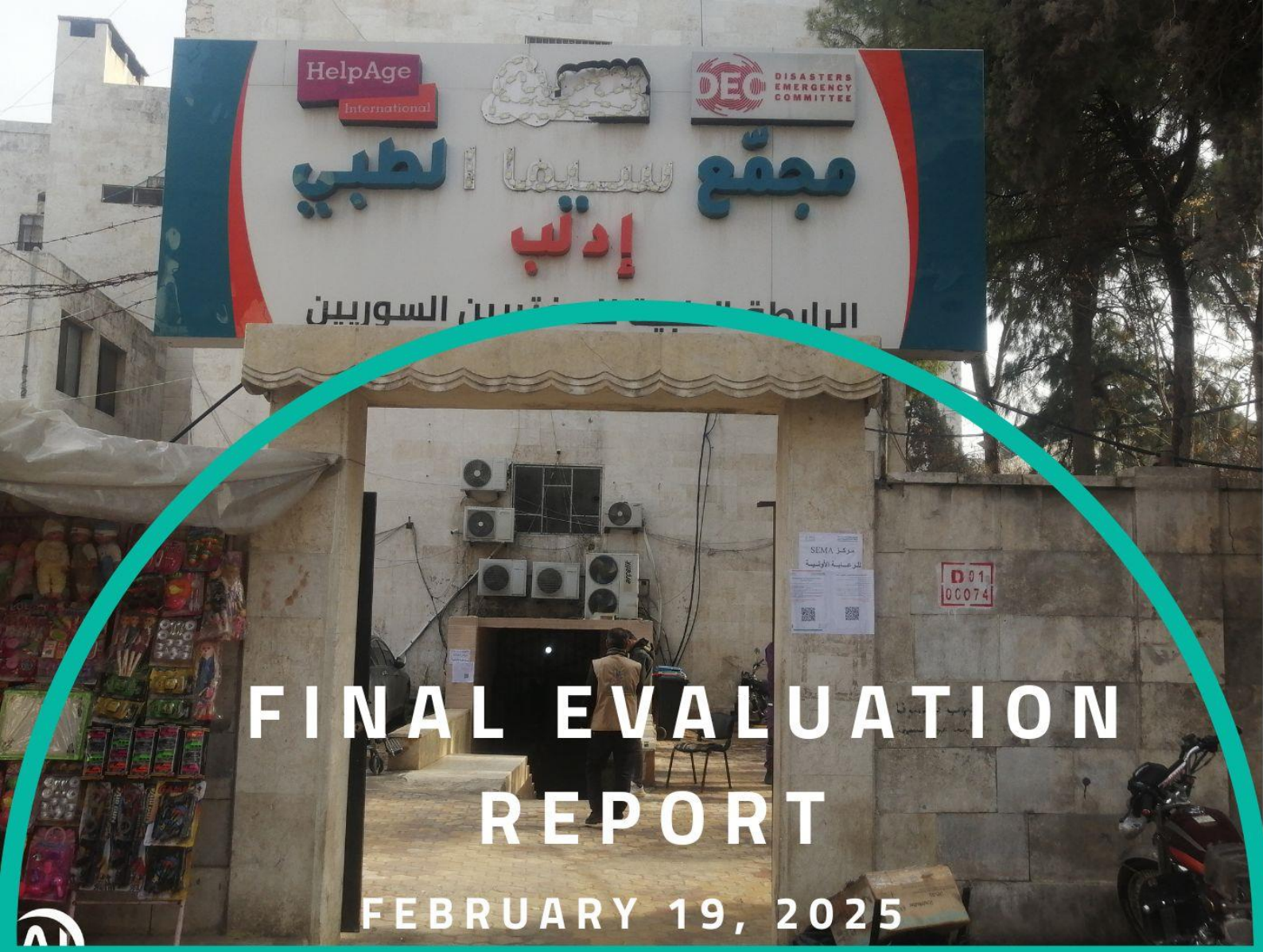

FINAL EVALUATION REPORT

FEBRUARY 19, 2025

MULTI-SECTORAL SUPPORT TO EARTHQUAKE-AFFECTED COMMUNITIES IN NORTH WEST SYRIA

DISASTERS EMERGENCY COMMITTEE

ageInternational

TRUST CONSULTANCY & DEVELOPMENT
شركة ثقة للاستشارات والتطوير

Revival hope

SEMA

ACRONYMS	
CHS	Core Humanitarian Standards
DAC	Development Assistance Committee
DEC	Disasters Emergency Committee
FGD	Focus Group Discussion
GBV	Gender-Based Violence
HAI	HelpAge International
HRO	Hope Revival Organization
HPM	Humanitarian Program Manager
ICU	Intensive Care Unit
IDI	In depth Interview
IGA	Income Generating Activity
ITT	Indicator Tracking Table
KII	Key Informant Interview
MEAL	Monitoring Evaluation Accountability and Learning
MPC	Multi-Purpose Cash
NFI	Non-Food Item
OECD	Organization for Economic Cooperation and Development
PDM	Post Distribution Monitoring
PSS	Psychosocial Support
PWD	Person with Disability

SEMA	Syrian Expatriate Medical Association
SMART	Specific Measurable Achievable Relevant and Time bound
MHPSS	Mental Health and Psychosocial Support
NWS	North-West Syria
PHC	Primary Health Care
WHO	World Health Organization

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EXECUTIVE SUMMARY

INTRODUCTION

Northwest Syria (NWS) continues to face severe humanitarian challenges stemming from prolonged conflict, the 2023 earthquakes, economic instability, and reduced international aid. In response to the earthquakes, Age International's implementing partner, HelpAge International led the project in partnership with the Syrian Expatriate Medical Association (SEMA) and Hope Revival Organization (HRO), implementing the Disasters Emergency Committe (DEC)-funded "Multi-Sectoral Support to Earthquake-Affected Communities in Northwest Syria." Initially launched in February 2023 in response to the earthquakes, the project entered its second phase from August 2023 to January 31, 2025. The project aims to address the urgent needs of earthquake-affected populations in NWS by integrating protection, healthcare, and livelihoods interventions, with a strong focus on older individuals. This evaluation specifically focuses on phase 2 of the project.

METHODOLOGY

The evaluation employed a mixed-methods approach, conducting **18** Key Informant Interviews (KIIs) with stakeholders including HelpAge International staff, implementing partners (SEMA and HRO), health workers, and community leaders. **10** Focus Group Discussions (FGDs) were conducted (**4** healthcare-focused and **6** livelihood-focused), ensuring gender segregation and inclusion of older people and persons with disabilities (PwD). **2** In-Depth Interviews (IDIs) were conducted with microgrant beneficiaries. Additionally, this evaluation included one field observation of the Primary Healthcare Centre (PHC) in Idlib and a comprehensive desk review of project documentation.

FINDINGS

Relevance

The health intervention demonstrated strong alignment with community needs, particularly in specialized services such as gynecology, dental care, and neurology. However, despite the initial consultation plans, community participation in service design remained limited. In the livelihood sector, interventions showed varying relevance across different training types, with dairy production receiving highest satisfaction. The universal feedback highlighted that the $315 microgrant amount was insufficient for sustainable business development.

Effectiveness

The health intervention successfully achieved its primary objectives with particular attention to older people's inclusion. PHC demonstrated strong accessibility features including ramps, wide doors, and priority treatment for older patients, though transportation remained a significant barrier for beneficiaries from remote areas. The livelihood training showed high effectiveness in delivery but faced limitations in impact due to the insufficient microgrant size.

Efficiency

The health sector demonstrated strong resource management and cost-effectiveness, despite challenges with salary disbursements. The early response phase showed particular agility in fund management, successfully navigating the complex banking environment in NWS. The livelihood component, while generally efficient, faced some challenges, particularly regarding the limited number of sewing machines available during sessions and difficulty for some participants attending sessions in cold and rainy weather.

Coherence

The health component demonstrated strong alignment with sector-wide practices and humanitarian coordination mechanisms, particularly through SEMA's established position within the health cluster. The livelihood sector primarily focused on avoiding service duplication through coordination with local councils.

Impact

The health services achieved significant positive outcomes across multiple dimensions, including improvements in physical health, mental wellbeing, and health-related behaviors. The livelihood component showed mixed results - while beneficiaries gained valuable skills and reported improved independence, the economic impact was limited by the small grant size. This was reflected in the PDM data, where 42.19% of microgrant beneficiaries reported no change in well-being, while 34.38% reported feeling much better.

Sustainability

While health beneficiaries reported expectations of long-term positive impacts, particularly in improved health awareness and behavior change, the exit strategy appears to be a work in progress. The livelihood intervention's sustainability was primarily compromised by the insufficient microgrant amount, despite beneficiaries gaining lasting skills and knowledge. Both components highlighted the need for more comprehensive pre-project analysis and stronger focus on transition planning.

BEST PRACTICES

- Accessible appointment system via phone and online links.
- Comprehensive healthcare service availability including assistive devices.
- Effective management of livelihood distribution mechanism.
- Prioritization of older people and PwD in healthcare delivery.
- Practical, hands-on vocational training approach.
- Adaptive project management in emergencies.
- Mid to long term service provision in the same area.

LESSONS LEARNED

- Multiple transfer mechanisms are necessary for operational continuity in NWS.
- General accessibility features need complementing with specialized geriatric services.
- Multi-directional referrals were crucial for effective healthcare delivery in a fragmented context.
- Limited equipment access in vocational training compromised skill development.
- Only selection through online links can exclude older people; integrating FGDs, phone support, or facilitated digital access ensures inclusive participation.
- Partner-led implementation created challenges in tracking older people's specific outcomes.
- Late introduction of exit planning created sustainability challenges.

RECOMMENDATIONS

- Establish regular community consultation sessions including quarterly town halls.
- Enhance needs assessment processes with in-depth FGDs.
- Link needs assessment participants to service recipients, remind them of their input, and inform communities in advance about FGDs, allowing participant nominations.
- Enhance transparency by clearly showing marginalized groups how their input shapes program decisions.
- Develop targeted recruitment strategy for female medical professionals.
- Partner with local transport providers to establish subsidized transport routes.
- Consider mobile healthcare services or teams as feasible alternatives.
- Establish a dedicated geriatric clinic or train geriatric focal points.
- Increase microgrant amounts based on business type and market analysis.
- Explore mentorship programs and integrate cash assistance to ensure proper microgrant utilization.
- Increase sewing machines to match group sizes and ensure sufficient hands-on practice.
- Conduct FGDs to shortlist accessible training topics and adjust session duration to reduce strain while increasing sessions for hands-on experience.
- Strengthen advocacy efforts within humanitarian clusters for older people's specific needs.
- Develop comprehensive remote coordination strategy for emergency situations.

INTRODUCTION

CONTEXTUAL BACKGROUND

Northwest Syria (NWS), similar to the entirety of Syria, faces severe humanitarian challenges stemming from over a decade of conflict, compounded by the 2023 earthquakes, economic instability, and reduced international aid. Across Syria, only 63% of hospitals and 52% of primary healthcare facilities remain fully functional, reflecting the profound degradation of the national healthcare system.[1] Vulnerable groups, such as older people, face mounting barriers to accessing health services, as the system struggles to cope with surging cases of communicable and non-communicable diseases, reproductive health issues, and a long-standing cholera outbreak.[2] The impact of these challenges is particularly acute for older adults, with 57% of those surveyed in NWS reporting at least one disability and 96% living with at least one health condition.[3] These barriers are compounded by limited access to healthcare: 10% cannot access primary healthcare services, 19% cannot access secondary services, and 65% face financial constraints,[4]worsened by the rising cost of medicine due to inflation and sanctions.[5]

This strain on basic health services is mirrored in the protection landscape, where psychosocial distress among affected populations has become pervasive. Women, children, and older people are particularly vulnerable, with the 2023 earthquakes worsening risks such as gender-based violence (GBV), child labor, and family separation.[6] In displaced communities, harmful coping mechanisms like early marriage and the restriction of women's and girls' freedoms have become more entrenched.[7] Older people face compounded challenges, including exploitation and limited access to essential services, further emphasizing the need for targeted mental health and psychosocial support (MHPSS) interventions, as well as broader advocacy efforts to safeguard their rights and dignity.

The economic situation in NWS further exacerbates these vulnerabilities, as prolonged instability has plunged 15.5 million Syrians into food insecurity, with 12.9 million on the brink of hunger.[8] The region's agricultural sector, once a critical livelihood source, has been decimated by deteriorating infrastructure, the effects of climate change, and escalating input costs.[9] This collapse has forced families to adopt unsustainable coping mechanisms, such as reliance on debt and child labor, which

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[1] OCHA,'Syrian Arab Republic: Critical Humanitarian Funding Gaps and Cost of Inaction as Identified for the Period of April - September 2024,'April 17, 2024

[2] WHO,'Afghanistan Health Cluster Bulletin, August 2024,'September 26, 2024

[3] HelpAge International. (2024). Needs assessment of older people: North-west Syria earthquake response

[4] Rapid needs assessment of older people: north-east Syria - HelpAge International

[5] USAID,'Syria - Complex Emergency Fact Sheet #6, Fiscal Year (FY) 2024,' April 9, 2024

[6] Global Protection Cluster. (2023, October). *Protection analysis update: Northwest Syria*

[7] Ibid

[8] UNHCR,'Over 5 million may need shelter support in Syria after quake, 'February 10, 2023

[9] iMMAP. (2023, November). *Crop monitoring and food security situation report: Northwest Syria*.

now affect 86% of households.[10] Rising food prices, driven by currency devaluation, have made basic sustenance increasingly inaccessible.[11] In response to these overlapping crises, and specifically the 2023 earthquakes, the Disasters Emergency Committe (DEC) launched an appeal leading to the implementation of the project 'Multi-Sectoral Support to Earthquake-Affected Communities in Northwest Syria' which aims to address the critical healthcare, protection, and livelihood needs of the most vulnerable populations.

ABOUT THE PROJECT

The multisectoral project, led by Age International's implementing partner, HelpAge International with their implementing partners, Syrian Expatriate Medical Association (SEMA) and the Hope Revival Organization (HRO), funded by the DEC was initially launched in February 2023 in response to the earthquakes. The second phase of the project, running from August 2023 and January 31, 2025, aims to address the urgent needs of earthquake-affected populations in NWS. With a focus on older individuals, the project integrates protection, healthcare, and livelihoods interventions to provide immediate relief while fostering long-term resilience and recovery. This evaluation specifically focuses on phase 2 of the project.

The project's multi-sectoral approach includes a wide range of interventions to support earthquake-affected communities in Northwest Syria. In the health sector, SEMA provides primary healthcare services, including internal medicine, pediatric, gynecology, dermatology, neurological, psychological support, two dental clinics, and a physical therapy clinic, along with a pharmacy, laboratory, and radiology department. Additionally, older people and individuals with disabilities receive social care and rehabilitation services, while mobile clinics offer home based care. Vulnerable individuals, including older people, also have access to dialysis services and mental health and psychosocial support within their communities.

For livelihoods, HRO promotes the economic independence of older people through vocational training, digital literacy training and income generating activities (IGA), such as dairy production, sewing, and cleaning materials production.

The project also provides Multi-Purpose Cash (MPC) assistance, enabling older people to meet their basic needs. In the shelter sector, vulnerable families, including those with older people, receive assistance to meet their shelter and non-food items (NFI) needs. Food security interventions ensure that vulnerable families can access sufficient nutrition.

In protection, the project supports older men and women with protection and psychosocial support (PSS) services within their communities. They also receive assistive devices to enhance their well-being. Additionally, the project emphasizes capacity-building and advocacy, raising awareness of older people's rights, amplifying their voices through community committees, and strengthening the capacity of humanitarian organizations to include older people in programming. Health workers are also trained in palliative care to improve responses in humanitarian crises.

[10] FXStreet Insight Team,' USD/TRY: The pace of Lira depreciation will slow in the year ahead – MUFG,'March 8,2024

[11] iMMAP. (2023, November). *Crop monitoring and food security situation report: Northwest Syria*.

By integrating these comprehensive interventions, the project aims to provide immediate relief while fostering long-term resilience and recovery for older people and other vulnerable populations in Northwest Syria.

Phase 2 of the project, which forms the basis of this evaluation, prioritizes the healthcare and livelihoods components to address the immediate needs of earthquake-affected individuals while supporting their long-term recovery.

Tabel 1: Targeted Individuals According to Sector and Location

Sector	Location	Targeted Individuals
Primary Health Care (SEMA)	Idleb Governorate, Idleb district, Idleb sub-district	66,000 individuals
Livelihoods (HRO)	Aleppo and Idleb Governorates	400 older individuals

PURPOSE AND OBJECTIVES

The evaluation focused exclusively on the core objectives of assessing the impact of Primary Health Care (PHC) services delivered by SEMA and livelihood activities managed by HRO, including vocational trainings, digital literacy workshops and microgrants. These components were central to addressing the critical health and economic resilience needs of earthquake-affected communities in Northwest Syria.

The selection of these activities was influenced by several key factors:

- **Depth of Impact Assessment** – Focusing on two key activities allowed for a more in-depth analysis of their impact while ensuring that resources were allocated realistically.
- **Experience with SEMA Health Activities** – HelpAge International has partnered with SEMA multiple times on similar health initiatives, making this an opportunity to assess the quality and impact of these efforts independently.
- **New Livelihoods Component** – The HRO livelihoods activities were chosen as they represent a new intervention that HelpAge International may consider replicating in other contexts.
- **Independent Selection** – These activities were selected independently by HelpAge International, without external influence from its partners.

Additionally, the evaluation examined the overall effectiveness of the project's implementation, including the coordination between HelpAge International and its partners, SEMA and HRO, and provided recommendations for future programming.

More specifically, the evaluation findings served two main purposes:

1. **Assessment of Project Outcomes:**

The evaluation assessed the effectiveness, relevance, efficiency, coherence, impact, and sustainability of the healthcare and livelihoods interventions. This included a focus on adherence to the Core Humanitarian Standards (CHS) commitments and accountability to the affected communities.

2. **Documentation of Lessons Learned:**

The evaluation documented key insights, best practices, and challenges, including partner feedback on engagement with HelpAge International. This covered areas such as technical support, resource sharing, involvement in decision-making, and capacity-strengthening efforts. These insights are meant to inform Age International's implementing partner,HelpAge International's future programming and partnership strategies.

CONCEPTUAL FRAMEWORK

The final evaluation assessed the project's effectiveness in addressing urgent health and livelihood needs while enhancing the resilience of earthquake-affected populations, particularly older individuals. The evaluation applied the six OECD/DAC criteria—Relevance, Coherence, Effectiveness, Efficiency, Impact, and Sustainability. Additionally, the evaluation specifically examined the cost-efficiency of healthcare and livelihoods activities, their alignment with the Core Humanitarian Standards, and the degree to which the services were inclusive of older people and people with disabilities. To enhance clarity, team has included a detailed evaluation matrix in a separate Excel file as annex 2. This allows stakeholders to easily view the criteria, evaluation questions, sub-questions, and corresponding data collection methods for each evaluation question.

METHODOLOGY

METHODS AND SAMPLING

DESK REVIEW

During the inception phase, the team conducted a comprehensive desk review to build a detailed understanding of the project. This review involved a thorough examination of key project documents provided by HelpAge International, SEMA, and HRO, such as the project proposal, logical framework, monitoring and evaluation plans, indicator tracking tables, internal and donor reports, workplans, and data from monitoring mechanisms, among others. Additionally, HRO shared the Post-Distribution Monitoring (PDM) survey report, which enabled an in-depth assessment of the micro-grants' activity.

This internal review was complemented by an exploration of external secondary sources to contextualize the evaluation and consider any external factors that may have influenced the project. Together, these steps formed a robust foundation for designing relevant evaluation tools and methodologies, ensuring alignment with HelpAge International's goals for the evaluation.

OBSERVATIONS

Trust conducted **one field visit** to the Primary Healthcare Centre in Idlib, where SEMA implements Primary Healthcare consultations. During the inception phase, the team designed a tailored observation checklist specific to the healthcare center. During the kick-off meeting, Trust together

with HelpAge International and SEMA, agreed to focus the observations on the PHC center itself rather than the activities taking place. This decision was made as the vocational training and cash distribution activities had already been concluded, making field observations no longer relevant for the livelihood's component. Instead, HRO agreed to share their Post-Distribution Monitoring (PDM) report with Trust.

For the health component, the checklist guided data collection by assessing key aspects of the healthcare facility, including its infrastructure, resources, and overall service readiness. The field visit also provided an opportunity to validate the project's alignment with the CHS. With HelpAge's approval, the team documented observations through photographs, ensuring adherence to strict ethical guidelines that prevented the identification of any individuals.

KEY INFORMANT INTERVIEWS

Key Informant Interviews (KIIs) were conducted with key stakeholders across project locations and activities. This approach served as a vital source of information from multiple levels and provided a broader overview of the project, stakeholders' perspectives on the implementation, including strengths and challenges faced during project implementation, significant achievements from their viewpoints, and the project's impact on the affected population. KIIs further allowed for the capturing of different viewpoints and insights from stakeholders with in-depth knowledge of the project.

Interviews were conducted with relevant HelpAge International program staff, partners, community leaders and representatives, local authorities, and cluster coordinators, as well as other relevant stakeholders involved in the response. Furthermore, KIIs with implementing partners aimed to gather feedback on the relationship with HelpAge International and support provided to locally led initiatives. Interviews were conducted both in person and remotely, each lasting about an hour. Through a purposive sampling strategy, Trust conducted a total of **18 KIIs** to reach a point of data saturation.

Tabel 2: Key Informant List

Respondent	Modality	Location	Implementing partner	Quantity
HPM EMENA	Remote	Istanbul, Turkiye	HelpAge International	1
Technical Coordinator /Advisor Health (SEMA)	In-Person	Idlib sub-district	SEMA	1
Technical Coordinator/Advisor Livelihood (HRO)	In-Person	Azaz/ Aghtrin sub district	HRO	1
Partner Staff (SEMA, HRO)	In-Person	Idlib sub-district	SEMA HRO	4

		Azaz/ Aghtrin sub district		
KIIs with Doctors/Health workers	In-Person	Primary Health Facility Idlib	SEMA	2
Health center supervisor/director/admin officers	In-Person	Primary Health Facility Idlib	SEMA	1
Trainer for vocational training	In-Person and Remote	Azaz/ Aghtrin sub district	HRO	2
Resilience advisor	Remote	Glasgow, UK	HelpAge International	1
Community leaders/ local authorities	In-Person	Idlib sub district Aghtrin/Azaz sub district	SEMA HRO	2
Health directorate representative	In-Person	Idlib sub district	SEMA	1
Health Cluster Coordinator	In-Person	Idlib sub district	SEMA	1
Older People Committees representatives	In-Person	Azaz/ Aghtrin sub distric	HRO	1
Total				**18**

FOCUS GROUP DISCUSSIONS

Focus Group Discussions (FGDs) were conducted with project beneficiaries to gather in-depth qualitative perspectives on the project's impact. These discussions provided valuable insights into beneficiary needs, challenges in accessing assistance, satisfaction with services, and the overall impact of healthcare and livelihood activities on their lives. The FGDs were segregated by age, gender, and disability to ensure diverse representation, with a particular focus on including older people and people with disabilities (PwD).

A total of **10 FGDs** were conducted, with 4 focused on healthcare and 6 on livelihood activities. Participants were selected using a purposive sampling approach based on beneficiary lists shared by HelpAge International and partners.

For healthcare-focused FGDs, 2 groups were conducted with female participants and 2 with male participants, each group consisting of six participants For livelihood-focused FGDs, 3 groups were conducted with female participants and 3 with male participants, also with six participants per group.

In FGDs with females, at least 50% of participants were 60 years or older, and 10% were persons with disabilities. In FGDs with males, similar inclusion criteria were applied: 50% aged 60 years or older, and 10% persons with disabilities. FGDs were facilitated by same-sex enumerators, following best practices to ensure a comfortable and respectful environment for participants.

Tabel 3: FGD Distribution

Governorate	Facility/Location	Gender segregation	Quantity	Inclusion criteria
Health				
Idlib	Primary Healthcare Centre in Idlib	Females	2	50% aged 60 or 60+ 10% with disabilities
Idlib	Primary Healthcare Centre in Idlib	Males	2	50% aged 60 or 60+ 10% with disabilities
Livelihood				
Aleppo	Azaz Sub-district	Females	1	50% aged 60 or 60+ 10% with disabilities
Aleppo	Azaz Sub-district	Males	2	50% aged 60 or 60+ 10% with disabilities
Aleppo	Aghtrin Sub-district	Females	2	50% aged 60 or 60+ 10% with disabilities
Aleppo	Aghtrin Sub-district	Males	1	50% aged 60 or 60+ 10% with disabilities
Total			**10**	

IN-DEPTH INTERVIEWS

As part of the evaluation**, two In-Depth Interviews (IDIs)** were conducted with beneficiaries of the microgrant program. These interviews provided an opportunity to gather detailed, qualitative insights into the experiences and outcomes of the microgrant recipients. The IDIs focused on understanding how the microgrants impacted beneficiaries' livelihoods, including any challenges faced, the effectiveness of the support received, and the overall contribution of the program to their economic resilience. The findings from these interviews complemented other evaluation data and contributed to a deeper understanding of the program's success and areas for improvement.

The selection of microgrant beneficiaries for the IDIs was done using purposive sampling. HRO provided a list of beneficiaries, from which Trust randomly selected two participants for the interviews, ensuring a fair and unbiased selection process.

MANAGEMENT RESPONSE SESSION

A half-day Management Response Session was conducted remotely, engaging 10 participants from HelpAge International, SEMA, and HRO, including program managers, MEAL specialists, field officers, and advisors. The session aimed to present and validate key findings, facilitate the sharing of experiences, identify common challenges and successes, and develop SMART recommendations.

Held after the submission of the draft evaluation report, the session provided participants with an opportunity to reflect on the findings and offer feedback before the final report was completed. Although the draft report had been shared in advance, the findings were still presented to ensure a comprehensive review and meaningful discussion.

The interactive session featured structured discussions and group activities, focusing on the healthcare and livelihood components of the project. This included the *'Rose, Thorn, and Bud'* reflection exercise, which allowed participants to identify key successes, challenges, and opportunities for improvement. While conducted primarily in English, there was room for questions and discussions in Arabic as needed.

Following the session, the draft evaluation report was updated to incorporate participants' insights and feedback, ensuring that the final report accurately captured stakeholder input and field perspectives.

CHALLENGES AND LIMITATIONS

- Overall, the project did not encounter significant challenges or limitations during data collection. However, one key limitation was the unavailability of trainer for KII due to the expiration of his contract by the time the operations team-initiated data collection.
  Mitigation: To address this, the team conducted one remote interview with a trainer to ensure relevant insights were still captured.

Despite this minor challenge, the evaluation process benefited from strong collaboration and transparent communication among all stakeholders. HelpAge International was highly collaborative, ensuring that implementing partners (SEMA and HRO) were involved from the very beginning.

Partners were included in the kick-off meeting, consistently CC'd in email communications, and engaged in a transparent process throughout. SEMA and HRO were also highly cooperative, actively participating in meetings, promptly sharing project documents, and providing clarifications during data collection. This seamless coordination and openness significantly contributed to the efficiency and effectiveness of the evaluation.

FINDINGS

RELEVANCE

Health Services

The health intervention demonstrated strong relevance to community needs, according to FGDs with beneficiaries in Idlib. Both male and female beneficiaries consistently reported that services met their requirements, particularly in gynecology, dental care, and neurology services. The free nature of services was especially valued, making healthcare more accessible to vulnerable groups. One female health beneficiary noted:

"There is no shortage of services required for visitors. The center has a radiology department, which is rare and highly needed, and also two dental clinics, one for men and the other for women. This is not available in every center or hospital, helping accommodate a larger number of visitors in one day."

Female Health Beneficiary, FGD, Idlib

This assessment was corroborated by medical staff KIIs, who emphasized the comprehensive nature of service provision across multiple departments and highlighted special attention to older people's needs through priority treatment and accessibility features.

In addition to beneficiary feedback, field visit confirmed that key healthcare resources were both available and accessible. The team observed that:

- Essential medicines were visibly stocked and available for free distribution.
- Patients were clearly informed about which medications were available at no cost. The pharmacy was designed with accessibility features, including ramps, clear signage, and low counters, ensuring ease of access for older people and people with disabilities.

Picture 1: Drug Storage Room

Picture 2: Pharmacy

However, while the services were relevant, community participation in their design and implementation was perceived as minimal. Across all four health beneficiary FGDs (two male, two female), the majority reported no involvement in planning or implementation, with only one female beneficiary mentioning that she had suggested the inclusion of advanced echo services in the women's clinic. While male beneficiaries indicated awareness of community meetings and the center's interest in community input, none had directly participated.

"I didn't directly participate in the planning or implementation of the health services, but I heard the center holds meetings with the local community."

Male Health Beneficiary, FGD, Idlib

However, a desk review of project documents revealed that according to HelpAge International's narrative plan[12], a diversity of stakeholders, including local councils, local leaders, older people, and PwD, had been consulted during Phase 1 and were expected to continue engagement in Phase 2. The plan outlined that:

- Design Phase: Access to services was one of the key messages shared by older people and PwD during Phase 1 implementation.
- Planning Phase: The activity plan was to be developed with input from local councils, local leaders, older people, and PwD.

12 HelpAge, DEC Turkey-Syria Earthquake Appeal Phase 2 Narrative Plan, June 2023

- Implementation Phase: Health services, including outpatient consultations, awareness-raising, and psychosocial support activities, were expected to involve active engagement from beneficiaries.

This contrast between documented project plans and beneficiaries' experiences suggests a possible gap in ongoing engagement and communication. While initial consultations were conducted at the project's start (Phase 1), beneficiaries currently feel disconnected from the planning process. One possible explanation for this disconnect is the two-year time lapse since these initial assessments, which were conducted by partners like SEMA and HRO. Additionally, the post-earthquake context disrupted operations, with many partner staff evacuating, leading to reduced community engagement.

While the services and equipment provided were highly perceived as relevant and comprehensive, one health staff member identified some operational needs, including additional female surgeons, specialists in endoscopy and digestive diseases, gastroscopy equipment, a dedicated gastroenterology clinic, and enhanced post-surgery care services.

Table 4 below provides an overview of the functional status of various clinics and diagnostic services observed during the field visit. It also details the number of full-time and part-time doctors/staff available at each clinic at the time of the visit. While most clinics were operational, the Psychiatry Clinic was found to be non-functional, with no staff available. Other clinics had varying numbers of full-time and part-time doctors, ensuring the provision of essential healthcare services.

There is no dedicated geriatric clinic within the center. Older patients receive healthcare services like any other beneficiary but are given priority in care. Additionally, on the top floor of the facility, there is a nursing home that operates separately from the healthcare center. If any of the residents require medical attention, coordination is facilitated through a designated representative to ensure they receive the necessary healthcare services from the center.

Tabel 4: Functional Status of Clinics and Doctors/ Staff

Question	Functioning	No of full-time doctors/staff	No of part-time doctors/ staff
Internal Medicine Clinic	✓	0	1
Paediatric Clinic	✓	0	1
Gynaecology Clinic	✓	0	1
Dermatology Clinic	✓	0	1
Neurology Clinic	✓	0	1
Psychiatry Clinic	✗	0	0
Dental Clinics	✓	2	0
Physical Therapy Clinic	✓	0	2

Geriatric Care Clinic	✗	0	0
Laboratory	✓	0	2
Radiology Department (MRI/CT/X-ray)	✓	5	2
Pharmacy	✓	2	0

Livelihood Services

The livelihood interventions showed varying degrees of relevance across different training types. Both male and female beneficiaries reported that dairy production training was highly relevant and provided comprehensive coverage of necessary skills. The sewing training presented more mixed results - while female beneficiaries reported it was suitable, one trainer noted that older participants faced physical challenges such as back pain and eyesight difficulties. However, the training remained valuable as participants could apply these skills both for potential income generation and for practical household needs like clothing repair and maintenance.

HRO implemented a multi-layered approach to community consultation for livelihood activities. The organization conducted surveys with the families of older people, particularly targeting households with older members, and held weekly meetings with older people committee representatives to identify priority training programs. These consultations informed the selection of training options that were then offered to beneficiaries through an online link.

However, at the beneficiary level, participation was primarily experienced as choosing from pre-selected training types. FGDs with both male and female beneficiaries in Azaz and Aghtrin indicated their involvement was limited to selecting their preferred training through the online system, with one male group noting they were simply informed of acceptance without awareness of the broader planning process. This disconnect between the preliminary community consultation process and beneficiaries' perception of their involvement suggests a potential gap in communicating how community input shaped the program design.

"I did not participate in making any decision other than the type of training I will attend."

Female Livelihood Beneficiary, FGD, Aleppo

During the management response session, the Age and Inclusion Specialist pointed out a key challenge: the groups consulted during the initial assessments often differed from those who ultimately received services. This observation helps explain the gap between initial consultations and beneficiaries' perceptions of their involvement in the program.

The session also emphasized that participation should be viewed as more than just the design phase—it includes how beneficiaries experience and provide feedback on services throughout the program's implementation. This broader view clarifies why, despite the strong relevance of services, beneficiaries reported limited participation beyond selecting their preferred training. The project's

narrow definition of engagement may have overlooked ongoing involvement through service delivery and feedback mechanisms.

Community leaders showed varying levels of engagement. While Idlib's community leader reported no direct involvement in decision-making processes, Azaz/Aghtrin local authorities were consulted regarding training locations, leading to a venue change from Aghtrin to Turkmen Bareh. The Older People Committee representatives reported more structured involvement through regular meetings and needs assessment surveys, which influenced the selection of training programs suitable for older participants.

Moreover, while detergent manufacturing training was based on community preferences, some participants expressed interest in additional skills like soap and toothpaste making. However, these additions would require separate equipment and training modules beyond the current program's scope. A consistent finding across multiple sources was the inadequacy of the grant amount ($315) to establish sustainable businesses, with microgrant beneficiaries reporting minimal involvement beyond identifying their equipment needs.

EFFECTIVENESS

Health services

Health intervention appears to have achieved its primary objectives, with particular attention to older people's inclusion, though with some areas for improvement. According to the Project Staff, the project achieved all planned indicators and sometimes overachieved in improving access to health and MHPSS services.

The intervention demonstrated particular effectiveness in its rapid response capabilities, with the organization accessing DEC funds within the first week of the appeal to enable immediate emergency assistance. Moreover, the health center demonstrated a clear commitment to older people accessibility, as evidenced in FGDs with health beneficiaries who consistently noted priority treatment for older patients, accessibility features, and specialized facilities.

"The center is dedicated to offering the best services of excellent quality, with a specific focus on older people. They are prioritized in receiving treatment... The center has successfully met the critical healthcare needs of the older people, people with special needs, women, and all community groups."

PHC Supervisor

Additionally, a female FGD participant from Idlib, who has special needs, shared her positive experience regarding the center's accessibility:

"I am a person with special needs, and I often face difficulty using public facilities, but in this center, the experience of using the restrooms was very comfortable and easy. The facilities were spacious enough to move a wheelchair, and the handles were available in appropriate places to facilitate movement. In addition, the cleanliness was excellent, and water was constantly available. There are special toilets for the elderly and people with special needs. This attention to the needs of people with special needs makes me feel comfortable and welcome."

Female Health Beneficiary, FGD, Idlib

The center's commitment to accessibility is further reflected in physical infrastructure improvements, such as wheelchair-accessible ramps and wide, passable doors.

Picture 3: Wheelchair Passable Door

Picture 4: Facility Enterance with Accessible Ramp

A brief observation of the PHC center confirms its accessibility and service quality:

Tabel 5: PHC Accessibility Observations

Question	Response
Are the opening hours clearly displayed?	Yes
Is the PHC accessible for people with disabilities?	Yes
Are all doors wide enough for a person in a wheelchair to pass through?	Yes
Are there assistive devices available at the entrance for beneficiaries?	Yes
Are the services offered displayed in a place visible to patients?	Yes
Is the facility well-maintained?	Yes

The Health Cluster Coordinator feedback confirms the intervention's effectiveness, particularly noting HelpAge International's contribution to addressing gaps in older people care services. The provision of essential medical equipment, medicines, and specialized health services for older people chronic conditions were highlighted as key achievements.

However, several challenges were identified. Medical staff KIIs reported high patient volume creating pressure on services, though this was partially mitigated by support staff. Transportation emerged as a significant barrier for older beneficiaries from remote areas, with multiple stakeholders, including the PHC supervisor and community leaders, suggesting the need for dedicated transportation services for older people. However, during the management response session, SEMA staff cited funding

constraints as the primary reason transportation support had not been integrated. In response, HelpAge International's Humanitarian Program Manager noted that this issue could have been anticipated and addressed during initial planning, suggesting that incorporating transportation costs early on would have allowed for dedicated funding streams.

This highlights a key gap in adaptive planning—while the post-earthquake context necessitated a rapid response, enough time has now passed for transportation services to be incorporated into the program's framework. The later observation was mirrored in the KII with HelpAge International who desired stronger inclusion of older people, citing that while SEMA's implementation included accessibility features like ramps and elevators, it still lacked specific geriatric clinics or specialized services for older people.

Livelihood services

The qualitative analysis indicates that the livelihood intervention was highly effective, particularly in the delivery of training. According to the KIIs and FGDs alike, the project showed explicit focus on older people inclusion, with the HRO's livelihood component being 100% focused on older people and incorporating their consultation into the design of vocational training.

The intervention's effectiveness was supported by several factors, including strong coordination with local authorities, careful beneficiary selection processes, and practical training approaches including product exhibitions. The Older People Committee representative noted regular consultations through meetings and surveys to understand older people's needs, indicating strong inclusion in program design.

However, the universal feedback pointed to insufficient financial support ($315) suggesting a significant limitation in achieving sustainable livelihood outcomes for older beneficiaries. This concern was particularly acute given the target population's vulnerabilities and additional needs. Consistent feedback across all livelihood FGDs requested increased grant amounts, with specific suggestions ranging from $1,000 for dairy projects to $1,500 for detergent manufacturing.

The MEAL coordinator at HRO noted that initially, the allocated amount per beneficiary was higher and intended for a selected group of the most vulnerable trainees. However, following discussions with the Protection Committee, indirect feedback from beneficiaries, and consultations with key stakeholders, HRO, with partner approval, reallocated the budget to ensure that all vocational training participants receive financial support to start their businesses. This approach prioritized inclusivity and broader impact, even if it meant adjusting the individual grant amounts.

"The training was excellent, and the trainer was excellent in all aspects. We learned theoretically and applied practically everything we were taught. But the financial amount of $315 is small, and buying the required equipment takes more than half of it."

Male Livelihood Beneficiary, FGD, Aghtrin, Aleppo

Technical coordinators and beneficiaries consistently reported that while the training enabled participants to gain skills, the limited financial support hindered their ability to establish sustainable businesses. Addressing this challenge in future programs may involve strengthening post-training

support, facilitating access to additional funding opportunities, or incorporating phased financial assistance based on business progress.

Findings from the PDM report[13] conducted by HRO reinforce this concern. Of the 129 beneficiaries who received microgrants, the PDM was conducted with 50% (64 beneficiaries). When asked "How satisfied are you with the grant and training provided by HRO for your business?" 51.16% said they were not quite satisfied, 37.21% responded with yes absolutely satisfied, 9.30% stated they were mostly satisfied and the remaining respondents (2.33%) reported not being satisfied at all.

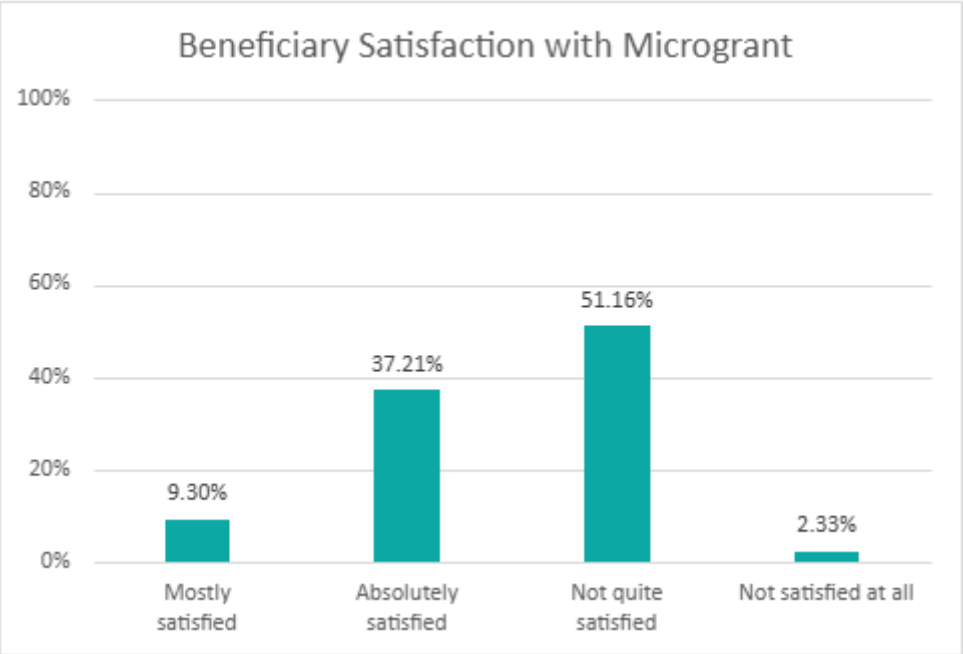


Figure 1: Beneficiary Satisfaction with Microgrant

These findings highlight significant dissatisfaction with the financial support component of the intervention, aligning with FGD and KII feedback regarding the grant amount being insufficient to establish sustainable livelihoods.

The scale of the intervention also presented challenges in terms of reaching the older population effectively. According to the Older People Committee representative, while the project maintained high-quality standards, it only reached 130 beneficiaries in an area with a much larger older people's population, suggesting limitations in the project's overall impact on the older people's community's economic independence.

[13] HRO, PDM report IGA activity, Dec 15,2024

EFFICIENCY

Health Services

The data indicates varying levels of efficiency across the health and livelihood components of the intervention. In the health sector, resource management and cost-effectiveness demonstrated overall positive outcomes, with comprehensive coverage of essential services and materials.

"The support provided has been excellent, estimated at around 90%. Everything requested—medications, consumables, center maintenance, operational costs, equipment repairs, and building renovations—has been fulfilled to the highest standard."

Primary Healthcare supervisor, Idlib

The early response phase demonstrated both operational agility and innovation in fund management. Despite the challenging operating environment in NWS, the organization developed alternative fund transfer mechanisms to overcome banking delays. They mobilized significant funding within the first week, enabling rapid implementation through partners. This agile financial management was crucial given the complex logistics of transferring funds into Syria, which required coordination between Turkish post offices and internal hawala systems. This was corroborated by medical staff who reported adequate provision of resources. However, significant systemic challenges emerged at the program management level, particularly regarding staff costs and resource integration.

"Cost-effective aspects included all staff being local, resulting in lower salary scales... However, the service-based program nature meant high staff costs... Donors sometimes view doctors as staff rather than service providers... [There is a] need for more integrated work to improve cost-effectiveness."

KII with Project Staff

While operational funding remained consistent, the intervention faced recurring challenges with salary disbursements. Multiple stakeholders, including medical staff, PHC supervisors, and program staff, reported delays in salary payments, though this did not significantly impact service delivery.

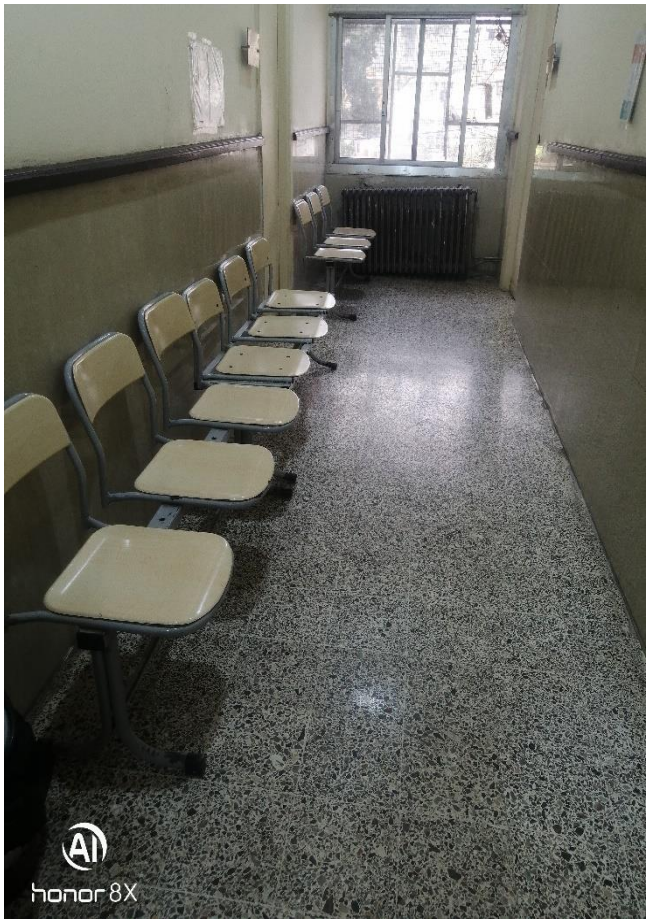
Beyond financial and operational efficiency, the availability and preparedness of staff play a crucial role in ensuring smooth service delivery. The following table summarizes key staffing and resource management factors at the PHC.

Tabel 6: PHC Staffing and Resource Readiness

Question	Response
Are patient files stored and archived correctly?	Yes
Are the staff whose names are registered on the employment list available today?	Yes
How many female staff members are at work today?	8

How many male staff members are at work today?	20
Have staff received training to work and communicate effectively with older people and people with disabilities?	Yes
Is there dedicated staff visibly available to assist older people and people with disabilities?	Yes
Are there visibly designated services or supplies for people with incontinence? (e.g., adult diapers, absorbent products)	No
Are there visibly designated services or materials for people with dementia? (e.g., quiet rooms, dementia-friendly signage)	No
Are there rooms available for private consultations?	Yes

The internal supervision system proved effective, with multiple sources confirming active monitoring and evaluation processes. An observation of reception and waiting areas was conducted to evaluate their accessibility, organization, and ability to support vulnerable groups. It was noted that the reception staff were able to assist vulnerable beneficiaries in navigating the facility, directing them to waiting areas, latrines, and specific departments. The waiting area was spacious, with clear signage and separate spaces for men and women. The area was accessible for all beneficiaries, including those with disabilities, and had sufficient seating and sterilization materials available.



Picture 5: Spacious Waiting Area


Picture 6: Patient Capacity in Waiting Area

The following table 7 summarizes key observations from the assessment. It was observed that there were no security guards or personnel providing security during the visit. Despite this, when asked during the FGDs about the feeling of safety while entering and receiving services at the center, beneficiaries expressed that they felt safe due to the presence of surveillance cameras installed throughout the center. They also noted that the presence of fire extinguishers contributed to their sense of security. Clear signs and easy-to-follow directions further helped beneficiaries navigate the center safely, providing additional peace of mind during their visit.

Tabel 7: PHC Reception and Waiting Area Observations

Question	Response
Are the reception staff able to help vulnerable beneficiaries to find waiting areas, latrines, specific departments within the facilities, etc.?	Yes
Does the waiting area have separate spaces for men and women?	Yes
Is the waiting area space sufficient for patient capacity?	Yes
Is the waiting area clearly designed to be accessible for all beneficiaries (e.g., ramps, wide spaces, accessible seating)?	Yes
Are there sterilization materials provided in the waiting areas?	Yes
Are there security guards or people providing security?	No
Is there visible accommodation for communicating with deaf people? (e.g., sign language interpreters, communication boards)	Yes
Are there male and female accessible toilets clearly marked and available?	Yes
Is the waiting area accessible for all, including older adults and people with disabilities?	Yes

Livelihood services

Overall, while the livelihood intervention showed positive outcomes in several areas, it also faced some efficiency challenges, particularly concerning resource allocation. Trainers reported that the number of sewing machines available during training was insufficient for the group size, which limited their practice opportunities. Moreover, the timing of activities was generally well-executed, with winter implementation benefiting participant engagement, though some participants - especially those traveling by motorcycle or on foot - faced transportation difficulties during cold and rainy weather. Community leaders emphasized that despite good quality training, the limited grant sizes constrained potential impact.

The efficiency of service delivery was also questioned from a broader perspective during the management response session. Participants emphasized that defining clear objectives at the outset could have greatly enhanced overall efficiency. As one participant noted: *"It is hard to define what is efficient if we did not decide what the objectives were."* Moving forward, it would be beneficial to establish these objectives in the weeks following the initial response. By setting clear goals after 2-3

weeks (or months) of emergency activities, the program could have better optimized its resources and ensured that interventions were both more focused and impactful.

COHERENCE

Health Services

The health component of the intervention demonstrated strong coherence with sector-wide practices and humanitarian coordination mechanisms. According to the Health Cluster Coordinator, there was systematic coordination between key actors, particularly HelpAge International and SEMA, with regular information exchange and balanced resource distribution to avoid service gaps.

The intervention's coherence was significantly strengthened through partner-led coordination mechanisms. Without maintaining their own office in Gaziantep, HelpAge International relied on implementing partners' established positions within coordination structures - particularly SEMA's strong alignment with the health cluster. According to the desk review of project documents, HelpAge International actively participated in relevant coordination platforms, including the Health and Protection Clusters, while its implementing partners were well integrated into both UN-led and NGO-led coordination systems in Turkey and Syria. Partners also contributed 4Ws information to the clusters, ensuring that activities were coordinated effectively and that duplication of services or geographic overlap was avoided [14] . This coordination ensured structured collaboration, preventing duplication of activities and geographic overlap, and enhancing the integration of primary healthcare services within the broader humanitarian response framework.

Picture 7: Complaint and Suggestion Box

The Health Directorate confirmed this coordinated approach, describing a unified planning system where *"all partners work under one plan that ensures the integration of the services provided, including primary, secondary, and other healthcare services."* This systematic coordination was evident at the facility level, where medical staff reported active referral networks both internally between departments and externally with other healthcare providers for specialized services like ICU care and imaging.

Furthermore, the integration of beneficiary feedback into service provision is a key component of ensuring coherence in health services. Ensuring beneficiaries have accessible channels for feedback and complaints enhances the responsiveness and alignment of services with community needs. Below is a summary table of the feedback and complaint mechanisms in place at the PHC.

[14] ibid

Tabel 8: Feedback and Complaints Mechanisms

Question	Response
Is there any visible information (such as posters or brochure) on feedback and complaint mechanisms around the PHC?	Yes
Is there a place (such as a suggestion box) where beneficiaries can submit feedback or complaints?	Yes
Is there a phone number visible where beneficiaries can submit feedback or complaints to?	Yes
Is there a method for beneficiaries to submit complaints or feedback anonymously?	Yes
Is there any information on how feedback and complaints are processed and addressed?	Yes
Are feedback and complaint mechanisms accessible to all beneficiaries, especially older adults?	Yes

Picture 8: Feedback and Complaint Mechanism Display

Project staff interviews revealed strong participation in clusters and alignment with international standards, noting that mental health support was based on WHO guidelines. However, they identified a need for stronger advocacy within clusters, particularly regarding older people's needs, suggesting room for improvement in utilizing coordination mechanisms for systemic change. During the

management response session, SEMA staff confirmed existing processes for sharing needs assessment data at the cluster level, but participants identified opportunities for better utilizing existing project data for advocacy purposes. This input highlights a critical area for improvement in advocacy within clusters—while coordination is strong, the potential for systemic change and enhanced inclusion of older people's needs within the clusters may be underutilized. By leveraging existing project data more effectively, there is an opportunity to advocate for more inclusive policies and services that are better tailored to the needs of vulnerable groups, especially older people.

Livelihood services

In the livelihood sector, coherence patterns were more localized. According to community leaders in Azaz/Aghtrin, coordination focused primarily on avoiding service duplication, with the local council playing a key role. They noted that Ihyaa Al-Amal was the only organization implementing vocational training and small grants in their area, suggesting limited opportunity for direct coordination with similar programs. The intervention aligned with standardized humanitarian cash assistance approaches, following established working group guidance on payment structures and timing for emergency and ongoing support.

The vocational training component showed varying levels of coordination awareness among different stakeholders. While some trainers reported having no information about coordination with other organizations, the Older People Committee representatives described an active case management system:

"There is case management in this regard, where the committee contacts and visits them to ensure their situation... However, there was a care center for older people, and the committee contacted the center's director before its closure and consulted him regarding activities during the planning stage."
KII with Older People Committee Representative

IMPACT

Health Services

The health services demonstrated significant positive impact across multiple dimensions. According to FGDs with health beneficiaries, both male and female participants reported substantial improvements in their health conditions across various specialties. Female beneficiaries particularly highlighted improvements in maternal health care, with multiple participants noting reduced anxiety during pregnancy and better prenatal care.

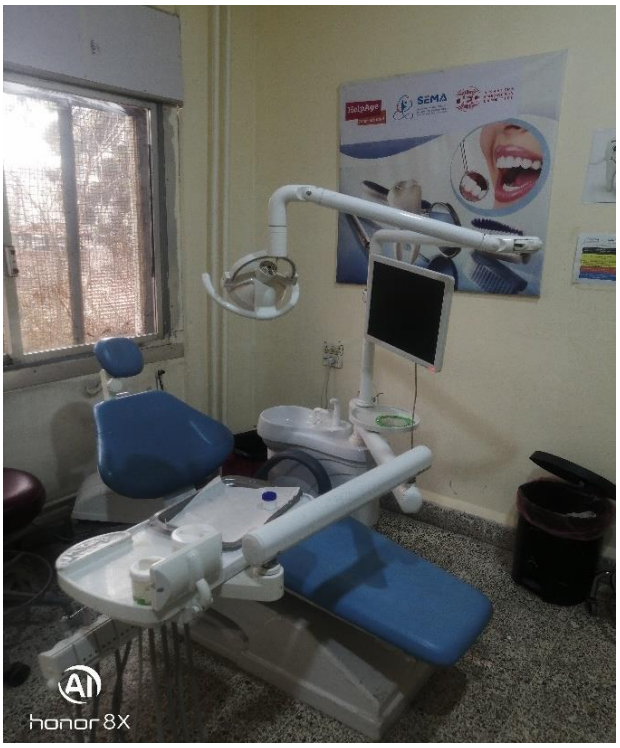
"The women's clinic at the center was a great support for me. I was suffering from some women's health problems, but after I started regular follow-ups at the center, my condition improved significantly... I feel comfortable and safe and know that I am getting the health care I need."
Female Health Beneficiary, FGD, Idlib

Male beneficiaries similarly reported positive health outcomes, particularly in managing chronic conditions and improving mobility. The impact manifested in several key areas:

1. Physical Health Improvements:

- Better management of chronic conditions (diabetes and blood pressure)
- Relief from acute conditions (dental pain, skin problems)
- Enhanced mobility and reduced neurological symptoms

2. Mental Health and Wellbeing:
   - Reduced anxiety, particularly among pregnant women
   - Improved confidence in health management
   - Enhanced sense of security in accessing healthcare
3. Behavioral Changes:
   - Increased proactive health management
   - Adoption of better health and hygiene habits
   - Regular health monitoring practices



Picture 9: Dental Clinic Room

The impact extended beyond direct health outcomes to behavioral changes. FGD participants across gender groups reported adopting healthier habits and taking more proactive approaches to health management. This included regular health monitoring, improved dietary habits, and better adherence to treatment regimens. As observed by medical staff in KIIs, these behavioral changes were supported by the center's emphasis on health education and preventive care.

Community leaders and the Health Directorate representative particularly noted the impact on the older populations. The provision of early diagnosis and appropriate treatment services was reported to have enhanced the quality of life for older community members. The PHC supervisor emphasized how the priority system for older patients and accessibility features contributed to improved health outcomes for this vulnerable group.

Livelihood Services

The livelihood component showed mixed impact. FGDs with beneficiaries across all groups revealed that while the training provided valuable skills and knowledge, the economic impact was limited by the small grant size. Both male and female participants consistently reported that while they gained professional skills in areas like dairy production, detergent making, and sewing, the $315 grant was insufficient to establish sustainable businesses.

The training did achieve some positive social impacts. Female beneficiaries reported improved independence and communication skills, with some noting they could now contribute to household expenses rather than depending on family members. Male participants highlighted the value of learning age-appropriate skills that allowed them to continue working without physical strain.

However, as noted by the community leaders and vocational trainers in their KIIs, the overall economic impact was constrained. While some beneficiaries managed to establish small-scale operations, most reported only minimal improvements in their financial situation. The Older People Committee representative highlighted that while the project helped meet basic needs, its reach was limited given the large elderly population in the area.

According to the PDM report shared by the HRO, 50% of the micro grant beneficiaries (64 out of 129) who were surveyed regarding their well-being compared to before receiving the grant. The results were as follows: 42.19% reported that their well-being remained about the same, 34.38% reported feeling much better, and 23.44% reported that their well-being was somewhat better. These findings indicate that while a portion of beneficiaries saw some positive changes, a significant percentage still reported no substantial improvement in their overall well-being, which aligns with the earlier observations regarding the limited economic impact of the small grant.

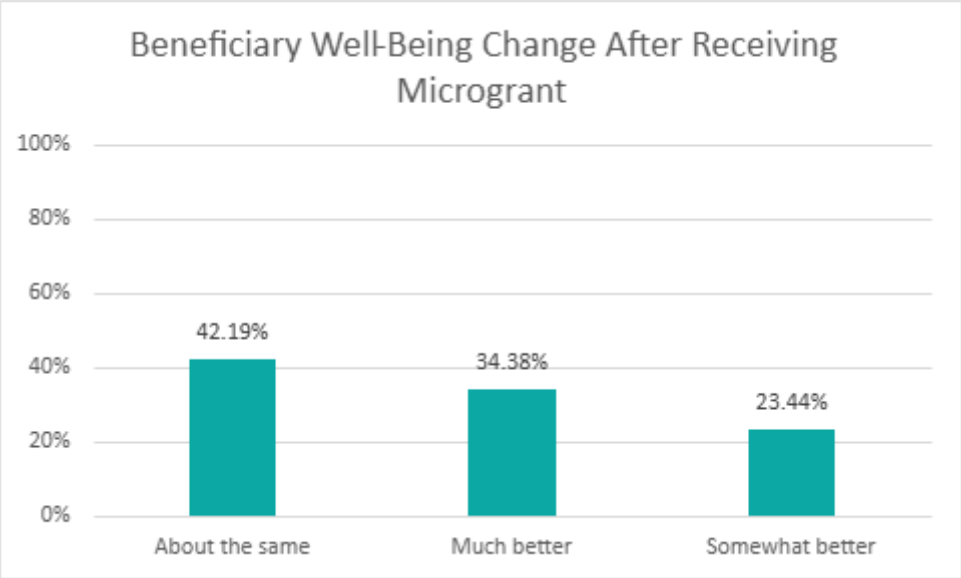


Figure 2: Beneficiary Well-Being Change After Receiving Microgrant

HelpAge International and partner staff interviews revealed that while the project met its numerical targets, the depth of impact was limited by financial constraints. Several KIIs noted that beneficiaries often had to choose between purchasing equipment and materials, limiting their ability to fully utilize their new skills and establishing sustainable livelihoods.

Thus, while the project's focus on skill-building is crucial, the Humanitarian Resilience Advisor pointed out during the session that the broader market conditions and demand ultimately determine whether these skills translate into sustainable livelihoods. He noted that, although the grant model was adjusted to serve more people with smaller grants, the core issue remained that the scale of support was insufficient, which can be addressed by expanding the grant size or incorporating additional support mechanisms.

To optimize the economic impact, several suggestions were raised during the management response session, including the addition of mentorship support. This could help beneficiaries better leverage their small grants and newly acquired skills, guiding them on how to navigate local markets and scale

their small businesses. Furthermore, integrating Multipurpose Cash (MPC) assistance would allow for more flexible financial support, ensuring that the grants are used for their intended purposes, whether it's for operational costs or materials that beneficiaries are unable to afford with the initial grant.

Additionally, leveraging community mechanisms like 'jamia' (community savings groups) could provide an additional layer of financial sustainability, enabling beneficiaries to pool resources and access funds beyond the program's constraints. Participants also highlighted the importance of connecting beneficiaries with external government and private sector opportunities, which could provide pathways to scale their businesses and access formal economic systems.

SUSTAINABILITY

Health services sustainability

Health beneficiaries consistently reported expectations of long-term positive impacts from the services provided. All beneficiary FGD participants across both male and female groups indicated that the services would have lasting effects on both individual and community levels. Sustainability was particularly linked to improved health awareness and behavior change. A male FGD beneficiary from Idlib shared the long-term impact of health services:

"The service had a long-term impact because the treatment and healthcare attention encouraged me to adopt new healthy habits and become more aware of my physical health."

Male Health Beneficiary, FGD, Idlib

However, the exit strategy appears to have faced some challenges and uncertainties. According to the Project Staff, while there were initial plans for sustainability including capacity building with local institutions and gradual handover to the community, some components weren't fully implemented. For instance, SEMA's proposal to charge small fees for PHC services wasn't implemented, as explained during the management response session. This fee structure could be considered as a backup plan in case the facility was unable to secure additional grants. Additionally, planned community consultations in the final two months were affected by context changes. The project is currently exploring handover of the PHC center to the Ministry of Health.

The health center's Technical Coordinator emphasized sustainability efforts through continuous monitoring, staff training, and health awareness activities. However, the data suggests that transportation challenges for older beneficiaries and the need for specialized geriatric services remain unresolved sustainability concerns. Furthermore, program staff advocated for "a more sustainable attitude" that would look at transition possibilities rather than just exit planning, noting that organizational focus often defaulted to cost recovery considerations over sustainability planning.

A desk review of project documents suggests that the exit strategy was designed to ensure service continuity through local stakeholder ownership and integration into existing systems. The planned strategy emphasized ongoing training and capacity building for local NGOs, community-based organizations, and leaders, aiming to equip them with the necessary skills to sustain services for older people and PwD. Additionally, efforts were reportedly made to collaborate with local health services

and legal protection agencies to ensure continued support post-project. While these measures were outlined, field-level findings indicate gaps in their practical execution, particularly in community consultations and financial sustainability strategies.

Livelihood services sustainability

The livelihood intervention shows mixed indicators for sustainability. While all livelihood beneficiaries across FGDs reported gaining lasting skills and knowledge, financial viability remains uncertain due to insufficient grant amounts. Male and female beneficiaries consistently emphasized that while the training would have long-term benefits, the insufficient grant amount severely limited their ability to establish sustainable businesses.

The exit strategy for the livelihood component primarily relied on providing beneficiaries with skills and initial capital to become self-reliant. However, as noted by the Partner Staff in Azaz/Aghtrin, while beneficiaries received training and documentation to continue their work independently, the financial support was inadequate for sustainable business establishment. This is evidenced by consistent feedback across all livelihood FGDs requesting increased grant amounts, with specific suggestions ranging from $1,000 for dairy projects to $1,500 for detergent manufacturing. This tension was particularly evident in decisions about service commitments, where early-phase choices about funding duration sometimes created later sustainability challenges.

Key lessons learned for future sustainability, as identified by the Project Staff, include:

- Need for more comprehensive pre-project analysis, including market analysis and feasibility studies.
- Importance of strengthening monitoring and evaluation despite the partner-led approach.
- Need for better consultation with partners on capacity building needs.
- Necessity of improving partner systems to include stronger focus on older people.

BEST PRACTICES

Tabel 9: Best Practices

Topic	Finding
Health	
Easy and Accessible Appointment System	Beneficiaries highlighted that they could book appointments via phone or online links, significantly improves access to care.
Comprehensive Service Availability	The PHC center was praised for offering a wide range of services, including various specialized clinics (e.g., neurology, gynecology, dermatology, dental, etc.), ensuring most medical needs were met in one place. The provision of assistive tools, such as wheelchairs, was particularly valued by elderly beneficiaries, improving their mobility and overall access to healthcare services.

Prioritization of Older people and PwD in Healthcare	Older patients and PwDs were given priority access to treatment, ensuring they were not turned away even without prior appointments. Adjustments like ramps, elevators, wheelchairs, and handrails improved accessibility.
Livelihood	
Practical, Hands-on Vocational Training	Training programs (dairy and cheese making, sewing, detergent production) were well-structured, hands-on, and relevant for most participants. Beneficiaries gained new skills and confidence in income-generating activities.
Effective Management of Livelihood Distribution Mechanisms	The well-managed distribution mechanisms for livelihood services ensured that beneficiaries received the right support in a timely and efficient manner. This was particularly important for ensuring that livelihood interventions were accessible to those most in need.
Cross-cutting	
Adaptive and Flexible Project Management in Emergencies	Flexibility in project design and constant communication helped overcome coordination difficulties, especially during security risks and limited staff availability.
Mid to long-Term Service Provision in the Same Area	The program's ability to provide services over a mid to long-term period in the same community allowed for consistent and continuous support. This approach helped in building trust with beneficiaries and ensuring that interventions were sustained over time.

RECOMMENDATIONS

Tabel 10: Recommendations

Finding	Recommendation	Responsible
Health Beneficiary FGDs indicated disconnect between initial community consultation and understanding of how input shaped program. Many beneficiaries expressed that they were not directly involved in the design or implementation of the program. Although they were aware that community meetings had taken place, none of the beneficiaries reported direct participation in decision-making.	Consider establishing regular community consultation sessions, including quarterly town halls and a transparent feedback loop system to ensure ongoing beneficiary involvement in planning and decision-making. Provide clear updates to beneficiaries on how their input is used.	SEMA
Livelihood program beneficiaries mainly participated in training selection through an online	Needs assessment surveys with families of older people and committee meetings are not enough. Enhance the needs assessment processes	HRO

system but lacked engagement in broader program planning.	by incorporating in-depth FGDs with direct beneficiaries or hard to reach groups to ensure a more inclusive and representative decision-making process. Additionally, increase transparency by clearly communicating with beneficiaries, particularly those from marginalized groups, how their input influences decision-making in program design. Additionally, it is recommended to explore ways to link original needs assessment participants to service recipients and periodically remind them of their contributions and ensure communities are informed in advance about FGDs and allow them to nominate participants.	
Shortage of female surgeons and specialists (e.g., endoscopy, digestive diseases). Beneficiaries also identified the need for additional services, such as eye care and gastroscopy equipment.	If possible, develop a targeted recruitment strategy for female medical professionals and specialists, offering competitive packages and professional development opportunities.	SEMA, HelpAge International
During both the KIIs and Manager Response Session, multiple stakeholders (PHC supervisor, community leaders) reported older people and PwD in remote areas face significant challenges accessing healthcare due to mobility issues and lack of assistive tools.	Partner with existing local transport providers to establish subsidized transport routes on clinic days. Develop a community-based volunteer driver network to assist PwD and older people. Ensure assistive tools are available for those in need. SEMA could also consider mobile healthcare services or mobile teams as an alternative where feasible.	SEMA
HelpAge International KII noted lack of dedicated	Establish a dedicated geriatric clinic. Alternatively, cosider	SEMA

geriatric clinic, despite general accessibility features.	training selected staff members as geriatric focal points within existing departments while exploring options for dedicated geriatric services.	
Universal feedback across FGDs, KIIs, and management response session indicated microgrant amount ($315) was insufficient for business startups, particularly for dairy/detergent projects.	Depending on the available funds, it is recommended to increase microgrant amount based on business type and conduct market analysis to determine the appropriate amount. Moreover, consider including performance-based top-ups to support sustainability. Other options include exploring mentorship programs and integrating MPC assistance to ensure grants are utilized for their intended purpose.	HRO/HelpAge International
Trainers reported limited availability of sewing machines for group size, limiting practice opportunities.	Increase the number of sewing machines to match group sizes to ensure participants have adequate hands-on practice opportunities.	HRO/HelpAge International
One trainer noted that older participants faced physical challenges such as back pain and eyesight difficulties during sewing training.	It is recommended to conduct FGDs with beneficiaries at the planning stage to shortlist training topics, ensuring they are accessible for older participants. Additionally, training sessions should be shorter in duration to reduce physical strain while increasing the number of sessions to provide sufficient hands-on experience.	HRO
Project staff emphasized the need for stronger advocacy within humanitarian clusters for older people's specific needs.	Strengthen advocacy efforts within relevant humanitarian coordination groups to ensure older people's needs are prioritized in funding, policy, and service delivery. This could include leveraging existing disaggregated data to advocate more effectively for older people's needs.	All

Security concerns due to earth quake aftershocks and limited presence of partner staff made coordination difficult, impacting the project's ability to involve all stakeholders. Remote support helped but had limitations.	Develop a remote coordination strategy that includes contingency plans for emergency situations, ensuring uninterrupted engagement with local stakeholders. Utilize digital platforms for continuous collaboration.	All

LESSONS LEARNED

Tabel 11: Lessons learned

Lesson	Finding
Health services	
The complex banking environment in NWS requires multiple transfer mechanisms to ensure continuity of operations. Single-channel approaches proved insufficient for reliable salary payments.	Medical staff reported delayed salaries despite available operational funding. The project successfully used a combination of Turkish post offices and hawala systems, demonstrating the value of diverse payment channels.
While general accessibility features (ramps, elevators) are important, they do not fully address older people's needs without specialized geriatric services.	Health Cluster coordinator and HelpAge International KIIs noted that despite good accessibility features, the lack of geriatric-specific services limited the intervention's effectiveness for older people's care.
Multi-directional referral systems proved essential for comprehensive healthcare delivery in a fragmented context.	Medical staff interviews revealed strong internal referrals between departments and external coordination with other healthcare providers for specialized services like ICU care and imaging.
Livelihood services	
Limited equipment access in vocational training significantly compromised skill development, particularly affecting older participants who needed more practice time.	Trainer KIIs and beneficiary FGDs highlighted how equipment constraints forced rushed practice sessions, with specific impacts on older participants who needed additional practice time.
Relying solely on online selection methods can create barriers to participation for older people. Future livelihood programs should incorporate more inclusive consultation methods, such as in-person FGDs, phone-based support, or facilitated digital access, to ensure that older beneficiaries can actively participate in shaping program decisions.	The selection of training options was facilitated through an online link, which allowed beneficiaries to choose from pre-identified training programs. While this provided a streamlined approach, it also posed challenges for older participants who may have limited digital literacy or access to technology. As a result, their engagement in the decision-making process may have been restricted.
Cross-cutting	
Partner-led implementation created challenges in tracking older people specific outcomes without dedicated monitoring systems.	Project staff interviews revealed difficulties in capturing older people specific data within partner reporting systems, leading to gaps in impact measurement for this target group.

Exit planning considerations introduced late in the project cycle created sustainability challenges.	Technical coordinators noted that sustainability discussions started too late, with examples of unimplemented components like SEMA's proposal for small service fees in PHC.

PROJECT TEAM

Tabel 12: Evaluation team

Name	Position
Abdo Almostafa	Operations Manager
Anum Shafique	Project Manager and Health technical Consultant
Lea Lyngø	Third Party Monitoring Department Manager
Seba Salim	Project Officer

ANNEX

ANNEX 1: PROTOCOLS AND QUALITY ASSURANCE

PROCESS OF DATA AND DATA ANALYSIS

Trust approached data analysis with a drive to deliver meaningful contributions and results through a holistic analytical approach. Once the project team had received the qualitative data, the team conducted a preliminary analysis to develop a sense of patterns and perspectives within the data sets. Next, the team uploaded the data sets to the analytical software program, Excel, and categorized them according to respondent types and locations.

Based on a thorough read-through of the data sets, the team discussed potential coding strategies, which led the team to a content analysis of thematizations of each project activity. The thematizations were organized within each of the above-mentioned project activities to incorporate findings into the conceptual framework. Finally, the team incorporated the findings into the evaluation report as well as visualized the thematizations.

REPORT WRITING

Trust analyzed the primary data collected from the field and compiled the findings into a comprehensive draft evaluation report. This report included detailed qualitative insights, a thorough description of the methodology, any limitations encountered, and key lessons learned. The draft was submitted to HelpAge International for review and feedback. Based on HelpAge International's input and additional insights from the Management Response session, Trust refined and finalized the report to ensure it was comprehensive and actionable. In addition, Trust prepared an executive summary in Arabic, highlighting the main findings, lessons learned, and recommendations to enhance accessibility for a wider audience.

QUALITY ASSURANCE

Trust had detailed field procedures in place to ensure the quality of data collected in line with the agreed plan. The team of field coordinators and enumerators was managed by the Operations Manager, who reported to the Project Manager, who provided oversight on all the field activities. During the preparatory phase, the Project Manager conducted at least one online training workshop for the entire field team. This training covered the assignment tools and objectives for the field team, at the end of which all inquiries or unclear aspects of the fieldwork were answered and addressed. All data collection tools were piloted.

Once data collection began, the Operations Manager and Project Manager managed and monitored the enumerators' work on a daily basis, ensuring that the pace of the interviews and field visits followed the plan. The Manager also reviewed incoming data and performed quality checks to ensure that the data met the standards. The Operations Manager reported to the Manager on a daily basis with updates about all the conducted fieldwork. Accordingly, the Project Manager provided the Operations Manager with feedback and instructions to make sure the fieldwork was conducted

accurately and in a timely manner. The Project Manager gave regular informal updates on progress to HelpAge International throughout the process and flagged any observations that required immediate attention in real time, as necessary.

The Trust team was committed to quality assurance at all stages of the evaluation cycle, including tool design, training of enumerators, conducting data collection, data analysis, and reporting. Trust's approach to ensuring high-quality data and accountability to clients was followed throughout the assignment.

ETHICAL CONSIDERATIONS

Trust was aware that vulnerable groups required special sensitivity during the process of data collection. For this reason, Trust ensured that the needs of all participants involved in the data collection process were considered, especially regarding ethnicity, age, gender, disability, and displacement status, to reflect the cultural differences, diversity, and unique needs of the affected population and persons of concern. Trust and its enumerators followed a strict set of standards to ensure that each tool was appropriate and sensitive to the contextual circumstances and the situation the participant was in. Trust always exercised discretion in data collection to ensure that the privacy and dignity of the affected population were preserved. Trust acted under a survivor-centered approach incorporating the standard GBV Guiding Principles, including the right to safety, confidentiality, dignity, self-determination, and non-discrimination. Trust also adhered to HelpAge International's Code of Conduct and Global Safeguarding Policy, ensuring that all actions aligned with the organization's commitment to the safety and well-being of all participants.

Enumerator Selection and Training: All field researchers were trained in collecting quantitative and qualitative field data while applying the humanitarian principles of "Do No Harm" and "Light Footprint." Trust ensured a 50/50 gender balance in field teams. Enumerators were selected from a pool of field staff in the relevant areas. Selection was vetted based on criteria including thematic experience, proximity to data collection sites in case of regional movement restrictions, conflict of interest (including personal working or family connections), affiliation with armed groups, and any other necessary requirements prior to data collection. Backup candidates were also identified in case of staff turnover. The enumerators received extensive training from the Operations Manager, the Project team, and Trust's Advisors/Trainers in the use of research tools, data collection, quality control measures, safety procedures and protocols, and the work/field management plan. The training was organized through online sessions and a role-play simulation. The training covered ethical issues and specific considerations for data collection with children and adolescents. Furthermore, enumerators were briefed on the particular importance of maintaining the integrity of the data tool, e.g., answer codes. At the end of the training, all unclear aspects and inquiries regarding the fieldwork were answered and addressed.

Trust also ensured that the field team incorporated a gender and disability inclusion perspective within the methodology and considered the implications for women and men of any planned action during this project. To ensure the protection, integrity, and dignity of all stakeholders in this project, Trust adopted a gender mainstreaming approach to the data collection process. This method followed the regulations in Trust's Gender Sensitivity and Gender Mainstreaming Standard Operating Procedures (SOPs). Trust's extensive local understanding allowed for the consideration of gender and disability

issues in the local context and assessment of the level and type of gender and disability constraints in the targeted community. The findings were analyzed with regard to gender differences, and the level of disability inclusion was assessed, including the distribution of resources, opportunities, constraints, and power within the specified location. Trust allocated female staff to moderate and facilitate interviews with female participants and male staff for male interviewees.

Lastly, Trust synthesized these strategies alongside HelpAge International's protocols, procedures, and policies to ensure the consideration of all ethical issues that could arise. Trust obtained the informed consent of participants to ensure that they could decide in a conscious, deliberate way on their participation in the data collection process. Further, the field teams followed strict ethical standards during research, monitoring, evaluation, and data collection. Trust also understood that the data collection process could cause unintended distress for participants. To prevent this, Trust ensured that all tools were adapted and appropriate for the situation and age of the participant and that field teams monitored participants' body language and responses to adapt questions accordingly. If a situation was suspected to involve risks to a participant, staff consulted with the organization and assessed the appropriate next steps.

DATA MANAGEMENT AND CONFIDENTIALITY

Trust employed strict data protection protocols in all its projects to ensure that data was collected, examined, and stored in a systematic and impartial manner. These protocols were designed in accordance with standard regulations and guidelines for the protection of sensitive and non-sensitive data.

In compliance with the European Union General Data Protection Regulations (EU GDPR), participants were informed in a concise, accurate, and transparent manner about how their data would be processed and for what purpose. If data was shared with third parties, participants were also informed. Participants had the right to request data correction, deletion, or destruction at any time, and any third parties with whom data had been shared were to be notified accordingly. Consent requests were clear and specific to each activity, and participants had the right to withdraw consent at any stage.

Trust ensured participant anonymity to encourage open and honest responses. Measures were in place to protect identities and prevent risks. Data was de-identified before sharing unless follow-up was required.

All data was stored on password-secured devices and software. Only the Operations Manager and project team had access to the data, which was directly transferred to Trust's Headquarters. Once transferred, raw files of personal data were deleted from collection devices, and enumerators were required to confirm deletion. Personal data was not longer than necessary, and all project-related data was deleted in accordance with agreements established with HelpAge International during the contracting phase.

ANNEX 2: CONCEPTUAL FRAMEWORK- TOOL MATRIX

Annex 2 contains the conceptual framework and tool matrix which is provided as an Excel file attached in the annex folder.

ANNEX 3: IN DEPTH INTERVIEWS (ANONYMIZED VIGNETTES)

Annex 3 contains the anonymized vignettes from the in-depth interviews. These are included in the annex folder.

ANNEX 4: EXECUTIVE SUMMARY (ARABIC VERSION)

The Arabic version of the Executive Summary has been attached as Annex 4.