FINAL EVALUATION REPORT

"Promoting the Full Enjoyment of the Rights of Persons with Disabilities and the Elderly, Jordanians from Host Communities, and Syrian Refugees"

Implemented by Fundación Promoción Social, ONG Rescate and the Al Hussein Society

Funded by the Generalitat Valenciana

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List of acronyms

AECID	Agencia Española de Cooperación Internacional para el Desarrollo
AHS	Al Hussein Society
CBOs	Community-Based Organisation
CBID	Community-Based Inclusive Development
CBR	Community-Based Rehabilitation
CSO	Civil Society Organisation
CwD	Children with Disabilities
ET	Evaluation Team
FGD	Focus Group Discussion
FPS	Fundación Promoción Social
GBV	Gender-Based Violence
GO	General Objective
GRHRBA	Gender-Responsive and Human Rights-Based Approach (GRHRBA)
GVA	Generalitat Valenciana
ISPO	International Society for Prosthetics and Orthotics
HR	Human Rights
HRBA	Human Rights-Based Approach
HRV	Human Rights Violations
MEAL	Monitoring, Evaluation, Accountability and Learning
MHPSS	Mental Health and Psychosocial Support
MoH	Ministry of Health
MoSD	Ministry of Social Development
MoUs	Memorandum of Understanding
NGO	Non-Governmental Organisations
NHF	Noor Hussein Foundation
OECD-DAC	Organisation for Economic Co-operation and Development – Development Assistance Committee
PSS	Psychosocial Support
PwD	Persons with Disabilities
RESCATE	ONG Rescate Internacional
SDG	Sustainable Development Goals
SO	Specific Objective

SoV	Sources of Verification
ToRs	Terms of Reference
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees
UNRWA	United Nations Relief and Works Agency for Palestine Refugees in the Near East
WGwD	Women and Girls with Disabilities
WwD	Women with Disabilities

A. Main messages

To Fundación Promoción Social (FPS): the organisation has added clear value by anchoring a complex, multi-partner intervention in a coherent strategy, strong monitoring, evaluation, accountability and learning (MEAL) systems and a rights-based approach, and now holds solid evidence to argue for multi-year, disability-inclusive programming. FPS's support to design, accompany and document this intervention has contributed to a project that is rated highly relevant, effective, impactful and efficient, with a realistic medium rating on sustainability that is linked mainly to systemic financing gaps rather than to weaknesses in design. Through its technical accompaniment and MEAL support, FPS has helped put in place outcome-oriented tools – including follow-up surveys, simple functional and psychosocial indicators and qualitative case documentation – that show, in concrete terms, how rehabilitation and caregiver support change people's lives. The experience confirms the strategic value of a consortium model that combines Al Hussein Society's service delivery capacity and national legitimacy with FPS's international positioning and its ability to translate evidence into donor-friendly language and advocacy messages. For the next phase, FPS is in a strong position to advocate with donors, including Generalitat Valenciana and others, for multi-year, system-oriented funding that consolidates institutional gains, secures realistic budgets for operational costs and explicitly incorporates sustainability and policy dialogue from the outset. The project also offers FPS an opportunity to refine its organisational "signature" in disability-inclusive, protection-sensitive programming, using the Jordan experience as a reference for work in other contexts.

To Al Hussein Society (AHS): the organisation has confirmed its role as a national reference actor for disability-inclusive rehabilitation and protection, capable of delivering high-quality services while strengthening systems that will outlast this project. The intervention shows that AHS can combine direct service delivery at scale – mobility aids, prosthetics and orthotics, physiotherapy, occupational therapy and psychosocial support (PSS) – with systemic investments in the Azraq Camp workshop, the CBID-oriented referral system, MEAL tools, and gender-based violence (GBV)- and safeguarding-related practice. Rights holders and caregivers consistently report tangible changes in mobility, pain, autonomy, participation and dignity, which confirms that AHS's technical and relational approach has direct impact on people's everyday lives. AHS has also demonstrated strong institutional ownership, absorbing under-budgeted costs, navigating complex infrastructure constraints and keeping services running in a context of high demand and funding pressure. At the same time, the project underlines the need to protect AHS from unsustainable financial and workload strain. Future phases should include explicit and realistic cost-sharing arrangements and multi-year funding that match the level of responsibility AHS carries. Looking ahead, AHS is well positioned to act as a centre of excellence and a key interlocutor for national authorities and donors on rehabilitation, assistive technology and disability- and GBV-sensitive practice, provided that its institutional strengthening is recognised and resourced as a strategic priority rather than treated as a by-product of project funding.

To ONG Rescate Internacional (Rescate): the organisation has successfully demonstrated that GBV- and protection-sensitive practice can be meaningfully integrated into a non-GBV specialised rehabilitation project, creating safer and more responsive services for women, men, girls and boys with disabilities. By developing the GBV and disability manual, delivering the five-day training and conducting structured mentoring visits, Rescate has significantly raised AHS staff capacity to identify risk, communicate safely, manage disclosures and refer appropriately, without trying to turn AHS into a specialised GBV case management actor. The project shows that practical, case-based mentoring is essential: shifts in staff attitudes and behaviour were most evident where training was followed by observation, feedback and ongoing support, not just one-off sessions. Rights holders – especially women and girls with disabilities (WGwD) – perceive services as more respectful, confidential and emotionally supportive, even if they do not always name GBV explicitly, indicating that changes in staff practice are already shaping user experience. At the same time, Rescate's work has clarified the limits of what can be achieved on GBV within a short, rehabilitation-focused project and underlines the need for stronger linkage with specialised GBV and mental health and PSS actors, rather than over-extending AHS's mandate. Building on this experience, Rescate is well placed to deepen GBV-sensitive practice in future phases, including with community-based organisations (CBOs) staff, to help design clear referral and supervision architectures, and to use this case as an example of responsible GBV mainstreaming in sectors beyond classic GBV programming.

To the consortium partners: the project has demonstrated the added value of a genuinely complementary consortium, where each partner brings distinct strengths that together produce results no single organisation could have achieved

alone. AHS has provided high-quality, disability-inclusive rehabilitation and assistive devices, rooted in a long-standing presence and trust in the target areas. FPS has contributed strategic vision, methodological rigour and outcome-focused MEAL, turning field experience into robust evidence and advocacy messages. Rescate has added specialised expertise in GBV and protection, ensuring that interactions with rights holders are safer, more ethical and more gender-sensitive. Jointly, the three organisations have delivered a project that is highly relevant, effective, impactful and efficient, with strong institutional strengthening and meaningful changes in the lives of rights holders and caregivers. At the same time, they have been honest about the limits of a one-year humanitarian project in terms of financial sustainability, structural inequalities and GBV dynamics. Together, they are now in a strong position to use the evidence generated in Jordan to advocate for multi-year, disability-inclusive and protection-sensitive programming and to engage public institutions in a more structured dialogue on the long-term financing and institutionalisation of rehabilitation and assistive technology.

To Generalitat Valenciana (GVA): its support has enabled a high-quality intervention that not only improved the lives of people with disabilities (PwD), older persons and caregivers in Azraq Camp and the host communities of Azraq, Mafraq and Ramtha, but also strengthened a key national organisation and generated lessons with relevance beyond this specific project. The evaluation shows that the funds provided have translated into very tangible outcomes: better mobility, reduced pain, greater autonomy and dignity for rights holders; reduced strain and increased competence for caregivers; and more capable, better connected local institutions. The project funded by the GVA stands as a concrete example of how targeted humanitarian financing can support both immediate protection and inclusion outcomes and medium-term system strengthening, especially when it is channelled through a consortium that combines national leadership with specialised technical support. At the same time, the results highlight the structural fragility of rehabilitation and assistive services in protracted crises and the need for multi-year, predictable funding and gradual public cost-sharing. The experience in Jordan offers the GVA a strong reference for its future policy and funding decisions: it confirms that investing in disability-inclusive, rights-based and gender- and GBV-sensitive interventions is both feasible and impactful, and it underlines the importance of accompanying local partners over time so that the changes initiated can be sustained and, where possible, scaled up.

B. Introductory aspects: background and description of the evaluation[1]

B.1. Background of the organisations

- FPS is a Spanish non-governmental organisation (NGO) with a long-standing presence in the Middle East, and particularly in Jordan, where it has implemented humanitarian and development interventions for over a decade. FPS's work in the country has consistently focused on vulnerable populations affected by protracted displacement, with a particular emphasis on social inclusion, protection, and access to basic services.

  Within the framework of this project, FPS acts as the lead applicant and coordinating entity, responsible for overall project oversight, donor liaison, and strategic coherence across partners. FPS's added value lies less in direct service delivery and more in its capacity to articulate multi-actor interventions, align local implementation with donor requirements, and integrate crosscutting priorities – such as gender equality, disability inclusion, and accountability – into project design and monitoring.

  FPS's institutional role in this intervention reflects a facilitative and governance-oriented approach, ensuring that implementation partners operate within a shared results framework, comply with donor standards, and remain aligned with humanitarian coordination structures in Jordan. This positioning is particularly relevant in a context characterised by high fragmentation of services and frequent funding volatility, where coordination and strategic clarity constitute enabling conditions for effectiveness.

- AHS is a Jordanian civil society organisation (CSO) specialised in rehabilitation services for PwD and older persons. Established in 1979, AHS is one of the longest-standing national actors in the disability and rehabilitation sector in Jordan and has developed extensive technical expertise in physiotherapy, occupational therapy, prosthetics and orthotics, and community-based rehabilitation (CBR).

[1] For more information, please see Annex 1 – Terms of Reference (ToRs) Evaluation 2025.

AHS has a strong operational footprint in both refugee camps and host communities, including Azraq Camp and northern governorates such as Mafraq and Ramtha. Its long-term presence in these areas has enabled the organisation to build trust with communities, develop contextualised service models, and maintain working relationships with humanitarian actors and public institutions.

In this project, AHS serves as the primary implementing partner, responsible for direct service delivery, case identification and evaluation, operation of rehabilitation facilities (including the Azraq Camp workshop), and coordination of referral pathways. Beyond service provision, AHS plays a central role in anchoring the intervention within a Community-Based Inclusive Development (CBID) approach, combining individual rehabilitation services with community engagement and coordination mechanisms.

AHS's institutional relevance to the project also lies in its capacity to absorb and operationalise capacity-strengthening inputs, particularly in relation to gender-sensitive and protection-oriented practices. The organisation's embeddedness in the local context positions it as a key actor for translating technical guidance into practice, while also highlighting structural constraints related to infrastructure, referral availability, and the broader humanitarian environment.

- Rescate is a Spanish humanitarian organisation with specialised expertise in protection, GBV, and PSS in crisis and displacement contexts. In Jordan, Rescate has accumulated experience working on GBV prevention and response, often in collaboration with national actors and specialised consultants, and with a strong focus on capacity strengthening rather than direct case management.

  Within this project, Rescate's role is technical and complementary, focusing on strengthening AHS's institutional capacity to identify, refer, and ethically manage cases of GBV affecting PwD and older persons. This includes the development of a tailored referral manual, delivery of specialised training, and follow up mentoring aimed at supporting practical application of newly acquired knowledge.

  Rescate's contribution is intentionally circumscribed: it does not replace specialised GBV service providers nor establish parallel response mechanisms. Instead, its added value lies in addressing a critical gap at the intersection of disability and GBV by equipping frontline rehabilitation and psychosocial staff with the tools needed to recognise risk, respond appropriately, and activate existing referral pathways. This positioning reflects good practice in protection mainstreaming within non-GBV-specialised interventions.

Complementarity and partnership rationale

The partnership between FPS, AHS, and Rescate brings together distinct but complementary institutional strengths: FPS's coordination and donor interface capacity, AHS's technical and operational expertise in rehabilitation and disability inclusion, and Rescate's specialised knowledge in gender and protection. The collaboration is structured to avoid duplication of roles, with each organisation operating within its comparative advantage.

This division of roles is particularly pertinent in the Jordanian humanitarian context, where service delivery gaps coexist with strong national expertise but limited resources. The partnership model adopted in this project reflects an attempt to maximise impact within a constrained budget by prioritising coordination, institutional strengthening, and the integration of crosscutting protection considerations into rehabilitation services.

B.2. Background of the project

The project was implemented in Jordan in a context marked by protracted displacement, structural vulnerability, and sustained pressure on national and humanitarian service systems. Jordan continues to host a large population of Syrian refugees alongside vulnerable Jordanian communities, particularly in northern governorates and in camps such as Azraq. Within this context, PwD, older people, and survivors of GBV faced compounded barriers to accessing health and rehabilitation services, as well as heightened protection risks.

In Azraq Camp, physical infrastructure constraints, limited availability of specialised services, and strict camp management regulations exacerbated exclusion for PwD and older persons. In host communities – particularly in Mafraq and Ramtha – vulnerabilities were shaped by chronic poverty, uneven service coverage, and overstretched local

health and social systems. Across both settings, disability-related needs remained persistently under-addressed, especially where they intersected with age, gender, and protection concerns.

The project aligned with the strategic vision of FPS and its country strategy for Jordan. Its general objective (GO) was to increase the protection and exercise of the right of access to health for Syrian refugees and vulnerable Jordanians, with a specific focus on functional diversity, age, and GBV. The specific objective (SO) was to improve the quality of life and health conditions of PwD and those in situations of extreme vulnerability – particularly older people and women and children who were GBV survivors – living in Azraq Camp and surrounding host communities.

The intervention was designed and implemented as a 12-month humanitarian project (15 August 2024–14 August 2025), combining direct service provision with institutional strengthening and coordination. It had a total budget of 393,390 euros, of which 388,325 euros were financed by the GVA and the remainder contributed by FPS, Rescate and AHS. It explicitly adopted a CBID approach, recognising that rehabilitation outcomes depend not only on individual services, but also on the existence of functional referral systems, institutional capacity, and community-level inclusion mechanisms. The project therefore sought to address both immediate needs and structural bottlenecks that limited access to inclusive rehabilitation and protection-sensitive services.

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Two interrelated results structured the intervention:

- Result 1 – Institutional strengthening focused on enhancing the technical and human capacities of AHS to provide specialised, multidisciplinary responses to refugees and non-refugees in situations of extreme vulnerability.
- Result 2 – Mobility and autonomy aimed to increase the mobility and autonomy of rights holders through the provision of customised assistive devices, rehabilitation services, caregiver training, and the integration of family members into care processes.

Geographically, the project operated in Azraq Camp and selected host community locations in Azraq Town, Mafraq and Ramtha, reflecting an intentional effort to address both camp-based and non-camp-based vulnerabilities. This dual focus acknowledged that needs related to functional diversity and ageing transcend administrative categories, while access to services and coordination mechanisms differ significantly between humanitarian settings.

The project was implemented during a period characterised by funding constraints and service gaps, particularly affecting specialised rehabilitation and protection services. These contextual conditions shaped implementation choices and reinforced the project's emphasis on strengthening existing capacities, improving coordination, and optimising referral systems rather than establishing parallel structures. This context is central to interpreting the scope and scale of results achieved.

B.3. Background of the evaluation[2]

The evaluation was commissioned as a final external evaluation of the project implemented by FPS, AHS, and Rescate in Azraq Camp and selected host communities in northern Jordan. It was conducted following the completion of the 12-month intervention and formed part of FPS's commitment to accountability, learning, and evidence-informed programming, as well as its reporting obligations towards the donor.

The evaluation was carried out in a context characterised by high operational complexity and structural constraints, including limited availability of specialised services, coordination challenges across actors, and volatility in humanitarian

[2] For more information, please see Annex 1 –ToRs Evaluation 2025.

funding. These factors were not peripheral, but constituted key framing conditions for the evaluation, influencing both the feasibility of certain evaluation questions and the level of claims that could be credibly made regarding outcomes, impact, and sustainability.

The Terms of Reference (ToRs) framed the evaluation as both an accountability and a learning exercise, seeking to assess the intervention against the Organisation for Economic Cooperation and Development – Development Assistance Committee (OECD-DAC) criteria while generating practical insights to inform future programming. At the same time, the evaluation was commissioned with limited financial and temporal resources, which required a deliberate prioritisation of analytical focus and methodological choices.

In response to these conditions, the evaluation adopted a focused and theory-informed perspective, privileging depth of analysis over exhaustive coverage. Rather than addressing all ToRs questions with equal weight, the evaluation concentrated on those dimensions most critical to understanding the project's contribution to its stated objectives, particularly institutional strengthening, coordination and referral mechanisms, protection mainstreaming, and improvements in mobility and autonomy of rights holders. Questions related to long-term impact and sustainability beyond the project timeframe were addressed in a more exploratory manner, consistent with the humanitarian nature and duration of the intervention.

The evaluation was designed to assess contribution rather than attribution. Given the absence of a counterfactual, the short implementation period, and the contextual complexity of rehabilitation and protection outcomes, the evaluation did not seek to establish causal impact. Instead, it examined how and to what extent the project contributed to improved practices, services, and enabling conditions for inclusion within existing constraints.

To maximise the utility of the evaluation, findings were shared with the implementing organisations during and after the evaluation process. The results were intended to inform future programme design, strengthen internal management and coordination processes, and support the replication or adaptation of successful approaches identified during implementation. The evaluation team was responsible for producing a credible, evidence-based, and practice-oriented report, highlighting achievements, challenges, and opportunities for learning.

Overall, the evaluation contributed to strengthened accountability to the donor and supported continuous learning among the partner organisations, while remaining analytically rigorous and methodologically credible within the constraints under which it was conducted. This background frames the analytical choices made and provides the lens through which the findings presented in subsequent sections should be interpreted.

B.4. General description of the evaluation process

The evaluation started in September 2025 and was conducted over a total of 25 working days. Fieldwork took place in Amman, and selected host communities in northern Jordan (Azraq, Mafraq and Ramtha), as well as remotely. The assignment was carried out by the Evaluation Team (ET), composed of Mireia Gallardo Avellan (Team Leader and Desk Support) and Haifa Haidar (Researcher and Fieldwork Leader). The ET worked in close coordination with FPS, AHS, and Rescate throughout the entire process.

The evaluation followed the methodology agreed with the commissioning organisation and the implementing partners, as described in the following sections. It combined desk-based analysis, qualitative fieldwork, and participatory validation moments, and was implemented through the following phases and activities:

- 1 day for the start-up of the evaluation, including contract initiation, clarification of scope, and initial coordination with FPS.
- 2 days for inception and check-in meetings with FPS and implementing partners, focusing on evaluation scope, expectations, feasibility of ToRs questions, and confirmation of roles and responsibilities.

- 4 days for the compilation and review of relevant documentation, including the project proposal, logical framework, monitoring reports, technical outputs and sources of verification (SoV), communication materials, and previous assessments, as well as the refinement of the evaluation matrix[3], indicators, and tools.
- 2 days for agenda confirmation and logistical arrangements, including respondent selection, scheduling of interviews and focus group discussions (FGD), and coordination of access to sites and stakeholders.
- 6 days of fieldwork, conducted through a combination of face-to-face and remote data collection methods, including key informant interviews, FGD, and consultations with rights holders, caregivers, implementing staff, and institutional stakeholders.
- 1 day for debriefing and preliminary validation, during which initial findings and emerging themes were discussed internally within the ET and shared informally with key project stakeholders.
- 3 days for data consolidation, triangulation, and analysis, integrating qualitative findings across sources and aligning them with the evaluation criteria and key evaluation questions.
- 5 days for drafting and revising the evaluation report, including the incorporation of feedback from FPS and partners and the finalisation of annexes.
- 1 day for the presentation and dissemination of evaluation findings to the commissioning organisation and implementing partners.

Methodological choices were made to ensure coherence and practical relevance of findings, while remaining proportionate to the scope and duration of the evaluation and intervention.

C. Evaluation methodology

C.1. Desk review[4]

The desk review constituted a foundational and continuous component of the evaluation process. Throughout the assignment, the ET systematically reviewed and analysed all relevant project documentation to compile primary and secondary information related to the intervention and its evaluability.

The first stage, implemented in September 2025 and home-based, was conducted at the outset of the evaluation and focused on building a comprehensive understanding of the project's design, objectives, intervention logic, and implementation context, as well as the scope and priorities of the evaluation as defined in the ToRs. This phase supported the clarification of the evaluation purpose, key questions, expected use of findings, and methodological boundaries, including those deriving from time and budgetary constraints.

During this initial phase, the ET reviewed core project documents, including the project proposal, logical framework and planning matrix, narrative and financial reports, monitoring tools, referral and case management documentation, training materials, communication products, and coordination records, among others. Particular attention was given to understanding the CBID approach underpinning the intervention, the structure of results and activities, and the roles and responsibilities of FPS, AHS, and Rescate.

Following initial exchanges with the implementing partners, the ET proceeded to consolidate key preparatory elements, including:

- The identification and sampling of sources of information and geographic locations.
- The refinement of the evaluation methodology and qualitative tools to be used during fieldwork.
- The clarification of roles, responsibilities and logistical arrangements.
- The identification of anticipated challenges, limitations and ethical considerations.

[3] For more information, please see Annex 2 – Evaluation matrix.

[4] For more information, please see Annex 3 - Desk Review.

- The integration of crosscutting approaches, particularly protection, disability inclusion, age sensitivity and gender.

The second stage of the desk review took place in parallel with fieldwork, between October-November 2025, during which additional documentation was requested and analysed to clarify emerging issues and contextual dynamics identified through interviews, FGD and observation. This iterative process allowed the ET to adjust lines of inquiry and deepen analysis where required.

A third stage of the desk review was conducted alongside data analysis and report drafting, in November and December 2025. During this phase, supplementary documentation was reviewed to validate findings, triangulate evidence and support the interpretation of results. This ongoing desk review ensured analytical coherence across data sources and strengthened the credibility of the evaluation conclusions.

C.2. Methodology, sources of information and sample

C.2.1. Evaluation approach

The evaluation adopted a mixed-methods approach, combining qualitative and quantitative techniques to generate a comprehensive and triangulated understanding of the project's performance, achievements and limitations. The evaluation design was developed in line with the ToRs and in close coordination with FPS, AHS and Rescate.

The evaluation followed a participatory, rights-based and inclusion-oriented approach, consistent with the principles guiding the intervention and the CBID framework. Particular attention was given to capturing the perspectives of rights holders – including PwD, older people and caregivers – as well as holders of obligations and holders of responsibilities, such as CBOs and service providers involved in referral, rehabilitation and protection processes. This approach ensured that the voices of those directly affected by the intervention informed both the analysis and the interpretation of findings.

The methodology combined desk review, fieldwork and systematic data analysis. It was designed to:

- Assess the relevance, effectiveness, efficiency, impact and sustainability of the intervention, in line with the ToRs.
- Examine institutional strengthening processes within AHS and partner organisations.
- Analyse coordination and referral mechanisms across humanitarian and local actors.
- Explore changes related to mobility, autonomy and access to services among rights holders.
- Identify lessons learned, good practices and actionable recommendations to inform future programming.

Given the humanitarian nature of the project, its duration, and the absence of a counterfactual, the evaluation adopted a contribution-based perspective rather than seeking to establish attribution. The analysis focused on understanding how and to what extent the project contributed to observed changes within existing structural and operational constraints.

Throughout the process, the ET maintained independence and analytical rigour, while engaging in continuous dialogue with the implementing partners to validate factual accuracy, contextual interpretation and emerging findings. This balance supported both accountability to the donor and meaningful learning for the organisations involved.

C.2.2. Sampling strategy and inclusiveness

A purposive and convenience sampling strategy was applied for qualitative data collection, in line with the scope of the evaluation, the humanitarian context, and ethical considerations related to protection-sensitive topics. The ET defined the selection criteria prior to fieldwork, and partner organisations supported the identification of potential respondents in accordance with these criteria. The final sample was validated by the ET to ensure methodological independence.

Sampling prioritised respondents with direct involvement in or substantive knowledge of the project, ensuring representation across the project's main areas of intervention: institutional strengthening, coordination and referral mechanisms, rehabilitation services, PSS, and protection mainstreaming. The approach sought to capture perspectives

from rights holders, caregivers, implementing staff, CBOs, and coordination actors, allowing for triangulation across levels of implementation and responsibility.

The primary categories of respondents included:

- PwD and older persons (women and men), reached through FGD in camp and host community settings.
- Caregivers of children with disabilities (CwD, women and men).
- Technical and PSS staff involved in rehabilitation and support services.
- Administrative, coordination, and management staff from the implementing organisations.
- Directors and focal points of partner CBOs.
- External stakeholders and coordination actors, including specialised consultants.

In relation to GBV, the sampling strategy was guided by ethical and safeguarding considerations. Women and children who are GBV survivors were not directly interviewed as part of this evaluation. Instead, GBV-related evidence was collected indirectly through:

- Key informant interviews with implementing partners.
- Interviews with the specialised GBV consultant involved in the project.
- Review of project documentation and SoV related to GBV capacity strengthening and referral practices.

In addition, during fieldwork, some women participating in FGD voluntarily shared testimonies indicating lived experiences of GBV. These testimonies were not solicited, were treated with confidentiality, and were analysed cautiously as qualitative insights rather than as representative data.

This approach reflects a deliberate balance between inclusiveness and do-no-harm principles, recognising the sensitivity of GBV-related issues and the non-GBV-specialised nature of the evaluation. The sampling strategy therefore aimed to ensure that protection dimensions were meaningfully assessed without exposing survivors to additional risk.

Overall, the sampling approach sought to include those most directly engaged in or affected by the intervention, ensuring a balanced representation of rights holders, holders of obligations, and coordination actors. Data gathered from different respondent groups were crosschecked through multiple tools and sources, supporting the robustness of the findings despite variations in participation levels and the absence of direct interviews with GBV survivors.

C.2.3. Data collection methods

Data collection combined multiple qualitative and quantitative methods to maximise depth, accuracy and triangulation. The following tools were used during the fieldwork:

- Semi-structured individual interviews, conducted with FPS, AHS and Rescate technical staff; representatives of partner organisations and CBOs; coordination actors; and specialised consultants, including GBV and protection experts.
- Group interviews, conducted with AHS technical teams and partner staff to explore collective perspectives on implementation processes, coordination mechanisms and institutional strengthening.
- FGD, conducted with PwD and older persons, as well as with caregivers of children and adults with disabilities, in both camp and host community settings.
- Questionnaires, designed and administered to rights holders (PwD, older persons and caregivers) to complement qualitative data and capture perceptions related to access, quality, relevance and outcomes of services.
- Direct observation, carried out during field visits to service delivery points, to contextualise findings and support interpretation of reported practices and outcomes.

All tools were designed to assess the evaluation criteria established in the ToRs and were adapted to the humanitarian, rehabilitation and protection context of Jordan. Interview, FGD and questionnaire guides were structured around the OECD-DAC criteria and integrated a gender-responsive, human rights-based and disability-inclusive perspective consistent with the CBID approach guiding the intervention.

Throughout the evaluation process, FPS, AHS and Rescate played a key coordinating role, facilitating access to respondents, supporting logistical arrangements and ensuring timely availability of documentation. This collaboration enabled the ET to adapt data collection modalities (face-to-face and online) as needed and ensured methodological coherence while preserving the independence of the analysis.

C.2.4. Sources of information and sample composition

The evaluation drew primarily on qualitative data collected during the fieldwork in October and November 2025, complemented by the ongoing review of project documentation. In total, 24 data-collection sessions were conducted across individual interviews, group interviews and FGD, engaging 66 participants (52 women and 14 men).

Two questionnaires were also administered to rights holders in both target groups and completed by 10 respondents (8 women and 2 men). Although the number of responses was limited, they provided supplementary reflections that helped contextualise and nuance the qualitative findings.

A summary of the sources of information consulted during the evaluation is presented in the table below.

Stakeholder group	Institution / affiliation	Type of session	Participants
Implementing partners	FPS	2 individual interviews	2 persons, 1 woman and 1 man
Implementing partners	AHS	3 individual interviews and 2 group interviews	9 persons, 8 women and 1 man
Implementing partners	Rescate	1 individual interview	1 woman
CBOs	Local CBOs (Azraq, Mafraq, Ramtha)	4 individual interview and 2 group interviews	8 women
GBV and protection specialists	External consultant	1 individual interview	1 woman
Rights holders – PwD and older persons	Project rights holders (Azraq, Mafraq, Ramtha)	4 FGD Questionnaire	26 persons, 19 women and 7 men (FGD) 2 women (questionnaire)
Rights holders – caregivers	Project rights holders (Azraq, Mafraq, Ramtha)	4 FGD Questionnaire	17 persons, 12 women and 5 men (FGD)

Stakeholder group	Institution / affiliation	Type of session	Participants
			6 women and 2 men (questionnaire)
Institutional stakeholders	United Nations High Commissioner for Refugees (UNHRC) and Nour Hussein Foundation (NHF)	1 group interview	2 women

This sample reflects the range of actors directly or indirectly engaged in the project and provides a solid basis for evaluating its achievements and institutional effects.

C.2.5. Data analysis and triangulation

Qualitative data analysis followed a structured, multi-stage process designed to ensure methodological rigour, coherence with the evaluation criteria set out in the ToRs, and the reliability of the findings. The approach combined deductive and inductive analytical techniques, allowing the ET to examine predefined areas of inquiry derived from the ToRs, the project's logical framework and results structure, while also capturing emergent themes arising from the fieldwork.

The analysis process comprised several interrelated steps:

- First, all qualitative data collected during the evaluation – including interview notes and transcripts, audio recordings, FGD summaries, observation notes, and questionnaire responses – were systematically organised by respondent category. These categories included rights holders (PwD, older people and caregivers), institutional and operational actors (AHS staff and management), partner organisations (FPS and Rescate), coordination and referral actors, and external technical stakeholders. The ET crosschecked field notes and transcripts to ensure internal consistency and accuracy prior to coding.
- Second, a coding framework was developed to guide the analysis. This framework integrated:
    - The evaluation criteria established in the ToRs (relevance, effectiveness, impact, efficiency, and sustainability).
    - The project's logical framework (GO and SO, Results 1 and 2, activities, indicators and SoV).
    - The emergent analytical categories reflecting key dimensions of the intervention, such as institutional capacity strengthening, functionality of referral systems, accessibility and quality of rehabilitation services, caregiver engagement, protection mainstreaming (including GBV-sensitive practices), coordination dynamics, and contextual constraints affecting implementation.

  This framework enabled a systematic categorisation of qualitative data while remaining sufficiently flexible to incorporate unexpected findings and context-specific issues.
- Third, all qualitative data were analysed through thematic coding. The ET identified recurring patterns, convergences, divergences and outliers across stakeholder groups and locations. Particular attention was given to:
    - Perceived changes in access to and quality of rehabilitation services.
    - Functionality and use of referral pathways based on the CBID approach.
    - Institutional learning and capacity strengthening within AHS.
    - Integration of protection and GBV-sensitive practices in non-specialised services.
    - Perceived changes in mobility, autonomy and well-being among rights holders.

- Caregiver involvement and perceived benefits.
- Operational and contextual barriers affecting service delivery in both camp and host community settings.

- Fourth, the findings emerging from qualitative analysis were systematically compared against the project's indicators, SoV, milestones and expected outputs and outcomes. This comparison allowed the ET to assess the extent to which planned results were achieved, to identify deviations from the original design, to recognise achievements beyond what had been initially envisaged, and to highlight areas where progress was more limited due to contextual or structural constraints.

Quantitative data derived from questionnaires administered to rights holders were analysed descriptively to complement the qualitative findings. While the quantitative component was limited in scope, it provided additional insights into perceived changes in access, satisfaction and functionality of services, and supported the interpretation of qualitative evidence.

Analytical findings were refined through iterative internal discussion within the ET. The team leader and fieldwork researcher jointly reviewed emerging interpretations to ensure contextual accuracy, minimise bias, and reconcile divergent readings of the data. This process strengthened the consistency and balance of the conclusions.

Triangulation was a central element of the analysis and was applied at multiple levels. It was conducted across data sources by comparing perspectives from rights holders, caregivers, implementing staff, partner organisations and external stakeholders. It was applied across methods by crosschecking evidence from individual interviews, FGD, questionnaires, direct observation and document review. It was also applied across locations and implementation modalities, contrasting experiences in Azraq Camp and host community settings, as well as across different types of services and activities.

This layered triangulation strengthened the credibility and reliability of the evaluation findings, ensuring that conclusions were grounded in diverse and corroborated evidence. It also supported the identification of contextual and institutional factors influencing performance and enabled the ET to distinguish between project-level contributions and broader structural conditions shaping outcomes.

C.3. Ethical principles, standards and norms

- Responsibility: the report mentioned any dispute or differences of opinion that might have arisen among the ET or between the ET and the commissioner of the evaluation in connection with the findings and/or recommendations. The ET corroborated all assertions, or disagreement with them noted.
- Integrity: the ET was responsible for highlighting issues not specifically mentioned in the ToRs, if this was needed, to obtain a more complete analysis of the intervention.
- Independence: to this end, the ET was recruited for its ability to exercise independent judgement. The ET ensured that it was not unduly influenced by the views or statements of any party. If the ET or the evaluation manager came under pressure to adopt a particular position or to introduce bias into the evaluation findings, it was its responsibility to ensure that independence of judgement was maintained. Where such pressures might have endangered the completion or integrity of the evaluation, the issue was referred to the evaluation manager who discussed the concerns of the relevant parties and decided on an approach which ensured that evaluation findings and recommendations were consistent, verified and independently presented.
- Incidents: if problems arose during the fieldwork, or at any other stage of the evaluation, they were reported immediately to the evaluation manager. If this was not done, the existence of such problems was not used to justify the failure to obtain the results stipulated in the ToRs.
- Validation and credibility of the information: the ET was responsible for ensuring the accuracy of the information collected while preparing the reports and it was ultimately responsible for the information presented in the evaluation report.
- Intellectual property: in handling information sources, the ET respected the intellectual property rights of the institutions and communities that were under review. All materials generated during the evaluation are the

property of FPS, AHS and Rescate, and can only be used by written permission. Responsibility for distribution and publication of the evaluation results rested with the organisations' local offices. With the permission of the organisations, the ET might make briefings or unofficial summaries of the results of the evaluation outside the organisations.

- Delivery of reports: if delivery of the reports was delayed, or if the quality of the reports delivered was clearly lower than what was agreed, the penalties stipulated in the ToRs were applicable.

C.4. Crosscutting components and/or approaches

As part of the evaluation, the following approaches and/or crosscutting components were taken into consideration:

- Gender approach and mainstreaming: the analysis of gender relations was an essential element to understand the impact that international development cooperation projects had on rights holders. There could not be a place for human development and lasting peace without the respect for the rights of women as well as the promotion of gender equity between women and men in societies benefiting from aid, including an intersectional feminist and decolonial perspective. This equity was also a strategic priority in all actions of project partners as well as its stakeholders. Therefore, in all phases of the evaluation process (desk review, fieldwork, data analysis and reporting), gender approach and mainstreaming were a central and crosscutting component for the ET. The evaluation results clearly addressed the impact that the organisations and the project had on gender relations between women and men.
- Environmental sustainability: given the nature and scale of the intervention, no significant environmental effects were expected. The evaluation nonetheless considered the responsible management and maintenance of mobility aids and the rehabilitation workshop (e.g. safe handling of materials and equipment) and found no evidence of notable negative impacts.
- Diversity and intersectionality as an asset in a rights perspective: women's and men's, girls' and boys' different backgrounds (gender identity, age, class, origin, ethnic group, sexual orientation, abilities, etc.) and experiences (e.g. displacement) were also recognised by the ET as an asset and valuable to the project. Therefore, they were actively included and respected from a human rights perspective during the evaluation process.
- Participatory approach: the ET worked with a participatory approach, in which stakeholders actively engaged in the development and implementation of the evaluation process. It was a fundamental aspect when it came to the ownership of the process by project partners, as well as the rights holders. During the evaluation process, participatory techniques were used, based on generating learning and knowledge.
- Human rights-based approach (HRBA): the ET worked throughout the evaluation process with a focus on human rights. The ET considered and treated actors and participants of the project not as mere recipients of development aid (or rights-holders) but as holders of rights, responsibilities and obligations.
- Conflict sensitivity approach: the ET took into consideration the conflict sensitivity approach to gain detailed understanding of the operational context, the project and the interactions between the two, to ensure that both, the project and the context, had a positive impact on conflict dynamics. In other words, to ensure that the project and partners' actions minimised negative impacts and maximised positive impacts on conflict.
- Safeguarding approach (including child protection): the ET ensured that the evaluation process, as well as during the partners' project ensured that everybody enjoyed the right to be safe no matter who they were or what were their circumstances. In other words, that all actors involved were protected from harm, abuse or neglect.

  All primary data collection followed the safeguarding and ethical standards of GVA, FPS, AHS and international good practice. Before each interview or FGD, participants were informed about the purpose of the evaluation, the voluntary nature of their participation and their right to withdraw at any time without consequences. Verbal informed consent was obtained, and confidentiality was ensured by avoiding names or other direct identifiers in the notes and by anonymising all quotations in this report.

Given the sensitivity of disability, age and potential GBV-related issues, the ET was briefed on the do-no-harm principle and on how to respond to signs of distress or disclosure of violence. When any discomfort was perceived, the conversation was slowed or redirected, and participants were reminded that they could stop the interview. Where appropriate and with the participant's agreement, individuals were signposted or referred to existing GBV/protection and PSS through the project's referral pathways. No serious safeguarding incident was reported during the evaluation.

- Learning and utilisation approach: the ET ensured that it considered throughout the intended final use of the evaluation and the needs of the primary intended users to maximise utilisation of findings and recommendations.
- Partnership approach: the ET ensured that the evaluation process took into consideration the relationship between project partners, as well as the relevance and effectiveness of the partnership for mutual learning.

D. Challenges and limitations

Several challenges and limitations affected the evaluation process and should be considered when interpreting the findings:

- No baseline study had been conducted prior to the start of the project. This constituted an important methodological limitation, as baseline data would have provided an initial reference point for assessing changes over time. Its absence limited the precision with which progress against certain indicators – particularly those related to changes in access, autonomy and institutional capacity – could be measured and constrained the assessment of longer-term effects.
- The evaluation was conducted under significant time and resource constraints. The limited duration and budget available for the evaluation required the ET to prioritise analytical focus. As agreed with FPS, this led to a deliberate concentration on selected key components under each evaluation criterion rather than an exhaustive coverage of all ToRs questions. This prioritisation influenced both the depth and breadth of analysis.
- Participation in the questionnaires administered to rights holders and caregivers was lower than anticipated. This limitation was expected by AHS, given contextual factors such as digital access constraints, fatigue among rights holders and the sensitivity of certain topics. Nonetheless, the ET considered it important to include these tools as an additional channel for data collection and reflection, even with the risk of low response rates.
- Azraq Camp could not be visited during the evaluation. As the project had already ended, the time required to obtain new access permits exceeded the available evaluation period. As a result, evidence related to activities in the camp was based primarily on interviews with partner organisations and stakeholders who implemented the project there, as well as on project documentation and SoV, rather than on direct consultations with camp-based rights holders. This limited the possibility of triangulating some findings in Azraq Camp with first-hand rights holders' perspectives, although the consistency between staff testimonies, coordination actors' views and available documentation provided a reasonable basis for analysis.
- As described in Section C.2.2, women and children who were GBV survivors were not interviewed directly for ethical and safeguarding reasons. This necessarily limited the depth of the analysis on GBV-specific outcomes and required reliance on indirect sources (key informants, GBV consultant, and voluntarily shared testimonies).
- The combination of limited baseline data, constrained evaluation resources and uneven participation in certain tools created gaps that could not be fully addressed through fieldwork alone. These limitations were mitigated through extensive triangulation, drawing on multiple data sources, respondent groups, methods and project documentation, including a substantial body of sources of verification provided by FPS, AHS and Rescate.

Despite these constraints, the evaluation generated sufficient and credible evidence to support robust findings and conclusions regarding the project's relevance, implementation processes and contributions within the scope and timeframe of the intervention.

Throughout the process, the flexibility and continuous support of FPS, AHS and Rescate were instrumental in overcoming logistical difficulties and securing access to respondents. Their collaboration enabled the ET to maintain methodological rigour and complete all planned activities despite the challenges encountered.

E. Main findings and results

E.1. Relevance

E.1.1. Is the intervention aligned with the needs and priorities of the population participating in the project?

E.1.1.1. Introduction

The evaluation examined the extent to which the project responded to the expressed needs and priorities of its primary rights holders: PwD, older people and their caregivers in Azraq Camp and host communities of Azraq, Mafraq and Ramtha, as well as women and children who are survivors of GBV. The analysis is based on the project documentation, and the evaluation data gathered through the fieldwork with rights holders, CBOs, and partner organisations.

The question of relevance is therefore understood not only in terms of technical fit (assistive devices and rehabilitation), but also in relation to protection, dignity, participation and the broader aspirations of rights holders for autonomy, reduced dependence and social inclusion.

E.1.1.2. Findings

A) Strong alignment with priority needs for mobility, pain reduction and functional independence

The project design explicitly emerged from prior needs assessments highlighting significant gaps in access to modified mobility aids, prosthetics and orthotics, and specialised rehabilitation services for PwD and older persons in the target areas. Hospital and UNHCR data had already indicated high demand for physiotherapy and assistive devices and low effective coverage, especially among Syrian refugees.

Implementation data confirm that these identified priorities were real and pressing:

- 719 modified mobility aids and 130 prosthetic/orthotic devices were ultimately delivered, while 664 rehabilitation and PSS sessions were conducted, exceeding the initial targets for all three types of therapy.
- The beneficiary follow up survey for 479 participants from the wider Tamteen intervention shows high levels of perceived usefulness of mobility aids and therapy in daily life, and significant reported improvements in independence, pain reduction and social participation.

Qualitative data from FGD with PwD and older persons in Mafraq, Azraq and Ramtha reinforce these trends. Participants consistently described improved ability to move within the home and community, reduced pain, greater comfort in sitting and sleeping, and increased capacity to manage self-care and household tasks after receiving customised devices and therapy. Several respondents linked these changes directly to project support, contrasting their current situation with previous years of immobility, dependence on relatives and social isolation.

The two online questionnaires completed by two women with disabilities (WwD)/older women also indicate that the project largely met their main needs, helped them in daily life, and improved both mobility and psychological wellbeing, although one respondent considered that activities were only "partly" sufficient and called for extended physiotherapy and economic support.

Taken together, these sources point to a high degree of alignment between the project's core package of mobility aids and rehabilitation and the priority needs identified by rights holders themselves.

B) Relevance of caregiver-focused support and training, with demand for greater intensity

Caregivers – primarily women, but also some men – face heavy physical and emotional workloads, often without prior training. By including them as explicit rights holders (training on mobility aids, basic rehabilitation techniques and PSS), the project recognised their central role in sustaining improvements and preventing neglect or institutionalisation.

FGD with caregivers and the eight responses to the caregiver questionnaire (six women and two men) confirm that training on transfers, positioning and home-based exercises, as well as the provision of wheelchairs and other aids, responded closely to their daily challenges, being perceived as highly useful and directly linked to their responsibilities. Respondents reported:

- Easier transfers and reduced physical strain ("it became easier to carry him").
- Children or older relatives "moving more freely" or sleeping with less pain thanks to appropriate seating and mattresses;
- Increased confidence in handling devices and in understanding which exercises to continue at home.

At the same time, caregivers stressed unmet or only partly met needs, particularly:

- More frequent and longer rehabilitation and PSS sessions, both for the PwD and for themselves.
- Continued emotional and PSS to manage stress, sadness and burnout.
- Complementary material support, such as diapers and specialised nutrition, which fall outside the project's scope but weigh heavily on household economies.

These perceptions suggest that the direction of support was highly relevant, but that the intensity and duration of caregiver-focused activities were insufficient in relation to the scale and chronic nature of their needs.

C) Alignment with protection and GBV-related concerns, but limited reach of specialised responses

The project explicitly recognised the heightened protection risks, and especially GBV risks faced by WGwD and older women, integrating GBV as a crosscutting concern rather than as a separate service line. This translated into:

- Development of a manual on identification and referral of cases of abuse and sexual violence against WGwD.
- A five-day training and subsequent follow up visits for AHS staff on disability-inclusive GBV risk identification, survivor-centred communication and safe referrals.
- Integration of GBV considerations into PSS and into the CBID referral system, in coordination with specialised GBV actors.

From a relevance perspective, this approach responded to real and serious concerns raised during interviews with staff, CBOs and the GBV consultant, who highlighted the frequency of violence, neglect and exploitation in households hosting PwD and the absence of adapted detection and referral mechanisms in rehabilitation settings prior to the project.

However, the evaluation also identified inherent limitations in the project's capacity to address survivors' needs in a comprehensive manner:

- The intervention did not aim to become a specialised GBV service provider; rather, it sought to strengthen identification and referral from within a rehabilitation project.
- Evidence on GBV-related outcomes show that only a small number of cases were identified and referred onwards.
- Some staff expressed that, despite improved skills, they still felt constrained by limited availability of survivor-centred services in certain locations and by camp-level restrictions on follow up visits.

In short, GBV-related actions were clearly relevant and filled an important gap at the interface between disability and protection, but the alignment with survivors' broader priorities (legal support, long-term PSS support and care, safe housing, livelihoods) remained partial due to mandate and resource constraints beyond the project's control.

D) Geographic and demographic alignment, with some gaps in reaching specific sub-groups

The project's geographic focus – Azraq Camp, Azraq Town, Mafraq and Ramtha – corresponds to areas with high concentrations of Syrian refugees and vulnerable Jordanians, with limited availability of specialised rehabilitation services. Mapping and partnership with local CBOs and health centres (Altakaful in Ramtha, Abaq Al-Firdaws and Qudrat in Mafraq, Al Aoun and Al Irfan in Azraq) ensured that services were brought close to communities, reducing travel costs and cultural barriers.

Project monitoring data show that it reached 583 rights holders (97 % of the target 600), with most Syrians and a slight over-representation of women and children compared with initial plans, patterns that reflect the higher visibility and expressed demand among these groups.

Nevertheless, some gaps in coverage emerged:

- Jordanian adults, particularly men, and some older persons were under-represented compared to the original target distribution.
- Participation in online questionnaires was limited, suggesting digital access and literacy barriers and potential evaluation fatigue.
- People living in more remote or unstable areas – especially in parts of Azraq Town and Ramtha – faced transport, health and economic obstacles that reduced their ability to attend sessions regularly.

These patterns indicate that, while the targeting logic was sound and broadly aligned with areas of highest need, structural barriers continued to limit effective access for certain subgroups.

E) Perceived relevance from the perspective of institutional stakeholders

Interviews with AHS, FPS and Rescate staff, as well as with UNHCR, NHF and CBOs representatives, converged on the view that the project addressed critical, previously unmet needs in the national and humanitarian landscape:

- AHS staff highlighted how the project allowed them to respond to long waiting lists for mobility aids and to introduce CBID-oriented follow up and home-based training.
- CBOs considered the project a "missing link" enabling them to offer tangible solutions to families they had accompanied for years.
- UNHCR and NHF valued the project's contribution to coordination structures and to filling technical gaps – particularly in customised mobility aids and disability-inclusive GBV risk identification – which they perceived as complementary to existing services rather than duplicative.

These views reinforce the conclusion that the intervention was not only relevant to individual rights holders, but also to local institutions striving to respond to complex, intersectional needs with limited resources.

E.1.1.3. Overall appreciation

Overall, the evaluation concludes that the relevance of the intervention is high. The project's core components – customised mobility aids, integrated rehabilitation and PSS, caregiver training and the CBID-based referral system – are closely aligned with the priority needs expressed by PwD, older persons and their caregivers in the target areas. The combination of technical assistance and institutional strengthening responded well to systemic gaps in Jordan's rehabilitation and protection landscape.

Relevance is somewhat more moderate in relation to GBV survivors, as the project's mandate and resources limited its ability to address the full range of survivors' priorities beyond safe identification and referral. In addition, geographic and demographic barriers meant that some groups – particularly Jordanian men and some older adults – benefited less than originally anticipated.

Despite these limitations, evidence from service uptake, follow up surveys, qualitative testimonies and stakeholder interviews consistently indicates that, for those reached, the intervention directly addressed their most urgent priorities:

moving with dignity, reducing pain, caring for relatives more safely, and feeling recognised rather than invisible. Within the boundaries of a one-year humanitarian project and the available budget, the design and implementation can therefore be considered highly aligned with the needs and priorities of the participating population.

E.1.2. How does the target group prioritise its needs? Do these priorities align with the project's objectives?

E.1.2.1. Introduction

This section explores how rights holders and caregivers themselves prioritised their needs, and to what extent these priorities corresponded to the objectives and core components of the project. The analysis draws primarily on the project documentation as well as the fieldwork with rights holders, CBOs and with partner organisations.

E.1.2.2. Findings

A) How rights holders and caregivers prioritise their needs

- **Immediate functional and mobility needs as the priority**

Across FGD and interviews, participants consistently described mobility and basic functional autonomy as their most urgent needs. Caregivers reported that they prioritised equipment and rehabilitation that allowed children and adults with disabilities "to move more freely", "sit properly", "eat safely", "sleep comfortably" and "be transported without pain". This translated into a strong demand for wheelchairs, specialised seating, standing frames, splints and other mobility aids, as well as physiotherapy and occupational therapy sessions to maximise their use.

Caregivers often described their decision making in very pragmatic terms: what would reduce pain, prevent deterioration and make daily care tasks more manageable. In Ramtha, for example, CBOs and health-centre staff highlighted that families "could not afford" essential devices such as commode chairs, hospital beds or high-quality braces, and therefore prioritised these over other forms of support when the project became available.

- **Continuity and accessibility of rehabilitation services**

A second major priority for both rights holders and caregivers was the continuity and accessibility of rehabilitation services. Participants repeatedly contrasted the long waiting times and limited availability in public services with the more responsive and structured support received through AHS and partner CBOs. Caregivers in Ramtha described the project as a "lifeline" for families who otherwise would not have been able to sustain regular physiotherapy or occupational therapy, particularly when sessions elsewhere were fee-based and unaffordable.

Rights holders and caregivers did not only prioritise having sessions, but having enough sessions over time to see real improvement. CBOs staff also underlined that rehabilitation needs, especially for children with complex disabilities, are long-term and cannot be adequately addressed through very short cycles of support.

- **Reduction of caregiver burden and need for PSS**

Caregivers systematically framed their priorities not only in terms of the PwD or the older relative, but also in relation to their own physical and emotional burden. In FGD, they emphasised exhaustion, anxiety about the future, and the need for emotional support, guidance and respite.

The caregiver questionnaires reinforce this picture: respondents stressed the value of learning practical exercises, receiving guidance on how to use devices, and having PSS sessions. At the same time, they explicitly requested more PSS, additional rehabilitation sessions and continued follow up, as well as practical material support such as nappies and milk for children. These responses suggest that caregivers prioritised a combination of technical support for care, emotional support for themselves, and material assistance to ease the economic strain of caregiving.

- **Autonomy, dignity and participation for adults and older persons**

PwD and older persons placed strong emphasis on independence, dignity and social participation. In questionnaires and discussions, they highlighted being able to move more independently, manage daily activities with less assistance, and feeling less of a "burden" on family members. Some older participants described feeling more confident and more respected as their mobility and pain levels improved.

CBOs staff in Mafraq and Azraq added that older persons particularly valued opportunities to gather, socialise and "feel seen", suggesting that social and emotional needs are closely intertwined with functional and health-related priorities.

- **Economic pressure and the cost of assistive devices**

Economic constraints cut across all other priorities. Both caregivers and CBOs representatives repeatedly stressed that assistive devices and continuous rehabilitation are far beyond the financial reach of most families. Devices such as wheelchairs, special seating, commode chairs, braces and hospital beds were described as expensive and unattainable without external support.

As a result, families tended to prioritise those items and services that had the greatest impact on daily functioning and that would be impossible to secure through other channels. At the same time, several respondents expressed the desire for additional financial support, including help with transport, medical costs, nappies and, in some cases, livelihood opportunities to stabilise household income.

- **Protection, safety and psychosocial wellbeing (including GBV)**

Finally, although not always framed explicitly in rights language, participants – particularly CBOs representatives – identified safety, psychological well-being and protection from violence as important needs. Staff in Azraq, for instance, suggested that programmes should include more structured support for "women who have been subjected to violence", combined with PSS sessions and safe spaces where they could speak openly.

GBV survivors were not directly interviewed, but some women spontaneously shared experiences of violence and distress during FGD and in open-ended questionnaire responses, where they also requested access to PSS for themselves. This indicates that protection and emotional safety are significant, albeit often less visible, priorities for part of the target group.

B) Alignment between priorities and project objectives

The priorities articulated by rights holders, caregivers and local actors align strongly with the core focus and design of the project, although they also point to areas where needs go beyond the project's scope.

- The emphasis placed by participants on mobility, functional autonomy and access to rehabilitation corresponds directly to Result 2 – Mobility and autonomy, which aimed to increase mobility and autonomy through customised assistive devices, rehabilitation services and caregiver training. The kinds of aids and services most valued by respondents (wheelchairs, specialised seating, splints, physiotherapy and occupational therapy) are precisely those financed and delivered through the project.
- The priority given to continuous, accessible and quality rehabilitation is broadly consistent with the project's CBID approach and its objective of rationalising and strengthening referral pathways. However, stakeholders repeatedly stressed the need for longer-term and more sustained support than the project could offer within a 12-month humanitarian framework and a limited budget. This suggests a partial gap between the scale and duration of the support envisaged in the design and the depth of need identified in the field.
- Caregivers' and CBOs' calls for PSS for both rights holders and caregivers resonate with the inclusion of this service within the project, and with the broader emphasis on protection and wellbeing. The project did provide PSS sessions and exceeded some of its initial targets, but stakeholders' requests for more and longer-term PSS indicate that this component, while relevant, was not sufficient to fully match perceived needs.

- The strong focus of respondents on economic pressures – including the cost of aids, transport and consumables such as nappies and milk – only partially aligns with the project's objectives. The intervention directly addressed structural cost barriers by financing expensive devices and services, which were a top priority for families. At the same time, many of the economic needs described (ongoing consumables, broader household poverty, livelihood opportunities) fall outside the explicit scope of this project and would require complementary programming.
- In relation to protection and GBV, the project's objectives were intentionally modest and centred on capacity strengthening of AHS staff and partners to identify risks and refer appropriately, rather than providing direct GBV case management. This is broadly aligned with the way GBV emerged in the fieldwork: as a significant concern, but one that respondents largely linked to the need for safe spaces, PSS and specialist services beyond what a rehabilitation-focused project can or should provide. The evaluation finds that the project responded to this priority indirectly and partially through GBV-sensitive training and referral tools, while leaving substantial unmet needs that would require dedicated GBV interventions.

E.1.2.3. Overall appreciation

Overall, the intervention is assessed as highly relevant to the way the target group prioritises its needs. The project design is closely aligned with the priorities most consistently articulated by rights holders and caregivers – namely mobility, functional autonomy, access to rehabilitation, and support for caregivers – and it addresses key financial and structural barriers to obtaining these services. At the same time, the fieldwork points to important unmet or only partially met priorities, particularly around the duration and intensity of rehabilitation support, sustained psychosocial assistance and broader economic insecurity. These gaps do not indicate a lack of relevance; rather, they reflect the limits of what a short, humanitarian-funded project can reasonably cover in a context of chronic and multi-dimensional vulnerability.

The evaluation concludes that the Relevance of the project is HIGH

E.2. Effectiveness

E.2.1. Have the intended specific objective and results been achieved? What internal and/or external factors have influenced the achievement of results?[5]

E.2.1.1. Introduction

This section assesses the effectiveness of the project in achieving its SO and the two expected results (Result 1 and Result 2). The analysis draws on the project documentation, and the data collected through the fieldwork with rights holders, caregivers, CBOs, institutional partners and project partners' staff, specially from AHS in targeted locations.

Given the one-year humanitarian timeframe and the shared responsibility of multiple actors, the evaluation looks at contribution rather than attribution. It focuses on whether the project delivered the planned outputs, the extent to which these translated into tangible changes in mobility, autonomy and protection, and the factors that enabled or constrained results.

E.2.1.2. Findings

A) Progress towards the SO and contribution to the GO

The SO was to improve the quality of life and health conditions of PwD and those in extreme vulnerability (older persons and women and children who are GBV survivors) in Azraq Camp and host communities. The GO was to

[5] For more information, please see Annex 4 - Project Indicator Tracking Matrix.

increase the protection and exercise of the right of access to health for Syrian refugees and vulnerable Jordanians, with a focus on functional diversity, age and GBV.

Quantitatively, the project came very close to meeting its overall coverage target. By July 2025, 583 rights holders had been served (97% of the planned 600), with women and children slightly over-represented relative to targets and Jordanian men and older adults somewhat under-represented.

Therapy provision exceeded expectations: 664 sessions were delivered (182 physiotherapy, 260 occupational therapy and 222 PSS), surpassing all three planned targets. A total of 719 modified mobility aids and 130 prosthetic/orthotic devices were distributed, supplemented by 60 additional devices financed directly by AHS.

Outcome-level data from the beneficiary follow up survey reinforce this picture. Among 348 respondents, 65.2% declared themselves "very satisfied", and a large proportion reported improvements in quality of life, reduced dependence in daily activities, and greater participation in social life.

Qualitative evidence from FGD and interviews with PwD, older persons and caregivers in the hosting communities, points in the same direction: participants described being able to move more freely, perform personal care and household tasks with less assistance, sleep with less pain, accompany family members outside the home and, in some cases, return to work or education.

At the same time, the scale and duration of the project inevitably limited how far it could advance towards the broader GO. The intervention contributed to greater realisation of the right to health for a defined group of rights holders in four locations, and it strengthened local capacities and referral pathways. It did not, and could not, transform systemic barriers such as poverty, transport costs, or the overall scarcity of specialised rehabilitation and GBV services in Jordan. Those structural issues remained visible in the testimonies of rights holders and partners.

Overall, the evaluation considers that:

- The SO was largely achieved: most participants experienced concrete improvements in mobility, functioning and wellbeing, and service coverage was close to the planned scale.
- The project contributed credibly to the GO by expanding effective access to rehabilitation and protection-sensitive services in the targeted areas and by strengthening one of the country's key specialist providers (AHS), but its contribution remains localised and time-bound.

Internal factors influencing SO achievement

- A clear focus on multidisciplinary, person-centred rehabilitation, combining devices, therapy and caregiver training, maximised the chances that services would translate into functional gains.
- Strong technical commitment within AHS and regular joint planning between FPS, Rescate and AHS enabled adaptive responses to demand, e.g. increasing session numbers, reallocating resources between sites.
- The presence of a MEAL officer and systematic use of feedback tools (e.g., complaint boxes, satisfaction surveys, follow up forms) provided an evidence base for small but meaningful course corrections throughout implementation.

External factors influencing SO achievement

- High unmet needs for rehabilitation and mobility aids created strong demand, which helped reach and retain participants but also generated waiting lists and expectations beyond project capacity.
- Physical access barriers, transport costs and security/regulatory constraints, especially in Azraq Camp, limited the regularity with which some rights holders could attend sessions.
- Economic hardship and the absence of parallel livelihood or social-protection support meant that some families struggled to maintain gains over time – a e.g. paying for transport, diapers, or specialised nutrition –, even though rehabilitation itself was free.

The evaluation concludes that the SO was largely achieved and that the project made a credible, locally significant contribution to the GO: it expanded effective, protection-sensitive access to rehabilitation and assistive devices for PwD and older persons in the targeted areas and strengthened AHS as a key national provider, while recognising that full realisation of the right to health for all PwD, older persons and GBV survivors in Jordan lies beyond the scope and duration of this single one-year intervention.

B) Result 1 – Institutional strengthening of AHS

Result 1 sought to expand the technical and human capacities of AHS to provide specialised, multidisciplinary responses to refugees and non-refugees in situations of extreme vulnerability. It also aimed to establish a CBID-oriented referral system, formalise partnerships with CBOs and institutions, maintain the Azraq workshop, and mainstream disability- and GBV-sensitive practices across AHS.

Achievement of Result 1

On the output side, Result 1 was largely achieved:

- Project and steering committees established and functioning: a Project Coordinating Committee and, later, a Steering Committee were set up, bringing together FPS, AHS, Rescate, UN agencies, NHF and key CBOs partners. Minutes and attendance sheets show that meetings were held throughout the project to review progress, address implementation bottlenecks (especially in Azraq Camp) and agree on strategic and operational decisions.
- CBID-oriented referral system designed and operationalised: AHS, with FPS support, developed and rolled out a referral system grounded in CBID principles. This included: agreed criteria for case prioritisation, standardised referral and follow up forms, and a basic digital database to track cases from identification to service delivery and follow up.
- Partnerships with CBOs and health facilities formalised: service mapping and outreach led to MoUs with several CBOs and health facilities in Azraq Town, Mafraq and Ramtha (including Al Takaful Health Centre, Abaq Al-Firdaws, Qudrat and Al Aoun). These agreements clarified roles in community outreach, case identification, provision of space for sessions and feedback mechanisms.
- Workshops in Azraq Camp and Amman maintained and upgraded: despite initial delays linked to camp procedures and maintenance, the Azraq workshop was preserved and gradually upgraded. Together with the main AHS workshop in Amman, it formed the technical backbone for the production, adaptation and repair of mobility aids, orthoses and prostheses.
- GBV and abuse-detection tools and training developed: Rescate and AHS co-developed a manual on the detection of abuse and sexual violence against children and WwD (particularly WGwD). Sixteen AHS staff (management, therapists and technical staff) received structured training and follow up mentoring on GBV detection, basic response and safe referral.
- Educational and awareness materials produced: AHS designed and disseminated brochures and visual materials on wheelchair maintenance, rehabilitation after amputation, pressure-ulcer prevention and abuse prevention. These were used systematically in individual and group sessions and remain available for continued use beyond the project.

These outputs translated into several concrete institutional changes (outcomes):

- More structured and transparent case management: staff reported that the referral system and tools helped to prioritise high-need cases, reduce ad hoc decision making and make referral pathways clearer for CBOs partners and communities. This improved transparency and perceived fairness in the allocation of limited services.
- Stronger AHS–CBOs network for CBID: CBOs in Mafraq, Azraq Town and Ramtha described a closer relationship with AHS and a clearer understanding of how to identify cases, what information to collect and how to follow up. Many saw their role as community entry points for disability-inclusive services reinforced.

- Enhanced technical and protection capacity within AHS: staff who participated in trainings and mentoring reported better skills in functional assessment, matching devices to individual needs, and integrating PSS considerations. They also described increased confidence in recognising and responding to indications of abuse or GBV, and in using safer communication with women, girls with disabilities and older women.
- Greater visibility and recognition of rehabilitation services: communication materials and joint activities contributed to positioning AHS as a key reference for inclusive rehabilitation in the targeted areas, which in turn supported demand for services under Result 2 and future collaboration with institutional actors.

At the same time, some aspects of Result 1 remained only partially achieved:

- Referral system institutionalisation is incomplete: while operational at AHS and in several partner CBOs, systematic use of the tools by all partners, regular joint analysis of referral data and interoperability with other agencies' systems were still under consolidation at project closure.
- GBV mainstreaming is at an early stage: internal knowledge, tools and confidence improved, but the number of GBV cases identified and referred remained modest relative to likely prevalence. This reflects under-reporting, stigma and the intentionally cautious scope of a non-specialised humanitarian project, rather than a lack of effort.
- System-level change beyond the AHS–CBOs network is emerging but limited: most capacity gains are concentrated in AHS and its closest partners. Wider changes – such as integration of adapted mobility aids into national insurance or formal recognition of CBID-based referral pathways in public protocols – are only beginning to be explored through advocacy and will require sustained engagement.

Internal factors for Result 1

Key internal factors that enabled progress included:

- AHS's established technical expertise in rehabilitation and mobility aids, which provided a strong base for formalising procedures and mentoring partners.
- There were complementary roles within the partnership, e.g. FPS led coordination, reporting and donor dialogue; AHS drove technical implementation, and Rescate brought specialised GBV know-how and safeguarding perspectives.
- Committed core staff, particularly the project manager, MEAL officer, technical coordinators and field team, who invested significant effort in adapting tools, solving practical problems and sustaining coordination spaces despite heavy workloads.

External factors for Result 1

External conditions both enabled and constrained Result 1:

- Availability of motivated CBOs partners in Mafraq, Azraq Town and Ramtha facilitated outreach and case identification, although their infrastructure, staffing and management capacities varied considerably.
- Regulatory and security constraints in Azraq Camp delayed some workshop maintenance and limited the speed with which new procedures could be implemented inside the camp, including restrictions on movements and approvals for materials and staff.
- Turnover and shifting priorities in external institutions (UN agencies, national foundations and other actors) occasionally disrupted coordination, requiring repeated relationship-building and adaptation by the project team.

Result 1 can be considered substantially achieved: the project put in place the core institutional building blocks for inclusive, protection-sensitive rehabilitation centred on AHS, even though full consolidation of the referral system, GBV mainstreaming and broader system change will necessarily extend beyond the life of this one-year intervention.

C) Result 2 – Mobility and autonomy of rights holders

Result 2 aimed to increase the mobility and autonomy of rights holders by providing customised mobility aids, rehabilitation and PSS sessions, and training for rights holders and caregivers in basic rehabilitation techniques and maintenance of devices.

Achievement of Result 2

On the output level, Result 2 was strongly achieved:

- Mobility aids and prosthetics: 719 modified mobility aids and 130 prosthetic/orthotic devices were delivered, with an additional 60 devices funded by AHS.
- Therapy sessions: the project exceeded targets for all three types of therapy, delivering 182 physiotherapy sessions (121% of target), 260 occupational therapy sessions (104% of target) and 222 PSS (148% of target).
- Training on use and maintenance of mobility aids, and on basic home-based rehabilitation, was systematically provided to rights holders and caregivers before or alongside device delivery and therapy, following CBID and VARD principles.

Outcome-level evidence from the follow up survey, FGD and the caregiver and adult/elder questionnaires shows that these outputs translated into meaningful improvements in mobility and autonomy for most participants:

- PwD and older persons reported walking or transferring with less assistance, being able to sit comfortably for longer periods, and performing daily activities (washing, dressing, cooking) more independently. Several respondents highlighted improvements in self-esteem and reduced social isolation as they could "go out more" or join family gatherings.
- Caregivers described reduced physical strain when transferring or pushing relatives, better understanding of safe positioning and exercises, and increased confidence in supporting rehabilitation at home. Some noted that children or older relatives "move more freely" or sleep better thanks to appropriate seating and mattresses.
- Many respondents (rights holders and caregivers) explicitly linked improvements in mobility and autonomy to increased dignity and a stronger sense of control over their lives.

While Result 2 was strongly achieved at output level and generated clear short-term functional gains, some dimensions remained only partially achieved:

- The duration and intensity of therapy and PSS cycles were often shorter than optimal for chronic conditions.
- Economic and transport barriers limited regular attendance for some rights holders, especially in more remote areas.
- Follow-up after the end of the project period was necessarily limited, leaving some gains vulnerable to reversal over time.

Internal factors for Result 2

- The multidisciplinary team (physiotherapists, occupational therapists, PSS staff and orthopaedic technicians) and their ability to work jointly around each case were key enablers of effectiveness, allowing integrated plans and consistent messaging to families.
- Robust needs-based selection criteria for mobility aids and therapy sessions helped ensure that limited resources were directed to those with higher levels of functional limitation, while also considering age, economic status and social support.
- The decision to couple each device and therapy cycle with practical training for caregivers enhanced the sustainability of outcomes beyond the formal project period.

External factors for Result 2

- High levels of economic vulnerability affected attendance and follow up, especially when families had to cover transport or lost daily income to attend sessions. This was particularly visible in more remote parts of Mafraq and Azraq Town.
- The uneven availability and accessibility of partner facilities (e.g. small or non-accessible premises, limited privacy) influenced the type and quality of sessions that could be delivered in each location.
- Broader contextual uncertainties – such as fluctuations in humanitarian funding and changes in local governance arrangements – created a degree of instability, but the project managed to cushion these impacts through flexible planning and use of the mobile clinic.

Result 2 can be considered strongly achieved: the project translated a high-volume package of customised mobility aids, multidisciplinary rehabilitation and caregiver training into tangible improvements in mobility, autonomy, pain reduction and daily functioning for most participating rights holders and caregivers, even though the intensity and duration of support were necessarily constrained by the one-year humanitarian timeframe and by structural economic and access barriers beyond the project's control.

E.2.1.3. Overall appreciation

Effectiveness is assessed as high for a one-year humanitarian intervention of this scope. The project delivered most planned activities, met or exceeded most service targets and generated concrete, perceived improvements in mobility, autonomy and wellbeing for most participating rights holders and caregivers. Institutional capacities within AHS and partner CBOs were appreciably strengthened, particularly around CBID-oriented referral practices, multidisciplinary rehabilitation and GBV-sensitive and safeguarding procedures.

At the same time, effectiveness was constrained by structural factors largely beyond the project's control: chronic poverty and economic insecurity, limited and costly transport, physical accessibility barriers in some locations, regulatory restrictions in Azraq Camp and the inherent difficulty of achieving lasting change in complex, long-standing functional limitations within a short timeframe. Coverage of Jordanian men and some older adults remained slightly below target, and work on GBV identification and referral – while important and innovative within a rehabilitation project – reached only a small proportion of the likely caseload.

Taken as a whole, the evidence indicates that the project made very good use of limited resources, generated meaningful benefits for those it reached and laid solid foundations – through strengthened systems, tools and partnerships – for deeper and more sustained change in any future phase. These changes represent a substantial and credible contribution to the SO and to the broader GO of enhancing access to health and improving the quality of life of PwD, older persons and their caregivers in the targeted areas, even though full realisation of this goal necessarily exceeds the scope of a one-year humanitarian project.

E.2.2. Have the planned activities been implemented, and were they sufficient and necessary to deliver the results? Were there specific activities aimed at promoting gender equality?

E.2.2.1. Introduction

This section examines the extent to which the activities planned in the project document were implemented as envisaged, and whether they were sufficient and necessary to deliver the SO and the two expected results. It also looks at how gender equality and GBV-sensitive practices were integrated, both through mainstreaming and through specific activities.

The analysis of activities and gender-related actions draws on the review of project documentation, and it was complemented by fieldwork data gathered through rights holders and caregivers, questionnaires and direct observation during site visits.

E.2.2.2. Findings

A) Implementation of planned activities

Across both results, most of the planned activities were implemented, with adaptations mainly related to timing, scope and modality rather than to their fundamental content.

Result 1 – Institutional strengthening and coordination

These activities included multi-day trainings, case discussions and ongoing mentoring for AHS technical staff, as well as regular coordination meetings with CBOs focal points to apply the new referral procedures in Mafraq, Azraq Town and Ramtha.

- Project and steering committees (AT1): the project set up the Project Coordinating Committee and later the Steering Committee, holding regular meetings (initial, follow up and 2025 steering meeting) with FPS, AHS, Rescate and key external stakeholders (UN agencies, NHF, CBOs). Minutes, agendas and attendance sheets show that these spaces were used to review progress, address bottlenecks (particularly in Azraq Camp) and agree on strategic and operational decisions.
- Initial mapping and partnerships (AT2): AHS and FPS carried out an initial mapping of existing services and CBOs in Mafraq, Ramtha and Azraq, which led to formal MoUs with several CBOs. This laid the groundwork for community-level case identification, local referral points and joint outreach.
- Follow-up and monitoring tools (AT3): the team developed and used a range of tools – beneficiary selection criteria, referral forms, case-tracking sheets, follow up visit reports and survey instruments – which, despite their simplicity, enabled systematic recording of cases, services and basic outcome information.
- Communication and dissemination (AT4): a package of communication materials was designed and disseminated (leaflets, posters, roll-ups and social media content) on mobility aids, wheelchair care, pressure-ulcer prevention, post-amputation rehabilitation, occupational therapy with children with cerebral palsy and project visibility. These were used in sessions with rights holders and caregivers and by partner CBOs.
- GBV and protection capacity-building: Rescate supported AHS through a GBV and disability-focused manual, staff training, follow up visits and mentoring, as well as inputs into referral protocols and safeguarding practices.

Result 2 – Mobility, autonomy and direct support

Rehabilitation support combined both centre-based sessions, community days and, in some cases, follow up phone calls to adjust devices and exercises after the initial fitting

- Case identification and evaluation: using agreed criteria and community outreach through CBOs, AHS staff identified and assessed PwD (including CwD) and older persons in Mafraq, Ramtha and (while access allowed) Azraq Camp. Evaluation included functional assessments and, where relevant, psychosocial screening.
- Assistive devices and technical services: the project provided customised mobility aids (wheelchairs, crutches, walkers, cushions, etc.), prosthetics and orthotic devices, drawing on the Azraq workshop and AHS's central facilities. Adjustments and repairs were carried out where needed.
- Rehabilitation and PSS sessions: physiotherapy and occupational therapy sessions were delivered, with a focus on pain reduction, improved mobility and increased independence in basic daily activities. PSS was provided on an individual basis and, in some locations, through small group formats.
- Caregiver training and follow up: caregivers received practical guidance on transfers, positioning, home-based exercises and device use. Educational materials and exercise sheets were used to support continuity at home, and follow up visits were conducted to adjust devices and reinforce instructions.

Overall, the activity portfolio was implemented to a high degree and was coherent with the intended results. The main gaps related to the limited duration of therapy and PSS cycles for some rights holders and to restrictions on access to

Azraq Camp once the project ended, which curtailed possibilities for extended follow up there. Within these constraints, gender- and GBV-sensitive components were largely delivered as planned, although their depth and continuity remained more modest than the needs and expectations identified among women, girls with disabilities and caregivers.

B) Sufficiency and necessity of activities to deliver results

Evidence from FGD, interviews and questionnaires indicate that the combination of activities was appropriate and, within the available time and budget, largely sufficient to achieve the expected short-term results.

- For Result 1, the mix of coordination structures, mapping, MoUs, referral tools and staff training was necessary to build a minimum functional CBID-oriented system. Stakeholders underlined that without a clear referral pathway, trained AHS staff, and active CBOs partners, the direct rehabilitation services of Result 2 would have reached fewer people and been less coherent.
- For Result 2, the package of assessment with customised device, therapy, caregiver training and follow up was repeatedly identified by rights holders and caregivers as what made change possible in practice. People emphasised that devices without training, or therapy without appropriate devices, would have been far less useful.

However, stakeholders also pointed to insufficient intensity in some components:

- Therapy and PSS cycles were often shorter than optimal for chronic conditions, and some caregivers and older adults expressed the desire for longer or additional cycles.
- Economic and transport barriers, while outside the project's formal scope, limited the ability of some rights holders to attend sessions consistently, suggesting that the activities were necessary but not always sufficient to secure regular participation.
- GBV-related work focused mainly on capacity-building and protocols; there was little scope within this project to undertake broader community-level prevention or to accompany survivors over time.

In short, the activity mix was appropriately chosen and necessary for the results achieved; however, the one-year timeframe and available budget constrained the scale and duration of several activities, leaving some needs only partially addressed.

C) Activities aimed at promoting gender equality and GBV-sensitive practice

Gender and protection considerations were integrated through both explicit activities and mainstreaming efforts:

- Targeting and participation patterns.
    - WGwD, older women and female caregivers were explicitly prioritised in outreach and case selection, reflected in the high proportion of women among FGD and questionnaire respondents.
    - Some men with disabilities and male caregivers also participated, which helped to normalise their caregiving roles and broadened the understanding of gendered care burdens.
- GBV and safeguarding activities.
    - Rescate's training and manual on GBV and disability equipped AHS staff to recognise risk factors, respond to disclosures in a safer way and activate existing referral pathways.
    - Follow up mentoring visits helped staff translate concepts into practice and provided space to discuss real dilemmas related to confidentiality, consent and safety.
    - Safeguarding messages and basic protection principles were incorporated into certain caregiver and rights holder sessions, particularly around respectful care, privacy and the right to refuse unwanted treatment.

- Gender-responsive service delivery.
    - Scheduling of sessions, separate FGD and the choice of female staff for some PSS and rehabilitation activities were used to reduce barriers for WGwD and for older women.
    - Communication materials were designed with gender-balanced imagery and explicitly included WGwD, helping to challenge stereotypes about who uses assistive devices and who can benefit from rehabilitation.

Despite these positive elements, the evaluation also found limitations:

- GBV-related outputs were primarily focused on staff capacity, and only a small number of GBV cases were formally identified and referred onwards. This is partly due to the project's non-specialised nature and short duration, but also reflects the complexity and stigma surrounding GBV disclosure, especially for WGwD and older women.
- There were few opportunities to involve men and boys explicitly in discussions about gender norms, caregiving and violence prevention, which could be an area for further development in a future phase.

Overall, gender equality and GBV-sensitive practice were meaningfully integrated into a non-specialised rehabilitation project, particularly through targeting of WGwD, older women and caregivers, and through Rescate's capacity-building with AHS staff. However, the depth and visibility of this work were constrained by the one-year timeframe, the project's rehabilitation mandate and the high levels of stigma surrounding GBV. A future phase would need more time, resources and specialist partnerships to translate these promising foundations into more systematic gender-transformative and GBV-responsive outcomes.

E.2.2.3. Overall appreciation

The project is assessed as having implemented most of its planned activities, with only minor adjustments driven by contextual and time constraints. The activities were logically connected to the two expected results and taken together, constituted a coherent package that linked institutional strengthening and coordination with concrete, person-centred rehabilitation support.

From an effectiveness perspective, the chosen activities were both necessary and, within existing limitations, broadly sufficient to deliver meaningful short-term improvements in mobility, autonomy and wellbeing for rights holders, while also reinforcing AHS's institutional role in the rehabilitation and CBID landscape. The main gaps relate not to the appropriateness of activities, but to their intensity and duration, which were inevitably limited in a one-year humanitarian project.

In terms of gender equality, the intervention went beyond simple sex-disaggregated data: it prioritised WGwD older women and caregivers, strengthened staff capacities on GBV and safeguarding, and integrated gender-responsive practices into service delivery. At the same time, the scale of GBV-specific work and broader gender-transformative activities remained modest, pointing to a need for deeper and longer-term engagement on these dimensions in any future phase.

The evaluation concludes that the Effectiveness of the project is HIGH

E.3. Impact

E.3.1. In what ways has the local partner been strengthened, and how is this expected to be sustained and further strengthened in the long term?

E.3.1.1. Introduction

This question focuses on the institutional impact of the project on AHS as the main implementing partner and, to a lesser extent, on the CBOs engaged in the intervention. The evaluation examined how AHS's technical, organisational and protection capacities were reinforced, what systems and structures were put in place, and the extent to which these changes are likely to be sustained and further strengthened over time.

The analysis draws on project documentation and the fieldwork with AHS, FPS and Rescate staff, as well as with CBOs representatives.

E.3.1.2. Findings

A) Strengthening of AHS's technical and service delivery capacities

The project significantly strengthened AHS's technical capacity to provide rehabilitation and mobility aid services in Azraq Camp and host community settings. A key institutional gain was the rehabilitation and operationalisation of the mobility aids workshop in Village 2 of Azraq Camp. The workshop underwent structural repairs, electrical and water system upgrades and sanitation improvements, resulting in a safe and functional space for repairing and adapting devices. AHS, in coordination with UNHCR and other partners, recruited and trained a volunteer to carry out day-to-day maintenance under AHS supervision and introduced templates and protocols aligned with international standards (for example the International Society for Prosthetics and Orthotics, ISPO) to guide maintenance procedures and rights holders' feedback.

Once operational, the workshop became a central hub for customised mobility aids, providing wheelchairs, crutches, prosthetics, orthoses and related devices across the targeted locations. The processes put in place – structured assessments, quality-controlled procurement, device customisation and systematic follow up – have strengthened AHS's capacity to deliver specialist services at scale and to maintain equipment over time, beyond the immediate life of the project.

B) Strengthening of systems for case identification, referral and follow up

At systems level, the project helped AHS design and roll out a CBID-oriented case identification and referral system that integrates internal processes with external coordination frameworks. The system includes unique identifiers for each case, digital and paper-based tools for data entry (including an online form), tracking of service delivery and follow up actions, and prioritisation criteria for different types of support. Within Azraq Camp, the system was aligned with the unified camp referral mechanism and coordinated with UNHCR, NHF and other agencies, while in host communities AHS used the system to connect with health services, rehabilitation centres and CBOs.

Although external partners did not fully adopt the digital referral template despite repeated follow up, AHS itself integrated the system into routine practice. The MEAL officer and project team use it to monitor rights holders' journeys, manage follow up visits and compile reports. In host community settings, mentoring visits and joint planning with CBOs also strengthened their role in identifying cases, supporting follow up and feeding community-level information into AHS's case-management system. Overall, the system not only improved day-to-day case management during the project but also leaves AHS with a more robust framework for future interventions, which can be expanded or adapted as other partners become more engaged.

C) Capacity building in protection, GBV and safeguarding

The project, with Rescate's technical leadership, invested substantially in strengthening AHS's internal capacity on disability, protection and GBV. A comprehensive manual on detecting abuse and sexual violence against CwD and WwD (especially WGwD) was developed, integrating international standards and Jordanian legal frameworks and providing clear guidance on survivor-centred approaches, communication with PwD and referral protocols.

On this basis, a five-day GBV and disability training was delivered to AHS staff, including physiotherapists, occupational therapists, social workers, a prosthetics and orthotics technician and project management staff. Pre- and post-tests showed substantial gains in knowledge and confidence to identify risks and make safe referrals. To ensure that learning

translated into practice, a monitoring, advisory and support system was implemented: between February and June 2025, a GBV expert conducted six structured follow up visits to Azraq Camp, Azraq Town, Ramtha and Mafraq, observing staff–rights holder interactions, discussing specific cases and providing individual feedback and mentoring. Observations indicated high adherence to referral and communication protocols and improved capacity to recognise GBV indicators.

Taken together, the manual, the training and the field-based mentoring visits have strengthened AHS's institutional capacity to integrate GBV-sensitive and safeguarding approaches into rehabilitation services. The manual and training package remain internal resources that can be reused for new staff and adapted for future projects.

D) Enhancement of MEAL and outcome measurement capacities

The project also contributed to strengthening AHS's MEAL systems. A specific survey design was developed to capture outcome-level changes such as service quality, dependence reduction, social integration and caregiver preparedness using a mix of quantitative and qualitative questions. This was operationalised in a large-scale rights holders follow up survey, which reached several hundred respondents and generated detailed data on satisfaction, timelines, appropriateness of devices, perceived quality of life and changes in dependence and community integration.

The MEAL officer played a central role in supervising data collection, checking quality, compiling rights holders follow up reports and integrating findings into project management. These practices have strengthened AHS's capacity to document outcomes, respond to feedback and communicate evidence to donors and authorities, thereby enhancing institutional credibility and its ability to advocate for sustained or expanded support.

E) Strengthening of coordination roles and external positioning

Through the project, AHS deepened its participation in coordination structures at camp and governorate level. AHS engaged actively in Azraq Disability and Age Task Force meetings, inter-agency community representative meetings in the camp, community-based protection working groups and, in Mafraq, child protection and GBV and referral working groups led by UNHCR. These spaces allowed AHS to present project updates, contribute to service mapping, discuss emerging needs and explore future directions such as potential replication of the AHS model in Zaatari Camp.

This increased visibility and engagement has reinforced AHS's position as a specialised rehabilitation and protection actor within Jordan's humanitarian architecture, tightened linkages between its services and broader protection systems and opened doors for future collaboration and scaling.

F) Foundations for sustainability and further strengthening

Many of the institutional gains supported by the project are embedded within AHS's core work and policies, which increases their likelihood of being sustained. The Azraq Camp workshop now functions as a permanent AHS facility with established protocols and a trained volunteer; the referral system and MEAL tools are integrated into regular operations; and the GBV manual and training materials are part of AHS's internal resources. Quarterly reporting to the Ministries of Health and Social Development and discussions on replicating the model in Zaatari Camp further anchor the intervention within national frameworks and future programming.

If multi-year funding is secured, these systems could be further strengthened through periodic refresher training, extending the mentoring model to new locations and expanding the use of the referral platform by external partners. Without such support, some of the new systems may be underutilised or operate at reduced scale, even if the core capacities remain within AHS.

E.3.1.3. Overall appreciation

The evaluation finds that the project has had a strong positive institutional impact on AHS, significantly reinforcing its technical, protection, MEAL and coordination capacities as a leading rehabilitation actor in Azraq Camp and the surrounding host communities. Investments in the Azraq workshop, the CBID referral and case-management system, GBV-sensitive tools and practice, and outcome-oriented monitoring have generated tangible improvements in AHS's ability to deliver and oversee quality services and have also contributed to strengthening the role of partner CBOs in case identification and follow up.

These gains are not limited to the project's timeframe: they are largely embedded in AHS's structures, procedures and human resources, and therefore provide a solid foundation for long-term strengthening. At the same time, their full consolidation and expansion will depend on continued funding, active use of the referral system by partners and ongoing technical support in protection and MEAL.

Taking these elements together, the institutional impact of the project on AHS is assessed as high, with promising prospects for sustained and further strengthening if adequate resources and partnerships are secured.

E.3.2. Has there been any change in attitudes among the rights holders population during the implementation period under review? Which anticipated long-term effects of the project have already been achieved, or are likely to be achieved? Is the target group aware of the effects achieved, or of those potentially achievable?

E.3.2.1. Introduction

This question explores the impact of the project at the level of rights holders and their caregivers, beyond immediate service outputs. It examines whether there have been changes in attitudes, expectations and behaviours among PwD, older persons and caregivers; which elements of the anticipated long-term effects have already emerged or are likely to materialise; and to what extent the target group is aware of the effects already achieved and of those that could be consolidated in future.

The analysis is based primarily on qualitative evidence from the project documentation and with the data collected through the fieldwork with rights holders and caregivers.

E.3.2.2. Findings

A) Changes in attitudes and behaviours among rights holders and caregivers

Across locations, rights holders and caregivers reported noticeable shifts in how they perceived disability, rehabilitation and their own capacity to act. Many participants described that, prior to the project, they saw their situation as largely static and unchangeable: pain and immobility were perceived as inevitable, and assistive devices were either unavailable, poorly adapted or seen as stigmatising. Following the intervention, a significant proportion expressed greater confidence in their ability to move, take care of themselves, participate in daily activities and, in some cases, re-engage with education, work or community life.

These attitudinal changes were closely linked to the experience of tangible improvements. Rights holders recounted that with properly adjusted wheelchairs, crutches or orthoses, and after receiving physiotherapy or occupational therapy, they could transfer more safely, sit comfortably, sleep better, perform personal care with less assistance and leave the house more frequently. Caregivers noted reduced fear of injury when lifting or moving relatives, and increased trust in the usefulness of exercises and devices. In several cases, participants emphasised that they had previously received devices that did not fit or were not explained properly, which had reinforced scepticism; the project's more personalised approach helped reverse this pattern.

The project also contributed to changes in help-seeking behaviour. Rights holders and caregivers reported that they were more willing to approach AHS or CBOs with questions or concerns, and more likely to request adjustments or follow up rather than abandoning devices that caused discomfort. Some caregivers explained that they felt less alone and more entitled to ask for support, having seen that rehabilitation and PSS could make a difference in their daily lives. At the same time, deep-rooted structural constraints and stigma have not disappeared: some families still internalise disability as fate and remain hesitant to expose relatives in public spaces, particularly women and girls, and not all community attitudes have shifted to the same extent as those of the direct beneficiaries.

B) Emerging and likely long-term effects

Several anticipated long-term effects of the project have already partially materialised, especially in relation to functional autonomy and the prevention of further deterioration. The provision and adaptation of appropriate mobility aids and

the training on their use have created conditions for sustained improvements in positioning, joint protection and safe movement. Rights holders and caregivers described how correct seating, support and pressure relief reduced pain, prevented or mitigated contractures and pressure sores, and allowed longer periods of comfortable sitting or standing. These changes, if maintained, can have long-lasting implications for health, comfort and independence.

Similarly, knowledge and skills acquired through physiotherapy and occupational therapy sessions – such as specific exercises, techniques for safe transfers, environmental adaptations and strategies to structure daily activities – are likely to continue generating benefits beyond the project's duration, if exercises are continued and devices remain functional. Some caregivers reported integrating exercises into daily routines and adapting the home environment (for example reorganising furniture, creating safer paths, adjusting bed heights), which can consolidate gains and reduce risk of falls or injury over the longer term.

At psychosocial level, the project has contributed to increased self-esteem, a sense of dignity and feelings of being valued among many rights holders, who noted that being listened to, assessed individually and followed up made them feel less marginalised. Caregivers also mentioned feeling more recognised in their role and more hopeful about their relatives' capacities. These attitudinal shifts can support longer-term outcomes in terms of social participation and inclusion, even if they remain vulnerable to economic shocks and wider social discrimination.

However, the durability of these effects is not guaranteed. The short project timeframe and the limited number of therapy and PSS sessions mean that some participants completed only a fraction of what would be clinically ideal for chronic conditions. Economic hardship, transport costs and competing responsibilities may impede regular use of devices or attendance at follow up appointments in future. Without continued maintenance of mobility aids, refresher guidance and accessible services, there is a risk that some functional gains will diminish over time. The project has nevertheless established a platform – in terms of devices, skills, relationships with AHS and CBOs, and increased awareness – from which longer-term change can be built if further support is secured.

C) Awareness of achieved and potential effects

Most interviewed rights holders and caregivers showed a clear awareness of the improvements they had experienced during the project. They were able to describe specific changes in mobility, pain, sleep, daily activities and emotional wellbeing, and to link these improvements to the use of devices, exercises or psychosocial sessions. Many also articulated, at least in general terms, what would be needed to sustain or enhance these gains: continued exercises at home, periodic adjustment and maintenance of devices, and access to follow up support when problems arise.

At the same time, there were indications of partial or uneven understanding of the limits of the project and of what could realistically be achieved in the longer term. Some participants expected prolonged or indefinite provision of therapy, PSS or material support (such as diapers, milk or transport), and expressed disappointment when services ended or could not be extended. This points to a tension between the increased recognition of the benefits of rehabilitation and PSS, and the constraints of a one-year humanitarian intervention with finite resources.

Awareness of GBV- and protection-related effects was more indirect. While few rights holders spontaneously mentioned GBV, some reported feeling more comfortable talking to AHS staff, greater trust in the confidentiality of conversations and a perception that staff were more attentive to emotional and relational aspects, especially with WGwD. This suggests that shifts in staff practice are beginning to be perceived by rights holders, even if the broader community is not yet fully aware of the potential role of rehabilitation services as safe entry points for protection and GBV referrals. Overall, the target group appears to be aware of the concrete effects achieved on mobility, autonomy and daily life, and partially aware of the potential for continued improvement and protection, with expectations sometimes extending beyond what a short-term project can provide.

E.3.2.3. Overall appreciation

The evaluation finds that the project has generated significant positive changes in attitudes and expectations among many rights holders and caregivers. Participants increasingly view disability not only as a fixed condition but as a situation that can be mitigated through appropriate devices, rehabilitation and support, and they feel more confident in their ability to act and seek help. Early long-term effects are visible in improved functional autonomy, pain management,

prevention of further deterioration and enhanced self-esteem and dignity, and there is a solid basis for these gains to persist if adequate follow up and maintenance are available.

The target group demonstrates a high level of awareness of the immediate benefits achieved and, to a certain extent, of what would be required to sustain them. However, this awareness coexists with limited understanding of the structural constraints and time-bound nature of humanitarian projects, sometimes leading to expectations that cannot be met in terms of duration of services and economic support. The attitudinal and functional changes observed are therefore meaningful but fragile, and their consolidation will depend on continued access to rehabilitation, maintenance of devices, reinforcement of exercises and clearer communication about available options and limits.

E.3.3. What gender-related impact has the project had?

E.3.3.1. Introduction

This question examines how the project affected women, men, girls and boys, both as rights holders with disabilities or in older age and as caregivers. It looks at gendered patterns of access to services, perceived outcomes, changes in roles and expectations, and the extent to which the project contributed to safer, more gender-responsive practices, including in relation to GBV risks and protection.

The analysis draws on disaggregated data from project documentation as well as from the fieldwork with rights holders and caregivers, AHS and Rescate staff on gender and GBV mainstreaming in service delivery.

E.3.3.2. Findings

A) Gendered patterns of access and coverage

Monitoring data indicate that the project reached a higher number of women than men overall, both as rights holders and as caregivers. Among direct rights holders, women and girls represented a slight majority of those assessed and served, and targets for female rights holders were generally met or exceeded, while male coverage was closer to or below target in several components. This pattern is particularly marked in PSS, where women and girls were overwhelmingly represented among participants, reflecting both their higher reported levels of distress and the greater social acceptability of women engaging in PSS activities. In physiotherapy and occupational therapy, as well as in access to mobility aids and prosthetics and orthotics, service use was somewhat more balanced, but female participation still tended to be higher than male.

Caregivers engaged by the project were predominantly women (mothers, wives, daughters), consistent with gendered caregiving roles in the Jordanian and Syrian contexts. Women caregivers participated actively in training sessions, follow up interviews and home visits, and often took the lead in implementing exercises at home and managing devices. A smaller number of male caregivers (fathers, husbands, brothers) were also involved, especially in managing transport, accompanying relatives to sessions and supporting physical tasks, but they were less present in structured caregiver sessions and PSS activities.

These patterns suggest that, in practice, the project was more accessible and attractive to women than to men, especially for PSS and caregiver-oriented components. While this contributed to responding to women's high burden of care and psychosocial stress, it also indicates that some gendered barriers (such as norms around masculinity, help-seeking and emotional expression) may have limited male engagement, particularly in PSS and caregiver support.

B) Changes in mobility, autonomy and caregiving roles from a gender perspective

For WGwD or in older age, the project's impact on mobility and autonomy had important gendered dimensions. Many female participants described how restrictive mobility, pain and dependence constrained their ability to move within and outside the home, participate in family life, attend social or religious activities and, for some, seek education or work. Through adapted mobility aids and rehabilitation, several women reported being able to leave the house more frequently, sit comfortably for longer periods, attend family gatherings, go to the market or health centres and, in a few cases, re-

engage in income-generating activities. These changes were often described as restoring dignity and visibility, counteracting gendered expectations that WwD should remain out of sight or confined to the domestic sphere.

For women caregivers, the project's effects on physical strain and emotional wellbeing were significant. Training and practical guidance reduced fear of injuring relatives during transfers, helped distribute physical effort more safely and provided strategies to integrate exercises into daily routines, easing the sense of constant crisis. Some women spoke of feeling more competent and confident in their caregiving role, and of experiencing moments of relief and recognition during sessions and follow up visits. However, the underlying gendered burden of care – the expectation that women carry primary responsibility for intensive, long-term care – remained largely unchanged, and economic pressures continued to weigh heavily on them.

The project also facilitated some shifts in male roles, although these were less pronounced and more uneven. Several male caregivers became more actively involved in practical aspects of care (for example adjusting devices, assisting with transfers, transporting relatives) and in interactions with AHS staff. Some men stated that they had gained a better understanding of their relatives' needs and of the importance of rehabilitation, which could support more equitable sharing of responsibilities in the longer term. Nevertheless, entrenched norms and limited male participation in PSS and caregiver sessions suggest that the project's capacity to transform gender roles in caregiving was partial and will require longer-term, deliberate effort to consolidate.

C) Gender, protection and GBV-related dimensions

At institutional level, the project had a clear gender-related impact through the strengthening of AHS staff capacities in gender, disability and GBV. The development of a manual on detecting abuse and sexual violence against CwD and WwD (particulary WGwD), the five-day training and subsequent mentoring visits contributed to increasing staff awareness of how gender, age and disability intersect to create specific risks of violence and exploitation. Staff reported feeling better equipped to communicate with WGwD, to recognise potential indicators of GBV and to respond in a more survivor-centred, confidential and respectful manner.

From the perspective of rights holders, these changes were reflected less in explicit references to GBV and more in perceptions of safety, respect and trust. WGwD described feeling that AHS staff listened to them, explained procedures more clearly and treated them with dignity. Some rights holders expressed greater comfort in raising sensitive concerns and a sense that staff would protect their privacy. For caregivers, especially women, the opportunity to speak about stress, conflict and family dynamics in a supportive environment was valued, even when discussions did not focus explicitly on violence. These perceptions suggest that gender-sensitive and GBV-aware practices are beginning to shape the way rehabilitation services are delivered, making them safer and more responsive spaces for WGwD.

At the same time, the scope of GBV-related impact was necessarily limited by the project's mandate and resources. The intervention did not include comprehensive GBV prevention or case management; referrals to specialised services were relatively few, constrained by stigma, fear of repercussions, limited availability of appropriate services and the short timeframe. There is no evidence that community-level norms related to gender and violence changed substantially during the implementation period. The main gender-related impact lies therefore in improved staff practice, safer interactions and increased awareness of risks, rather than in measurable changes in GBV incidence or broader social norms.

D) Persisting constraints and risks

Despite these positive gender-related impacts, important constraints remain. WGwD and older women continue to face higher barriers to mobility, participation and access to services than men, due to a combination of poverty, care responsibilities, safety concerns and restrictive norms. The heavy care burden on women was alleviated but not structurally reduced, and without complementary interventions in livelihoods, social protection and gender equality programming, economic dependence and social expectations are likely to continue limiting their choices.

Men and boys, particularly those socialised into norms of self-reliance and emotional restraint, may still be under-served in psychosocial and caregiver support. Limited male engagement in these components risks leaving their specific stressors unaddressed and may also constrain the potential for more equitable sharing of caregiving and household responsibilities. Addressing these gaps would require more explicit strategies to engage men and boys, both as rights

holders and as caregivers, in ways that resonate with their experiences and challenge harmful norms without exposing them or others to additional risks.

E.3.3.3. Overall appreciation

The evaluation finds that the project has had a meaningful gender-related impact, particularly in improving access to rehabilitation and PSS for WGwD, reducing the physical and emotional burden on women caregivers and strengthening AHS staff capacities to deliver gender- and GBV-sensitive services. WGwD and in older age have gained mobility, autonomy and visibility, while women caregivers have acquired skills, confidence and, to some extent, psychosocial relief. Staff are more aware of gendered risks and better prepared to respond ethically to sensitive situations, contributing to safer and more respectful service environments.

At the same time, the project's ability to transform deeper gender inequalities and GBV dynamics was necessarily limited by its scope, duration and mandate. The heavy burden of unpaid care work on women, men's lower participation in psychosocial and caregiver-focused components and the persistence of structural barriers and restrictive norms mean that the gender-related impact, while positive, remains partial and fragile. Consolidating and expanding this impact will require sustained efforts to integrate gender and GBV considerations into future phases, strengthen linkages with specialised GBV and gender equality actors and address the economic and social factors that shape how women and men experience disability, care and protection.

Beyond the intended changes described above, the project also generated some unintended or unforeseen effects. On the positive side, visible improvements in mobility and functional autonomy appear to have strengthened trust in AHS and partner CBOs beyond the immediate circle of direct rights holders, with several participants encouraging neighbours and relatives to seek assessment and support. Joint work around the referral system and GBV-sensitive practice also contributed to closer collaboration between AHS, CBOs and other actors in Azraq Camp and the host communities, creating informal coordination links that extend beyond the strict boundaries of the project. At the same time, the quality and intensity of support received by some families raised expectations that could not always be met within a one-year, resource-limited intervention. Rights holders and caregivers frequently requested continued therapy, additional devices or economic assistance (for example diapers, milk or transport), and some expressed frustration when they understood that these could not be provided. The project also made previously "invisible" needs more visible, including GBV risks, without being able to address all cases within its mandate and resources, and placed additional emotional and workload pressure on AHS staff. While there is no evidence of groups being harmed by the project, these unintended effects underline the importance of explicit expectation management, clear communication about scope and limits, and realistic planning for staff support and follow up in any future phase.

The evaluation concludes that the Impact of the project is HIGH

E.4. Efficiency

E.4.1. Were funds available within the planned timescales? Were there any deviations from the approved project design?

E.4.1.1. Introduction

This question examines two related aspects of efficiency: the availability and use of funds over time, and the extent to which implementation remained aligned with the approved project design. It looks at whether financial resources were made available within the planned timescales, how budgetary constraints and cost pressures affected delivery, and whether there were significant deviations from the original logical framework and activity plan.

The analysis draws on the project documentation, and information collected during the fieldwork from AHS and FPS staff.

E.4.1.2. Findings

A) Availability and flow of funds over time

Across the available documentation, there is no indication of major delays in donor disbursements or in the internal transfer of funds that would have systematically blocked implementation. Quarterly narrative and financial reports were prepared by AHS and reviewed by FPS, and the project was able to initiate activities in all main result areas (AT1–AT5, Result 1 and Result 2) within the planned 12-month period. The final report notes that the project remained aligned with the logical framework and donor regulations, and that quarterly narrative and financial reporting requirements were fulfilled, with expenditures tracked and shared with the donor.

Delays and bottlenecks affecting timelines were primarily linked to administrative, procurement and infrastructure issues rather than to a lack of funds per se. In quarterly report 1, policy and administrative delays – particularly slow signing of MoUs and approval processes with some partners – slowed aspects of coordination and integration of services. Procurement of mobility aids also took longer than anticipated at times, requiring enhanced communication and follow up with suppliers and the establishment of contingency measures.

A particularly significant challenge concerned the maintenance and rehabilitation of the Azraq Camp workshop in Village 2. When NHF withdrew and the caravans were handed over to AHS, the site was found in poor condition (broken tanks, damaged windows, vandalism), and the maintenance budget initially allocated in the project was insufficient to cover the actual costs. AHS and partners sought additional contributions (including partial support from UNHCR) and prioritised critical repairs within the available lines, which allowed the workshop to become operational, but required careful re-allocation and tight financial management rather than fresh, timely injections of new funds.

In addition, the project budget did not include a dedicated line for some operational costs of rehabilitation sessions (such as consumables like electrodes, gel and TheraBands), which had to be covered from AHS's own stock to maintain service delivery.

This reflects a limitation in budget design rather than a delay in fund availability, but it did affect how efficiently resources could be used and increased the implicit co-financing burden on AHS.

Overall, available evidence suggests that funds were broadly available within the planned timescales and that implementation was not fundamentally delayed by late disbursements. Instead, efficiency challenges stemmed from under-budgeted items, unexpected infrastructure costs in Azraq Camp and the time required to navigate administrative procedures and supply-chain issues.

B) Deviations and adaptations relative to the approved project design

In terms of design fidelity, the project largely implemented the set of activities approved in the original proposal. The main components – creation and functioning of the project and steering committees, initial mapping and engagement of CBOs, establishment and operation of the CBID referral system, rehabilitation and maintenance of the Azraq Camp workshop, provision and customisation of mobility aids and prosthetics, delivery of physiotherapy, occupational therapy and PSS sessions, caregiver training, communication and awareness activities, and development and roll out of GBV and disability tools and training – were all carried out as planned.

However, several adaptations and operational deviations took place in response to contextual challenges and safety considerations:

- Referral system scope and functioning: the project invested in a digital referral template and attempted to collect structured data from multiple partners, but several organisations did not adopt the template or provided incomplete information despite repeated follow up. As a result, the referral system was progressively limited to partners that effectively engaged, and more informal channels (waiting lists, direct partner communications) continued to play a role.
- GBV follow up modalities: the original intention to conduct GBV-related follow up more broadly was reconsidered in light of safety constraints. Following discussion in the project committee, GBV follow up visits were restricted to partner centres rather than home visits, to mitigate risks to survivors and staff. This adaptation

significantly affected how GBV-related support could be operationalised but did not change the project's overall objectives or the role of Rescate's technical support.

- Azraq Camp workshop rehabilitation: the poor condition of the workshop caravans after NHF's withdrawal and the resulting budget shortfall meant that maintenance and rehabilitation of the site required re-prioritisation within existing lines and external contributions. This delayed the full operationalisation of the workshop compared to initial expectations and forced the team to phase repairs, focusing first on safety and minimum functionality.
- Re-phasing of some outputs: certain communication and awareness products (such as the set of brochures) were finalised and printed later in the project than initially envisaged, with distribution concentrated in quarters 3 and 4. Similarly, preparatory work for the final external evaluation (development of ToRs, agreement on scope) took place in quarter 3, with fieldwork foreseen for quarter 4. These shifts reflect re-phasing rather than substantive design changes.

Despite these adjustments, the final report explicitly notes that the project remained aligned with its logical framework and donor regulations, and that thematic investments (workshop, referral system, GBV manual and training, communication, planning and MEAL) translated into the expected types of outputs and outcomes. No major changes to the GO/SO, expected results or core activity clusters are reported, and quantitative targets were largely met or closely approached.

E.4.1.3. Overall appreciation

From an efficiency perspective, funds appear to have been available broadly within the planned timescales, and the consortium, particularly AHS, demonstrated strong capacity to keep implementation moving despite administrative delays, infrastructure problems and under-budgeted items. The main financial constraints related to underestimated costs (workshop maintenance, rehabilitation consumables) and high demand relative to resources, rather than to late disbursement of funds. These were managed through re-prioritisation, partner contributions and the use of AHS's own stock, at the cost of additional pressure on the implementing partner.

In terms of design fidelity, the project adhered closely to the approved logical framework and activity plan. All major components were implemented, and adaptations were largely pragmatic responses to contextual and safety constraints (such as limiting GBV follow up to partner centres, narrowing the effective scope of the digital referral system and re-phasing certain outputs). These adjustments did not alter the project's objectives or overall structure; rather, they reflect adaptive management aimed at preserving effectiveness and protection standards within the existing design and budget.

Taken together, these elements support a positive assessment of efficiency in relation to the availability of funds and adherence to the approved design, while acknowledging that budget underestimation for some cost categories and infrastructure challenges in Azraq Camp created tensions that could be mitigated in future phases through more conservative cost estimates, explicit budgeting for operational consumables and early contingency planning.

E.4.2. Were the timelines set out in the project design met? What internal and/or external factors contributed to any delays?

E.4.2.1. Introduction

This question examines the timeliness of implementation in relation to the 12-month project design and planned sequencing of activities. It looks at whether key components were implemented within the envisaged timeframe and identifies internal and external factors that contributed to any delays or re-phasing. Particular attention is given to the timing of major milestones such as the rehabilitation of the Azraq Camp workshop, the roll-out of the CBID referral system, the delivery of rehabilitation and PSS services, and the GBV and disability training and mentoring.

The analysis draws on the project documentation, as well as with the data collected through AHS, FPS and Rescate staff.

E.4.2.2. Findings

A) Adherence to overall timelines

Overall, the project was implemented within the planned 12-month period, and the main components foreseen in the design were completed on time. Initial mapping and engagement with CBOs, establishment of the project and steering committees, case identification and assessment, provision of mobility aids and prosthetics, delivery of physiotherapy, occupational therapy and PSS sessions, caregiver training, communication activities and the development of GBV/disability tools all took place during the implementation window.

Sequencing was broadly respected: community mapping and partner engagement started early, rehabilitation and PSS services ran throughout most of the period, and capacity building and communication activities were implemented once core service delivery was underway. Some activities, particularly those related to systems-strengthening and training, were compressed into the second half of the project due to earlier administrative and infrastructure challenges, but they were nonetheless carried out before project closure.

B) External factors contributing to delays

Several external factors influenced the timely implementation of specific activities. First, policy and administrative procedures with external stakeholders took longer than anticipated. The signing of MoUs and formal approvals with some CBOs and public institutions was slower than expected, delaying aspects of the referral system roll-out and the start of some field activities, especially in host community locations.

Second, infrastructure constraints in Azraq Camp had a direct impact on the timing of the workshop's rehabilitation and full operationalisation. When NHF withdrew and the caravans in Village 2 were handed over to AHS, they were in poor condition, with broken water tanks, damaged windows and signs of vandalism. The maintenance budget initially foreseen in the project was not sufficient to cover the actual costs of making the space safe and functional. Time was needed to assess the damage, mobilise complementary contributions (including support from UNHCR) and phase repairs. This delayed the full functioning of the workshop compared to the original expectations.

Third, the wider supply and operational context also affected timelines. Procurement of mobility aids and consumables was occasionally slowed by supplier response times, the need to adapt orders to complex cases requiring customised devices and logistical constraints linked to the project's wide geographic coverage (Azraq Camp, Azraq Town, Ramtha and Mafraq). Bad weather and transport barriers at certain moments further complicated travel for staff and rights holders, making it harder to maintain planned schedules for home visits and follow up. The team mitigated these constraints by optimising travel routes, combining visits and using phone or online communication where feasible, but some delays in device delivery and follow up were unavoidable.

C) Internal factors and adaptive management

Internal factors also contributed to the re-phasing of a few activities, although they were generally well managed. The GBV and disability training for AHS staff, initially planned earlier in the project, was delivered later than envisaged to accommodate trainer availability and coordination with Rescate and to ensure that the manual and training materials were fully ready. This reduced the time available for post-training consolidation but was compensated by focused mentoring visits in the remaining months.

Similarly, the development and operationalisation of the CBID referral system took longer than planned, not only because of external partner delays but also due to the time required for AHS to refine tools, set up the online form and integrate the system into routine practice. In practice, the team adapted by concentrating efforts on partners most willing to engage with the tool and by maintaining some informal communication channels (waiting lists, direct coordination) in parallel.

On the operational side, the under-budgeting of certain costs (such as some rehabilitation consumables) required AHS to cover gaps from its own stock. While this did not stop activities, it added an extra layer of internal management effort and contributed to a sense of working under continuous resource pressure, which sometimes constrained how quickly new cycles of sessions could start.

Across these areas, the project team and partners applied mitigation measures, such as revising activity schedules, intensifying follow up with partners, re-prioritising tasks, and using interim solutions (for example relying on the Amman workshop and mobile services while the Azraq workshop was being rehabilitated). Delays were generally documented in quarterly reports and discussed in project and steering committees, where decisions were taken to protect core outputs and adapt timelines without changing objectives.

E.4.2.3. Overall appreciation

The evaluation finds that, despite several specific delays and re-phasing, the project's overall timeliness was good. The main activities were completed within the planned 12-month period and broadly followed the intended sequence, allowing the project to achieve its SO and most result-level targets.

Delays were driven largely by external factors – slow administrative procedures, unexpected infrastructure problems in the Azraq Camp workshop, procurement and logistics challenges – rather than by late disbursement of funds or major internal bottlenecks. Internal factors, such as the time required to finalise training materials and operational tools, also played a role but were managed through adaptive re-scheduling and focused mentoring.

Given the extent of these contextual and structural constraints, the way the consortium maintained momentum, adjusted timelines and protected core results supports an assessment that the timeliness of implementation was high, while highlighting the importance of more conservative planning for infrastructure rehabilitation, procurement and partner coordination in any future phases.

The evaluation concludes that the Efficiency of the project is HIGH

E.5. Sustainability

E.5.1. Have the individuals and institutions involved been clear about their responsibilities?

E.5.1.1. Introduction

This question explores how clearly roles and responsibilities were defined and understood among the different actors involved in the project, and how this contributes to institutional ownership and sustainability. It looks at formal arrangements (committees, MoUs, policies), as well as how these translated into day-to-day practice for AHS teams, FPS and Rescate staff, CBOs partners and camp-level stakeholders.

The analysis draws on the project documents, alongside the fieldwork with AHS, FPS, Rescate and CBO staff and representatives.

E.5.1.2. Findings

A) Formalisation of roles at consortium and committee level

At consortium level, responsibilities were defined with AHS as lead implementing agency, FPS as the main technical and coordination partner and Rescate as the specialist GBV and protection partner. This division of labour is reflected in project documentation and committee structures: AHS chairs the Project Coordinating Committee, retains decision making authority over project activities, documentation and public communications, and leads service delivery and data management; FPS contributes technical guidance, liaison with the donor and participation in strategic meetings; Rescate leads GBV/disability content, the development of the manual, training and mentoring of staff.

The Project Coordinating Committee ToRs clearly sets out its advisory and coordination role, membership, and the distinction between committee support functions and AHS's executive responsibility. The executive director of AHS chairs the committee, and the project manager acts as reporter, with bi-monthly meetings to review progress, track action points and follow up on referral and partnership issues. This framework has helped to clarify institutional

responsibilities: AHS leads implementation and system oversight, while FPS, Rescate, UNHCR and CBOs contribute according to their mandate and expertise without blurring lines of accountability.

B) Clarity in MoUs and detailed policies with CBO partners

At local level, a series of MoUs between AHS and CBOs in Northern Azraq, Mafraq and Ramtha set out partner roles in concrete terms. Across these agreements, AHS is responsible for assessments, provision of rehabilitation services and assistive devices, implementation of the CBID-aligned referral system and stewardship of rights holders' data and documentation. CBOs are tasked with outreach and identification of rights holders, providing logistical support and facilities, coordinating with other service providers to avoid duplication and, in some cases, nominating representatives to participate in coordination meetings.

The MoUs systematically emphasise that AHS maintains sole decision-making authority over project activities, communications and documentation, while partners are recognised as facilitators and supporters. Annex A on detailed policies reinforces this by specifying data ownership (AHS), data-sharing protocols, documentation standards and visibility rules, as well as AHS's oversight of referrals and the requirement that disputes or uncertainties about referrals be escalated to AHS. This package of MoUs and policies provides a clear, written articulation of "who does what", especially around referrals, data, communication and service delivery.

Within the camp context, coordination with UNHCR and other actors follows the unified camp referral system, with AHS integrating its CBID tool into that framework and respecting camp regulations. Responsibilities for infrastructure maintenance and workforce mobilisation in the Azraq workshop (e.g. through the Incentive-Based Volunteering mechanism) were defined in collaboration with UNHCR, while AHS retained technical and supervisory responsibility for services delivered from the workshop.

C) Assignment of roles within AHS and partner teams

Within AHS, roles are differentiated between management (executive director, project manager, project coordinator), technical staff (physiotherapists, occupational therapists, prosthetics and orthotics technicians, psychosocial staff) and MEAL functions. Quarterly reports and internal tools show that responsibilities for case identification, assessment, provision of services, follow up and documentation are distributed across this multidisciplinary team, with referral focal points designated to coordinate GBV-related issues and external referrals.

The GBV/disability training and the associated manual further clarify individual responsibilities regarding safe identification, informed consent, documentation and referral of sensitive cases. Staff are trained on what they can and cannot do (basic PSS and safe referral, but not specialised GBV case management), and on how to use the referral form and follow project protocols. The follow up supervision system led by the GBV expert reinforces these expectations in practice, through observation, feedback and case-based mentoring.

CBOs partners also reported a relatively clear understanding of their role as facilitators: helping to identify and mobilise rights holders, providing spaces for activities, hosting outreach and contributing to the mapping and referral system, while deferring to AHS on clinical decisions and technical standards. Committee minutes and MoUs confirm that CBOs are expected to avoid duplicate referrals, coordinate with other providers and respect AHS's approval procedures for documentation and public communication.

D) Areas where clarity remains partial

Despite this overall clarity, the evaluation identified some areas where responsibilities, while defined on paper, were not yet fully internalised or consistently enacted in practice.

First, uptake of the digital referral system has remained uneven. While AHS's responsibility for system design, oversight and data management is clear, some partners have been slower to provide up-to-date data or to consistently use the standard template. This has limited the degree to which responsibilities for active use of the tool – rather than simply having it available – are fully owned by all institutions.

Second, at field level, the boundaries between "referral" and "direct problem-solving" can at times be blurred for staff and volunteers, especially in contexts of high need and limited services. Although protocols emphasise that AHS cannot

provide economic assistance or comprehensive GBV case management, some staff still feel pressure to respond directly to requests for material support or to "fix" issues beyond their mandate. This reflects the tension between clear formal responsibilities and the humanitarian impulse to help, rather than a lack of information.

Third, while committee and MoUs structures clearly position AHS as lead and partners as facilitators, some CBOs would like a more explicit recognition of their role in sustaining local outreach and accountability mechanisms beyond the project period. This does not indicate confusion about current responsibilities, but points to a need to clarify how roles will evolve if the project is extended or transitions into a different funding or partnership model.

E.5.1.3. Overall appreciation

Overall, the individuals and institutions involved in the project have been clearly informed about their responsibilities, and these responsibilities are generally well understood and respected in practice. The combination of a formal Project Coordinating Committee with a detailed ToRs, institution-specific MoUs, annexed policies on data and referrals, and GBV/protection protocols provides a robust framework for role clarity at both institutional and individual levels.

AHS's leadership as implementing agency, the supporting roles of FPS and Rescate, the facilitation and outreach roles of CBOs and the coordination functions of UNHCR and other actors are consistently reflected in project documents and interviews. Where ambiguities or tensions appear, they relate mainly to the degree of partner uptake of specific tools (such as the digital referral system), the human tendency of frontline staff to go beyond their formal remit in highly vulnerable contexts and open questions about the future evolution of roles in a possible next phase.

On this basis, the clarity of roles and responsibilities is assessed as high and provides a solid foundation for sustainability: institutional mandates are well defined, local partners are positioned as key facilitators and AHS retains the leadership and system stewardship necessary to maintain and further develop the services and coordination mechanisms initiated under this project.

E.5.2. If part of the cost of sustaining the results must be covered institutionally once the project ends, have public institutions stated their commitment to assume these costs? Do they have the financial capacity to do so?

E.5.2.1. Introduction

This question looks at whether public institutions – primarily the Ministry of Health (MoH), the Ministry of Social Development (MoSD) and, in the camp context, UNHCR as the main duty-bearer – have expressed concrete commitments to assume part of the costs needed to sustain project results, and whether they have the financial capacity to do so.

The analysis draws on the project documents and the fieldwork data collected with AHS, FPS and Rescate staff, CBOs and coordination stakeholders, as well as documentation review from coordination forums such as the Azraq Disability and Age Task Force.

E.5.2.2. Findings

A) Formal commitments and current practice of public institutions

The project sought to position AHS's work within existing national and humanitarian frameworks rather than as a parallel system. Quarterly reports were submitted to the MoH and MoSD in line with national regulations, and AHS actively participated in disability, protection and GBV coordination mechanisms at camp and governorate level. This reflects a degree of institutional recognition: public authorities and UNHCR are aware of the project's role, see AHS as a specialised actor and accept reporting obligations as part of broader oversight.

However, available documentation does not indicate that MoH or MoSD have made explicit, formal commitments to assume the recurrent costs of the model developed through the project (for example, funding for mobility aids, ongoing rehabilitation sessions or Azraq workshop operations) once donor funding ends. The final report's sustainability section

highlights "continued engagement with UNHCR and government agencies" and alignment with national frameworks, but it does not report specific pledges, budget lines or co-financing agreements from public institutions.

In Azraq Camp, UNHCR has provided limited, targeted support – for example contributing to some aspects of the workshop's rehabilitation (such as installing a water tank) – and participates actively in coordination and case prioritisation. Yet this support is framed as partial, project-bound assistance rather than a commitment to cover the full recurrent costs of running and maintaining the workshop or financing assistive devices and rehabilitation services in the long term.

Sustainability recommendations in the final report further underscore that the current situation falls short of institutional cost-sharing. One of the key recommendations is to "plan for sustainability" by developing a financing strategy with diverse sources, explicitly including government budgets and advocating for the integration of modified mobility aid services into national health insurance schemes. The fact that such advocacy is framed as a future priority indicates that systematic public funding is not yet in place.

B) Financial capacity and broader funding context

The broader funding context in Jordan, and in Azraq Camp in particular, is characterised by budget constraints and reductions. Minutes from the Azraq Disability and Age Task Force describe efforts to reduce costs by unifying committees, concentrating services under "one partner per service" where possible and creating a unified database to avoid duplication, explicitly in response to widespread budget cuts. Coordination actors repeatedly underline that "one organization cannot cover all assistance 100%", and discussions focus on how to rationalise existing humanitarian resources rather than expand public financing.

Similarly, some partners report funding gaps or temporary suspension of activities due to lack of resources, and UNHCR's contribution to Azraq Camp infrastructure (for example the workshop) is described as limited in scope. This suggests that humanitarian and public actors are already working under severe financial pressure, with limited room to absorb new recurrent costs such as those associated with specialised rehabilitation and assistive technology.

Within this context, the project has relied primarily on donor funding and AHS's own institutional resources. AHS has covered under-budgeted items (notably some rehabilitation consumables) from its own stock to keep services running, and has shouldered a significant part of the operational and management burden for maintaining the Azraq workshop and delivering services in host communities. While this demonstrates strong local ownership, it also highlights that sustainability currently depends more on AHS's capacity and future external funding than on public budgets.

C) Likelihood of institutional cost-sharing after project end

Given the absence of explicit public commitments and the constrained fiscal and humanitarian environment, the likelihood that public institutions will, in the short term, assume a substantial share of the project's recurrent costs appears limited. Authorities and UNHCR recognise the value of AHS's work, integrate it into coordination structures and receive regular reporting, but there is no evidence of earmarked budget allocations for taking over the financing of mobility aids, routine rehabilitation sessions or workshop operations once the current donor-funded phase ends.

At the same time, the project has contributed to laying some foundations for potential medium- to longer-term institutionalisation. Submitting reports to MoH and MoSD, integrating activities into sector working groups and explicitly recommending advocacy for the inclusion of modified mobility aids in national health insurance schemes position AHS to push for gradual public cost-sharing in the future. However, this remains an objective rather than an achieved commitment within the timeframe of the project under review.

E.5.2.3. Overall appreciation

In relation to this question, the evaluation finds that public institutions have not, to date, stated clear, concrete commitments to assume the recurrent costs needed to sustain the project's main results once external funding ends, nor is there strong evidence that they currently have the financial capacity to do so at scale. Authorities and UNHCR acknowledge the relevance of the intervention, integrate AHS into coordination and reporting frameworks and provide limited, targeted support, but systemic cost-sharing or budgetary absorption of services has not yet materialised.

Sustainability in financial terms therefore rests primarily on AHS's institutional resilience and its ability, together with FPS and other partners, to secure new donor funding and advocate for progressive integration of rehabilitation and assistive device services into national budgets and insurance schemes. In the short term, this represents a significant vulnerability: while technical and organisational sustainability prospects are relatively strong, financial sustainability beyond the project cycle remains uncertain and dependent on external resource mobilisation and policy change rather than on firm public commitments.

The evaluation concludes that the Sustainability of the project is MEDIUM

F. Conclusions

F.1. Relevance

The intervention is assessed as highly relevant to the situation of PwD, older persons and their caregivers in Azraq Camp and the host communities of Azraq, Mafraq and Ramtha. It was conceived and implemented in a context of protracted displacement, chronic underfunding of specialised rehabilitation services, and limited availability of affordable assistive devices. Against this backdrop, the project's GO and SO – enhancing access to health and rehabilitation and improving quality of life for people in situations of extreme vulnerability – respond directly to the main gaps identified by stakeholders during the evaluation.

Evidence from FGD with PwD and older persons, as well as from the follow up survey and questionnaires, shows that mobility, pain reduction and functional autonomy are among the highest priorities for rights holders. Participants consistently described how physical limitations, lack of appropriate devices and long-standing pain restricted their ability to move, work, participate in family life and maintain dignity. The services provided through the project – assistive devices, prosthetics and orthotics, physiotherapy and occupational therapy – are therefore closely aligned with these priorities. Many respondents reported concrete improvements in mobility and independence, better sleep, reduced pain and greater participation in daily activities.

The project's focus on caregivers also matches a critical, and often neglected, area of need. Caregivers described high physical, emotional and financial burdens associated with long-term care, particularly for CwD and older relatives with complex support needs. The training and counselling offered by AHS staff, together with practical guidance on using devices and exercises at home, were perceived as highly useful and directly linked to their daily responsibilities. At the same time, caregivers expressed a desire for more frequent sessions, longer-term PSS and additional economic relief, illustrating both the relevance of the chosen approach and the scale of unmet needs that remain beyond the scope of a short humanitarian project.

From an institutional perspective, the emphasis on strengthening AHS's technical and organisational capacities, consolidating the Azraq workshop and enhancing referral and coordination mechanisms is strongly justified. National and local actors repeatedly highlighted AHS as one of the few organisations able to provide specialised, affordable rehabilitation in the targeted areas. Investments in staff training, tools, protocols and coordination structures therefore address a real systemic bottleneck and contribute to improving the overall offer available to rights holders in both camp and host community settings.

The integration of protection and GBV-sensitive practices into a non-GBV-specialised rehabilitation project also responds to documented gaps at the intersection of disability, age and violence. Through Rescate's support, AHS staff gained greater awareness of GBV risks and referral options, which is particularly relevant given the high levels of vulnerability and dependence reported by participants. However, the project's mandate and resources did not allow for comprehensive GBV prevention and response programming, and some unmet needs in this area remain.

Despite its strong overall relevance, the evaluation identified several areas of partial alignment between needs and project scope. Rights holders and caregivers frequently prioritised ongoing, long-term access to therapy and assistive devices, whereas the project could only provide time-bound support to a limited number of participants. Economic hardship, requests for livelihood opportunities and material support (for example, paying for diapers, milk, transport) emerged as

crosscutting concerns, but lay largely outside the project's objectives. Similarly, while PSS was valued, the intensity and duration of PSS activities were insufficient to meet all expressed needs.

In summary, the project's design and implementation are strongly aligned with key priorities articulated by PwD, older people, caregivers and local actors. Where misalignments appear, they relate mainly to the depth and breadth of support that can be offered within a one-year humanitarian intervention and to needs (particularly economic and long-term PSS) that would require complementary or multi-sectoral programming.

F.2. Effectiveness

The intervention is assessed as highly effective in achieving its SO and most planned results within a one-year humanitarian timeframe. Output targets for the provision and adaptation of mobility aids, prosthetics and orthotics, and rehabilitation sessions were largely met or exceeded, and services reached a substantial number of rights holders across Azraq Camp, Azraq town, Ramtha and Mafraq. Monitoring data, follow up reports and stakeholder interviews consistently point to perceived improvements in mobility, functional autonomy, pain reduction and daily participation among many participants.

The integrated rehabilitation package – combining technical assessment, customised assistive devices, physiotherapy, occupational therapy and caregiver guidance – translated into concrete short-term outcomes. Rights holders and caregivers described better positioning, safer transfers, reduced physical strain, increased independence in activities of daily living, and, in some cases, renewed participation in education, work, or social life. The rehabilitation workshop in Azraq Camp and the technical teams in the different locations were widely recognised by stakeholders as technically competent, responsive and able to adapt support to individual needs.

Effectiveness was further enhanced by the CBID-oriented approach and coordination efforts. Partnerships with CBOs and other actors, formalised through MoUs, improved identification of cases and follow up in communities. Case documentation, home visits and phone follow up enabled AHS staff to adjust devices, reinforce exercises and address emerging problems. Rescate's contribution to gender, GBV and safeguarding mainstreaming strengthened the ethical quality of service delivery and staff capacity to respond more safely to potential protection concerns, even if the number of GBV-related referrals remained modest.

At the same time, several factors limited the depth and continuity of results. The short project duration and finite resources meant that therapy cycles and PSS activities were sometimes shorter than clinically ideal, and continuity beyond the project end was difficult to guarantee, especially for complex or chronic conditions. Economic hardship and transport costs constrained attendance for some rights holders despite services being free of charge. Physical accessibility barriers, competing household responsibilities and the high burden on caregivers also influenced participation. In addition, the lack of a formal baseline and limited use of standardised outcome measures reduced the ability to quantify change over time, although qualitative evidence of improvement is strong.

Overall, within these constraints, the project can be considered highly effective in delivering meaningful short-term improvements in mobility, autonomy, pain and participation for a significant number of rights holders, while also strengthening AHS's technical capacity and local referral systems.

F.3. Impact

The project has generated a strong positive impact at both institutional and rights holder levels, within the limits of a one-year humanitarian intervention. At institutional level, the intervention significantly strengthened AHS as a specialised national actor in disability-inclusive rehabilitation and protection. The rehabilitation and operationalisation of the Azraq Camp workshop, the development of a CBID-oriented referral and case-management system, the creation and roll-out of a GBV and disability manual with associated training and mentoring, and the enhancement of MEAL tools and practices have left AHS with more robust technical, protection and monitoring capacities. These gains are largely embedded in AHS's core structures and systems and are therefore likely to be sustained, provided that sufficient resources and partnerships are available to maintain and expand them.

At the level of rights holders and caregivers, the project has contributed to meaningful changes in attitudes, expectations and daily life. Many PwD and older persons moved from seeing their situation as static and unchangeable to recognising that mobility, pain and dependence can be mitigated through appropriate devices, rehabilitation and support. Tangible improvements in functional autonomy, pain management, positioning, sleep and participation in daily activities were widely reported, and some caregivers integrated exercises and environmental adaptations into their routines, laying the groundwork for longer-term benefits. Psychosocially, the intervention enhanced self-esteem, dignity and feelings of being valued among many rights holders, and gave caregivers a greater sense of competence and recognition.

From a gender perspective, the project had a particularly notable impact on WGwD and older women, who gained mobility, autonomy and visibility, and on women caregivers whose physical and emotional burden was partially alleviated through training and PSS. AHS staff now have stronger capacities to deliver gender- and GBV-sensitive services, making rehabilitation spaces safer and more responsive, especially for WGwD. Some shifts in male roles as caregivers also emerged, though more modestly.

At the same time, the impact observed is partial and fragile. The heavy burden of unpaid care work on women, persistent economic hardship, transport barriers, physical inaccessibility and restrictive gender norms continue to limit the extent and durability of change. The short duration of the project and finite number of therapy and PSS sessions mean that many participants could not receive the intensity of support that would be clinically ideal, and long-term continuity is not guaranteed. Male rights holders and caregivers remain under-represented in psychosocial and caregiver-focused components, and there is no evidence of significant changes in community-level norms around gender and GBV within the implementation period.

Overall, the project's impact is substantial in terms of institutional strengthening, early functional and psychosocial gains for rights holders and caregivers, and improved gender- and GBV-sensitive practice. These effects provide a solid platform for longer-term change, but their consolidation and expansion will depend on sustained investment in AHS and CBOs capacities, multi-year rehabilitation and PSS, stronger links to GBV and gender equality programming, and clearer communication about what can realistically be achieved and maintained over time.

F.4. Efficiency

The project demonstrates a generally high level of efficiency in using resources to deliver planned outputs within the envisaged timeframe, while adapting pragmatically to contextual constraints. Funds were made available broadly within the planned timescales, and there is no evidence of systematic delays in disbursement that would have blocked implementation. AHS and FPS maintained regular financial and narrative reporting, monitored expenditures against budget and fulfilled donor requirements. Major components of the intervention – including mapping and partner engagement, rehabilitation and PSS services, strengthening of the Azraq Camp workshop, development of the referral system, GBV/disability training and communication activities – were implemented within the 12-month period, with only moderate re-phasing of some capacity-building and systems-strengthening activities.

Where efficiency was challenged, this related less to financial flows and more to underestimation of certain cost categories, unexpected infrastructure problems and the time required to navigate administrative and procurement processes. The maintenance budget initially allocated for the Azraq Camp workshop proved insufficient given the poor condition of the caravans at handover, and additional support had to be mobilised while repairs were phased and prioritised. Similarly, the absence of a dedicated budget line for some rehabilitation consumables meant that AHS had to cover these from its own stock. These factors created pressure on the implementing partner and implied implicit co-financing, even as services continued without interruption.

In terms of adherence to the approved design, the project remained closely aligned with its logical framework and activity plan. The core structure of the intervention did not change, and deviations were largely adaptive adjustments to manage risks and constraints: narrowing the effective scope of the digital referral system to the most engaged partners, limiting GBV-related follow up to partner centres rather than home visits for safety reasons, and re-phasing some communication outputs and training activities. These adaptations did not alter objectives or expected results; instead, they were used to protect effectiveness and safeguarding standards within the existing budget.

Within a total budget of 393,390 Euros, the project delivered services to 583 rights holders, provided 719 modified mobility aids and 130 prosthetic devices, and delivered 664 rehabilitation and psychosocial sessions, alongside significant investments in staff training, the Azraq Camp workshop and the referral and MEAL systems. In this sense, the scale and mix of outputs are considered appropriate to the available financial envelope, although this required AHS to absorb some under-budgeted operational costs from its own resources.

Taken together, the evidence suggests that the project achieved a good balance between timely delivery, fidelity to design and responsive adaptation. Efficiency was high given the context, but it rested partly on AHS's willingness and capacity to absorb under-budgeted costs, reallocate internally and invest significant management effort in problem-solving. Future phases could further enhance efficiency by integrating more conservative cost estimates for infrastructure and operational consumables, building explicit contingency into the budget and planning, and clarifying from the outset the extent of any expected co-financing by partners.

F.5. Sustainability

The project has laid strong foundations for technical and organisational sustainability, especially within AHS and its network of community-based partners, but faces significant vulnerabilities in terms of long-term financial sustainability and institutional cost-sharing. Roles and responsibilities among AHS, FPS, Rescate, CBOs and UNHCR are clearly defined through the Project Coordinating Committee ToRs, MoUs and detailed policies, and these arrangements are generally well understood and respected in practice. AHS has emerged as the recognised lead for specialised rehabilitation and assistive devices, with CBOs acting as key facilitators for outreach, identification of rights holders and hosting activities, and Rescate providing structured GBV/protection capacity-building and mentoring. This clarity of mandates and the embedding of new tools (referral system, GBV manual, MEAL instruments) in AHS's routine work provide a solid basis for sustaining approaches and practices beyond the life of the project.

At the same time, there is no evidence that public institutions have yet committed to absorbing a substantial share of the recurrent costs associated with the model, such as funding for mobility aids, routine rehabilitation sessions, PSS or operation and maintenance of the Azraq workshop. While AHS reports regularly to the MoH and the MoSD and participates actively in coordination mechanisms, this recognition has not translated into budgetary allocations or formal cost-sharing agreements. In the camp context, UNHCR has contributed selectively to infrastructure improvements and coordination but does not commit to covering full running costs. The broader funding environment is characterised by budget constraints and reductions, with humanitarian actors already under pressure to rationalise services rather than expand them.

In practice, the sustainability of results currently depends on AHS's institutional resilience and its capacity, together with FPS and other partners, to mobilise new donor resources and advocate for progressive integration of rehabilitation and assistive device services into national systems. AHS has already absorbed under-budgeted costs (e.g. rehabilitation consumables) and taken on a significant share of management and operational responsibility, which demonstrates strong ownership but also highlights the risk of over-reliance on a single national actor. Overall, the prospects for sustaining technical and organisational gains are assessed as good, while financial sustainability remains uncertain and contingent on future funding and policy developments rather than on firm public commitments at this stage.

G. Lessons learnt

G.1. Relevance

- Integrated rehabilitation packages are highly valued. Combining devices, therapy and follow up produces changes that rights holders perceive as meaningful in their daily lives (mobility, pain reduction, self-care, participation).
- Caregiver support is not optional but central to relevance. Training, counselling and practical guidance for caregivers directly influence the effective use of devices and exercises at home and are perceived as a key benefit of the project.

- Institutional capacity strengthening increases systemic relevance. Investing in AHS's workshop, technical teams and referral systems benefits not only project participants but also the wider population served by AHS beyond the project period.
- Protection and GBV-sensitive practices can be mainstreamed in rehabilitation services. This works when staff receive tailored training, practical tools and ongoing mentoring, and when clear referral pathways to specialised GBV and protection actors are in place.
- Short humanitarian timeframes are in tension with chronic needs. One-year projects are highly relevant but cannot fully address long-term rehabilitation and PSS needs; expectations must be managed, and continuity strategies prioritised.
- Economic vulnerability shapes how people prioritise needs. Requests for diapers, milk, transport and livelihood opportunities show that even though rehabilitation is free, related costs and household poverty strongly influence access and perceived usefulness.

G.2. Effectiveness

- Integrated, tailored packages drive results. Combining assessment, customised devices, therapy and follow up generates measurable improvements in mobility, autonomy and pain for many participants; stand-alone distributions or sessions would likely have had a much weaker effect.
- Continuity and follow up are critical to consolidating gains. Home visits, phone follow up and mentoring visits to CBOs were key to adjusting devices, reinforcing exercises and maintaining motivation, but are resource-intensive and hard to sustain under short projects.
- Caregiver engagement strongly influences outcomes. When caregivers receive clear guidance, training and emotional support, devices and exercises are used more appropriately at home and functional improvements are more likely to be maintained.
- CBID-oriented coordination increases effectiveness. MoUs and collaboration with CBOs, local committees and other service providers improved case identification, follow up and referral, particularly in host community settings.
- Economic and access barriers limit the full potential of rehabilitation. Even when services are free, transport costs, loss of daily income, household care responsibilities and inaccessible environments reduce session attendance and dilute impact.
- Short humanitarian timeframes constrain outcomes for chronic conditions. One-year projects allow meaningful short-term progress but cannot fully address long-term rehabilitation and psychosocial needs; expectations and clinical protocols must be adapted accordingly.
- Outcome data need to be embedded from the start. The absence of a structured baseline and simple outcome tools made it harder to demonstrate change over time, even though qualitative evidence was strong.
- GBV-sensitive practice can be mainstreamed, but referrals require specialised partners. Staff can integrate safer communication, basic psychosocial skills and initial response to disclosures into rehabilitation work, but comprehensive GBV case management lies beyond the mandate and capacity of a rehabilitation organisation alone.

G.3. Impact

- Institutional investment multiplies impact. Strengthening AHS's workshop, referral system, GBV capacity and MEAL practices has effects that reach beyond individual rights holders and the project period, enhancing the organisation's ability to deliver quality rehabilitation and protection in future interventions.

- Attitudinal change is anchored in tangible improvements. Rights holders' and caregivers' attitudes shifted when they experienced concrete gains in mobility, pain reduction and autonomy; purely informational or awareness activities would have had much weaker impact without visible changes in daily life.
- Functional and psychosocial gains are meaningful but fragile. Improvements in positioning, mobility, self-care and self-esteem can have long-term effects, but are vulnerable to economic shocks, discontinuation of services, device deterioration and persistent environmental barriers.
- Caregiver empowerment underpins sustained impact. When caregivers feel competent, supported and recognised, they are more likely to continue exercises, maintain devices and advocate for their relatives, increasing the likelihood that benefits will persist beyond the project.
- Community-based structures extend the reach of impact. CBOs and local committees play a key role in identifying cases, supporting follow up and feeding back community-level information, and can help maintain relationships and practices after project closure, especially in host communities.
- Gender-sensitive practice improves safety and quality, even within non-GBV projects. Training, manuals and mentoring on gender, disability and GBV improved staff communication, confidentiality and responsiveness, making rehabilitation services safer entry points for WGwD, even where comprehensive GBV programming is not possible.
- Deep gender inequalities and GBV dynamics require longer-term, multi-sectoral engagement. While the project alleviated some burdens on women and improved staff practice, it did not fundamentally change the heavy care responsibilities placed on women, men's lower engagement in PSS and caregiver support, or community norms around gender and violence.
- Expectations must be carefully managed in short humanitarian projects. As rights holders and caregivers see what rehabilitation and PSS can achieve, expectations for continuity, intensity and additional support (including economic assistance) naturally grow; without clear communication and realistic planning, this can undermine the perceived impact when services end.

G.4. Efficiency

- Underestimation of infrastructure and operational costs undermines efficiency. The poor initial condition of the Azraq Camp workshop and the lack of a dedicated budget line for some consumables showed that even a well-planned intervention can face efficiency pressures if key cost categories are under-budgeted.
- Timely funds are not sufficient on their own. Although funds were available broadly on time, administrative procedures, procurement delays and infrastructure constraints still affected timelines, demonstrating that efficiency depends as much on systems and context as on disbursement schedules.
- Adaptive management can protect results but has a management cost. Re-phasing activities, revising procurement plans, narrowing the scope of the referral system and adjusting GBV follow up modalities allowed the project to stay on track, but required significant time and flexibility from AHS, FPS and Rescate staff.
- Using existing structures is efficient, if their condition and requirements are fully understood. Building on the existing Azraq Camp workshop and on CBOs networks helped reduce duplication and capitalise on prior investments, but only once the real condition of the caravans and the needs of partners were fully recognised and addressed.
- Implicit co-financing needs to be recognised and managed. Covering under-budgeted items such as rehabilitation consumables from AHS's own resources allowed services to continue, but also shifted some financial risk and burden onto the implementing partner.

- Digital tools require realistic expectations and partner buy-in. The experience with the referral system shows that investing in online templates and structured data collection can support efficiency, but only if partners have the capacity and motivation to use them; otherwise, parallel informal channels will persist.
- Geographic dispersion and access constraints affect the cost of reaching people. Serving rights holders across Azraq Camp, Azraq Town, Ramtha and Mafraq increased travel time and logistical complexity, and required careful planning of visits and follow up to use staff time and transport resources efficiently.

G.5. Sustainability

- Clear roles and formal agreements support institutional sustainability. Well-defined responsibilities in ToRs, MoUs and policies help anchor practices and systems in institutional mandates, making it easier to maintain them beyond a single project.
- Sustainability rests as much on systems as on individual projects. The CBID referral mechanism, GBV manual, MEAL tools and workshop procedures are assets that can be reused and adapted, independent of specific funding cycles, provided institutions remain committed to them.
- Local ownership can bridge gaps, but has limits. AHS's willingness to absorb under-budgeted costs and assume extensive operational responsibilities has been crucial for sustaining services, yet it also exposes the organisation to financial and workload strain.
- Public recognition does not automatically lead to cost-sharing. Being visible in coordination spaces, submitting reports and gaining acknowledgement from ministries and UNHCR are important, but they do not by themselves guarantee that public institutions will fund services.
- Financial sustainability is the weakest dimension. While technical and organisational aspects show strong continuity prospects, long-term financing for specialised rehabilitation and assistive devices remains highly dependent on external donors and AHS's own resources.
- CBOs are important anchors for continuity at community level. Local partners can continue outreach, basic follow up and feedback after a project ends, but they require minimal support, information and clear expectations for their role in future phases.
- Advocacy for policy and financing change needs to be planned from the start. Integrating recommendations on insurance coverage, government funding and institutionalisation of services only at the end of a project limits the time available to influence policy and budget processes.

H. Recommendations[6],[7]

H.1. Relevance

Strategic recommendations

- Consolidate and scale the CBID-oriented rehabilitation model. Use the evidence from this project to advocate with GVA and other donors for multi-year support that combines direct rehabilitation, caregiver support, and institutional strengthening of AHS and CBOs.
- Position rehabilitation and assistive devices as essential health and protection services. In dialogue with national authorities and coordination platforms, promote recognition of rehabilitation as a core component of inclusive health and protection responses for refugees and host communities.

[6] When relevant and/or convenient, the ET provided some specific recommendations or suggestions throughout the document.

[7] For more information, please see Annex 5 – Recommendations' table summary.

- Deepen strategic partnerships for GBV and psychosocial support. Building on Rescate's contribution, formalise or strengthen agreements with specialised GBV and MHPSS actors so that rights holders identified through AHS services have safe, predictable access to comprehensive support.
- Link rehabilitation with livelihoods and social protection where feasible. Explore partnerships and referral pathways with agencies providing cash, social protection or livelihood support, to address the economic barriers that limit the impact and perceived relevance of rehabilitation gains.
- Invest in outcome-oriented monitoring from the outset. For future phases, include simple, rights holders-defined outcome indicators (mobility, independence, participation, caregiver burden) and tools that can track change over time, even in the absence of a formal baseline.

Operational recommendations

- Prioritise continuity of support for the most vulnerable cases. Within resource limits, consider transparent criteria for extending therapy cycles or follow up for those with complex conditions, severe pain or very limited autonomy, and document the rationale.
- Strengthen and systematise caregiver-centred activities. Expand structured caregiver sessions (including group support where appropriate), ensure they are scheduled at convenient times, and integrate practical exercises that can be easily replicated at home.
- Further operationalise GBV-sensitive practices in day-to-day work. Continue refresher training sessions and case-based mentoring for AHS staff on safe disclosure, basic psychosocial skills and referral protocols, ensuring that protection considerations are consistently applied in assessments and follow up.
- Enhance communication about project scope and limits. During enrolment and follow up, clearly explain the duration of services, what can and cannot be provided (e.g. economic support), and available external referral options to reduce frustration generated by unmet expectations.
- Facilitate physical and financial access to services. Where possible, coordinate transport support with other actors, cluster appointments to reduce travel costs, and explore outreach or mobile-team options for people with the greatest mobility restrictions.
- Simplify and adapt feedback mechanisms. Maintain short, orally administered or assisted questionnaires for people with low literacy, and integrate a few core satisfaction and outcome questions into routine sessions to increase response rates.
- Document and share illustrative case stories. With informed consent, compile anonymised case examples that show how improved mobility, autonomy and caregiver capacity translate into better quality of life, to support future advocacy and fundraising.

G.2. Effectiveness

Strategic recommendations

- Protect and extend continuity of rehabilitation support. For future phases or similar projects, negotiate multi-year funding where possible so that therapy cycles, device maintenance and PSS can continue beyond one year and follow up is not abruptly interrupted.
- Consolidate the integrated rehabilitation model as a flagship approach. Use evidence from this project to promote the combination of customised devices, multidisciplinary therapy and caregiver support as a standard of good practice in disability-inclusive humanitarian health and protection.
- Strengthen formal partnerships for GBV and MHPSS referrals. Build on Rescate's contribution by establishing or reinforcing written agreements and referral protocols with specialised GBV and MHPSS actors so that cases identified in rehabilitation services have timely access to comprehensive support.

- Embed simple outcome-oriented monitoring tools. Co-develop with AHS staff and rights holders a small set of functional, pain and participation indicators and easy-to-use tools (for example brief scales or rating questions) that can be applied at intake and discharge to demonstrate change.
- Advocate for measures that reduce access barriers. With local authorities and humanitarian coordination platforms, promote complementary support (transport subsidies, accessible infrastructure, flexible scheduling) that enables rights holders to attend sessions regularly.

Operational recommendations

- Apply transparent criteria for prioritisation and extended follow up. Within resource limits, define and communicate criteria to identify high-priority cases (for example severe functional limitations, high pain, complex conditions, very vulnerable caregivers) who may benefit from longer therapy cycles or additional follow up.
- Plan rehabilitation cycles with clear expectations. At enrolment, agree with rights holders and caregivers on realistic goals, number of sessions and expected responsibilities at home, and revisit these periodically to maintain motivation and manage expectations.
- Systematise follow up modalities. Clarify the minimum package of follow up (phone calls, home visits, check-ups at the workshop) for different categories of cases, and record follow up contacts consistently to support clinical decision making and learning.
- Enhance coordination with CBOs and local actors. Continue mentoring and technical support to CBOs involved in identification and follow up, including joint planning of community days and feedback loops so that community observations inform clinical decisions.
- Mitigate economic and access barriers at project level where feasible. Cluster appointments for families travelling from afar, coordinate transport support with other agencies when possible, and explore limited outreach or mobile visits for people with the greatest mobility restrictions.
- Integrate a few core outcome and satisfaction questions into routine practice. Use brief, orally administered questions at key points in the rehabilitation process to capture changes in mobility, autonomy, pain and caregiver burden and to inform real-time adjustments.

G.3. Impact

Strategic recommendations

- Consolidate and fund institutional strengthening as a deliberate impact strategy. For future phases, position investments in AHS's workshop, referral and case-management system, GBV/safeguarding capacity and MEAL tools as core impact pathways, and seek multi-year funding to maintain and deepen these institutional gains.
- Build on early functional gains to support longer-term autonomy. Use the devices, skills and relationships established by this project as a platform for subsequent interventions that reinforce exercises, adjust devices over time and address environmental barriers, particularly for rights holders with chronic or complex conditions.
- Integrate gender and GBV considerations more explicitly into long-term planning. Ensure that future project designs systematically incorporate gender analysis, GBV risk mitigation and partnerships with specialised GBV and gender equality actors, so that rehabilitation services can function as safer, more effective entry points to comprehensive support.

- Strengthen links with livelihoods and social protection to stabilise impact. Develop or reinforce referral pathways with agencies providing cash assistance, social protection and livelihood opportunities, recognising that economic insecurity directly affects the sustainability of rehabilitation and psychosocial gains.
- Support CBOs as ongoing community anchors. Continue investing in the capacities of CBOs involved in the project so they can sustain case identification, community follow up, basic counselling and feedback loops after project phases end, particularly in Azraq Town, Mafraq and Ramtha.
- Promote outcome-oriented evidence for advocacy. Use the outcome-focused MEAL tools piloted in this project (for example follow up surveys, simple functional and psychosocial indicators, case stories) to document impact and advocate with donors and authorities for multi-year, disability-inclusive rehabilitation and protection programming.

Operational recommendations

- Plan for continuity and handover of support from the outset. When starting new project cycles, define in advance how follow up, device maintenance and referral will be handled after the end of funding, and communicate this clearly to rights holders and caregivers to manage expectations while exploring realistic continuity options.
- Maintain and reinforce the workshop and maintenance functions. Ensure that the Azraq Camp workshop has the minimum resources, supervision and technical support required to continue providing maintenance and adjustments, and consider extending similar maintenance capacities in host community locations where feasible.
- Systematically support caregiver resilience and shared responsibility. Expand structured caregiver sessions, including group spaces where acceptable, to address emotional stress, problem-solving and mutual support, and explore ways to involve men more actively in caregiving and psychosocial components.
- Engage men and boys more deliberately in psychosocial and rehabilitation processes. Develop targeted strategies (for example male-focused outreach, adapted session formats, role models) to increase the participation of male rights holders and caregivers in PSS and caregiver support, addressing norms that discourage male help-seeking.
- Continue to operationalise gender- and GBV-sensitive practice in daily work. Maintain refresher training and case-based mentoring for AHS staff, with particular attention to communication with WGwD, confidentiality, safe disclosure and referral procedures, and integrate simple prompts into assessment and follow up tools to remind staff of these dimensions.
- Use simple, rights holder-friendly communication about impact and limits. During assessments, sessions and follow up contacts, explain in accessible language what benefits can realistically be expected, what rights holders and caregivers can do to sustain gains (for example exercises, device care) and what options exist for further support through AHS, CBOs or specialised services.
- Document and share impact stories in a gender-sensitive way. With informed consent and robust safeguards, compile anonymised case examples that illustrate how improved mobility, autonomy and caregiver capacity have changed women's and men's lives, and how institutional strengthening has improved services, to support learning, accountability and fundraising.

G.4. Efficiency

Strategic recommendations

- Integrate conservative cost estimates and contingency into future budgets. For any new phase, ensure that budgets include realistic allocations for infrastructure rehabilitation and maintenance (particularly in existing

facilities with uncertain condition), as well as specific lines for essential rehabilitation consumables and workshop operations, with a modest contingency to absorb unforeseen costs.

- Clarify co-financing expectations with partners from the outset. If AHS or other partners are expected to cover certain operational costs or contribute in-kind resources, make this explicit in project design and agreements, so that efficiency gains are not achieved at the expense of unrecognised financial pressure on local actors.
- Treat systems- and capacity-strengthening as core efficiency investments. Continued support to the Azraq workshop, the referral system and MEAL tools should be framed as central to efficient service delivery, not as add-ons, and resourced accordingly in multi-year planning.
- Balance ambition and feasibility in geographic coverage. When designing future interventions, consider the trade-offs between reaching multiple locations and the travel and logistical costs involved, and explore models that cluster services or use mobile teams to reduce duplication and travel time.

Operational recommendations

- Conduct early, detailed assessments of existing infrastructure. Before finalising budgets and timelines, carry out thorough technical assessments of facilities to be used (such as workshops or CBOs centres) to identify hidden costs and necessary repairs, and adjust plans accordingly.
- Strengthen procurement planning and supplier relationships. Develop or update procurement plans that account for lead times, prioritise critical items, and, where feasible, establish framework agreements or preferred-supplier arrangements to reduce delays in obtaining devices and consumables.
- Make budget lines for consumables explicit and monitored. Include clear, visible lines for physiotherapy and occupational therapy consumables and basic repair materials in future budgets, and monitor their use systematically to anticipate shortages and avoid ad hoc coverage from partner stock.
- Plan timelines with explicit buffers for coordination and approvals. When setting activity schedules, build in realistic time for MoUs negotiation, coordination with public institutions and partner onboarding, so that modest delays do not cascade into compressed implementation periods for training and systems-strengthening.
- Continue using and refining adaptive management mechanisms. Maintain regular project and steering committee meetings as spaces to review progress, discuss delays, agree on re-phasing and document mitigation measures, so that adjustments remain transparent, timely and aligned with objectives.
- Optimise travel and follow up strategies. Continue clustering visits, combining home visits with other field tasks where appropriate and using remote follow up (phone, online) when face-to-face contact is not essential, to reduce travel time and costs without compromising quality of support.

G.5. Sustainability

Strategic recommendations

- Develop a medium-term sustainability and financing strategy with AHS at the centre. Co-design, with AHS, a multi-year strategy that sets out realistic scenarios for maintaining key services and systems (workshop, rehabilitation, PSS, referral and GBV-sensitive practice), combining donor funding, potential public contributions, social insurance mechanisms and AHS's own resources.
- Engage public institutions in structured dialogue on cost-sharing. Move beyond information-sharing toward targeted advocacy with the MoH, the MoSD and relevant insurance bodies, aiming at incremental steps such as partial coverage of specific assistive devices, inclusion of defined rehabilitation services in insurance packages or small budget lines in relevant programmes.

- Position AHS as a reference centre within national systems. Support AHS to formalise its role as a specialised rehabilitation and assistive technology centre of excellence, which can strengthen its case for public funding, formal partnerships and integration into national plans.
- Consolidate and expand the role of CBOs as community-level partners. Continue investing in CBOs capacities to identify cases, support follow up, provide basic PSS and maintain local accountability mechanisms, so they can act as enduring connectors between rights holders and AHS or other services.
- Integrate sustainability considerations into the design of any future phase. From the outset of a next project, define explicit sustainability objectives, indicators and activities (policy dialogue, joint planning with ministries, gradual transfer of certain costs), rather than treating sustainability as a late-stage add-on.

Operational recommendations

- Make the costs of sustaining key functions visible and tracked. Identify and quantify the recurrent costs of the Azraq workshop, rehabilitation sessions, PSS, referral system maintenance and GBV-related mentoring, and monitor them regularly to inform dialogue with donors and public institutions.
- Agree in advance on the extent of AHS's institutional contribution. Clarify, in future agreements, which cost categories AHS is realistically able to cover from its own resources and where external funding is essential, to avoid unsustainable implicit co-financing.
- Maintain and periodically update core tools and protocols. Ensure that the referral system, GBV manual, safeguarding procedures and MEAL tools are kept up to date, accessible to staff and integrated into induction and refresher training, so that practices do not erode over time.
- Strengthen succession and knowledge transfer within AHS and CBOs. Document key processes and lessons, and ensure that more than one staff member or focal point is familiar with critical systems (referral, workshop operation, GBV protocols), reducing dependence on specific individuals.
- Explore diversified resource mobilisation options. Support AHS to identify and pursue a mix of funding sources (bilateral donors, foundations, corporate social responsibility's contributions, small-scale cost-recovery where appropriate and equitable) that can complement public funding and reduce reliance on a single donor.
- Keep rights holders informed about the limits and possibilities of continuity. Communicate clearly with rights holders and caregivers about what can realistically be sustained after project closure, what support will remain available through AHS and CBOs, and what pathways exist for accessing other services, to reduce frustration and support informed expectations.