3 (Methodology), WHO staff mapped challenges and opportunities for the Response going forward during evaluation workshops. The consolidated output of that exercise is presented in Tables 10, 11, and 12 along the themes of strategic direction, operational environment and programming, and human and financial resources.

Table 10: Strategic direction.

Challenges	Opportunities
- WHO does not have a post-conflict country strategy. WHO has to be ready at HQ/regional level to have a clear pathway for Syria and similar contexts.	- Discussions on health diplomacy – NEXUS, outbreak response, healthcare system rebuilding.
- Protracted emergency affects planning - not able to have sustainability in planning or programming.	- WoS Response has shown its ability to bring together solid plans and strategies as the context evolved.
- GoS developing a narrative about "returning to what they had before". This would eliminate WHO's ability to institutionalize progress made during the Response and also prohibit the chance to "build back better".	- If WHO is able to secure an audience with the GoS and advocate on achievements and possibilities, it may be possible to build on: (i) the role and place of civil society in health and (ii) the digitalization of health information.
- National policy for mental health is not adequate. Same issue for GBV. Resistance and cultural sensitivity.	- WHO conducting policy advocacy. Aiming to update policy on rights for people with mental health issues.
- Unpredictability of UN resolution on cross-border operations from Gaziantep to NWS. Likely to end in July 2021. Difficult to secure extended coverage in the affected area.	- Partnerships are responding to the needs in the area and NGOs are expected to continue operating irrespective of the UN resolution.
- Unclear what happens to NGOs in NWS that constituted the backbone of the health system for the past decade if Gaziantep hub is closed. WHO to clarify its role in addressing this question.	- WHO may be able to advocate for NGOs' ability to work in Syria after the closure of the cross-border work (e.g., registration with the GoS as a recognized NGO). - Some local NGOs have become international and could potentially be engaged by WHO in other emergencies.

Table 11: Operational environment and programming.

Challenges	Opportunities
- Limitations on WHO's ability to expand cross-line support to NES. Difficult to secure balanced and extended coverage of the entire country. - WHO will experience the same challenges for NWS if cross-border access from Turkey is closed.	- Remote communication platforms provide opportunities for capacity building in hard-to-reach areas. - WHO seeing success in cross-line efforts and believes there will be continued improvements. - COVID-19 response presents opportunities for building relationships with key stakeholders.
- Difficult to secure and deliver COVID-19 equipment – lack of needed items in global market. Anticipated challenges in COVID-19 vaccination- competition between regular immunization and COVID-19 vaccination requirements.	- Ability to receive some supplies from Jordan (considered as local market), WHO headquarters, and Dubai.
- Delayed approvals, closed borders, sanctions, and inflation impede importing and delivering medical supplies and medicines. Beirut port explosion further complicating these challenges.	- Finding ways to improve the health system through emergency response programmes (i.e., building capacity of civil society through partnerships); securing funds for rehabilitation of healthcare facilities.
- Depleted healthcare workforce - many left the country. - Lack of development funding to rebuild human resources.	- NGO and partner network prepared to provide health services to community and returnees, using health as entry point to social cohesion.

Table 12: Human and financial resources.

Challenges	Opportunities
- Ensuring wellbeing and safety of staff, e.g., WHO staff did not evacuate when staff from other UN agencies were evacuating.	- Convening and coordinating power of WHO. - Technical expertise and capacities of staff inside Syria.
- Needs are high in areas previously under non-GoS control. Donors lose funding interest when areas go back under government control. Government of Syria provides less support to these locations than areas that were under its control throughout the crisis. - Amount of financial resources available will stay the same while need continues to grow. Donor prioritization is changing while country needs are becoming higher. - Difficult to convey needs are increasing while the scale of conflict is decreasing. Lack of non-humanitarian funding instruments prevent recovery investment.	- The creation of the Mental Health Gap national core team; they can support service delivery at community level. - Enhance Family Wellbeing Centres. Centres support livelihoods, combining with health outcomes. - COVID-19 underscored weaknesses in the health system for which no humanitarian intervention exists. Creates a clear call for other funding instruments for Syria. - Credibility of WHO among donor community. - NEXUS, plus "health for peace" dividends.

7. Conclusions

WHO provided an increasingly relevant and broadly effective response in Syria, delivering on its critical functions within a difficult operating environment marked by significant access constraints and politicization of health in humanitarian aid. The early decision to work with IPs supported the coverage of services and reach to vulnerable populations. Integrated services across partner networks and investments in response-level systems and internal coordination mechanisms from the end of 2017 into 2018 increased the efficiency of its operations. The WoS operational model enabled a high degree of responsiveness across geographic locations and changing lines of control. This has been achieved in an overall context of shrinking levels of flexible funding, the uncertain continuity of cross-border authorization, and the devastation caused to national health systems and the health workforce by the violent and protracted nature of the crisis.

While WHO entered Syria in 2012 and started cross-border operations in 2014, the current structure for the "Whole of Syria" response model was largely defined and consolidated three years later at the end of 2017. From 2018 through 2020, the Organization incrementally invested in response-wide systems, including regular operational review meetings, protocols for joint contingency planning, parameters for determining needs and the required funding allocations for each hub, guidelines for the implementing partner application process, the system for WoS harmonized KPI reporting, and a wholistic approach to VfM analysis.

The role of the EMRO WHE team in coordinating the Response provided a necessary connecting point between the hubs, as well as a decision authority on contested issues. The WoS Health Cluster Coordinator based in Amman and the EMRO office also facilitated neutral connections with health actors in northeast Syria, a dynamic which remains relevant today and may prove necessary in northwest Syria if cross border access is revoked. During the volatile years of 2018, 2019, and into early 2020, the multi-hub approach allowed WHO to retain the necessary independence of each response office within its geographic area and the conflict lines of the crisis. The decentralized structure and independence of the response hubs supported access negotiations to besieged and hard to reach areas by locating response leadership within closer proximity to the relevant authorities, fostering dialogue. This same approach then enabled the Organization to shift responsibilities between offices as different parties to the conflict gained or lost control of territory, increasingly moving the center of the operation to the Damascus hub. Without the 'ways of working' defined at the end of 2017 and the routines they created, WHO would not have had the collaborative energy necessary to manage these transitions as successfully as it did.

Despite its number of years in operation, response-level systems and protocols remain under-developed and some initiatives to address the gaps proved difficult to sustain. This appears to be the cause of insufficient institutional policies and procedures to respond to a complex, protracted humanitarian emergency, as well as the difficulty in justifying significant investments in harmonizing multi-hub systems without the certain authorization of cross-border operations. This has contributed to issues in staff recruitment, contracting, and prolonged vacancies, as well as an overall diminished information environment on the performance, coverage, and efficiency of the response. It has also impacted the durability of partnerships, leading to gaps in critical services. Questions remain on the extent of WHO's reach in northeast Syria, southern Syria, and Turkish-controlled areas of northern Syria. Without more transparent communication and protocols for establishing the true extent of services in sensitive areas, it will be difficult for response leadership to internally agree on gaps in these locations, how to best address them, and how to message challenges to UN stakeholders, funding partners, and responsible Member States.

Several lessons from the Response are applicable for WHO going forward. They include learning on the application and structure of multi-hub operations and the benefits of and approaches to localization in health services. The experience of the response team may also inform global policies and strategy, signaling the need for a stronger articulation of guidelines for complex and protracted emergencies in the ERF and GPW and increased global investments in WHO's cluster coordination mandate and vision for monitoring, evaluation, and VfM analysis.

Table 13 summarizes the factors driving success and areas for improvement in the Response under the evaluation questions of relevance, effectiveness, coverage, and efficiency. This informs the recommendations presented in the following section.

Table 13: Success factors and areas for improvement, by evaluation question.

Theme	Success Factors	Areas for Improvement
Relevance	- Consistent emphasis on the importance of the humanitarian principles in emergency response. - Significant efforts to collaborate with UN agencies, IPs, and donors, while operating within the legal frameworks for WHO's presence in Damascus and cross-border activities. - Adoption of the severity scale approach to needs identification and prioritization and the role and strength of Health Cluster Coordinators at pivotal moments of the crisis. - Tailored health programming for women (e.g., reproductive health) and the GBV pilot in WCO Syria support gender-sensitive programming. - Institutional guidance and provisions for operating in a health emergency contained in the GPW13 and 2017 ERF.	- Inconsistent interpretation within the Organization on how to practically apply humanitarian principles in the Syrian context and within WHO's governance structure. - Absence of distinct 'conflict setting' guidance within the ERF. - Limited systematic conflict analysis, notwithstanding efforts made in the FCDO partnership. - Limited consistency of needs analysis at field level in response hubs. - Limited evidence of gender analysis and mainstreaming within operations. - Perceived decreasing levels of collaboration and transparency in WHO's relationships with other UN agencies in recent years. - Questions about WHO's ability to deliver on its critical functions in northeast Syria.

Theme	Success Factors	Areas for Improvement
Effectiveness	- Adaptability to the changing dynamics of the Response. - Technically qualified and highly dedicated staff. Early support to the newly emerging Syrian civil society and implementing partner modality. - Process for structuring coordination across response hubs (improving from late 2017).	- Inconsistent measurement of progress against targets for response level indicators. - Insufficient data disaggregation on vulnerability criteria within performance metrics. - Limited evidence on coherent approach to service targeting and assessment of barriers to access as affected by gender, age, disability, or affiliations within the conflict. - Limited sustained contact with affected populations or inquiry into the quality of care received by partner agencies. - Recurring staff vacancies in critical positions and short duration of IP contracts and gaps between contract renewals.
Coverage	- Integrated services across partner networks, referral systems, and support to mobile units. - Adaptability of the WoS response model to the changing dynamics of the conflict, decision to work with a range of IPs, and supportive relationship with health facilities / authorities across the country and conflict lines. - Coordination and leadership of the 4Ws process within the Health Cluster and establishment and use of health information and surveillance systems (HeRAMs and EWARS/N) to identify emergent needs and target support. - Introduction of the severity scale analysis.	- Gaps between IP contract renewals. - Limited data disaggregation on service coverage and funding allocations according to severity scale. - Insufficient evidence on the use of vulnerability and gender analysis at the field level, including for use in targeting services. - Accountability to Affected Populations (AAP) frameworks for use in the Health Cluster and by partners are missing or could not be provided. - -Questions about WHO's coverage in the Turkish-controlled Peace Spring area, Southern Syria, and NES. - Unclear expectations for how WHO documents, verifies, and shares information about work in sensitive locations (e.g., northeast Syria). - Proportionally larger funding gaps for WCO Syria compared to the Gaziantep office, based on the required contributions identified by WHO.
Efficiency	- Working with IPs and strong partner networks. - Persistence of highly dedicated staff "in spite of the challenging systems" and the use of buffer stock / prepositioning of supplies. - WoS 're-boot' meeting in 2017 and the institutionalization of systematic operational review meetings. - Creation of a VfM approach in 2018.	- Staff vacancies, contract gaps, and short contracts. - Short IP contracts and gaps between contract renewals. - Limited data available to meaningfully assess and understand trends on cost-per-treatment / service costs and variable operating costs between response offices. - VfM approach has not been replicated, limited evidence of its integration into regular operations.

8. Recommendations

This final section provides WHO with recommendations for how to further improve its Response in Syria and humanitarian action in other contexts. It provides action items on the areas of: strategy and positioning, programming, and operations. It also presents 'points for further inquiry', which describe areas of learning WHO can explore internally to extend the evaluation's utility.

8.1 Evaluation recommendations

The recommendations listed here target the strategy, programming, and operations levels of response capacity. They cover different levels of the Organization, including global, regional, and hub-levels.

A. Strategy / Positioning – Global Recommendations

1. **Consolidate humanitarian / armed conflict response framework for the WHO Health Emergency Programme.** Consider a global review of WHO's adherence to and operational interpretation of the humanitarian principles in conflict-setting emergencies, including the principles of humanity and impartiality compared to the principles of independence and neutrality. Future revisions to the ERF should include distinctions between armed conflict and complex emergencies from other types of health emergencies. Guidance should be provided on the contextualization of humanitarian principles for WHO in conflict settings, given its mandate to work within the Ministries of Health of Member States. Clarification should also be given on the scope of WHO operations and service provision in protracted crisis, including the degree of applicability of the "provider of last resort" clause in this setting.

2. **Review – and possibly renew - level of institutional investment in cluster coordination capacity, program monitoring and evaluation, and VfM analysis.** Consider whether current levels of WHO global investment are sufficient to sustain institutional commitments at the field level. Focus should include consideration of WHO's development and retention of highly capacitated staff in these functions and their availability to support emergency response contexts.

B. Strategy / Positioning – Regional and Country Recommendations

3. **Enhance conflict analysis to ensure conflict sensitive programming at response and regional/district-levels:** Review existing practice and consider developing regular and systematic conflict analysis (including protection analysis as recommended by IASC) that will feed strategic, programmatic and operational decision-making. Consider mainstreaming of conflict analysis and conflict sensitivity at all levels through adopted tools as well as staff capacity building.

4. **Maintain critical "WoS" structures, including the role of the EMRO office and the WoS Cluster Coordinator based in Amman.** As the Response considers its structure going forward, neutrally positioned roles and responsibilities in EMRO and Amman should be maintained until: (a) there is an improvement in the conditions for dialogue and engagement between the Damascus office and the Kurdish Self-Administration and/or the Syrian Government regains complete control over northeast Syria, (b) there is a clear path to dialogue and engagement between the Damascus office and opposition-controlled areas of northwest Syria and Turkish-controlled northern Syria, (c) there is a political resolution of the crisis that enables WHO to provide equal and impartial levels of services to all areas of the country without obstruction or threat of loss of operational space.

5. **Review opportunities for collective UN approach to constraints in northeast Syria.** There is a consistent position across UN, Donor, and several WHO stakeholders that WHO needs a creative and bolder approach to the challenges it faces in northeast Syria and, potentially, in northwest Syria if the cross-border authorization for Gaziantep is removed in July 2021. WHO should consider opportunities to convene other UN agencies facing access constraints and identifying a collective risk and/ or advocacy approach in terms of what the agencies are willing to do or publicly say in their efforts to secure humanitarian access to these locations. Strategically engage the Resident Coordinator in this discussion.

C. Programming – Regional and Country Recommendations

6. **Improve use and documentation of gender and vulnerability analysis.** Map current practice and gaps for the systematic use of gender and vulnerability analysis in programming, including the tools in use and when and how they are deployed. Develop a coherent approach and SOPs for gender and vulnerability in program design, partner selection, targeting of services, and addressing barriers to health. Integrate SOPs into in existing program cycle modalities.

7. **Improve protocols for field-level needs analysis and service targeting according to health needs.** Map current practice for the systematic use of field-level needs analysis, including the tools in use and when and how they are deployed. Develop a coherent approach on service targeting in partner selection, partner monitoring, training and capacity building efforts, and the distribution of medicine and medical supplies.

8. **Enhance response-level M&E system.** Create a dedicated unit to support response-wide M&E. This function can also support the M&E capacity of WCO Syria but should not be layered into the existing and significant responsibilities for health cluster information management. Invest in a more robust and regular approach to outcome monitoring and accountability to affected populations, harmonized across each hub. Review current levels of understanding on reporting requirements and support staff training as needed. Improve disaggregation of indicators along key variables of location, severity scale, sex, and displacement status. Develop protocol to review performance data during or ahead of the operational review meetings or other hub-level management meetings.

9. **Develop guidelines for hub closure or transfer of responsibilities between hubs.** Develop a clearer protocol or set of guidelines to follow in the event of hub closure or the transfer of responsibilities, including expectations for knowledge transfer and lessons learned exercises, important provisions for information security, and how to best approach the re-allocation of assets to other hubs if convoy access to Damascus is limited or impossible. Review experiences from Amman and replicate learning.

10. **Re-assess VfM approach for sustainability.** Consider whether the approach developed for measuring VfM is sustainable in the context of the Response, including staff turn-over, demands on staff time, and the maturity of response-level information and reporting systems. If the approach remains applicable, re-assess current VfM performance to compare against the 2019 baseline.

11. **Review and enhance progress on COVID-19.** Review the degree to which the COVID-19 strategy for Syria is sufficiently unified across geographic locations (including northeast Syria), identifying areas for improvement as needed or lessons for the future. Enhance communications with partners and authorities in areas outside GoS control. Sustain advocacy with the Government of Syria on vaccine access in northeast Syria.

D. Operations - Regional and Country Recommendations

12. **Adapt staff contract clauses to the challenges of the cross-border operating environment.** Consider providing longer staff contracts for the Gaziantep office with stipulations for deployments elsewhere in the EURO region or through the global surge deployment capacity if the post closes due to removal of cross-border authorization. Review successful examples of this approach used previously in the Organization.

13. **Strengthen knowledge management in the Response.** Improve information sharing and availability of key documents across response offices, with particular attention to common tools and templates for program operations. Demarcate the types of information that should be accessible across response offices (e.g., templates for partner applications) versus those that should not (e.g., actual submitted partner applications). Consider formally documenting the Response 'ways of working', including a specified organigram within the Response, articulated roles and responsibilities between response leaders at regional vs. hub levels, and a short explanation of the key protocols used to support inter-hub coordination.

14. **Review and explore improvements for IP contracting**. Proactively assess and pursue opportunities to create longer and a fewer number of contracts. This should include an internal review on the cause of gaps between contract breaks and the extent to which WHO can plan or organize for them in advance, including supporting IPs with government pre-approvals, staggering contracts to avoid service gaps, and advocating with donors on the number of review processes partners are subject to every year. Consider standardizing administrative approaches between WCO Syria and the Gaziantep Field Office in regard to IP proposal templates, reporting templates, and monitoring approach and requirements.

15. **Conduct a response-level financial review.** Review and collectively interpret the financial data presented in this evaluation, including funding allocations between hubs, the increasing cost-per-treatment trend, and the differences in spending per person in need in WCO Syria and the Gaziantep Field Office. Review the degree to which funding allocations (as decided by WHO or required by conditional donor agreements) are prioritized according to severity scales, vs. overall population in geographic areas, vs. operational costs of the programming in different hubs. Consider the extent to which flexible funds are used to cover needs in areas that are not prioritized in earmarked funding. Continue to advocate with donors on the funding requirements for WCO Syria, while exploring a shift to development donors as needed.

8.2 Points for further inquiry

Based on questions raised by the data presented in this report that are outside the capacity of the evaluation to address, the following points for further inquiry could be explored by WHO to extend the learning from this report:

- Review the extent to which the Response benefitted from the surge capacity deployments provided for under the 'no regrets policy' of the ERF, considering whether additional provisions are needed for critical vacancies.
- Review and interpret the overall drop in provided treatment courses and varied performance of WCO Syria on treatment courses over the 2016-2020 period. Note if there is a data-based or a response-based explanation.
- Review and interpret the comparative volume of programming delivered by WCO Syria between geographic locations as presented in this evaluation. Note whether there is a data-based or a response-based explanation.

Appendices

Appendices include the following:

1. Evaluation Matrix
2. Summarized Key Informant List
3. Document Review List
4. Evidence Strength Score Sheet
5. Evaluation Terms of Reference

Evaluation Questions	Sub-Questions	Indicator / measure of progress	Data Sources	Data Collection Methods	Data Analysis Methods / Triangulation	Evidence Availability / Reliability Assumptions
Relevance EQ 1: How well aligned has WHO's response to the Syria crisis been during the years under review (2016-2020) with the stated needs of the government, the specific needs of the affected population, and with WHO's broad approach to humanitarian action and health emergencies in light of the GPW13 and the SDGs as well as its normative guidance on health emergencies?	1.1 How well aligned has WHO's response to the Syria crisis been with the stated needs of the Government and with other local authorities and local health actors?	- Perception of WHO staff, implementing partners, cluster members, national governments on the relevance and appropriateness of the WHO response in Syria - Comparison of WHO's documented strategy, prioritized programming areas, and actual achievements with the needs reports and strategies produced by national and local authorities, local health actors. - Documented and reported extent to which WHO engaged in consultative process with national and local authorities and local health actors in establishing response objectives and activities - Comparison of WHO's global policies for alignment with national and local health priorities against documented and reported objectives, prioritized activities, and actual achievements	- Key informants (WHO staff, implementing partners, cluster members, government reps) - WHO document library	- Formal document review - Secondary data analysis - Key informant interviews - Implementing partner FGDs	- Thematic analysis of qualitative information - Triangulation between data sources - Participatory stakeholder analysis - Participatory development of critical moments timeline	- Availability of and response from targeted stakeholders for participation in interviews, workshops, and FGDs - Availability of background documentation - Reliability of quantitative results data and reported achievements
	1.2 How well aligned has WHO's response to the Syria crisis been with the specific needs of the affected population?	- Perception of WHO staff, implementing partners, cluster members on the relevance and appropriateness of the WHO response in Syria - Comparison of WHO's documented strategy, prioritized programming areas, and actual achievements with the needs assessments and monitoring reports produced in consultation with and reflective of inputs from the affected population. - Documented and reported extent to which WHO engaged in consultative process with the affected population in establishing response objectives and activities - Comparison of WHO's global policies for alignment with the needs of the affected population against documented and reported objectives, prioritized activities, and actual achievements	- Key informants (WHO staff, implementing partners, cluster members) - WHO document library	- Formal document review - Secondary data analysis - Key informant interviews - Implementing partner FGDs		
	1.3 To what extent has WHO's response to the Syria crisis been aligned with WHO's broad approach to humanitarian action and health emergencies in light of the GPW13 and the SDGs as well as its normative guidance on health emergencies?	- Perception of WHO staff and representatives from other UN agencies on the alignment of WHO's response in Syria with WHO, UN, and sectoral strategies, policies, and guidelines for health in emergencies - Comparison of WHO's documented strategy, prioritized programming areas, and actual achievements with WHO's policies and guidelines for action in emergencies and ambitions articulated in the GPW13 - Comparison of WHO's documented strategy, prioritized programming areas, and actual achievements with the health goals articulated in the SDGs - Comparison of WHO's documented strategy, prioritized programming areas, and actual achievements with its guidance on health in emergencies	- Key informants (WHO staff, representatives from UNICEF, UNFPA, and UNDP, cluster members) - WHO document library	- Formal document review - Secondary data analysis - Key informant interviews		
	1.4 How has the situation changed over time, and in different areas of the country, and how well has WHO adapted its response to rapidly changing needs and conditions?	- Documented and reported timeline of critical events, noting key internal and external factors and the consequent impact contributing to their significance - Documented and reported adaptations of WHO's operational presence and approach, connected to critical events - Documented and reported adaptations of WHO's programmatic priorities, connected to critical events and inclusive of choices in target groups, services, and modalities for service delivery - Reported experience of WHO staff, partners, and external stakeholders with planned or actual adaptations in WHO's response	- Key informants (WHO staff, implementing partners, cluster members) - WHO document library	- Formal document review - Secondary data analysis - Key informant interviews - Implementing partner FGDs - Localization case study - WHO workshops		
	1.5 To what extent has WHO's Syria response been explicitly informed by gender analysis and undertaken in a gender-sensitive manner and their geographic locations?	- Perception of WHO staff, implementing partners, cluster members on the degree of gender mainstreaming within the WHO response in Syria - Comparison of WHO's strategy and protocols for gender analysis and gender mainstreaming in program design and delivery with documented practice - Degree of WHO staff familiarity with, exposure to, or recollection of WHO use of gender analysis in program design and selection of modalities - Practice of and learning from gender disaggregation of reported objectives, prioritized activities, and actual achievements - Review of gender analysis in select WHO proposals / donor agreements - Review of WHO's use of gender analysis in selection, funding, and support to implementing partners	- Key informants (WHO staff, implementing partners, cluster members) - WHO document library	- Formal document review - Secondary data analysis - Key informant interviews - Implementing partner FGDs - Localization case study		

Evaluation Questions	Sub-Questions	Indicator / measure of progress	Data Sources	Data Collection Methods	Data Analysis Methods / Triangulation	Evidence Availability / Reliability Assumptions
Effectiveness EQ2: What results has WHO achieved in the Syria response during the years under review (2016-2020), whether intended or unintended?	2.1 To what extent have the planned objectives and outcomes been achieved by WHO's Syria response	- Comparison of perceived and documented planned objectives for the response, including the intended results for the WoS operational model and the achievements of WHO's programming under its critical functions in emergencies - Documented and reported degree to which the response influenced, contributed to, or directly resulted in equitable access to healthcare, including how this was considered in the program design, targeting, and evidenced in documented acheivements - Target vs. actual analysis on key indicators associated with the reported objectives for the response, including WHO internal reporting, cluster reporting, and donor reporting - Examples of key WHO achievements and innovations - Examples of key challenges or roadblocks to achievement of planned objectives	- Key informants (WHO staff, implementing partners, donor reps, cluster members) - WHO document library	- Formal document review - Secondary data analysis - Key informant interviews - Localization case study - WHO workshop	- Thematic analysis of qualitative information - Triangulation between data sources - Analysis on the differences between planned targets and end-of-year achievements as reported within WHO's harmonized reporting system and across cluster reporting - Participatory development of critical moments timeline	- Availability of and response from targeted stakeholders for participation in interviews, workshops, and FGDs - Availability of background documentation - Reliability of quantitative results data and reported achievements
	2.2 To what extent has WHO's Syria response produced unintended outcomes (positive or negative) and how has it managed these?	- Comparison of planned versus reported outcomes across internal and external reports, including consideration of spill-over effects, security or access related consequences, and impacts of WHO's presence in an area for the affected population - Extent to which unintended outcomes are identified and reported in WHO's monitoring of affected populations and within feedback systems - Examples of positive or negative unintended outcomes described by WHO staff, implementing partners, cluster members, and local or national government authorities and local health actors	- Key informants (WHO staff, implementing partners, cluster members, government reps) - WHO document library	- Formal document review - Secondary data analysis - Key informant interviews - Implementing partner FGDs - Localization case study - WHO workshops		
	2.3 Are there any differential results across various vulnerable groups?	- Documented and reported extent to which WHO includes vulnerability analysis in beneficiary targeting, selection, and data disaggregation in monitoring and follow up - Documented and reported extent to which WHO articulated a targeting strategy and approach to beneficiary identification, reach, and feedback (including considerations of vulnerability and equity) - Documented and reported extent to which concerns about equitable access to healthcare influenced vulnerability analysis and the application of the findings from this analysis - Target vs. actual analysis on disaggregated key indicators associated with the reported objectives for the response, including WHO internal reporting, cluster reporting, and donor reporting - Examples of positive or negative differential results across vulnerable groups as described by WHO staff, implementing partners, cluster members, and local or national government authorities and local health actors	- Key informants (WHO staff, implementing partners, cluster members) - WHO document library	- Formal document review - Secondary data analysis - Key informant interviews - Implementing partner FGDs - Localization case study		
Coverage EQ3: To what extent has WHO's interventions reached all segments of the affected population, including the most vulnerable, during the years under review (2016-2020)?	3.1 To what extent has WHO's interventions reached all the most vulnerable groups in Syria (e.g., those displaced, women, children, persons with disabilities, healthcare and aid workers, and other sub-segments of the population)?	- Documented and reported locations and categories of vulnerable groups in Syria, including changes over time within the evaluation period of 2016-2020 - Documented and reported extent to which WHO includes vulnerability analysis in beneficiary targeting, selection, and data disaggregation in monitoring and follow up - Documented and reported degree to which the response influenced, contributed to, or directly resulted in equitable access to healthcare, including how this was considered in the program design and targeting and implementation strategy - Target vs. actual analysis on disaggregated key indicators associated with the reported objectives for the response, including WHO internal reporting, cluster reporting, and donor reporting - Analysis of budget and expenditures allocated by location, interventions, and program - Documented and reported reach of WHO intervention's compared to documented locations and categories of vulnerable groups in Syria - Examples of successful / innovative and blocked / failed attempts at access to vulnerable populations	- Key informants (WHO staff, implementing partners, cluster members, UN reps) - WHO document library	- Formal document review - Secondary data analysis - Key informant interviews - Implementing partner FGDs - Localization case study	- Thematic analysis of qualitative information - Triangulation between data sources - Analysis on the differences between planned targets and end-of-year achievements as reported within WHO's harmonized reporting system and across cluster reporting	- Availability of and response from targeted stakeholders for participation in interviews, workshops, and FGDs - Availability of background documentation - Reliability of quantitative results data and reported achievements
	3.2 Are there any gaps in terms of the coverage vis-à-vis needs (geographical reach, gender, persons with disabilities and other sub-segments of the population)?	- Documented and reported locations and categories of vulnerable groups in Syria, including changes over time within the evaluation period of 2016-2020 - Documented and reported extent to which WHO includes vulnerability analysis in beneficiary targeting, selection, and data disaggregation in monitoring and follow up - Documented and reported extent to which degrees of vulnerability are assessed and prioritized for response targeting - Documented and reported degree to which the response influenced, contributed to, or directly resulted in equitable access to healthcare, including how this was considered in the program design and targeting and implementation strategy - Target vs. actual analysis on disaggregated key indicators associated with the reported objectives for the response, including WHO internal reporting, cluster reporting, and donor reporting - Analysis of budget and expenditures allocated by location, interventions, and program - Documented and reported reach of WHO intervention's compared to documented locations and categories of vulnerable groups in Syria - Examples of successful / innovative and blocked / failed attempts at access to vulnerable populations	- Key informants (WHO staff, implementing partners, cluster members) - WHO document library	- Formal document review - Secondary data analysis - Key informant interviews - Implementing partner FGDs - Localization case study		

Evaluation Questions	Sub-Questions	Indicator / measure of progress	Data Sources	Data Collection Methods	Data Analysis Methods / Triangulation	Evidence Availability / Reliability Assumptions
Efficiency EQ4: How efficiently has WHO used the resources at its disposal (including financial, human, physical, intellectual, organizational and political capital, as well as partnership) to achieve maximum results in the Syria crisis in the timeliest and most efficient manner possible during the years under review (2016-2020)?	4.1 How successfully has WHO been able to deliver services in a timely manner?	- Extent to which WHO includes timeliness and timing in monitoring systems and tracking of service delivery - Extent to which timeliness appears as part of beneficiary satisfaction or complaint in WHO's monitoring of affected populations and within feedback systems - Comparison of planned delivery time with actual receipt of services - Reported experiences of WHO staff, implementing partners, and cluster representatives with service timeliness, including successes and delays in challenging situations	- Key informants (WHO staff, implementing partners, cluster members) - WHO document library	- Formal document review - Secondary data analysis - Key informant interviews - Implementing partner FGDs - Localization case study	Thematic analysis of qualitative information Triangulation between data sources Analysis on the differences between planned vs. allocated human and financial resources as reported in WHO financial reporting	Availability of and response from targeted stakeholders for participation in interviews, workshops, and FGDs Availability of background documentation Reliability of financial reporting and staffing records
	4.2 How well has WHO used the financial, human, physical, intellectual, organizational and political capital at its disposal, as well as its partnerships, to achieve results?	Documented and reported extent to which WoS budgetary and staffing needs are met and how this has changed over time - Documented and reported mechanisms/processes to ensure optimal use of resources and extent to which these mechanisms/processes are utilized - Perception of WHO staff, implementing partners, cluster members on how well has WHO used resources at its disposal in its response in Syria, including financial, human, physical, intellectual, organizational, political capital and its partnerships.	- Key informants (WHO staff, implementing partners, cluster members) - WHO document library	- Formal document review - Secondary data analysis - Key informant interviews - Implementing partner FGDs - WHO staff workshops		
	4.3 What have been areas of particularly higher and lower efficiency (factoring in issues of opportunity cost as well as standard resource use)?	Documented expenditures, according to targeted vs. received budget and burn rates by operational area Documented areas of over or under-resourcing, according to stated objectives, priorities, or institutional initiatives Perceived areas of inefficient/challenging use of WHO's resources and corresponding evidence of WHO's mitigation or corrective measures Examples of particularly efficient use of WHO's resources	- Key informants (WHO staff, implementing partners, cluster members) - WHO document library	- Formal document review - Secondary data analysis - Key informant interviews - Implementing partner FGDs - Localization case study		
	4.4 How well has WHO addressed the unique challenges of delivering humanitarian aid through cross border and cross line operation?	Documented and reported challenges and opportunities related to WHO delivery humanitarian aid through cross border and cross line operations - Reported and documented approaches to remote management, including monitoring of assets, expenditures, and service delivery - Reported experiences of WHO staff, implementing partners and cluster members with WHO delivery of humanitarian aid through cross border and cross line operation as compared to the reported or documented experiences of other UN agencies in Syria	- Key informants (WHO staff, implementing partners, cluster members, UN agencies staff) - WHO document library	- Formal document review - Secondary data analysis - Key informant interviews - Implementing partner FGDs		
Explanatory factors EQ5: What have been the main internal and external factors influencing WHO's ability to respond in the most relevant, effective, efficient and equitable manner possible during the years under review (2016-2020)?	5.1 What have been the main internal factors enabling and inhibiting WHO's ability to respond in the most relevant manner possible?	- Reported and documented challenges or opportunities related to organizational systems, structures, practices, and culture - Extent to which reported and documented experiences or perceptions on enabling or inhibiting factors align or diverge between internal stakeholder groups - Extent to which reported experiences on enabling or inhibiting factors align or diverge between perceptions and documented record - Examples of how WHO responded / reacted when confronted with a challenge or persistent inhibiting factor - Examples of how WHO responded / reacted when presented with an opportunity or enabling factor	- Key informants (WHO staff, implementing partners) - WHO document library	- Formal document review - Secondary data analysis - Key informant interviews - Implementing partner FGDs - Localization case study - WHO workshops	- Thematic analysis of qualitative information - Triangulation between data sources - Participatory stakeholder analysis - Participatory development of critical moments timeline	- Availability of and response from targeted stakeholders for participation in interviews, workshops, and FGDs - Availability of background documentation - Reliability of quantitative results data and reported achievements
	5.2 What have been the main external factors enabling and inhibiting influencing WHO's ability to respond in the most effective manner possible?	- Reported and documented challenges or opportunities related to the external environment, including political, normative, and financial factors - Extent to which reported and documented experiences or perceptions on enabling or inhibiting factors align or diverge between internal and external stakeholder groups - Extent to which reported experiences on enabling or inhibiting factors align or diverge between perceptions and documented record - Examples of how WHO responded / reacted when confronted with a challenge or persistent external inhibiting factor - Examples of how WHO responded / reacted when presented with an external opportunity or enabling factor	- Key informants (WHO staff, implementing partners, UN reps, government reps, cluster members) - WHO document library	- Formal document review - Secondary data analysis - Key informant interviews - Implementing partner FGDs - Localization case study - WHO workshops		
	5.3 To what extent has WHO monitored its performance and the factors affecting it, learned from this information and knowledge, and fed these sources of learning into its on-going response?	- Perceptions on the extent to which WHO systems for monitoring performance matched the programming structure and information needs of different stakeholders - Extent to which WHO staff and implementing partners demonstrate knowledge of and familiarity with WHO systems for monitoring performance, including in their own use for strategy development, decision making, public engagement, advocacy, etc. - Comparison of documented WHO systems and requirements for monitoring against documented and reported practice - Examples of how WHO uses information from its monitoring system, including challenges or innovations within the system and its application - Reported and documented practice with Third Party Monitoring, including perceived challenges and benefits	- Key informants (WHO staff, implementing partners, donor reps, cluster members) - WHO document library	- Formal document review - Key informant interviews - Implementing partner FGDs - Localization case study		

The summary table provided for Appendix 3 is anonymized to ensure confidentiality of interviewed stakeholders, as described in Section 3 of the Evaluation Report (see "Evaluation Ethics and Quality Control").

Individuals who qualify for more than one stakeholder group are only counted once in a primary identified group (e.g., Implementing Partners who were interviewed as IPs and not primarily as cluster members are listed under IPs; former WHO Response Hub staff who are now engaged with WHO in a Regional Office were recorded according to their previous role with the Response Office).

Stakeholders who left the position for which they were interviewed are recorded under the stakeholder group of their previous post (e.g., former UN / SSG members who are no longer with the UN are recorded under the UN Representatives group).

Stakeholder group	Agency or office engaged	No. of consulted stakeholders (individuals)
ERG members	WCO Syria, Gaziantep field office, EMRO, EURO, WHE Geneva, FCDO Syria	10
WHO – regional and global	EMRO, EURO, Internal Audit	7
WHO – response hub	WCO Syria – Damascus, WCO Syria – Homs, WCO Syria – Qamishli, WCO Syria – Aleppo, Gaziantep field office, Amman hub, Erbil hub	22
Donor representatives	FDCO, ECHO	5
UN representatives	UN / SSG, OCHA, UNDP, UNICEF, UNHCR	12
Implementing partners	SDI, UOSSM, Al Hekma hospital, Tamayouz Social Care Association, Al Ber and Social Services Association, MENTOR, Caritas, SREO Consulting	14
Government representative	Health Directorate – Hama	1
Health Cluster members / Other humanitarian actors	International Rescue Committee, SRD, IDA, NES Forum / Health Working Group, UPP, ICRC	6

The evaluation reviewed over 340 documents across 12 categories of requested information. This Appendix provides an overview of the primary documents referenced for the evaluation report, according to information category and the title of document as received by WHO.

serial	Information Category	Information sourced
1	WHO Global Policies and Strategy Documents	- General Program of Work 13 - Emergency Response Framework, second edition 2017 - WHO Strategic Framework for Emergency Preparedness, 2017 - Grant Letters of Agreement SOPs, December 2020 - WHO Framework of Engagement with Non-State Actors - WHO Geneva Organigram
2	FCDO Framework Agreement and Reports	- DFID WHO Framework Agreement_Final Signed Oct 2015 - Final Business Case (2016) - MoU amendment no. 4 - Bridge Funding Extension (April 2020) - Logframe Workbook_Q1-13 (2020) - Donor Reports to FCDO (Narrative and Logframe) Q1 - Q13 - 2019 and 2020 Annual Review Meeting Aide Memoires - DFID Q4 Meeting_Logframe Targets (March 2018) - DFID WHO_Revision of Indicators and Milestones - Y3 and Y4 FCDO Output Scoring with Results - Presentations on Monitoring and Evaluation (Q6, Q8, Q12)
3	Strategy Papers, WoS Governing Documents, Annual Reports, Donor Updates	***Strategy Papers*** - Global Humanitarian Overview 2019 and 2020 - WoS Vision and Approach, 2020 - WoS Futures, 2019 - Longer term options + "New Directions for 2019 (PPT) - WHO SAR Humanitarian Response Plan 2018 - WoS Joint Operational Plan 2018 (plus Annex) - UNCT Syria Context Analysis 2019 - Maintaining humanitarian space in Syria_Joint Donor Paper (Nov. 2018) - COVID-19 Strategic Preparedness and Response Plan (July 2020) **Governing Documents** - WoS Coordination Arrangements - SAR Country Cooperation Strategy, 2016-2018 - HCT Protection Strategy, 2017-2018 - SAR Biennuim Work Plans + associated docs, 2016-2020 - UN Strategic Framework for Cooperation in Syria, 2016-2019 - Updates on the UN Strategic Framework 2021-2023 - Summary Note_UNSF_20200917_For UN Audience - UNSF_2021-2023 Draft Zero Working Draft - UNSF 2018 Full Year Reporting - WoS Health Cluster Structure (ppt)
4	Ministry of Health or Government of Syria Strategic Documents and Policies	- Government of Syria Health Policy 2020-2024 - National Strategic Plan 2019-2030

serial	Information Category	Information sourced
5	Needs analysis and response analysis	- WHO Emergency Contingency Fund Annual Report 2018 - SAR Humanitarian Needs Overviews, 2016-2020 - SAR Humanitarian Response Plans, 2016-2020 - Health Sector Severity Scale_ Maps, Values, and Methodology (2020) - HeRAMS reports - EWARS reports - Syrian Country Office – COVID-19 Response Plan – Presentation on the implementation of EMRO - Mission Recommendations, 19/08/2020, Whole of Syria Coordination Meeting - Selection of Assessment Reports on: Covid 19, Al Hol, IDP Camps in NES, Cancer Management Care, - Collective Shelter, Hospital Assessments - Damascus Health Sector Assessment Registry (2018 and 2019)
6	HRP End of Year Reports, Annual Reports, Donor Updates	**HRP End of Year Reports** - HRP Mid and End Year Reports, 2017-2019 **Annual Reports** - WHO SAR Annual Reports, 2016-2019 - Health Emergency Response in Syria, WHO Turkey Annual Report, 2017 and 2018 - Health Emergencies Programme, Annual Report, 2018 **Donor Updates** - WHO Syria / Whole of Syria, Donor Updates - 2016-2019 - Donor update for EMRO, August 2020
7	Response monitoring / Response performance data	**Institutional Performance Tracking:** - GPW13 'Methods for Impact Measurement' and 'Output Scorecard' and 'Output Scorecard Scale' - IOAC Monitoring Framework - Delivering impact at the country level operational planning 20-21 - Summary of progress tracking tables **Indicators and Logframes:** - WHO WoS Reporting_Key Performance Indicator Summary Reports, 2017-2020 - WoS Health Cluster: Overall logframe, logframes per hub, logframe reports - COVID-19 Response Monitoring Framework - Health Sector (March - Oct 2020) - Syria COVID-19 Morbidity and Mortality Summary, December 2020 - COVID-19 Response Dashboard, April - July 2020 **Other:** - DAM, 'Voices of Beneficiaries' files - GZT, beneficiary satisfaction monitoring and reports - Coverage and activity maps - Monitoring tools of delivered assistance (including raw data, where available) - Cluster Coordination Performance Monitoring Surveys, Jordan (2018), Damascus (2016, 2018, 2020), Gaziantep (2018 and Draft 2021) - Health Sector, 4Ws (sample from NES, Damascus, and WoS levels) + WHO 4Ws Flow of Information 2020 - Health Sector Bulletin Updates

serial	Information Category	Information sourced
8	Financial reporting, budgets (including expenditures), VfM	- DFC Monitoring Report (2020) - WHO Emergency Contingency Fund Annual Report 2018 - Global Fund Allocations documents - EMR Country Offices KPI Dashboard (Region and Syria Specific) 2020-2021 - WoS Funding Status 2020 - 15122020 - WoS Funding Update and Donor Engagement – 28062020 - WoS Annual Status of Funding Analysis - WoS Funding distribution_Implementation Overview HRP 2019 - WoS_Status of funding analysis 2019 - WoS Funding and Distribution Overview Q1, Q3, and Q4 - Grant letters of agreement monitoring report (2020) - DFC Monitoring Report (2020) - Project Management Overview reports, 2017-2019 - SAR budget center summary, 2016-2021 - SAR financial reports, 2016-2019 - SAR 'status of funding' Excel, 2016 and 2017 - SAR 2020 budget updates (OCR budget updates, financial analysis OCR including COVID) **Value for Money** - DFID WHO WoS VfM Analysis Y2 + Annex 12 - Y3 - VfM Update - DFID Q4 Meeting_VfM (March 2018) - DFID Q5 Meeting_VfM (July2018) - VfM Presentation DFID AR July 2018 - VfM Reporting Template - WHO WoS VfM Workplan, V.4 (June 2018)
9	Implementation Reports, Meeting Minutes, Internal Memos	- GZT Internal SitReps, 2020 - GZT Monthly Reports, 2020 - GZT Status Reports, 2017 and 2018 - Update on COVID-19 Vaccination in Syria (Feb 2021) - EMRO Mission_COVID Response Implementation (PPT 2020) - Meeting Minutes, Strategic Review Meeting / Syria Operational Strategic Review - Oct 2020, Jan 2018, #s 13-15, #6 - Damascus Health Cluster, Meeting Minutes, 2017-2020 - WHO Health Emergencies Programme, Global Health Cluster Partner Meeting, 23-24 June 2016
10	Government MoUs, IP LoAs, and IP Technical Reports to WHO	- Biennial Collaborative Agreements for Turkey / GZT, 2016-2021 - DAM MoUs with MOH - TEMPLATES_IP Contract and MoU Agreements for Gaziantep and Damascus - WCO Syria, FCDO-funded LoAs and IP technical reports to WHO (2016-2019) - WCO Syria, sample of "other donor funded" LoAs and IP technical reports to WHO (2018-2020) - Gaziantep Field Office, sample of FCDO and non-FCDO IP technical reports to WHO (2018-2020) - Damascus, Partner Mapping (2020)
11	Contingency Planning	- South Syria_WHO Contingency and Response Plan (2018) - Northwest Syria_Contingency and Response Plan + Annex 1-3 (2018)
12	Evaluations and Learning Reviews	- Whole of Syria Review_Draft Report (2016) (covering UN WoS Approach) - FENSA Evaluation 2019 - Independent Review of Cross-border Operations from Jordan into Syria (2019) - IOAC Mission Report, Turkey, 2020 (+ "Syria in general, IOAC Brief, October 2020) - Report of the Internal Auditor, Oct. 2020

Appendix 4: Evidence strength score sheet.

Key

■	Sufficient evidence was acquired to propose the finding with a high level of certainty
■	Sufficient evidence was acquired to propose the finding, but evidence limitations allowed for only a medium level of certainty
■	Insufficient evidence was acquired to propose the finding

Table of Findings

	Finding Statement	Comments
	EQ1: Finding 1 WHO provided an increasingly relevant response in a context marked with conflicting interests between the central government of Syria, WHO's Member States and funding partners, the wider UN and humanitarian community, and the evolving – sometimes rapidly shifting – needs of the population.	Finding is well covered across evaluation data sources and methodology. No critical gaps.
	EQ1: Finding 2 WHO's operational structure enabled flexibility and adaptation to fluctuating lines of control, while participating in the UN WoS approach and its governing frameworks.	Finding is well covered across evaluation data sources and methodology. No critical gaps.
	EQ1: Finding 3 WHO's critical functions, including Direction and Coordination, Health Information, Health Operations and Technical Expertise, and Operations Support and Logistics, filled an essential role for the humanitarian community and for the affected population in Syria.	Finding is broadly covered across available data sources. Data and perspectives of the affected population is limited.
	EQ1: Finding 4 The Response aligns with WHO's broad approach to humanitarian action, at times revealing gaps in the extent of global priorities, investments, or guidance for protracted crises and conflict settings	Finding is well covered across evaluation data sources and methodology. No critical gaps.
	EQ2: Finding 1 WHO was broadly effective in its objectives across its critical functions, with varying levels of achievement over time, locations, and program objectives.	Finding is broadly covered across available data sources. Performance data and perspectives of the affected population is limited.
	EQ2: Finding 2 WHO has not consistently measured progress against targets for response level indicators or sufficiently disaggregated data to monitor equitable results across vulnerable populations.	Finding is well covered across evaluation data sources and methodology. No critical gaps.
	EQ2: Finding 3 Data collected from the affected population through Third Party Monitoring shows a high rate of general satisfaction, with critique on the selection and distribution of needed medicines.	Finding is well covered within relevant evaluation data sources. No critical gaps.
	EQ2: Finding 4 While there is limited evidence of significant unintended outcomes (positive or negative) in the affected population, workshops with WHO staff and WHO documents highlight the positive, unexpected impact of the Organization's early investment in Syrian civil society.	Finding is well covered within the referenced data sources. Finding would be strengthened with additional reflection from Government officials and the affected population.

	Finding Statement	Comments
	EQ3: Finding 1 While WHO invested considerable efforts to reach all segments of the affected population, it faced access, funding, and logistical constraints. Programming modalities and the WoS operational model supported coverage in hard-to-reach locations and improved access to health on culturally sensitive issues.	Finding is well covered across evaluation data sources and methodology. No critical gaps.
	EQ3: Finding 2 While the Response follows a clear process for identifying needs at country and sub-district levels, the evaluation was not able to identify consistent use or evidence of field-level procedures for targeting services by vulnerability and ensuring their reach across vulnerable groups.	Finding is well covered within relevant evaluation data sources. No critical gaps.
	EQ3: Finding 3 Response-level data is limited on coverage according to sex, age, disability, displacement status, or location by severity scale classification and Response hub. This signals reduced capacity to ensure coverage and access to services across all segments of the population.	Finding is well covered within relevant evaluation data sources. No critical gaps.
	EQ3: Finding 4 WHO applied several strategic and operational strategies to address the political and access challenges of ensuring coverage across geographic locations and conflict lines. While these efforts were broadly successful, questions remain about current reach into key locations of the country.	Finding is well covered across evaluation data sources and methodology. No critical gaps.
	EQ3: Finding 5 As a trend, data suggest increasing reach in central Syria in a context otherwise marked by a decline or stasis in the volume of services provided by WCO Syria sub-offices in southern Syria, northwest Syria, and northeast Syria. In recent years (2019-2020), WCO Syria received proportionally less funding for its level of required contributions compared to the Gaziantep Field Office.	Finding is well covered within the referenced data sources. Finding would be strengthened with additional years added to the analysis, expanded analysis across Response hubs, and through interpretation by WHO staff on possible contributing factors. This information was not available for inclusion in the evaluation.
	EQ4: Finding 1 The degree to which WHO efficiently used its resources to reach its objectives varies by program design, partnerships, human resourcing, financial resourcing, and the dynamics of the Response model.	Finding is well covered across evaluation data sources and methodology. No critical gaps.
	EQ4: Finding 2 There are many examples of efficient program designs and modalities used across the Response, with particular emphasis on health services. Performance is mixed on its supply chain and logistics function.	Finding is well covered across evaluation data sources and methodology. No critical gaps.
	EQ4: Finding 3 While working with IPs and strong partner networks enabled more efficient program designs and modalities, short IP contracts and gaps between contract renewals contributed to unnecessary delays in service delivery and reduced sustainability in investments like staff training and IP capacity building.	Finding is well covered across evaluation data sources and methodology. No critical gaps.
	EQ4: Finding 4 Frequent and prolonged staff vacancies, contract gaps, and short staff contracts affected Response efficiency and contributed to delays in service delivery.	Finding is well covered across evaluation data sources and methodology. No critical gaps.

Finding Statement	Comments
EQ4: Finding 5 Financial analysis reveals a trend of decreasing flexible funds. There are also indications of increasing costs-per-treatment and higher operating costs in the Gaziantep Field Office compared to the Damascus hub. Available data to not allow for a meaningful assessment on trends for cost-per-treatment / service costs and variable operating costs between Response offices.	Finding is well covered within the referenced data sources. Finding would be strengthened with additional years added to the analysis, expanded analysis across Response hubs, and through interpretation by WHO staff on possible contributing factors. Important data points were not available for inclusion.
EQ4: Finding 6 The structure for and level of internal coordination active in Response operations evolved during the years under review. Reforms and progress made from the end of 2017 improved Response efficiency, while aspects of its governance and accountability lines remain under-defined.	Finding is well covered across evaluation data sources and methodology. No critical gaps.
EQ4: Finding 7 WHO's initial VfM analysis of Response operations revealed that 75% of assessed activities provided high impact at a low level of investment. Additional VfM analysis is needed to assess trends over time. There is limited evidence that VfM is integrated into WHO operations.	Finding is well covered across evaluation data sources and methodology. No critical gaps.
EQ5: Finding 1 Access challenges and the heavily politicized operating environment of the Response are the leading inhibiting factors, while the ability of the WHO Response model to continuously adapt as a way to meet these challenges is the most cited example of the Organization's enabling factors.	Finding is well covered across evaluation data sources and methodology. No critical gaps.
EQ5: Finding 2 A number of internal and external inhibiting factors affected the WHO's ability to ensure gender and beneficiary feedback systems and sufficient, flexible human resources. Successes in these areas depended on the professionalism of WHO staff and implementing partners.	Finding is well covered across evaluation data sources and methodology. No critical gaps.
EQ5: Finding 3 The Response uses a number of approaches to generate learning and reflection. Improvements could be made on Response-level systems for M&E, financial monitoring, and the exchange of learning or promising practice between staff, cluster members, and implementing partners.	Finding is well covered across evaluation data sources and methodology. No critical gaps.

Independent Evaluation of WHO's Whole of Syria response Final Terms of Reference
20 August 2020

Background

1. The complex protracted and frequently changing humanitarian crisis in Syria, which is now entering its tenth year, continues to pose numerous health challenges. More than 12 million people are in need of humanitarian health assistance, including over 6 million internally displaced persons (IDPs) living in camps or other temporary or informal settlements, and over 5.6 million people have fled the country.[1] The humanitarian situation in northwest Syria remains one of the most acute and severe in the world, with over 2.8 million people dependent on humanitarian assistance supplied almost entirely from cross-border operations from southern Turkey. Population movements are expected to continue for the foreseeable future, with hundreds of thousands of civilians simultaneously fleeing and returning.[2]

2. Alongside the many other humanitarian assistance requirements in this crisis, the multifaceted and complex health needs of the affected population have been a critical concern. Displaced Syrian families face further challenges in the form of limited access to basic and emergency health care, a lack of medicine, over-burdened health facilities, and less protection against communicable diseases as an already-fragile immunization network has been disrupted by the conflict – this coinciding with a mass displacement, which has further increased the risk of outbreaks. Deliberate destruction of water networks, especially in northeast Syria and restrictions on chlorine transport, have left large parts of the population temporarily without access to safe drinking water and 35 to 50 per cent of the population relying on alternative and often unsafe water sources in the long run.[3]

3. As a result, the incidence of diseases such as measles, diarrheal illnesses, scabies and cutaneous leishmaniasis has been exacerbated by displacement, barriers to access, disruption of control mechanisms due to hostilities, interrupted funding, and poor overall living conditions. Immunization coverage rates remain low despite mass vaccination campaigns and routine vaccination to curb the spread of diseases such as polio and measles. Although data on disease burden since the onset of the conflict have been scarce, studies have estimated that over one-quarter of Syrians suffer from one or more non-communicable diseases (NCDs)[4] that are treatable with medicines, yet life-threatening if untreated. The United Nations estimates that 25 per cent of IDPs are women of reproductive age, and 4 per cent are pregnant women who require sustained maternal health services, including emergency obstetric care.[5]

4. Syrian refugees face humanitarian and health challenges similar to those of IDPs. Four countries neighbouring Syria (i.e., Lebanon, Jordan, Iraq and Turkey) currently host over 5.5 million Syrians, representing over 95 per cent of the total number of registered Syrian refugees, and Turkey alone

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[1] Syria Humanitarian Needs Overview, 2020.
[2] Humanitarian Needs Assessment Programme, 2020. Population Assessment, January – July 2020, Syrian Arab Republic.
[3] Syria Humanitarian Needs Overview, 2020.
[4] Reference on Syria statistics of NCDs.
[5] Humanitarian Needs Overview, 2019, Syria; https://hno-syria.org/data/downloads/en/full_hno_2019.pdf, accessed 29 July 2020.

hosts approximately 65 percent of registered refugees.[6] Only 8 per cent of this population are currently living in camps, and the majority are struggling to settle in unfamiliar urban and rural communities. Among the determinants of poor health outcomes are extreme poverty; poor living conditions, including lack of clean water and sanitation and crowded makeshift settlements; a shortage of health care facilities and staff; and barriers to access. Evidence also suggests that many refugees face a range of major health conditions that can be life-threatening, including a high prevalence of NCDs such as hypertension and cardiovascular diseases [7,8], and communicable diseases such as tuberculosis and hepatitis B and C. Specific segments of the population face particular challenges – e.g., anaemia and chronic malnutrition in children and women's health (in particular reproductive health).

5. The physical health issues stemming from the crisis are accompanied by mental health issues as well. A global analysis undertaken by WHO indicates the prevalence of mental disorders such as depression, anxiety, post-traumatic stress disorder (PTSD), bipolar disorder and schizophrenia to be at 22.1 per cent at any point in time in conflict-affected populations.[9] A further study suggests that 35-38 per cent of Syrian refugees living in Iraq suffer from PTSD symptoms[10], and other studies find a high prevalence of PTSD and depression among Syrian refugees in Turkey.[11,12, 13]

6. WHO leads the health response to the crisis in Syria, and its engagement in Syria continues to be aligned with the overall UN approach and humanitarian architecture for the Whole of Syria (WoS) response as defined by the WoS Strategic Steering Group (SSG).[14] WHO's response takes into account the need to plan for different response scenarios based on variations in geographic context, governance structures, health needs and access modalities. WHO implements its response through its main office in Damascus and five sub-offices within Syria, complemented by cross-border operations from one external hub in Gaziantep, Turkey (operations extended till July 2021), and until recently from Erbil, Iraq, and Amman, Jordan. WHO's response to the Syria crisis is coordinated from two WHO Regional Offices: the Regional Office for the Eastern Mediterranean (EMRO) and the Regional Office for Europe (EURO).

7. WHO and health partners provide vital health care services to affected populations, including refugees and IDPs, returnees, displaced and host populations. For example, in 2019, WHO's office in Damascus supported over 1.68 million medical procedures and over 8.5 million treatment courses. In addition, WHO provided authoritative technical guidance and expertise, coordinated the work of over 180 health partners and trained more than 25 000 health staff. It also monitored and verified attacks on health care throughout Syria and advocated for the protection of health care and respect for international humanitarian law. [15] In addition, WHO leads in improving

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[6] UNHCR, 2020, https://data2.unhcr.org/en/situations/syria, accessed 30 July 2020.

[7] Strong J, et al. Health status and health needs of older refugees from Syria in Lebanon. Conflict and Health, 2015;9(1):12.

[8] Doocy S, et al. Prevalence and care-seeking for chronic diseases among Syrian refugees in Jordan. BMC Public Health. 2015;15(1):1097.

[9] Charlson, Fiona et al. "New WHO prevalence estimates of mental disorders in conflict settings: a systematic review and meta-analysis" Lancet vol. 394 (2019). doi: 10.1016/S0140-6736(19)30934-1

[10] Ibrahim H, Hassan CQ. Post-traumatic stress disorder symptoms resulting from torture and other traumatic events among Syrian Kurdish refugees in Kurdistan Region, Iraq. Front Psychol. 2017;8:241.

[11] Acarturk C, et al. Prevalence and predictors of posttraumatic stress and depression symptoms among Syrian refugees in a refugee camp. The Journal of Nervous and Mental Disease. 2018;206(1):40–5.

[12] Alpak G, et al. Post-traumatic stress disorder among Syrian refugees in Turkey: a cross-sectional study. International Journal of Psychiatry in Clinical Practice, 2015;19(1):45–50

[13] Chung MC, et al. The relationship between trauma centrality, self-efficacy, posttraumatic stress and psychiatric co-morbidity among Syrian refugees: Is gender a moderator? Journal of Psychiatric Research, 2017;94:107–15.

[14] WHO's Whole of Syria Operations in 2020 - Vision and Approach in 2020

[15] Annual Report 2019, WHO Syrian Arab Republic.

primary health care (PHC) and outreach services, strengthening secondary services, improving public health surveillance of disease outbreaks, strengthening preparedness for and management of trauma, training of health workers and professionals in psychological interventions, and in the provision of essential mental health services.

8. In 2013, WHO established a field office in Gaziantep (GZT) to coordinate cross-border health aid to northwestern Syria (NWS) and fill gaps in the public health system for a population of over 4 million with a focus on life-saving interventions. In addition to providing technical support, service delivery and maintenance of contracts for health implementing partners in NWS, coordination and information management, procurement and logistical support, and maintaining routine immunization through the Syria Immunization Group, WHO GZT also leads the implementation of critical health services, including primary healthcare, vaccination, trauma care and chemical incident management. Key programmes led by WHO GZT in NWS include: Primary Health Care; Secondary Health Care and Trauma Management; Health Cluster Coordination and Information Management; Immunization; Surveillance and Outbreak Response (Early Warning, Alert, and Response Network); Cross-Border Supply Line Operational Support and Logistics; and Management and Administration. Furthermore, the Refugee Health Programme, initiated in 2016 jointly with the Turkish Ministry of Health, has become a WHO flagship model of access to quality, affordable and culturally sensitive health services for refugees with similar standards as those for resident citizens. Since the beginning of this programme, almost 2,000 Syrian health care workers have been trained in seven refugee health training centres to work in one of the 151 such centres throughout Turkey, and over half of these medical professionals have already been hired by the Turkish Ministry of Health to provide health services for Syrian refugees.[16] In addition, WHO country offices in other countries such as Lebanon, Jordan, Iraq, and Egypt actively engage in mobilizing resources and partnerships and in providing necessary services to Syrian refugees.

Rationale

9. This evaluation is being commissioned by EMRO to provide one of the main donors to WHO's Syria response, the United Kingdom Department for International Development (DfID), an independent assessment of WHO's overall response in Syria. In addition, there is sound rationale for the evaluation based on WHO's own internal strategic considerations. The first of these considerations revolves around the resources expended on the Syria crisis: substantial financial and human resources have been mobilized and used by WHO in response to the crisis in Syria. With funding of over USD 302 million in 2016-2020, WHO engages in work together with its partners inside Syria, and from cross-border operations in Gaziantep (and previously from Amman and Erbil as well), to respond to health needs from a whole-of-Syria approach. A similar level of funding is expected for WHO's response to Syria crisis for the foreseeable future.

10. The second consideration leading to the commissioning of this evaluation is rooted in the reality that the Syria response represents a protracted crisis whose future trajectory is uncertain. WHO will continue to play a major role in addressing health needs and vulnerabilities of the affected populations throughout Syria for the foreseeable future. In addition to this, emerging COVID-19 pandemic in the region also necessitates WHO's critical role in supporting the Governments and local health actors in promoting the health and protecting the lives of refugees and IDPs. The on-

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[16] WHO Regional Office for Europe (2019). World Health Organization in Turkey, Health emergency response to the crisis in the Syrian Arab Republic, Annual Report 2018.

going response can and should be aided by the learning that evaluation can bring, in the same way that other humanitarian actors have assessed their response.[17,18,19,20,21,22,23]

11. The third consideration prompting the commissioning of this evaluation centres on the centrality of humanitarian action within WHO's current organizational priorities and overall strategic direction. WHO's 13th General Programme of Work (GPW13) represents a framework not only for how the Organization will achieve results from 2019-2023, but also how it will drive public health impact at country level in a manner that maximizes its contributions to the achievement of the Sustainable Development Goals (SDGs).[24] One of the three ambitious targets of GPW13 is to better protect one billion more people from health emergencies. Understanding and addressing challenges in relation to relevance, coverage, efficiency, and effectiveness of its operations in such an important health and humanitarian crisis as that of the Syria response will be critical in achieving the targets set in WHO's strategic documents. The learning garnered from this evaluation could therefore be of wider benefit to the Organizational as a whole.

12. For these reasons, an independent evaluation of WHO's response to the Syria crisis is timely, as it stands to offer findings and recommendations that can help reinforce both organizational learning and accountability for its Syria operations, and for the Organization more broadly.

Objectives and Purpose

13. The aim of the evaluation is to provide an independent, comprehensive and robust assessment of WHO's emergency response in Syria, including its strategy, interventions, operations, performance and results, as well as its engagement and coordination with partners toward these same ends. The evaluation will document successes, challenges and best practices, and will provide lessons learned and recommendations for future use by management to inform policy and decision-making.

14. The evaluation is intended to serve both learning and accountability purposes. From a learning standpoint, it will offer WHO and its partners an opportunity to reflect on what has worked well and been accomplished in the Syria response, what has worked less well, and why, so as to inform key decisions and actions in the Syria response moving forward in a changing context. As noted above, the learning produced on WHO's Whole of Syria response stands to benefit the Organization's broader work in humanitarian settings, given the centrality of health emergencies (and health in humanitarian emergencies) in the GPW13. From an accountability standpoint, the

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[17] Syria Coordinated Accountability and Learning (CALL) Evaluation Synthesis and Gap Analysis, 2016, https://interagencystandingcommittee.org/system/files/ocha_syria_web_interactive_2.pdf, accessed 30 July 2020. [18] Evaluation of UNICEF's humanitarian response to the Syria Crisis, 2015, https://www.unicef.org/evaldatabase/index_91062.html, accessed 30 July 2020.

[19] Evaluation of the UNFPA response to the Syria crisis (2011-2018), https://www.unfpa.org/admin-resource/evaluation-unfpa-response-syria-crisis-2011-2018, accessed 30 July 2020.

[20] Corporate emergency evaluation of the WFP regional response to the Syrian crisis (January 2015- March 2018), https://docs.wfp.org/api/documents/WFP-0000100097/download/, accessed 30 July 2020.

[21] Evaluation of OCHA response to the Syria crisis, 2016, https://www.unocha.org/sites/dms/Documents/OCHA%20Syria%20Evaluation%20Report_FINAL.pdf, accessed 30 July 2020.

[22] Independent evaluation of the Syria crisis humanitarian and resilience package, 2019, https://www.dfat.gov.au/sites/default/files/syria-crisis-humanitarian-resilience-package-evaluation-report.pdf, accessed 30 July 2020.

[23] Humanitarian programme process evaluation, 2015, DFID Syria Crisis Unit, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/500434/Eval-DFID-Syria-Humanitarian-Prog.pdf, accessed 30 July 2020.

[24] WHO (2018). Thirteenth General Programme of Work 2012-2023, http://apps.who.int/gb/ebwha/pdf_files/WHA71/A71_4-en.pdf?ua=1, accessed 30 July 2020.

evaluation will provide WHO's external stakeholders (e.g., Governing bodies, Member States, donors, partners) with an objective, impartial perspective on these issues in a manner that can help them better understand WHO's accomplishments and challenges in its efforts to achieve results in this very challenging environment – and to enable them to engage in the most meaningful manner with WHO with this knowledge in hand.

15. The principal users of this evaluation will be WHO senior management (e.g., EMRO and EURO Regional Directors, the WHO Health Emergencies Programme, the Director-General), the staff directly involved in the Syria response, and heads of WHO country and field offices. External stakeholders constitute other key users.

Scope and focus

16. The evaluation will assess the relevance, effectiveness, coverage and efficiency dimensions of WHO's response to the Syria crisis. It will look broadly at WHO's entire response to the Syrian crisis from 2016-2020, with a view to assessing its contributions to results, including that of the response from various offices of WHO at local and country levels in EMRO and EURO, and support and coordination with regional and global levels. It will also include the operations in Northeast and Northwest Syria. Although it will cover the past five years of the response (and the frequently changing nature of the situation over these five years, along with the variable state of stabilization in different areas of the country in more recent years), it will, as noted above, also be forward-looking in providing useful and actionable recommendations to facilitate future policy and decision-making.

17. The overarching evaluation questions for this exercise, together with their associated sub-questions, are framed according to the United Nations Evaluation Group (UNEG) evaluation criteria of relevance, effectiveness, coverage and efficiency, as well as the explanatory factors influencing WHO's ability to respond. These questions and sub-questions are as follows:

Evaluation questions	Sub-questions[25]
EQ 1: How well aligned has WHO's response to the Syria crisis been with the stated needs of the government, the specific needs of the affected population, and with WHO's broad approach to humanitarian action and health emergencies in light of the GPW13 and the SDGs as well as its normative guidance on health emergencies? *(Relevance)*	1.1 How well aligned has WHO's response to the Syria crisis been with the stated needs of the Governments involved and with other local authorities and local health actors? 1.2 How well aligned has WHO's response to the Syria crisis been with the specific needs of the affected population? 1.3 To what extent has WHO's response to the Syria crisis been aligned with WHO's broad approach to humanitarian action and health emergencies in light of the GPW13 and the SDGs as well as its normative guidance on health emergencies? 1.4 How has the situation changed over time, and in different areas of the country, and how well has WHO adapted its response to rapidly changing needs and conditions? 1.5 To what extent has WHO's Syria response been explicitly informed by gender analysis and undertaken in a gender-sensitive manner and their geographic locations?
EQ2: What results has WHO achieved in the Syria response, whether intended or unintended? *(Effectiveness)*	2.1 To what extent have the planned objectives and outcomes been achieved by WHO's Syria response? 2.2 To what extent has WHO's Syria response produced unintended outcomes (positive or negative) and how has it managed these? 2.3 Are there any differential results across various vulnerable groups?

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[25] The evaluation sub-questions will be finalised at the inception phase.

EQ3: To what extent has WHO's interventions reached all segments of the affected population, including the most vulnerable? *(Coverage)*	3.1 To what extent has WHO's interventions reached all the most vulnerable groups in Syria (e.g., those displaced, women, children, persons with disabilities, healthcare and aid workers, and other sub-segments of the population)? 3.2 Are there any gaps in terms of the coverage vis-à-vis needs (geographical reach, gender, persons with disabilities and other sub-segments of the population)?
EQ4: How efficiently has WHO used the resources at its disposal (including financial, human, physical, intellectual, organizational and political capital, as well as partnership) to achieve maximum results in the Syria crisis in the timeliest and most efficient manner possible? *(Efficiency)*	4.2 How successfully has WHO been able to deliver services in a timely manner? 4.3 How well has WHO used the financial, human, physical, intellectual, organizational and political capital at its disposal, as well as its partnerships, to achieve results? 4.4 What have been areas of particularly higher and lower efficiency (factoring in issues of opportunity cost as well as standard resource use)? 4.5 How well has WHO addressed the unique challenges of delivering humanitarian aid through cross border and cross line operation?
EQ5: What have been the main internal and external factors influencing WHO's ability to respond in the most relevant, effective, efficient and equitable manner possible? *(Explanatory factors)*	5.1 What have been the main internal factors enabling and inhibiting WHO's ability to respond in the most relevant manner possible? 5.2 What have been the main external factors enabling and inhibiting influencing WHO's ability to respond in the most effective manner possible? 5.3 To what extent has WHO monitored its performance and the factors affecting it, learned from this information and knowledge, and fed these sources of learning into its on-going response?

Methodology

18. The evaluation will rely on a mix of qualitative and quantitative methods, including secondary analysis of documentation and datasets, coupled with primary data collection through interviews, focus groups and surveys as deemed necessary, and any other data collection methods identified during the inception phase. Key stakeholder groups include: WHO staff working directly on the Syria response and those supporting them from various offices at different levels; the Government of Syria; representatives of refugee host governments; donor agencies; United Nations partner agencies; nongovernmental organizations, civil society organizations, and other partners working across Syria; and, whether directly (through primary data collection) or indirectly (through secondary or tertiary data analysis), representatives of the affected populations of Syrian IDPs and refugees. Most or all data collection will likely be undertaken remotely in light of current travel restrictions.

Deliverables

19. At the outset of the exercise the evaluation team will develop an **inception report**, following the principles set forth in the WHO Evaluation Practice Handbook and the UNEG Norms and Standards for Evaluation and Ethical Guidelines for Evaluation. The inception report will include a rigorous and transparent methodology to address the evaluation questions. The evaluation team will adhere to WHO cross-cutting evaluation strategies on gender, equity, vulnerable populations and human rights and include to the extent possible disaggregated data and analysis.

20. The inception report will also provide a detailed stakeholder analysis and a clear indication of which stakeholder groups will be consulted and engaged in the evaluation process, and the approaches and strategies that will be used to identify and reach out to those stakeholder groups. In addition, it will include an evaluation matrix that identifies the overarching data collection methods and specific data sources that will be used to answer each evaluation (sub)question.

21. **The evaluation report** will likewise be based on the quality criteria defined in the WHO Evaluation Practice Handbook. It will present the evidence found through the evaluation in response to all evaluation criteria, questions and issues raised. It should be relevant to decision-making needs, written in a concise, clear and easily understandable language, of high scientific quality and based on the evaluation information without bias. The evaluation report will include an executive summary and evidence-based conclusions and recommendations directly derived from the evaluation findings and addressing all relevant questions and issues of the evaluation. Once finalized, the evaluation report will be posted on the WHO Evaluation Office website (www.who.int/about/evaluation/en/), in keeping with the WHO Evaluation Policy (2018).

22. A joint management response to the evaluation recommendations will be prepared by EMRO and EURO and posted on the WHO Evaluation Office website along with the evaluation report. Dissemination of evaluation results and contribution to organizational learning will be ensured at all levels of the Organization, as appropriate.

Evaluation management

23. The evaluation will be conducted by one or more consultants with extensive experience in the evaluation of humanitarian response, specifically in the context of protracted emergencies and preferably with experience in the evaluation of health emergencies and/or of health interventions in humanitarian emergencies. The evaluation team leader will have demonstrated experience leading such evaluations; s/he will be responsible for the overall conduct of the evaluation under the guidance of the Evaluation Manager and the WHO Evaluation Office.

24. A designated staff member from the WHO Health Emergencies (WHE) team in the WHO Regional Office for the Eastern Mediterranean will serve as Evaluation Manager, with the support of the WHO Evaluation Office for quality assurance and for advice on the evaluation process so as to ensure adherence to United Nations Evaluation Group (UNEG) norms and standards, including maximum independent and impartiality of the evaluation.

25. An evaluation reference group (ERG) will be established in order to ensure the evaluation's relevance, accuracy and utility while still ensuring that it is conducted in an objective, independent and impartial manner. The role of the ERG is to advise on process and to provide feedback on key evaluation deliverables (i.e., the inception report and draft report). The ERG will be chaired by a representative of the WHO Evaluation Office, in keeping with its role in providing overall quality assurance and ensuring an optimal level of independence, impartiality and objectivity in the evaluation and transparency and good practice in the management response process.

Evaluation timeline

26. The evaluation will begin in September 2020 and the finalized evaluation report must be issued to key stakeholders by March 2021.

Key milestones	Date	Comments
Draft inception report	30 September 2020	Based on desk review of key documents provided by WHO and on interviews with a select number of key stakeholders, the draft should reflect evaluation team's understanding of the evaluation objectives and purpose, and of WHO's Syria response. It should also specify the overall approach, scope, methods, stakeholder analysis, and potential uses of and utilization entry points for the evaluation, as well as any other relevant
Final inception report	25 September 2020	Overall quality assurance to be provided by the WHO Evaluation Office. Draft to be revised based on this feedback, and on feedback provided by the ERG in writing and/or in a meeting of the ERG with the evaluation team.
Completion of data collection	16 November 2020	Assistance to be provided by evaluation manager in supplying relevant documentation and materials, as well as stakeholder lists and email introductions between key stakeholders and the
First report draft	15 January 2021	High-quality first draft to be pre-reviewed by the WHO Evaluation Office for overall quality assurance and revision before being shared more widely with the evaluation manager and ERG.
Presentation of report to ERG	28 January 2021	Feedback from the ERG.
Final report	19 February 2021	Evaluation team to address feedback and comments from WHO Evaluation Office, evaluation manager and ERG, and to reflect its consideration of all comments in a matrix summarizing its
Presentation of report to EMRO/EURO management	End February/ Early March 2021	Virtual presentation to the Senior Management.
Dissemination and management response	March- April 2021	Report to be posted on WHO website and disseminated; WHO Evaluation Office to advise EMRO/EURO on management response.