



# evaluation of the unrwa family health team reform

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## Commissioning office

Evaluation Division of the UNRWA Department of Internal Oversight Services

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Cover Photo: A nurse at the UNRWA Al-Nuzha Health Centre in Amman, Jordan explaining to a patient with a non-communicable disease (NCD) about how to use the newly released NCD smart phone application “Your health with UNRWA” and how it connects to her electronic health record in UNRWA e-Health system. © 2020 UNRWA Photo by George Awwad

## About UNRWA

UNRWA is a United Nations agency established by the General Assembly in 1949 with a mandate to provide humanitarian assistance and protection to registered Palestine refugees in the Agency’s area of operations, namely the West Bank, including East Jerusalem, Gaza, Jordan, Lebanon and Syria, pending a just and lasting solution to their plight. Thousands of Palestine refugees who lost both their homes and livelihood because of the 1948 conflict have remained displaced and in need of significant support for over seventy years. UNRWA helps them achieve their full potential in human development through quality services it provides in education, health care, relief and

social services, protection, camp infrastructure and improvement, microfinance and emergency assistance. UNRWA is funded almost entirely by voluntary contributions.

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## Acronyms

|          |  |
|----------|--|
| AAP      | Accountability to Affected Populations   |
| CIP      | Civil Insurance Programme  |
| CMM      | Common Monitoring Matrix   |
| CSO      | Civil Society Organisation   |
| COVID-19 | Coronavirus disease  |
| DIOS     | Department of Oversight Services   |
| ERG      | Evaluation Reference Group   |
| FGD      | Focus Group Discussions  |
| FHT      | Family Health Team   |
| FMDP     | Family Medicine Diploma Programme  |
| GBV      | Gender-based violence  |
| GEWE     | Gender Equality and Women's Empowerment  |
| GOJ      | Government of Jordan   |
| GOS      | Government of Syria  |
| HC       | Health Centre  |
| KII      | Key informant interviews   |
| LFO      | Lebanon Field Office   |
| MCH      | Maternal and Child Health  |
| MHPSS    | Mental Health and Psychosocial Support Services                                |
| MOH      | Ministry of Health   |
| MTS      | Medium-Term Strategy   |
| NFI      | Non-Food Item  |
| PA       | Palestinian Authority  |
| PHC      | Primary Healthcare   |
| NCD      | Non-Communicable Disease   |
| PLWD     | People living with disability  |
| PRJ      | Palestine Refugees in Jordan   |
| PRL      | Palestine Refugees in Lebanon  |
| PRS      | Palestine Refugees from Syria  |
| RBM      | Results Based Management   |
| RMNCH    | Reproductive, Maternal, Neonatal and Child Health                              |
| RSS      | Relief and Social Services   |
| SDG      | Sustainable Development Goals  |
| ToC      | Theory of Change   |
| UN       | United Nations   |
| UNEG     | United Nations Evaluation Group  |
| UNRWA    | United Nations Relief and Works Agency for Palestine Refugees in the Near East |
| WHO      | World Health Organisation  |

## Executive Summary

### Background and Context

1. UNRWA operates 141 primary health care facilities, providing comprehensive primary healthcare, both curative and preventative, to Palestine refugees across Gaza, Jordan, Lebanon, Syria, and the West Bank. Around 2.97 million Palestine refugees are registered users of UNRWA Health Centres, and a large proportion of this population is highly dependent on UNRWA to meet their basic health needs. In 2011, UNRWA introduced a Health Reform Strategy to modernise UNRWA health services, introduce a person-centred focus and make services more efficient.
2. The reform process included the introduction of the Family Health Team approach (FHT Approach and the introduction of electronic medical records (e-Health). The FHT Approach aimed to introduce a person-centred approach to UNRWA's health care provision with improved quality of care. Health staff were reorganised into multidisciplinary Family Health Teams, comprising at least a doctor, nurse, midwife, pharmacist, and a clerk. FHTs provide holistic and continuous care to Palestine refugees at all stages of life. The FHT Approach provides individuals with a single point of contact for all health concerns and provides staff with a comprehensive understanding on an individual's medical history and needs.

### Evaluation purpose

3. The evaluation serviced a dual purpose of **learning** to understand factors supporting or hindering the FHT Reform's intended results and to inform decision-making ahead of UNRWA's development of the 2023-2028 Medium Term Strategy; and **accountability** to assess the quality and results of the FHT Reform relative to its intended outcomes. The evaluation applied the OECD DAC criteria of relevance, coherence, efficiency, effectiveness, impact, and sustainability. The evaluation mainstreamed considerations of gender, human rights, and vulnerability.
4. The evaluation took place between November 2020 and August 2021. Except for some focus group discussions in Gaza, the evaluation was conducted remotely due to the COVID-19 pandemic. The evaluation used a mixed methods approach. This included a desk review and analysis of quantitative e-Health data. Interviews were undertaken with UNRWA HQ health staff, as well as senior management from other UNRWA programme areas and external stakeholders such as UNRWA health donors and WHO representatives. In each field of operation, the evaluation team completed interviews with Senior Health Staff, UNRWA Area and Health Centre staff, UNRWA partners and host government representatives, as well as individual interviews and (where possible) focus groups with Palestine refugees. In total, 220 interviews and 16 focus group discussions were completed.

### Key Findings and Conclusions

#### Relevance and Coherence

5. **Finding 1:** The FHT has consistently been relevant to and coherent with UNRWA's strategic goals on health, including addressing the growing burden of Non-Communicable Diseases (NCDs) among the Palestine refugee population. To a large extent, it has also been consistent with UNRWA internal policy commitments on cross-cutting issues of gender, protection, and disability although these are not always operationalized in practice. Externally, the FHT is coherent with World Health Organization (WHO) guidance. Host authority and partner government representatives from Jordan, Lebanon, and oPt confirmed that UNRWA's implementation of the FHT Approach is ahead of their own aspirations as they are seeking to move to a more family health focused approach themselves.
6. **Finding 2:** While the FHT Approach is deemed as a relevant and appropriate model to respond to the emerging needs of Palestine refugees, including growing NCD prevalence, there is scope to

strengthen it to be more responsive to the needs of specific groups if informed by gender and vulnerability analysis.

7. **Conclusion:** The FHT Approach has responded to Palestine refugees' needs across all five UNRWA fields. The FHT Approach responded to the growing prevalence of NCDs amongst the Palestine refugees, in line with global trends, as well as the needs of an ageing and growing population, with specific health needs regarding elderly care and maternal and child health. Overall, the FHT Approach has enabled greater continuity of care and early detection, prevention, and management of diseases. The evaluation found that the FHT model has helped UNRWA to manage the disease-related challenges facing the Palestine refugee population in a more appropriate and effective manner than the organisation's previous approach to health care.

8. The FHT Approach did not consider Mental Health and Psychosocial Support Services (MHPSS), Gender Based Violence (GBV) and disability in its original design; services addressing these areas have been integrated over time, in a manner that reflects UNRWA's cross-cutting commitments and policy on gender, protection and disability. These policies are highly relevant to the needs of the population and if executed well, will add value to the model. However, gaps remain between policy and integration of these services on paper, and reality in practice. The FHT Approach has not been provided with sufficient resources to implement these services consistently and the approach needs to be underpinned by stronger gender and vulnerability analysis to fully meet the needs of groups accessing these services.

9. Externally, the FHT is well aligned with host authority's systems and policies. The approach, alongside the e-Health system, are well-regarded examples for partner governments looking to move towards an FHT Approach in their own service delivery. At a high-level there is strong coordination between UNRWA and Ministries of Health (MoH) on matters relating to maternal health, immunisation, and the COVID-19 response. However, cooperation with local authorities to increase beneficiaries' awareness of available services is less effective.

### Efficiency

10. **Finding 3:** There have not been sufficient resources in place to efficiently implement the FHT Reform. This trend worsened following UNRWA's financial crisis in 2018, making it challenging to implement the FHT Approach across all fields. Internally, internal communication and management has been historically weak. Externally, the FHT has had good coordination and collaboration and is regarded as a valuable partner.

11. **Finding 4:** Monitoring and evaluation (M&E) of the FHT has been weak due to a poor conceptualization of M&E at the design stage. While e-Health has significantly improved the gathering and reporting of data, challenges remain around data accuracy, e-Health infrastructure, and the use of data in decision-making.

12. **Finding 5:** There is mixed evidence as to whether the FHT Reform has improved health programme efficiency. There are some indications that efficiency savings have been made, however these are challenged by ongoing difficulties in fully implementing the FHT Approach.

13. **Finding 6:** The FHT cannot be achieved at lower cost. Its funding is already limited in relation to requirements that are steadily increasing. However, it has allowed UNRWA to continue to meet the needs of a growing Palestine refugee population and prevent health outcomes from deteriorating.

14. **Conclusion:** In terms of organization and streamlining of work, the FHT Approach has created more efficient health services. The FHT has enabled the redistribution of tasks from medical officers to other staff members including midwives and nurses, making better use of staff's skillsets, and allowing better share of workloads. The integration of MHPSS, Disability services, and to a lesser extent GBV services, under HC management is an efficiency gain.

15. UNRWA has assessed efficiency against performance indicators including contact time, number of medical consultations per medical officer per day, antibiotic prescription rates and ratio of repeat to

first visits. In theory, the FHT should enable improvements in each of these indicators. The extent to which this has been realized is mixed and varies by field. These have naturally been influenced by fluctuating populations and evolving needs externally, and financial and staff resource constraints internally. While there is a positive trend in these indicators overall, this has not been a smooth trajectory.

16. The main factors challenging the reform's efficiency gains are financial and staff resource constraints. Across all fields, UNRWA struggles to supply sufficient financial resources to implement the FHT which in turn limits the ability to fully staff the model. As resources are stretched and the model cannot be implemented to its full potential, any efficiency gains are limited. Internal communication and management were found to be weaknesses of the reform and FHT Approach's implementation.

17. A significant weakness of the FHT Approach from the outset has been its planning, monitoring and evaluation. M&E was insufficiently considered in its planned design; with no underlying Theory of Change articulating the intended outcomes of the FHT Reform. As a result, it is difficult to assess if the FHT Approach has achieved what it was intended to achieve. Using health outcomes as the key indicator of the success of the FHT Approach is problematic since their achievement or non-achievement cannot be solely attributed to UNRWA.

18. There remains a need for systematic evaluation and use of the qualitative learning about the reform process and its implementation to inform continuing improvement. While e-Health has significantly improved the gathering and reporting of data, challenges remain around data accuracy, e-Health infrastructure, and the use of data in decision-making.

19. The Palestine refugee voice has been insufficiently and inconsistently included in the FHT Approach. M&E, patient and/or staff satisfaction surveys and annual assessments evaluating improved quality of care throughout the five fields of operation have not been conducted systematically or aggregated to gain an agency wide perspective on progress. The data gathered is not sufficiently disaggregated to show the impact of the FHT Reform on certain groups (e.g., youth, men, women, disability).

### **Effectiveness and Impact (Contribution)**

20. **Finding 7:** Measuring the extent to which the FHT Approach has improved health outcomes for refugees is complex. Overall, health outcomes have not improved. Where changes have occurred, it is difficult to attribute this to the FHT Approach due to data constraints, changes to the refugee population, and the wider operating context.

21. **Finding 8:** Most Palestine refugees indicated improvements with quality of care and conveyed a general satisfaction with UNRWA's health services. The FHT Approach has effectively increased continuity of care, enhanced the organization of services, and contributed to perceived improved quality of care by refugees and health staff. However, shortages in staff and medical commodities have undermined the perceived improvement of care and patient satisfaction in all five fields.

22. **Finding 9:** The reorganization of health staff into FHTs is regarded favourably by most health staff. However, this has been less effective in centres which have struggled to staff the FHT model. The financial crisis impacted UNRWA's ability to properly staff and train the FHTs, negatively impacting the FHT Approach's effectiveness and derived benefits.

23. **Finding 10:** Since 2011, some linkages have been established between UNRWA's health programme and other departments to address cross-cutting issues including MHPSS, inclusion and protection, and health education. However, the FHT and other UNRWA service areas largely remain siloed and where linkages do exist, the FHT has not been a causal driver.

24. **Finding 11:** The FHT Approach's adaptability and resilience varies between fields. In Gaza, the FHT has proved effective in absorbing shocks and stresses whereas in Syria, where the FHT Approach is less established, it has not shown the same resilience. In both contexts the FHT does not bridge the



humanitarian-development nexus nor was the FHT model appropriate for responding to the COVID-19 pandemic.

25. **Finding 12:** The FHT Approach's original design did not focus on gender equality and women's empowerment, protection results, or results for people living with disabilities. While there have been efforts to mainstream policies related to these issues, the design and implementation of the FHT has not been appropriately adjusted to achieve results in this area. GEWE and protection results were not achieved because the FHT Approach does not challenge traditional systems of oppression.

26. **Conclusions:** Assessing the extent to which the FHT Approach has contributed to improved health outcomes for refugees is complex, given the many other factors that affect health outcomes and weaknesses in the process and outcome indicators monitored. A key driver for the FHT Reform was to address NCDs more effectively. There is some evidence that the FHT Approach has supported the better management of NCDs, using diabetes as a tracer indicator, as there has been an increase in the proportion of diabetes patients controlling their illness with FHT support between 2012 and 2020, agency wide. NCD patients are attending Health Centres more regularly. Maternal health outcomes have improved across the agency since 2011, but it is not clear whether improvement can be wholly attributed to the FHT Reform, as women's take up of antenatal care has recently decreased.

27. Despite the mixed improvements in health outcomes, Palestine refugees generally indicated that quality of care has improved and, in general, were satisfied with UNRWA's health services. The FHT Approach has enabled an increased continuity of care, recognized both by refugees and frontline health staff. The integration of MHPSS has been welcomed and has improved Palestine refugees' access to mental health care, contributing to overall wellbeing.

28. However, shortages in frontline health staff and medical commodities have undermined perceived improvement of care and patient satisfaction in all five fields. There is a perception among Palestine refugees across all five fields that UNRWA services are not the best on offer and because medications are free of charge, they are perceived as poor quality and generic.

29. UNRWA's approach to gender mainstreaming in the FHT has focused largely on improving women's health including maternal and child health. However, the FHT Approach has had little impact on women's empowerment and decision-making. The FHT Reform has reinforced cultural norms and by its very nature has not challenged traditional family structures; women's health, and in particular family planning, continues to be influenced by other family members including male family members and mothers-in-law.

30. There also remain gaps in how men access and are included in services, and the provision of male-specific services. While gender parity in the workforce has been prioritized, this is still a work in progress across all fields. This is largely shaped by the supply of women for medical officer and management roles but also influenced by support for progression within the organization.

31. Protection is the area where the FHT Approach has made the least impact, particularly regarding GBV. There is a disconnect between the GBV services provided at Health Centres and beneficiaries understanding of the services on offer. Often, beneficiaries were unaware of the GBV support services on offer or were nervous accessing them due to concerns of stigma and confidentiality.

32. The services provided vary by field and Health Centre, often contingent on the capacity of individuals to drive the services forward, and tended to be reactive, placing the onus on women to self-report. While UNRWA has mainstreamed disability awareness into the FHT, many Health Centres remain poorly accessible for people living with disabilities and staff confidence in screening for and assisting people with disabilities was consistently institutionalized.

33. Overall, the FHT remains largely siloed from other UNRWA initiatives. The evaluation did find evidence of cooperation with the Education, Protection, and RSS departments on matters of health education, disability, MHPSS and GBV, however these were limited. Cross-cutting linkages varied by field and are highly dependent on an individual's approach and connections to achieve meaningful

referrals and holistic support for beneficiaries, provided by multiple UNRWA departments. Moreover, where this did occur, it was not so much a function of the FHT, but rather UNRWA's overarching policies on these cross-cutting issues. The FHT is not a key enabler for action on cross-cutting issues and it is likely that collaboration would still happen under a different health care approach.

34. UNRWA staff, both at Field Office and Health Centre level, appreciated the reorganization of frontline health staff into FHTs. As discussed under Efficiency, this has allowed for more streamlined services and redistribution of workload. However, UNRWA has a high staff turnover rate and due to ongoing financial challenges across the agency, is not able to replace staff or fund training for all staff. Inability to recruit adequate numbers of staff and deliver the training necessary to successfully embed such a large-scale reform has negatively impacted the FHT's approach's effectiveness and derived benefits.

35. While staff are supportive of the FHT Reform and recognize its value compared with UNRWA's previous model, there are clear capacity and knowledge gaps. Staff shortages mean that staff often shoulder increased burdens with a risk of burnout. Investment in supportive infrastructure (e.g., e-Health, training for non-Medical Officer (MO) staff) has been insufficient. The focus of training on the FHT Approach model on MOs rather than more broadly across the FHT has meant that there is inconsistent knowledge across the FHT. There is a real risk that institutionalized knowledge and implementation of the model will decline due to turnover and short-term contracts.

36. The FHT has been implemented in rapidly changing external contexts within the UNRWA fields. The evaluation considered the FHT Approach's resilience to shock and conflict in Syria and Gaza as well as during the COVID-19 pandemic. During periods of conflict or crisis, UNRWA has taken the deliberate decision to suspend the FHT Approach in favour of emergency response teams.

37. In the case of Gaza where the FHT Approach was piloted and is well-embedded, the FHT has helped embed resilience; it has supported UNRWA's ability to pivot responses to emergency contexts and provide the tools and structure to return to business as usual. In contrast, in Syria the FHT Approach was implemented later due to ongoing conflict in the country. As such the FHT Approach is not well-established, and the overall system is not as resilient to shock and disruption.

38. The FHT model was not appropriate for responding to the COVID-19 pandemic, and UNRWA took the decision to revert HCs to separate curative and preventative services to ensure protection from infection. It is unclear for all fields when 'normal' delivery of services post-pandemic will resume but there is a need for ongoing planning across the agency regarding what the FHT Approach will look like post-pandemic.

39. There is a risk that it will not 'bounce back' given the ongoing resource issues and that knowledge of the reform and ways of working will be lost as new staff recruited during the pandemic will not have been trained on the FHT and will lack experience in implementing it. Service users may also have lost familiarity with the FHT integrated model.

### Sustainability

40. **Finding 13:** Although the FHT model has continued to function for ten years, it has not always been implemented according to its design. In all fields the FHT has, at some point, been suspended or 'broken' to continue delivering services, limiting the reform's ability to meet its intended outcomes. Furthermore, two major factors impact the sustainability of the reform: financial and human resource constraints.

41. **Conclusions:** Throughout the current mid-term strategy period, UNRWA has experienced acute financial crisis across the agency which has affected all its programme areas. This coupled with growing demands, through an increasing and ageing Palestine refugee community and higher expectations and needs for health care, has placed a real strain on UNRWA's provision of primary health care, which undermines the reform's sustainability.

42. The evaluation observed that in all fields the FHT has, at some point, been suspended or 'broken' to continue delivering services. We note that the suspension of the FHT Approach in times of emergency response, such as during conflict or the COVID-19 pandemic is a deliberate decision by UNRWA. However, the longer the term of suspension the more difficult it is to reinstate the approach. This limits the reform's ability to meet its intended outcomes.

43. While the FHT Approach is highly relevant to the needs of Palestine refugees, there is nonetheless a negation perception of the FHT Approach, and UNRWA health services more generally amongst the Palestine refugee population. There is a clear belief amongst many refugees that the FHT Approach has inherited the negative characteristics of the public health system such as inefficiency and bureaucracy. Many also held the belief that UNRWA health services, including free of charge medication, were limited and poor quality. Negative refugee perceptions of the FHT model may also affect its sustainability.

44. While the evaluation did find that the FHT Approach provides a highly relevant and effective model for providing health services in a holistic and efficient way, ensuring adequate resourcing, staffing and prioritizing effective communication on what it offers to Palestine refugees will all be key to its future success.

### Recommendations

|   |   |
|---|---|
| 1 | The UNRWA Health Department should develop a needs-based request for the Programme Budget to fully support the effective implementation of the FHT Approach and the core health programme in all fields. This should include a thorough workforce analysis for each field, elaboration of resources to address training needs, and resources to apply a prevention-focused approach to NCD management. The needs-based budget should also be used for advocacy purposes and to work towards a fully funded family health team approach.                                       |
| 2 | Invest in attracting and retaining high-quality staff and maximizing the potential of existing staff through the provision of training and support.   |
| 3 | Ensure the FHT Approach is underpinned by robust gender and vulnerability analysis, which considers the needs of specific groups, and enables UNRWA to deliver gender and vulnerability/disability-sensitive health services.   |
| 4 | Ensure strong planning processes support the sustainability of the FHT Approach and the gains it has achieved including planning for post-COVID-19 and developing strong partnerships.  |
| 5 | Revise the M&E of the FHT in line with the development of the new MTS: to ensure the impact of the FHT Reform can be measured, that there is better integration of the perspectives and perceptions of Palestine refugees in M&E, that there is better documentation and dissemination of lessons learned regarding the FHT Approach, that there is quality and consistency of data gathered, that data against all indicators can be disaggregated according to gender and other protection/vulnerability factors, and that necessary upgrades to e-Health are put in place. |
| 6 | Raise awareness and improve accessibility of GBV services available at Health Centres. Mainstream UNRWA health staff's understanding of GBV support through ensuring staff are adequately trained to identify GBV survivors and that there are clear and consistent referral mechanisms for GBV cases.  |
| 7 | Invest in integrated services that help the FHT to better address beneficiaries' cross-cutting needs such as MHPSS and disability, including partnerships and referral mechanisms, community awareness, staff training, infrastructure and needs analysis.  |
| 8 | Improve community engagement with Palestine refugees and communication of the FHT Approach.   |

## 1. Introduction

### Evaluation Purpose and Scope

- This evaluation serves the dual purposes of learning and accountability:
  - Learning:** To inform the decision-making and preparations of UNRWA's Health Department in its contributions to the development of the 2023-2028 Medium Term Strategy (MTS), and to identify factors that have supported or hindered the achievement of the FHT Reform's intended results.
  - Accountability:** To assess the quality and results of the FHT Reform relative to its intended outcomes. The evaluation is framed around the OECD DAC evaluation criteria of relevance, coherence, efficiency, effectiveness, impact, and sustainability to consider the intended objectives, design, and implementation, as well as results and impact achieved of the FHT Reform.
- The key evaluation questions were refined collaboratively with UNRWA during the evaluation inception phase as follows:

| Evaluation criteria and questions |  |
|-----------------------------------|--|
| Evaluation Criteria               | Evaluation Questions   |
| Relevance and coherence           | To what extent was the FHT Reform strategy and FHT Approach coherent to relevant agency policies and commitments as well as those of UNRWA health partners and host governments?                                   |
|                                   | To what extent has the FHT Reform strategy and FHT Approach aligned to the needs of Palestine refugees in the five fields of operation and the evolving contexts within them?                                      |
| Efficiency                        | To what extent have the appropriate resources/internal and external communication/coordination and collaboration/clarity of roles/M&E/governance and policy been in place to efficiently implement the FHT Reform? |
|                                   | How could the same outputs be attained at lower costs, or higher outcomes be achieved with the same resources?   |
| Effectiveness and impact          | To what extent has the FHT Approach met its intended objectives?   |
|                                   | What contributions/outcomes can be linked to the reforms and the FHT Approach?   |
|                                   | What have been the unintended impacts/consequences of the FHT Reform?  |
|                                   | To what extent has the FHT Approach been able to adapt (absorbing shocks and stresses) to recent and projected changes in context?   |
|                                   | What factors have enabled or hindered the achievement of results?  |
| Sustainability                    | What are the major factors that have influenced the sustainability of the reform interventions and outcomes?   |

- The evaluation draws on primary and secondary evidence gathered from UNRWA HQ, and the five fields of operation: Gaza, Jordan, Lebanon, Syria, and the West Bank. The primary scope of the evaluation is the FHT Approach, including the activities and processes, implementation, resourcing, monitoring, and reporting. Given the long time period of the reform, the evaluation will consider the entire Family

Health Team Reform period from 2011 until the end of the data collection period in May 2021 but pay particular attention to the period of the latest UNRWA strategic period (2016–2020) in terms of health outcomes and the more recently integrated elements of the Family Health Team reform. This focus on the later period recognizes the long period of the health reform and staff and patient turnover, as it is likely that there will be stronger institutional and client memory of the most recent strategic period.

4. The evaluation has been conducted by a core team of four evaluators, with expertise in health, migration, gender, and organizational development, supported by data collectors in each of UNRWA's fields of operation.

## Background

5. UNRWA, a UN humanitarian agency, is the principal duty bearer for approximately 5.7 million Palestine refugees in the Near East. Palestine refugees, some of whom are doubly displaced, live either in refugee camps or within host communities in Gaza, Jordan, Lebanon, Syria, and the West Bank, including East Jerusalem. In each of these fields of operation, refugees of different ages, genders and abilities face multiple and different kinds of vulnerability due to (amongst others) conflict, economic instability, food insecurity, the COVID-19 pandemic, as well as disasters such as the explosion in Beirut on 4 August 2020, which destroyed most of the city's harbour and the country's stored grains.

6. A substantial percentage of the Palestine refugee population within each field of operation is highly dependent on UNRWA's health services. In Lebanon, governmental policies excluding Palestine refugees in Lebanon (PRL) and Palestine Refugees from Syria (PRS) from accessing public health services as well as the country's current economic collapse, has inevitably placed UNRWA as the main provider of health services to the large majority of PRLs and PRS. In Syria, years of conflict have eroded the country's public health infrastructure and led to increased levels of poverty amongst PRS, consequently resulting in increased dependency on UNRWA's health services.

7. Though all Palestine refugees in Jordan (PRJ) originating from the West Bank are in principle granted the right to access public health facilities in Jordan<sup>1</sup>, this same right is not granted to ex-Gazans or PRS without valid Jordanian documentation. In the West Bank, refugees' dependency on UNRWA's health services are mostly due to: (1) inability to afford the governmental insurance scheme (\$200.00 per person/ per application); (2) non-eligibility for the governmental insurance scheme (must be working in the public sector); and (3) free access to services and medication provided by UNRWA in comparison to cost-sharing scheme on all services and medication provided by the MoH. Finally, in Gaza, a 15-year blockade as well as repeated outbreaks of military hostilities by Israel, has rendered the MOH heavily reliant on international assistance, establishing UNRWA as the largest health provider in the area.<sup>2</sup>

8. UNRWA provides comprehensive primary health care – both preventive and curative – in fixed Health Centres (HCs) and mobile Health Centres to Palestine refugees. It deals with geographically dispersed rights holders facing a quadruple health burden – a remaining need for Reproductive, Maternal, Neonatal and Child Health (RMNCH), a high and increasing incidence of non-communicable diseases (NCDs), a large burden of psychiatric and mental health issues, as well as a burden of conflict-related injuries and rehabilitation.

9. In 2011, the accumulated number of outpatient consultations across UNRWA's five fields of operation was 10.66 million medical consultations, an increase of 2.6% from 2010. Additionally, the average number of medical consultations per/doctor per/day had also increased from 101 in 2010, to 104 in 2011, with each of the five fields exceeding UNRWA's target of 80 medical consultations

<sup>1</sup> Most PRJ came directly from the historical Palestine to Jordan in 1948, and a proportion came from WB in 1967 and as such have Jordanian documentation

<sup>2</sup> Please see Annex H for further detail of context by Field Office

per/doctor per/day<sup>3</sup>. Increasing population growth, coupled with limited and reduced funding, placed UNRWA's already stretched health resources under more strain. Furthermore, UNRWA was also confronted with several pertinent realities concerning the health of Palestine refugees.

10. UNRWA introduced a Health Reform Strategy in 2011, which introduced the Family Health Team approach (FHT Approach). Through the FHT Approach, UNRWA intended to "improve and modernize primary health care (PHC) services into a comprehensive, efficient, people-centred primary care system through a FHT Approach that can meet the evolving needs of the Palestine refugee population now and in the future".<sup>4</sup>

11. Under the new model, each patient and their family are allocated to a FHT that is comprised of a family practitioner or medical doctor, and a nurse and midwife, whose roles are to provide the comprehensive services (medical, psychological, social) to the patient and their family throughout their lifecycle. The essential services and/or comprehensive services that are provided within UNRWA's Health Centres include general outpatient consultations, maternal and child health care, non-communicable disease prevention and management, and communicable disease prevention, management, and surveillance. Mental Health and Psychosocial Support Services (MHPSS) were incorporated into the FHT Approach services package, and by 2019 it was available in 129 HCs across all fields of operation.

12. The FHT Approach was introduced in response to growing NCD predominance amongst the Palestine refugee population, with diseases such as diabetes, cardiovascular, cancer and chronic respiratory illnesses accounting for seventy to eighty per cent of deaths amongst the UNRWA target population. Based on international best practice, the FHT Approach was identified as the best model for addressing these health needs.

13. The Family Health team approach was thus developed based on the Canadian health care model. As such, it plays a key role in fulfilling the second Strategic Outcome of UNRWA's mission, namely, to protect refugees' health and reduce their disease burden and in contributing to the Sustainable Development Goals (SDGs), Goal 3: Ensure healthy lives and promote well-being for all at all ages. The focus of Agenda 2030 on those at risk of being left behind emphasizes the crucial role of UNRWA in this regard.

14. Fundamental to the Family Health Team approach is a person-centred focus, based on (1) holistic, life-long care and continuous care for the entire family, and (2) long-term patient/family-provider relationships. Families register with a family health team comprising a doctor, nurses, and auxiliary health staff, who work together to provide comprehensive health services to the families registered with them. The Strategy has been implemented in phases since 2011; from initial implementation in 34 UNRWA Health Centres (HCs) in 2012, and despite escalating conflict that affected the functionality of HCs and service delivery, implementation has reached all 140 Health Centres by 2020.

15. An e-Health information system introduced in 2009 has been implemented alongside the FHT Approach to enhance needs-based decision-making and planning, and to improve the efficiency and quality of care. Several improvements and amendments of the e-Health system have enabled its application in more areas of planning, e.g., during emergencies, and for medicine and supplies management. By 2020, the e-Health system was operational in 139 out of 140 Health Centres.

16. In addition, an in-service Family Medicine Diploma Program (FMDP) was introduced in 2015 to enhance the practical and clinical skills of UNRWA medical officers. Other initiatives to strengthen the approach included the introduction of an appointment system, improving referral and feedback systems, physical modifications to HCs, standardization of infrastructure, equipment, medicines, and supplies, and strengthening Field Office support capacity.

<sup>3</sup> UNRWA, Annual Health Report, 2011

<sup>4</sup> UNRWA, Health Reform Strategy, 2011

## Methodological Approach

17. The evaluation undertook a detailed inception phase to inform the design of this evaluation, including undertaking interviews and document review with key stakeholders. The evaluation also developed a retrospective Theory of Change for the FHT which has informed our understanding of the FHT Reform's intended results.<sup>5</sup> An evaluation matrix was developed setting out the evaluation questions criteria and the intended methods and stakeholders to address each evaluation question.

18. The evaluation has taken a primarily qualitative approach to data collection, gathering evidence to 'tell the story' of the UNRWA FHT Reform and the difference it has made. Qualitative evidence has been triangulated where possible with secondary quantitative data from UNRWA (i.e. annual reports, e-Health) to develop evaluation findings and recommendations.

19. The evaluation sought to ensure that cross-cutting issues of gender, protection, disability and human rights were well-integrated into the evaluation's design, implementation and analysis and that data collection tools and sampling were gender and conflict sensitive, considering tensions between different groups of Palestine refugees and applying careful consideration to those who have been doubly displaced and may experience heightened vulnerability.

20. Focus groups were disaggregated by nationality (i.e., between PRS and PRL/J) and were disaggregated where possible by gender and age, creating safe spaces for engagement for women and accounting for power relations between different family members e.g., mothers-in-law and daughters-in-law.

## Data collection

21. The key data collection methods for this evaluation were remote key informant interviews (KIIs) which were conducted using semi-structured questionnaire guides to gather views and perceptions from key informants. Interviews were undertaken with UNRWA HQ health staff, as well as senior management from other UNRWA programme areas and external stakeholders such as UNRWA health donors and WHO representatives.

Table 1: Interviews Conducted Per Field and Per Stakeholder Group

|           | UNRWA HQ Health Staff | UNRWA HQ Staff (other programs) | UNRWA Field Office Staff | UNRWA Health Centre Staff | Palestine Refugees      | Donors | Partners |
|-----------|-----------------------|---------------------------------|--------------------------|---------------------------|-------------------------|--------|----------|
| HQ        | 7                     | 4                               | 3                        | 1                         |                         | 3      | 2        |
| Gaza      |                       |                                 | 5                        | 2 FGDs<br>6 interviews    | 6 FGDs<br>12 interviews |        | 3        |
| Jordan    |                       |                                 | 4                        | 2 FGDs<br>5 interviews,   | 33 interviews           |        | 3        |
| Lebanon   |                       |                                 | 3                        | 2 FGDs<br>5 interviews    | 33 interviews           |        | 3        |
| Syria     |                       |                                 | 6                        | 2 FGD,<br>5 interviews    | 33 interviews           |        | 0        |
| West Bank |                       |                                 | 5                        | 2 FGDs<br>5 interviews    | 33 interviews           |        | 3        |

22. In each field of operation, the evaluation team completed interviews with Senior Health Staff, UNRWA Area and Health Centre staff, UNRWA partners, and host government representatives, as well

<sup>5</sup> See Annex J for further details on the ToC and methodological approach

as individual interviews and (where possible) focus groups with Palestine refugees.<sup>6</sup> The sampling approach is outlined in Annex J. Interview guides were designed using the evaluation matrix, tailored to each stakeholder group, using knowledge of their context, to elicit detailed descriptions that respond to the review questions. In total, the evaluation completed 225 interviews and 16 focus groups with the respondents listed in Table 1.

23. The evaluation team also undertook a review of key documentation pertaining to the FHT Reform and used this to triangulate findings and to map the reform trajectory and contextualize other qualitative data collected. The evaluation team drew on sources including, but not limited to, the UNRWA Medium Term Plan 2005-2009, the UNRWA Medium Term Strategy 2010-2015 and the 2011 Health Reform Strategy, project and implementation documents, human resources documents including revised job descriptions, reform progress reports, annual health reports and independent reviews of the Family Health Team (See Annex D for a full list of documents reviewed).

24. The evaluation team conducted analysis of data gathered individually and as a team to 'test' emerging findings to ensure they are both validated and triangulated and then took an aggregate view of evidence across the evaluation questions and criteria to develop robust findings and recommendations, ensuring that findings were derived from multiple sources to ensure triangulation.

25. The evaluation criteria of relevance, coherence, efficiency, effectiveness, and sustainability were used to guide the identification of enablers and constraints that affected impact in different cases, and for different groups. Secondly, a contribution analysis lens was used to form a view on where reforms within the FHT Approach have had/are having a demonstrable effect, the significance of this (in context) and the prospect for such gains to be sustained and built on further.

### Limitations

26. A key limitation for this evaluation was the COVID-19 pandemic, which affected the availability of stakeholders for interview and the evaluation team's ability to undertake field work as planned given the worsening situation in a number of UNRWA fields of operation and the restrictions on travel across the different fields. The evaluation team originally planned to undertake face-to-face data collection with Palestine refugees through focus groups, ensuring separate engagement with men and women, with a range of ages, and with NCD and MCH patients.

27. However, given the changing COVID-19 context, this was only possible in Gaza. Individual remote interviews of Palestine refugees were completed in other fields. This meant that the evaluation was unable to engage with as many Palestine refugees as intended to ensure the inclusion of their views in this evaluation. Extra resources were made available by UNRWA to increase the number of individual interviews. However, the format of individual phone interviews with Palestine refugees was suboptimal in terms of the logistics of arranging these, which may have affected the frankness of responses.

28. The evaluation team was unable to obtain the requisite permissions to undertake primary data collection with Palestine refugees and UNRWA partners in Syria. Instead, the evaluation engaged with staff from different UNRWA departments (Education, Relief and Social Services (RSS) etc.) who are themselves Palestine refugees and UNRWA service health users. While this has added to the voices of Palestine refugees in Syria to the evaluation, engagement with this group was not as extensive as that with Palestine refugees in UNRWA's other four fields and there may be some inherent bias in perspectives given that they are UNRWA staff.

29. A limitation to the evaluation is the lack of an existing Theory of Change or results framework for the FHT Approach. A time series of monitoring data that would permit analysis of the FHT process, quality and outcome indicators over time is not available, and there is no baseline data. Available data which can be construed as outcomes or process improvement indicators have been used where possible to triangulate qualitative data collected by the evaluation.

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<sup>6</sup> Ibid



30. An additional limitation was the reliance on UNRWA quantitative data for determining health outcomes. This evaluation did not collect primary data on health outcomes and is thus reliant on secondary data from UNRWA documentation regarding improvements in health outcomes over time. The only health outcomes reported by UNRWA are on NCD prevalence and maternal health. Similarly, there is no data over time showing improvements in quality of services. To mitigate this, we have ensured that our findings, conclusions, and recommendations for this evaluation are derived from multiple sources and triangulated.

## 2. Key Findings

### 2.1 Relevance

Evaluation Question: To what extent has the FHT Reform strategy and FHT Approach aligned to the needs of Palestine refugees in the five fields of operation and the evolving contexts within them?

**Key finding:** While the FHT Approach is deemed as a relevant and appropriate model to respond to the emerging needs of Palestine refugees, there is scope to strengthen it to be more responsive to the needs of specific groups if informed by a gender and vulnerability analysis.

#### a. Emerging Needs

31. Around 2.97 million Palestine refugees (50.3% of the overall population) are registered users of UNRWA Health Centres (HCs) and are dependent on UNRWA for access to primary health care (PHC).<sup>7</sup> While Palestine refugees rely on UNRWA to meet a range of health issues, there are major themes driving Palestine refugees' health needs, both at the start of the FHT Reform in 2011, and today. These themes are: NCDs, gender and GBV, MHPSS and disability.

32. Firstly, increased life expectancy amongst Palestine refugees has resulted in an ageing population. Combined with risk factors such as sedentary lifestyle, unhealthy diet, obesity, and smoking, this has resulted in a growing prevalence of Non-Communicable Diseases (NCDs). NCDs, including cardiovascular disease, chronic respiratory diseases, diabetes mellitus, hypertension, and cancer, are the most prevalent NCDs and impose a significant burden on UNRWA resources. NCDs present the largest burden of morbidity and mortality amongst the Palestine refugee population. In 2020 alone, 43,502 patients were treated for diabetes mellitus and 116,763 for diabetes and hypertension.<sup>8</sup>

33. Secondly, there are high fertility rates amongst the Palestine refugee population with 30% of the population under 18-years old.<sup>9</sup> Maternal mortality rates and infant mortality rates are relatively high amongst the population.<sup>10</sup> Many women also access family planning and antenatal care through UNRWA; in 2020 176,574 women used UNRWA family planning services.

34. Studies examining the prevalence of GBV within the occupied Palestinian territory (oPt), have shown that the high percentage of unemployment, deteriorating socio-economic conditions, restrictions on freedom of movement, expansion of settlements in the West Bank, bombardment of Gaza, and persistent Israeli occupation are all contributing factors towards violence against women.<sup>11</sup> With regards to Palestine refugees, UNRWA asserts that contributing factors such as "*Conflict, displacement and ongoing occupation...*" are placing the refugee population at greater risk for protection concerns, including GBV.<sup>12</sup>

35. Finally, Palestine refugees are a highly vulnerable population. There is a growing rate of mental health and psychosocial-related disorders amongst the population,<sup>13</sup> affected by poor socio-economic conditions, displacement, exposure to political violence, Israeli occupation, and the difficult living

<sup>7</sup> UNRWA, Health Annual Report, 2020

<sup>8</sup> UNRWA, Health Annual Report, 2020

<sup>9</sup> UNRWA, Health Annual Report, 2020

<sup>10</sup> UNRWA, Health Annual Report, 2020

<sup>11</sup> UN Women (2013) Building ties: Towards integrated strategies and policies for empowering Palestinian women, Research Report, UN Women.

<sup>12</sup> UNRWA, Experience in GBV programming: lessons learnt from the first five years, 2015

<sup>13</sup> UNRWA, Health Annual Report, 2020

conditions experienced within refugee camps. Additionally, due to injuries from ongoing and acute conflicts, disability is a prevalent issue amongst Palestine refugees in Gaza. While these are major trends, health needs do vary by field, due to the unique and evolving contexts of each. Details on the emerging contexts and health needs of each field is provided in Annex H.

### **b. NCDs**

36. The FHT Approach is a relevant model for meeting the current health needs of Palestine refugees resulting from increased life expectancy and increasing chronic non-communicable diseases (NCDs). The FHT Approach provides an effective response towards NCDs as it is comprehensive, ensures continuity, and provides equal levels of programmatic dedication towards the promotion, prevention, and management of diseases. Interviews with senior UNRWA health staff at HQ and across its fields of operation, as well as with partners and host or national government representatives confirmed the relevance of the FHT Approach in responding to the needs Palestine refugees faced with the changing disease profile and population demographic as outlined above.

37. The large majority of health staff interviewed, acknowledged that the FHT Approach is better suited than the previous model to addressing the needs of the Palestine refugee population. Prior to the FHT Approach, UNRWA's health services faced difficulties in providing the same level of care through the traditional model of primary healthcare, which was based on a vertical approach and disease specific Health Centres. The FHT Approach is perceived as effectively addressing the needs of the population, as it provides continuity of care, provides a holistic approach to care, establishes trust/familiarity between team and community, and enables increased prevention, early intervention, and management of diseases, including specific targeting of NCDs.

### **c. Gender**

38. Since its inception, the health programme has focused on priority issues including maternal and child health care (MCH), family planning, increasing breast screenings, improving men's participation in pre-conception care, school health, disability inclusion and since 2019 MHPSS, as well as utilizing UNRWA Health Centres to address GBV, and striving for gender parity among UNRWA health staff.<sup>14</sup> Gender focal points are embedded in each field to raise awareness of gender-related issues and address any challenges arising.

39. UNRWA's Gender Equality Strategy 2016-2021, places its intermediate outcome 2.2 as, "Refugees' Health Is Protected and the Disease Burden Reduced, Taking into Account the Specific Health Needs and Rights of Women, Men, Boys and Girls."<sup>15</sup> Though the outcome clearly states that health interventions will address the "specific health needs" of all genders and age groups, UNRWA's health department did not conduct a gender analysis while designing the FHT Approach.

40. This would have been integral to understanding the barriers to health and power in decision-making processes within each gender, as well as identifying the relevant tailored services (promotion, prevention, assessment, and intervention). This has limited the extent to which the FHT is fully aligned with the needs of women and girls, boys, and men.

41. The FHT addresses individuals within their family units to understand holistic contextual factors impacting an individual's health situation; this is fundamental to its approach. However, the design of the FHT Approach, whereby families can only be registered under the husband or fathers name, has to a great extent normalized gender-related power dynamics that position men at the head of the household with decision-making power.

42. While UNRWA does not require all women attain their husbands' consent to access family planning services, there has been a deliberate drive by UNRWA to include men in family planning decisions. While this does encourage more couples to participate in family planning services than otherwise would, in

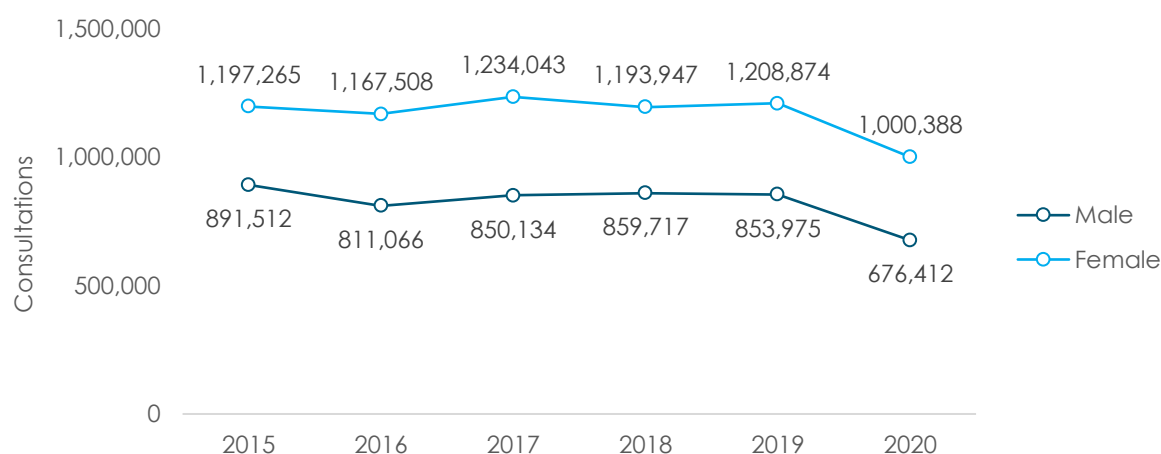
<sup>14</sup> UNRWA, Health Annual Report, 2019

<sup>15</sup> UNRWA, Gender Equality Strategy 2016-2021, 2019

the Middle East, women's decision-making powers and/or control over family planning decisions, such as contraceptive use, is constrained and heavily influenced by other family members, in particular the husband and mother-in-law<sup>16</sup>. Thus, there is potential to weaken women's power within decision-making processes.

43. Unmarried women's access to sexual and reproductive health services (SRH) is often hampered by the general cultural belief that unmarried women do not need health education and SRH services because they should not be sexually active. The implementation of the FHT Approach, with a focus on the family as a whole, whether through a husband or under the guardianship of a father has, to a large extent, not recognised the health needs of unmarried women.

Figure 1: Number of First Time Medical Consultations Agency-Wide, 2015-2020<sup>17</sup>



44. Fewer men than women regularly access UNRWA services and there are fewer male-specific services (see Figure 1). This means that men principally access UNRWA services for curative care or if they have an NCD that requires regular attention and are therefore not receiving the same level of well-rounded, preventative care as women beneficiaries. Women attend the Health Centres more regularly for their own health needs, to bring their children for appointments or to use the Health Centres as a social space. As such women are more likely to benefit from preventative care as well as the holistic services and health information and promotion present at the Health Centres, such as that on MHPSS.

45. There are several reported reasons why men do not attend the Health Centres often. Health Centres are generally open at the same time as men are at work making it harder for them to access services in convenient times around the working week. Women bear the primary responsibility for bringing their children for appointments, meaning that men have less reason to regularly attend the Health Centre. Several beneficiaries stated that men felt uncomfortable waiting in waiting rooms with women for extended periods of time.

46. When men did attend the Health Centres, female beneficiaries reported that they gave men priority to reduce the time they had to spend in waiting rooms. Male beneficiaries in Gaza stated that female doctors were a major barrier for accessing services. Due to the conservative culture, they preferred speaking with male doctors only. While they were often referred by female doctors to male doctors, this was not always an option and as such deterred male beneficiaries. If beneficiaries are not treated by their assigned doctor, the FHT Approach breaks down.

#### d. Gender Based Violence

47. In 2009, UNRWA established GBV prevention as a priority and began mainstreaming GBV across all agency programmes including health. GBV is considered a cross-cutting issue for the FHT Reform,

<sup>16</sup> Alomair, N., Alageel, S., Davies, N. et al. Factors influencing sexual and reproductive health of Muslim women: a systematic review. *Report Health 17*, 33 (2020). <https://doi.org/10.1186/s12978-020-0888-1>

<sup>17</sup> UNRWA, Health Annual Report, 2015-2020

and GBV services have been integrated into the approach, in response to the clear need for GBV services amongst the population.

48. GBV mainstreaming within the FHT Approach has focused on establishing effective referral processes. Identification and referral pathways have been established, building frontline staff's capacity to manage GBV cases. Monitoring systems have also been established, and all health staff interviewed across the fields of operation confirmed that there is a clear need for GBV services amongst the population. They stated the FHT Approach has increased GBV identification and response because, *"FHT aims at developing a relationship of trust between the team and the patient, the approach can help us in detecting cases that require protection or other forms of assistance"*.

#### **e. MHPSS**

49. UNRWA's MHPSS framework outlines the role of primary healthcare services in providing the necessary care/support for beneficiaries through promotion, proper identification, early intervention and referral.<sup>18</sup> By 2020, UNRWA had effectively integrated MHPSS services within 139 HCs (completed MHPSS integration in all HCs in West Bank, Gaza, Lebanon and Syria), with integration remaining for one HC in Jordan, that was delayed due to the ongoing COVID-19 pandemic.<sup>19</sup>

50. All frontline health staff interviewed across the five fields stated that there is a strong need for MHPSS services, and that MHPSS services are an integral component within the package of comprehensive services provided at HCs. Although those interviewed stated that they felt more competent in the identification and provision of PSS through trainings received (mhGAP & PFA), the availability of an in-house psychosocial counsellor and/or a visiting psychiatrist was seen by health staff as crucial in improving how well the MHPSS needs of the surrounding community could be addressed.

51. For HCs that lack the presence of MHPSS specialists, the frontline health staff found that the provision of MHPSS services was challenging due to time constraints, *"Mental health patients don't receive their fair share. We ask the other patients to wait a bit longer outside so that we could properly sit with them, but even with that they still need more time which we are incapable of providing..."*.

52. Similar to frontline health staff, Palestine refugees interviewed also confirmed the need and importance of MHPSS services provided for the community, *"especially since the camp is subjected to constant incursions by the Israeli army, there are many martyrs in the camp, and their families are suffering, the unemployment and poverty rate is high, all of these causes a psychological crisis that must be dealt with by the team,"* with some participants advocating for more MHPSS services. Most Palestine refugees were more aware of the MHPSS services being provided by their HCs, with several participants within each field stating that they and/or a family member had accessed the MHPSS services.

#### **f. Disability**

53. As indicated by UNRWA, it is estimated that (15%) of the Palestine refugee population registered with UNRWA are ailing from a disability, with a higher percentage of people living with disabilities in crises affected communities such as Gaza, Syria and the West Bank.<sup>20</sup> People with disabilities tend to be at greater risk of experiencing forms of violence, abandonment and poverty, further hindering their access to basic services, including health.

54. In response, UNRWA established a Disability Policy in 2010, and in 2017 finalized the Disability Inclusion Guidelines, with the primary objective of ensuring that all persons with disabilities are appropriately included within UNRWA services and programmes.<sup>21</sup> With regards to health, disability mainstreaming took place through staff awareness and capacity building, the renovation of HCs for improved accessibility, and inclusion of screening for disabilities within e-Health.

<sup>18</sup> UNRWA, Mental health and Psychosocial Support Framework, 2017

<sup>19</sup> UNRWA, Annual Health Report, 2020

<sup>20</sup> UNRWA, Disability Inclusion Guidelines, 2017

<sup>21</sup> UNRWA, Disability Inclusion Report, 2018

55. Interviews with Palestine refugees who have a disability or have a family member with a disability, have stated that access to HCs that can address their health needs as well as facilitate their access to other basic services (NFIs, specialized centres, financial assistance), which is essential for their overall well-being.

Evaluation Question: To what extent was the FHT Reform strategy and FHT Approach coherent to relevant agency policies and commitments as well as those of UNRWA health partners and host governments?

**Key finding:** The FHT has consistently been relevant to and coherent with UNRWA's strategic goals on health. To a large extent it has also been consistent with UNRWA internal policy commitments on cross-cutting issues of gender, protection, and disability although these are not always operationalized in practice. Externally, the FHT is coherent with World Health Organization (WHO) guidance. Host authority and partner government representatives from Jordan, Lebanon, and oPt confirmed that UNRWA's implementation of the FHT Approach is ahead of their own aspirations as they are seeking to move to a more family health focused approach themselves.

56. UNRWA's FHT Approach is consistent with global normative guidance on health. According to the WHO, the emerging health needs in the Middle East and North Africa region (MENA) resulting from the "changing epidemiologic and demographic profile in countries of the Region" had created demands for services that provided continuity of care. Therefore, "Countries of the Region should commit to and implement family practice as the principal means for the delivery of primary health care services."<sup>22</sup>

57. The FHT was selected as a best practice model for addressing growing needs for NCD care. This decision was based on international best practice and examples of the model in practice in Canada and Brazil. Both these countries faced similar issues to those faced by UNRWA and the Palestine refugee population in providing NCD care to a growing and aging population.<sup>23</sup>

58. Numerous studies on populations with similar demographic profiles, including those in Canada and Brazil, have concluded the benefits of a FHT Approach against the "traditional" model of primary healthcare (PHC). Additionally, the FHT Approach outperformed the traditional modality of care in continuity, comprehensiveness, family focus, equity, and professional formation.<sup>24</sup>

59. In terms of internal policy and strategy coherence, both UNRWA Medium Term Strategies<sup>25</sup> covering the FHT Approach evaluation time period detail the FHT Approach objectives and there is clear coherence between the objectives outlined in the strategy and the FHT Approach. In the UNRWA Medium Term Strategy 2016-21<sup>26</sup>, the strategy emphasizes a life-cycle approach built into the MTS and UNRWA health services, providing targeted support for refugees at each stage of their life. e.g., pre-, and post-natal care to support women's health and reduce maternal and child mortality rates.

60. In policy terms, UNRWA considers gender, protection, and disability to be cross-cutting issues and UNRWA is committed to mainstreaming these issues across the health programme, including within the

<sup>22</sup> WHO, Conceptual and strategic Approach to Family Practice: Towards Universal Health Coverage through Family Practice in the Eastern Mediterranean Region, 2014?

<sup>23</sup> Seita, A. (2015) 'Governing the reform of the United Nations Health Systems for Palestine Refugees: Moving Mountains' in Reich, MR and Takemi, K. Governing Health Systems: For National and Communities Around the World.

<sup>24</sup> Arantes, Luciano José, Shimizu, Helena Eri, & Merchán-Hamann, Edgar, The Benefits and Challenges of the Family Health Strategy in Brazilian Primary Health Care: A Literature Review. *Ciência & Saúde Coletiva*, 21(5), 1499-1510, 2016. Available at: <https://dx.doi.org/10.1590/1413-81232015215.19602015>

<sup>25</sup> MTS 2010-15 AND 2016-21

<sup>26</sup> UNRWA, UNRWA Mid-term Strategy 2016-21

Family Health Team approach. Gender mainstreaming within the FHT is based on the 2007 UNRWA Gender Policy and the 2016-2021 UNRWA Gender Equality Strategy.<sup>27</sup> As stated in UNRWA's Health Reform Strategy, "The Family Health Team approach provides a multi-faceted platform from which to address crosscutting issues, such as diet and physical activity, education, gender-based violence, child protection, poverty and community development."<sup>28</sup>

61. The mainstreaming of GBV, MHPSS and disability were not included within the initial design of the FHT Approach, and there was no specific analysis undertaken of these cross-cutting issues to inform their integration into the FHT Approach design. Aspects of them were gradually integrated as components within the comprehensive primary care services.

#### **a. Coherence and coordination with Host Authorities and partner governments**

62. Interviews with stakeholders from Host Authorities and partner governments<sup>29</sup> highlighted that UNRWA's FHT Approach is coherent with their own ambitions around delivering PHC and that UNRWA was considered equivalent to or even to be ahead of them in having implemented the FHT Approach and the accompanying e-Health.

63. For example, in Lebanon, the health system has historically been dominated by public-private partnerships and the provision of specialist rather than family doctors. Consequently, the National Health Strategic Plan 2016-2020 was developed to promote the country's progress towards Universal Health Coverage (UHC) and Lebanon is moving to integrate mental health and NCD early detection into its primary health care, as UNRWA has under the FHT Reform<sup>30</sup>.

64. In Jordan, the primary health care system is more similar to the FHT Approach delivered by UNRWA. However, there is a lack of a universal health system and weaknesses in the national health information system.<sup>31</sup> The partnership between the Jordanian MoH and the UNRWA health programme is seen as strong and collaborative, with government respondents seeing UNRWA's work on the FHT Approach and e-Health as providing an important lesson-learning opportunity.

65. In the oPt, the Palestinian government has committed to developing a roadmap for universal health coverage starting with strengthening primary health care through the family practice approach, including establishing provider networks, health financing reform, incorporating strengthening of costing and strategic purchasing, and enhancing service delivery and planning, including through defining a universal health coverage-benefit package.

66. In terms of collaboration, UNRWA works with the Ministries of Health (MoH) and host authorities in Gaza, Jordan, Lebanon, the West Bank and Syria. There is strong collaboration and coordination especially with regards to NCDs, vaccination campaigns and MCH. In each field there are Field Disease Control Officers, who are involved in the NCD and communicable disease (CD) task force committees that are chaired by the MoH of the respective countries.

67. UNRWA is viewed as an essential coordinating and collaborating partner by the different host authorities in the COVID-19 response. UNRWA's e-Health system is ahead of the health information systems used by governments of UNRWA's host countries, therefore data sharing is mostly limited to NCDs, CDs, and MCH. As such, the ability to share other health data (i.e. MHPSS) and to do so at an efficient speed is lacking.

68. Several representatives from different NGOs/CSOs/CBOs operating within the health sector were interviewed from Gaza, Jordan, and Lebanon. The level of knowledge with regards to the FHT Approach and services provided by UNRWA was relatively high amongst all participants. UNRWA's collaboration and coordination with the different organizations has increased under the FHT Approach, especially

<sup>27</sup> UNRWA, Health Annual Report, 2019

<sup>28</sup> UNRWA, Health Reform Strategy: Modern and Efficient UNRWA Health Services – Family Health Team Approach, 2011

<sup>29</sup> Except for Syria as the evaluation was unable to interview a MoH representative there.

<sup>30</sup> WHO, Lebanon Country Coordination Strategy 2019-2023, 2019

<sup>31</sup> National Strategy for the Health Sector, 2016-2020, Jordanian Government

with regards to community health education activities/campaigns, GBV and other protection issues.

69. It was clear through the interviews, that UNRWA's health department is making a concerted effort towards providing safer protection mechanisms/services through its coordination and collaboration with the CSOs (Women's Affairs Centre - Gaza, Women's Programme Centre-Lebanon/Jordan) concerned with the overall well-being of women and children. However, all participants interviewed stated that UNRWA needed to strengthen its coordination efforts, be more responsive towards joint collaborations/initiatives, and utilize the experience and capacity of surrounding CSOs to fill existent and/or emerging gaps.



## 2.2 Efficiency

Evaluation Question: To what extent have the appropriate resources/internal and external communication/coordination and collaboration/clarity of roles been in place to efficiently implement the FHT Reform?

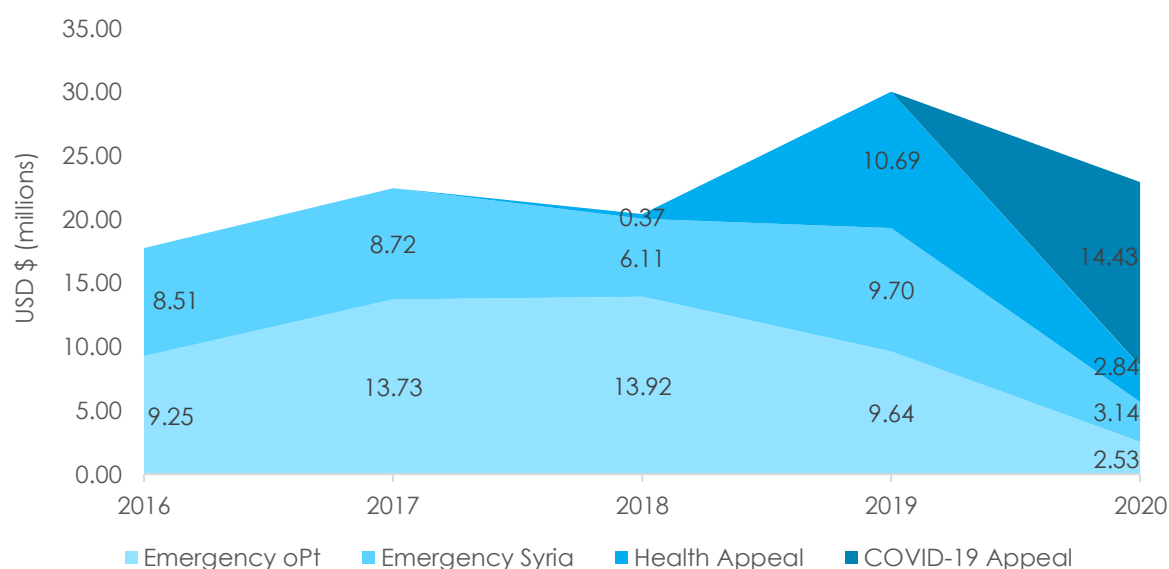
**Key finding:** There have not been sufficient resources in place to efficiently implement the FHT Reform. This trend worsened following UNRWA's financial crisis in 2018, making it challenging to implement the FHT Approach across all fields. Internally, internal communication and management has been historically weak. Externally, the FHT has had good coordination and collaboration and is regarded as a valuable partner.

### a. Resources

70. Since 2018, UNRWA has experienced a significant funding crisis which has impacted upon the resources available for UNRWA health services including the FHT Approach and increased reliance on Emergency Appeal funding. Following the withdrawal of the USA as UNRWA's largest donor, the agency faced a funding shortfall of \$446 million USD, out of the \$1.2 billion USD required to cover all the agency's core running costs for health, education, relief and social services (RSS) and infrastructure maintenance.<sup>32</sup> In 2019, total Health Programme expenditure was approximately \$111.1 million USD.<sup>33</sup>

71. The FHT Approach is primarily funded through the core health budget. However, due to the ongoing financial crisis, all fields rely heavily on Emergency Appeal funding to provide services and respond to contextual changes as illustrated in Figure 2.<sup>34</sup> Due to ongoing conflict, Syria is particularly reliant on the emergency budget to respond to a changing health context.

Figure 2: Millions in Emergency Appeal Funding in USD<sup>35</sup>



72. In Gaza, an Emergency Health Appeal was launched in 2018 in response to emergency health needs stemming from injury and casualties in the Great March of Return (GMR). This appeal intended to provide further support to the Gaza UNRWA health system to absorb increased demand. Funds within

<sup>32</sup> UNRWA, Health Annual Report, 2019

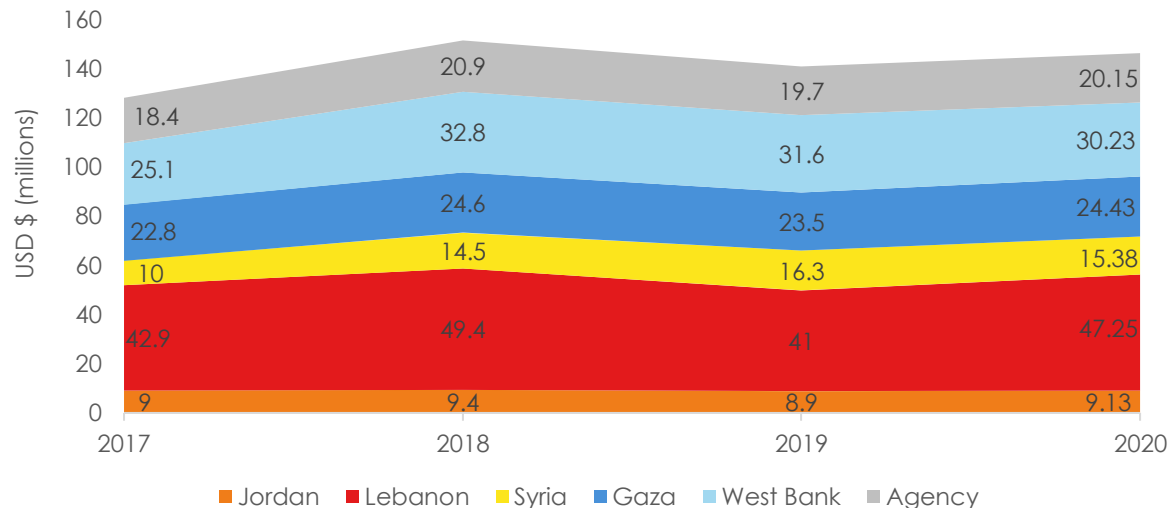
<sup>33</sup> UNRWA, Health Annual Report, 2019

<sup>34</sup> Data Requested from and provided by UNRWA on 11/04/21

<sup>35</sup> Data Requested from and provided by UNRWA on 11/04/21

other Emergency Appeals also support the UNRWA health services. The need for Emergency Appeals to support core health services illustrates the critical constraints faced by the FHT Approach. This is a particular problem as the Palestine refugee population remains heavily dependent on UNRWA for the provision of health services.

Figure 3: Health Expenditure Per Registered Refugee, Regular Budget (USD) <sup>36</sup>



73. Figure 3<sup>37</sup> shows health expenditure per registered Palestine refugee. This varies significantly by field with the highest costs in Lebanon and the lowest costs in Jordan, reflecting Palestine refugees' heavy reliance on UNRWA services in the former, and the broader access of Palestine refugees to public and private health services in the latter. While each field has certain fluctuations in spend, under the FHT model there has been a general increase in health expenditure per registered refugee in 2020 relative to 2017. Although the upward trajectory from 2017-2018 was disrupted by UNRWA's financial crisis in 2018, health expenditure per registered refugee is beginning to recover. 2020 figures should of course be considered carefully as the COVID-19 pandemic altered the extent to which Palestine refugees have accessed UNRWA health services, but also the amount that UNRWA has spent on health services through the COVID-19 Emergency Appeal.

74. Apart from Syria and the West Bank, spending declined in 2019 following the 2018 financial crisis but has increased during 2020 due to the COVID-19 pandemic. However, other than in Lebanon, this level of expenditure remains below the value that the WHO recommends for the provision of health services in the public sector of \$40 to \$50 USD per capita.<sup>38</sup> This illustrates the significant financial constraints that the FHT Reform faces in providing core health services, particularly as the Palestine refugee population grows and UNRWA's health budget declines.

75. Staff are core to the FHT Approach and account for the majority of spend in most fields; reductions in funding mean that staff levels are insufficient, leading to reductions in services available. Between 2016 and 2020 GFO spent on average 67% of their programme budget on staff costs, JFO spent 69%, SFO spent 53% and WBFO spent 63%. The exception is the LFO who spent 35% of their programme budget on staff costs.<sup>39</sup> The lower staff cost in Lebanon reflects the higher health unit cost per capita for UNRWA to support Palestine refugees given Palestine refugees' reliance on UNRWA services and high costs of private hospitalisation in Lebanon. Full details of Health Programme Budget and Staff Expenditure are listed in Annex G.

76. Health Staff interviewed across all UNRWA fields reported that they do not have enough health staff to meet the needs of the FHT model. Due to UNRWA's funding crisis, the health department is

<sup>36</sup> UNRWA, Health Annual Reports, 2017-2019, Data Requested from and provided by UNRWA on 11/04/21

<sup>37</sup> Data for Health Expenditure per Registered Palestine Refugee, Regular Budget is not available before 2017

<sup>38</sup> UNRWA, Health Annual Report, 2019

<sup>39</sup> Data requested from and provided by UNRWA on 21/04/21

currently unable to replace staff who leave the organization and cannot hire temporary staff to cover absences. Many medical officers and nurses are shared between teams, meaning the approach is not properly implemented and staff are over-burdened. While the funding crisis is beyond UNRWA's control, its subsequent impact has negatively impacted the high-quality of services envisioned by the reform.

## **b. Internal and External Communication**

77. While a small number of Field Office staff stated that they were consulted during the FHT's design, none of the frontline health staff interviewed in this evaluation had been consulted in the initial design of the FHT Approach. Some viewed their absence during the design phase as a definite shortcoming on behalf of UNRWA, stating that senior management would have benefited from visiting the centres, observing how they function as well as meeting different frontline health staff including Medical Officers (MOs), nurses and midwives, to gain their thoughts with regards to the FHT design and implementation.

78. Some participants believe that decisions at UNRWA mirror a top-down approach whereby programmatic changes are decided in "*Amman*", and then rolled out onto the different fields with little consideration to each field's specific context. Some participants stated that the lack of their involvement within the planning and design of the FHT Approach caused initial confusion amongst the frontline health staff in trying to adapt to the new modality of work.

79. The Health Department typically employs three levels of management: Field Office, Area office, and HCs. The Field Offices are tasked with supervising and supporting the Area offices, and likewise the Area offices are responsible for supervising the different HCs located within their designated area of operations. As such, the chain of communication is directed from the Field Office onto the Area office, and then to the Head of Centres within each respective HC.

80. Communication between Field Offices, Area offices and frontline health staff appeared to be weak in some fields, particularly in Lebanon and Jordan. Participants stated that new programmatic additions and revisions, such as e-Health updates were predominantly communicated through emails, with little to no dialogue between the frontline health staff and upper management. Frontline health staff stated that communications were around new instructions only. HC visits by Area or Field Offices are not routinely conducted, with some FHTs stating that they have not directly engaged with anyone from their Area or Field Office within the last year.

81. Although participants acknowledged that COVID-19 has played a role in reducing in-person HC visits by field staff, participants believe that Field Offices should make a greater effort to engage with health staff, by phone or through virtual meetings. Weak communication between some Field Offices, Area offices and health staff has resulted in their feeling undervalued and underappreciated. As such, health staffs' general morale is low, with a substantial number of those interviewed mentioning staff burnout as a significant issue in their team.

82. At the onset of FHT Approach's implementation, facilitating community engagement to garner community acceptance of the FHT model was a primary objective of all five fields of operations. Community engagement took on different forms across the five fields, with some fields such as Gaza establishing Health Centre Friendship Committees (HCFC) comprised of HC staff and community representatives, other fields concentrated on directly engaging leaders of popular committees.

83. However, the HCFC and/or community leaders/members were not involved in the design of the FHT Approach, but rather, their engagement was directed towards fostering community acceptance through awareness campaigns/activities and establishing a direct link with the community to respond to emerging concerns and needs.

84. The level of community engagement and promotion of the FHT Approach was not consistent throughout the fields. Some FHTs stated their HC actively engaged with the community to promote the FHT Approach, while other FHTs stated that the promotion of the FHT Approach should have been stronger, more inclusive of community leaders, and better organized.

85. A substantial proportion of all Palestine refugees interviewed had very little or no knowledge about the FHT Approach model, including the rationale for structuring services according to the FHT Approach and its benefits to service users. While the lack of observed knowledge or awareness of the FHT Approach by Palestine refugees may be justified for first time users, the majority of participants included within this evaluation are long time users.

86. Low knowledge with regards to the FHT Approach amongst many of those interviewed may signify the lack of ongoing and systematic engagement of the community by UNRWA. Some community representatives stated that HC representatives provided unsatisfactory responses to any complaints raised by the community and that UNRWA's financial crises are generally used as the main justification for any programmatic shortcomings and/or issues. Community representatives noted that more should be done to strengthen the coordination of activities between UNRWA and the community.

### **c. Clarity of Roles**

87. As outlined in UNRWA's Health Reform, to maximize human workforce resources the reform has shifted selected health tasks from MOs to nurses and midwives, and administrative tasks from nurses to clerks.<sup>40</sup> Within the formation of the FHT, each team member plays a designated role in the support and treatment of patients, ensuring holistic and efficient patient management. As such, clear professional roles definitions of each team members' individual responsibilities and professional scope are necessary for the FHT to succeed.

88. These have been clearly defined both in theory and in practice. For example, several human resources assessments (e.g., Management Review HC-Lebanon) took place in 2011, leading to the reclassification of certain positions, revision of job descriptions, and creation of new positions to support the FHT Approach. All frontline health staff interviewed stated that their professional tasks and responsibilities were well understood and clear; this is an improvement on the previous model.

89. However, the shortage in sufficient numbers of all types of health staff, has resulted in some team members, depending on the resource pressures in each HC, shouldering additional tasks and responsibilities which are not reflected in their job descriptions nor financially compensated for, as discussed above under Resources.

Evaluation Question: To what extent has the monitoring and evaluation of the FHT been effective and improved data use?

**Key Finding:** Monitoring and evaluation (M&E) of the FHT has been weak due to a poor conceptualization of M&E at the design stage. While e-Health has significantly improved the gathering and reporting of data, challenges remain around data accuracy, e-Health infrastructure, and the use of data in decision-making.

90. When assessing the effectiveness of the M&E in place to effectively implement the FHT Approach, it is important to note that UNRWA's approaches to M&E have evolved over time and that the FHT Reform has taken place over a long period, covering multiple strategic periods and results frameworks.

### **a. M&E in FHT design**

91. It is clear from documentary review and interviews with stakeholders that monitoring and evaluation was insufficiently included in the original design of the FHT Approach; there was no underlying Theory of Change articulating the intended outcomes of the FHT Reform and the assumptions and risks associated with the reform were not clearly articulated.

<sup>40</sup> UNRWA, Health Reform Strategy, 2011

92. Although the reform began in 2011, a logical framework was not developed until 2014. This set out the intended outputs of the FHT Approach (reduction of doctors' workload, utilization of the appointment system as demand control, improvement in the rational use of antibiotics). It also outlined the intended outcome of improvements in quality of care and better control of NCDs and other conditions as outcomes, which would ultimately lead to the desired impact of a long and health life expectancy. However, there was no baseline assessment conducted at this time to generate data against which progress could be measured.

93. The FHT Reform process progress was reported on annually in 2012, 2013 and 2014 (through internal exercises), as well as in an internal evaluation in 2014. However, few stakeholders in interviews referenced the existence of the FHT log frame and the use of specific indicators or M&E approaches to measure its progress and success. Furthermore, from 2014 onwards, there does not seem to have been specific, documented reporting of the FHT Reform at either a field or organizational level.

94. Instead, progress towards health outcomes since then has been documented at a strategic level for the MTS. Health data is gathered, reported on, and analysed primarily against strategic Outcome 2: Health is protected, and disease burden is reduced. This is set out in the agency's Common Monitoring Matrix (CMM) with four outcome indicators and twenty-one output indicators, all of which are quantitative. The agency's Annual Operations Reports report against selected CMM indicators, as do the Agency's Annual Health Reports. These also detail agency-wide trends for selected CMM indicators disaggregated by field of operation, as well as selected data from national health surveys.

95. The 2017-18 UNRWA Multilateral Organization Performance Assessment (MOPAN) found that UNRWA has a well-considered and robust results-based monitoring system, which generates a large amount of data that informs planning and decision-making within different levels of the organization. This view was supported by the Evaluation of UNRWA's Monitoring and Reporting Activities on the MTS, which found that the UNRWA health programme benefits from a set of mature and globally tested indicators with evident value to UNRWA's day-to-day work and management decision-making.

96. However, the majority of interviewed senior health staff at a HQ or field level for UNRWA recognized ongoing weaknesses in the agency's current approach to M&E. They highlighted the challenges of using health outcomes as the principle means by which to measure the FHT Reform's success given that the achievement or non-achievement of these cannot be solely attributed to UNRWA.

97. Additionally, the focus on health outcomes along with no quality indicators is also problematic as maternal mortality may be low, but patients may still not be happy with the quality of care they receive. It is not sufficient for UNRWA to judge quality based on service user numbers, as given that the services are free, there is a strong incentive for Palestine refugees to use them, and in some cases, no viable alternatives.

98. It was also highlighted by interviewees that the current approaches to M&E do not really capture what was referred to as the 'missing middle'; that is the qualitative learning about the reform process itself and how this has happened across the agency. There was limited evidence of the sharing of practice across UNRWA's fields of operation and the reliance on quantitative data means that the 'story' of how the reform was rolled-out is lost.

99. There have been annual retreats for the health programme's senior management where FHT Reform progress has been discussed but there is no evidence of how this knowledge exchange was operationalised or how this has filtered down to other UNRWA staff. There has been a missed opportunity to document learning about the successes and challenges of the FHT.

## **b. Refugee voice in M&E**

100. Another significant weakness noted in interviews with UNRWA staff and in discussions with Palestine refugees is the lack of Palestine refugees' voices in the monitoring and evaluation of the FHT and UNRWA's health programme more broadly. Palestine refugees are the ultimate beneficiaries of UNRWA's work, yet the 2017-18 MOPAN assessment found that despite an MTS commitment to

strengthen the framework for accountability to affected populations (AAP), a unified framework for refugee participation within UNRWA's Results-Based Management (RBM) cycle is not yet elaborated or well-integrated with results monitoring activities.

101. After the initial rollout of the FHT Approach in 2012, UNRWA initiated several assessments to evaluate patient/staff satisfaction and the quality of care (e.g. patient satisfaction surveys, staff satisfaction surveys, FGDs), as well as Health User Committees. Since then, however, patient and/or staff satisfaction surveys and annual assessments evaluating improved quality of care throughout the five fields of operation have not been conducted systematically or aggregated to gain an agency wide perspective on progress and the Health User Committees appear defunct.

102. As noted previously, there was limited specific analysis of the needs of specific groups regarding the FHT Reform (i.e. gender, disability) and with limited inclusion of refugee voices in M&E, UNRWA may not be fully aware of how the FHT is responding to the needs of its users and the results being achieved regarding these different groups. Furthermore, Palestine refugee participants in this evaluation raised the lack of clear complaint mechanisms. While some Health Centres have complaint boxes, service users stated that when they approached UNRWA with issues, no follow up or feedback was provided.

### **c. Crosscutting issues in M&E**

103. There was mixed evidence as to the extent to which cross-cutting issues have been considered in the M&E of the FHT. A small number of UNRWA staff interviewed felt that the FHT and e-Health has enabled a clearer focus on gender, age, disability, and protection and that it is possible to disaggregate data according to these identifiers. However, from documentary review of quarterly and annual health reports, aside from some gender-specific indicators (e.g., maternal health), health indicators are not sufficiently disaggregated to show the impact of the FHT Reform on particular groups (e.g., youth, gender, disability).

104. Indeed, some stakeholders suggested that the health programme had regressed in M&E relating to gender, following a decision three years ago to stop gender disaggregation of some health indicators. There is little disaggregation of indicators on disability and inclusion, particularly in MHPSS data where these issues are pertinent.

105. There are steps underway to address this to some extent. In 2020, the Department of Planning approached the Health Department to disaggregate another 13 indicators by sex. The Director of Health at HQ has agreed to this, but implementation has been slowed down by the need for the Health Department and IMTD to adjust the e-Health reports. In 2021, the Health Department disaggregated four more indicators by sex and will have disaggregated reporting for seven indicators in total in 2021.

### **d. e-Health**

106. The e-Health system is the key platform used to gather monitoring data for UNRWA's health programmes and staff and Palestine refugees recognise it as having improved patient experience and increased efficiency. Throughout the interviews with Palestine refugees, the implementation of the e-Health system was the most mentioned and/or recognized programmatic component that had resulted in improved organization of health services.

107. With regards to e-Health, beneficiaries stated that it enabled easy access to their complete medical files by the FHT, *"When you give your name or your child's name, they can display the whole file and see everything related to the history"*. Participants also stated that e-Health facilitated a smoother referral to both the pharmaceutical and laboratory services for requested medication and tests. Palestine refugees indicated that the implementation of the appointment system decreased overcrowding at the HCs, which in turn, resulted in better organized services.

108. Though some beneficiaries communicated that e-Health caused delays, primarily due to infrastructural issues such as electricity cuts and weak internet connectivity, most participants interviewed were satisfied with the services provided by e-Health. Similar to the findings of the present

review, an evaluation of the e-Health system conducted in 2017 found that (78.1%) of surveyed patients were satisfied with the e-Health system.<sup>41</sup>

109. A majority of UNRWA staff interviewed were also positive about the ways in which e-Health had been significant in supporting the efficient implementation of the FHT. They cited that it had led to efficiencies in terms of managing patient flows, freeing up doctor's time to enable more consultations, making prescriptions, and reducing 'doctor/drug/medicine-shopping' as there is a historical record for each patient.

110. However, challenges remain regarding the implementation and use of e-Health, as well as issues around data quality. Interviews with UNRWA staff, the e-Health Evaluation<sup>42</sup> and the Evaluation of UNRWA's Monitoring and Reporting Activities on the MTS<sup>43</sup> have all highlighted challenges or issues with the e-Health system. One of the main challenges was the lack of offline capacity of the e-Health system; this was noted as being a particular challenge in Syria where there are often connectivity issues.

111. The fact there is no offline mode for e-Health has meant that staff have to manually enter data afterwards, which was perceived to cause errors in data entered or at times, missing data. Some staff highlighted that the e-Health system had potentially improved recorded health outcomes as it enabled more accurate recording of a patients progress and disease trends. However, it was noted in a number of interviews that there are still concerns around the accuracy of data, with a number of senior managers at HQ level questioning the accuracy of how data is recorded and staff capacity at field level to input reliable and accurate data.

112. Whilst training on e-Health was rolled-out when it was first launched, a large number of staff commented on the lack of ongoing training on e-Health, particularly for new staff, and that there had been a lack of investment in the infrastructure to support e-Health over time, including the age and speed of the servers available for e-Health.

113. An additional challenge noted was the difficulty in aggregating data using the e-Health System. If UNRWA staff want to aggregate data at an area or field level, this needs to be done manually, which could lead to mistakes and limits the speed and ease at which UNRWA staff can identify trends and issues. The e-Health transformation plan intends to address this, and a number of issues identified around e-Health, but it is still under development, and appears to be currently lacking funding.

114. Staff also mentioned the lack of integration of e-Health with other UNRWA programme areas. For example, the lack of a link between health and protection was cited as a particular concern, where GBV cases are identified by health staff and then referred, but then there is no feedback loop within the current reporting systems as to how cases are addressed.

#### **e. Data analysis and use**

115. There was generally consensus that since the FHT began and e-Health started, data analysis and use of health data has improved. For example, UNRWA staff interviewed cited that at area level, when reviewing the data of individual Health Centres, managers were able to see if particular Health Centres had high numbers of NCD defaulters and follow-up, as necessary.

116. However, interviews with senior staff and the Evaluation of UNRWA's Monitoring and Reporting Activities on the MTS, indicated limited understanding of the data on the factors underpinning performance (whether negative or positive) and the use of M&E information to identify bottlenecks.

117. Health reporting tends to be quantitative, rather than including any qualitative data regarding challenges and the factors underpinning results achieved. Stakeholders from HQ and across the fields of operation described UNRWA as having a weak evaluative culture and that there was limited recording or dissemination of learning across the agency on the FHT Reform.

<sup>41</sup> UNRWA, Evaluation of the E-Health Project, 2017

<sup>42</sup> UNRWA DIOS - Evaluation of the E-Health Project, 2016

<sup>43</sup> UNRWA, Evaluation of UNRWA's Monitoring and Reporting Activities on the MTS, 2020

Evaluation Question: To what extent has the FHT Reform improved health programme efficiency?

**Key finding:** There is mixed evidence as to whether the FHT Reform has improved health programme efficiency. There are some indications that efficiency savings have been made. However, these are challenged by ongoing difficulties in fully implementing the FHT Approach.

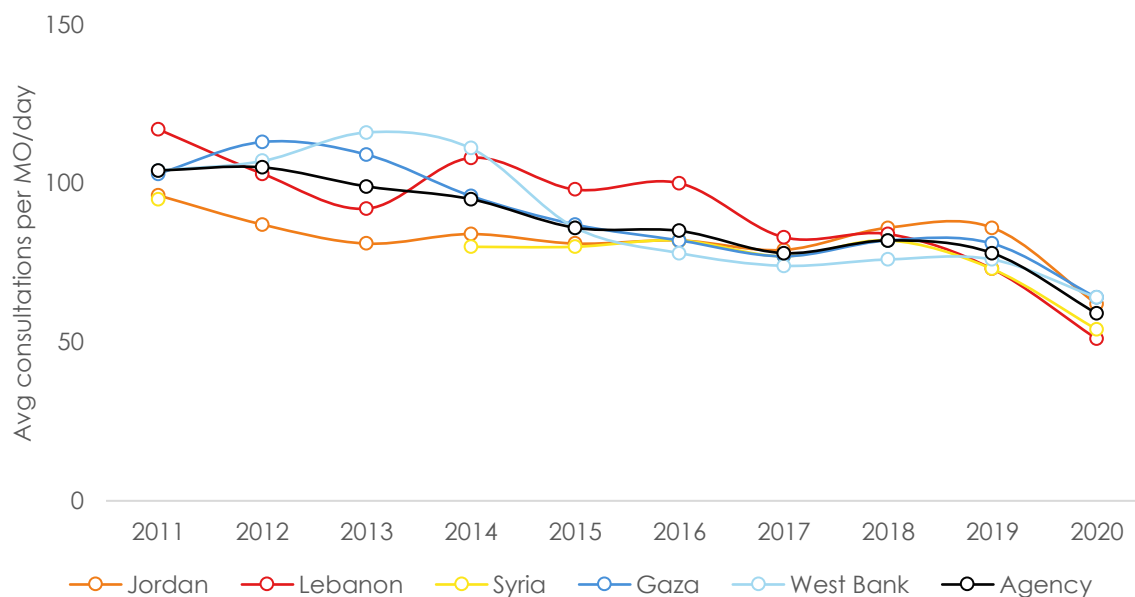
118. Across all fields, UNRWA staff at HQ, Field Office, and Health Centre level report that the FHT Reform has created a more efficient health service. Efficiency indicators include:

- 1) The number of consultations per MO per day
- 2) Improvements in contact time
- 3) Antibiotic prescription rates
- 4) Ratio of first to repeat visits

119. Full data on these indicators is included in Annex G.

120. The reduction in the number of consultations per MO per day can be used as an indicator for performance efficiency because it indicates that service users' health needs are addressed in fewer appointments and staff are able to spend more time with service users. The FHT Approach has improved UNRWA's performance against this indicator overall. In 2011, prior to the FHT Reform, UNRWA received 10.66 million consultations across all fields which reduced to 8.72 million consultations in 2019.<sup>44</sup>

Figure 4: Average Medical Consultations Per Medical Officer Per Day<sup>45</sup>



121. Figure 4 shows that since the FHT Reform began in late 2011, average medical consultations per MO per day have also declined at agency level and across all fields. This is an overall positive trend with fewer appointments suggesting better treatment and diagnosis, and in turn less need for repeat visits. Agency-wide, medical officers now see fewer patients per day with an average of 78 per day in 2019 compared with 104 in 2011.<sup>46</sup>

<sup>44</sup> UNRWA, Health Annual Report, 2011

<sup>45</sup> UNRWA Annual Health Reports 2011 to 2020 and data requested and received from UNRWA on 11/04/21

<sup>46</sup> UNRWA, Health Annual Report 2019, UNRWA Health Annual report, 2011

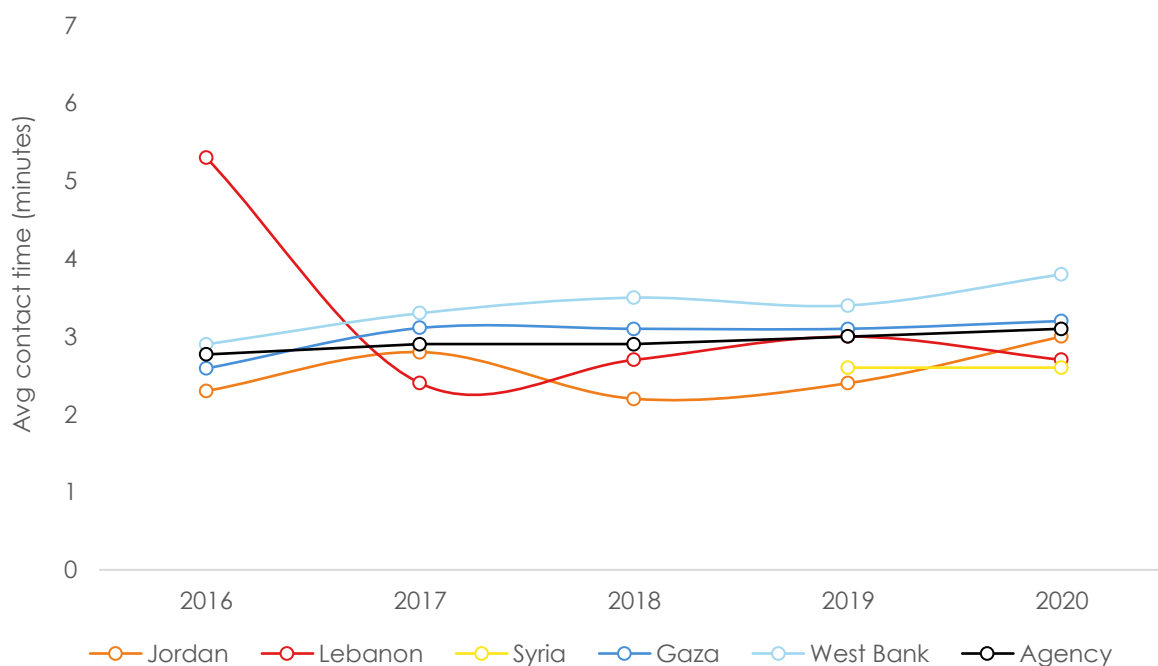


122. The COVID-19 pandemic and reduction of in-person services saw a further reduction to 58.8 consultations per day agency-wide and reduced the total medical consultations at agency level to 5.80 million.<sup>47</sup> However, it should be noted that this does not reflect increased efficiencies in line with the overall effectiveness of the reform. Rather, it reflects deliberate steps taken to control patient attendance at HCs during the pandemic. While it does continue a downward trend in the number of consultations per day, it cannot be attributed to the FHT Approach and is therefore not considered in this analysis.

123. These trends can be attributed to several aspects of the wider FHT Reform. The appointment system has streamlined workloads through planned allocation. It has also enabled the redistribution of tasks from MOs to nurses and midwives reducing the burden on medical officers. UNRWA staff attributed the decline in appointments to the FHT Approach itself, whereby the fact that service users visit a dedicated MO for all their needs and are prevented from visiting MOs and HCs with whom they are not registered, has reduced 'doctor shopping' amongst service users. The improved quality of care that comes from one MO who has a thorough knowledge of their patient's medical history, has reduced the number of times a service user comes to an appointment and the number of Health Centres they need to access.

124. However, agency level figures mask disparities between fields: for example, the numbers for Jordan have fallen more slowly and it has shifted from a below-average number of daily consultations to the highest of the five fields in 2018 and 2019, with 86 medical consultations per doctor per day.<sup>48</sup> Staff in Jordan expressed concern around the high number of consultations per doctor, attributing this to increased staff shortages.

Figure 5. Average Contact Time Per Medical Officer Per Day in Minutes<sup>49</sup>



125. The second indicator against which efficiency gains can be measured is improvements in contact time. Contact time can also be used as a proxy for quality of service, as longer appointment times allow for better diagnoses. Since 2016, all fields with the exception of Lebanon have seen increased contact time, as shown in Figure 5. Reduced antibiotic prescription rates also indicate efficiency improvements and have also improved across all fields. In theory, both these measures suggest the FHT has improved quality of care through better diagnosis and treatment.

<sup>47</sup> Data requested from and provided by UNRWA on 11/04/21

<sup>48</sup> UNRWA, Health Annual Report, 2019

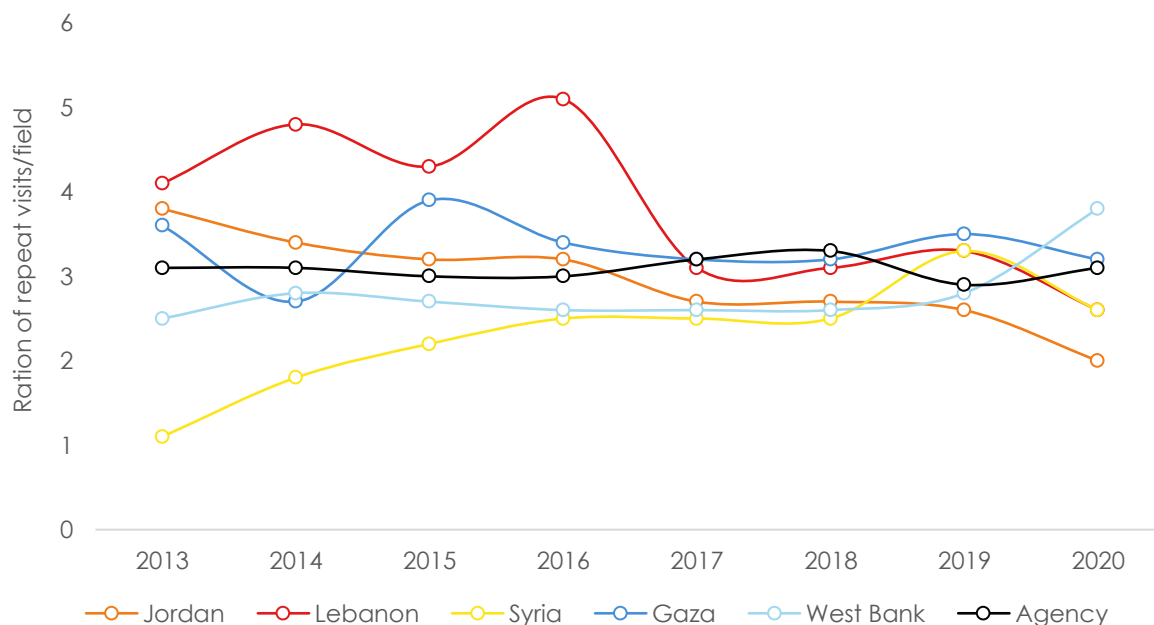
<sup>49</sup> UNRWA, Health Annual Report, 2011-2019, Data Requested from and provided by UNRWA on 11/04/21

126. However, improvements in contact time are small and, excluding the unusual trend of 2020, Syria, Jordan, and Lebanon (with the exception of 2019) have not achieved UNRWA's target contact time of three minutes. Of course, this can be linked to staff shortages due to UNRWA's financial crisis, as discussed throughout this report. The number of Medical Officers required as per WHO's WISN methodology falls short of the reality of staff numbers in the fields. However, overall, this suggests that the real effects of longer contact time, such as better identification of health issues reducing the need for curative care and hospitalisation at a later date, are limited.

127. Ratio of repeat to first visits is used as a performance indicator, as a lower ratio would likely indicate that care is of a higher quality and more holistic, as doctors are diagnosing issues more efficiently and reducing the need for return visits. While there has been an overall decline in the number of appointments, the reduction in the ratio of repeat to first visits has been limited, as shown in Figure 6. At agency level, the ratio has only decreased from 3.1 in 2013 to 2.9 in 2019 (rising again to 3.1 in 2020 during the COVID-19 pandemic disruption) and the ratio varies by field.

128. While Jordan and Lebanon have shown improvements, ratios in Gaza have remained relatively stable. In Syria, the ratio has increased from 1.1 in 2013 to 3.3 in 2019. While in the West Bank, the ratio remained relatively stable before increasing from 2.6 in 2018 to 3.8 in 2020. However, these figures must be contextualized as beneficiaries were less likely to attend Health Centres in the height of the conflict in Syria. Staff reported that these were not yet at the levels they hoped for as the reform intended to significantly reduce the need for repeat visits; this has not been realised in practice.

Figure 6. Ratio of Repeat to First Visits, Per Field<sup>50</sup>



129. Efficiency gains, such as consultation time, are too small to have a noticeable impact on Palestine refugee's experience of UNRWA services. Furthermore, the efficiency indicators do not include reduction of waiting times, which is a key factor in how beneficiaries positively or negatively perceive their experience of using UNRWA services. Gaza, Syria, and Lebanon had the highest rate of participants stating that waiting times have not been reduced nor consultation times increased.

130. PRL mentioned several factors that may be contributing to short consultations and long waiting times, such as consistent overcrowding owing to UNRWA being the main health provider for PRL, economic collapse increasing reliance on UNRWA services, the presence of PRS in some areas increasing demand on HCs and UNRWA's financial crises driving staff shortages.

<sup>50</sup> UNRWA Annual Health Reports 2013 to 2020 and data requested and received from UNRWA on 11/04/21

131. Some service users also reported perceptions of favouritism and nepotism within HCs, which they believed contributed to inefficient and lower-quality services. For example, in Lebanon, some participants reported that it was easier to get an appointment if an individual knew someone working at the HC, that they were being over-charged for hospital treatments that UNRWA had referred them for and that health staff were recruited in a nepotistic manner and not based on their qualification. Participants who reported these issues perceived them to be linked with public corruption scandals UNRWA has faced in recent years. These individual-level perceptions and claims cannot be substantiated by this evaluation.

132. The FHT Approach has clearly not led to the same efficiency gains in each field. There are key themes that negatively impact upon efficiency gains across the fields. These are each field's wider operating context and stability, including level of dependency on UNRWA services, Palestine refugees' access to the other health care providers, and most importantly the consistency with which the FHT Approach is implemented in HCs.

133. UNRWA staff consistently reported that the FHT Approach is not properly implemented in many HCs due to a lack of resources. If the model is not fully implemented with the correct number of staff per team, positive efficiency gains will be lost. An understaffed or shared FHT means that waiting times increase, contact time is reduced and the workload on staff increases. In turn, this contributes to a poorer quality of care and a reduced focus on preventative care. There is a risk that the potential for long-term efficiency and cost savings will be lost if the model is not adequately resourced and implemented.

**Evaluation Question: How could the same outputs be attained at lower costs, or higher outcomes be achieved with the same resources?**

**Key finding: The FHT cannot be achieved at lower cost. Its funding is already limited in relation to requirements that are steadily increasing. However, it has allowed UNRWA to continue to meet the needs of a growing Palestine refugee population and prevent health outcomes from deteriorating.**

134. The FHT Approach cannot deliver the same outputs at lower costs. As referenced under Resources, the Health Programme already faces challenges in delivering the FHT implementation within the core budget and is heavily reliant on project and emergency appeal funding. UNRWA also spends far less per capita (see Figure 8 and Figure 9) in comparison with WHO norms of \$40 to \$50 USD per capita<sup>51</sup>, reflecting the extent to which services are delivered on a tight budget.

135. Across all fields, Health Centres are stretched to meet the staffing requirements for full FHTs. This reduces the extent and quality of services UNRWA can offer and undermines the functioning and effectiveness of the FHT Approach. It further reduces the likelihood of achieving the reform's aims of providing a high-quality health service and taking an early detection and prevention-focused approach to NCD management.

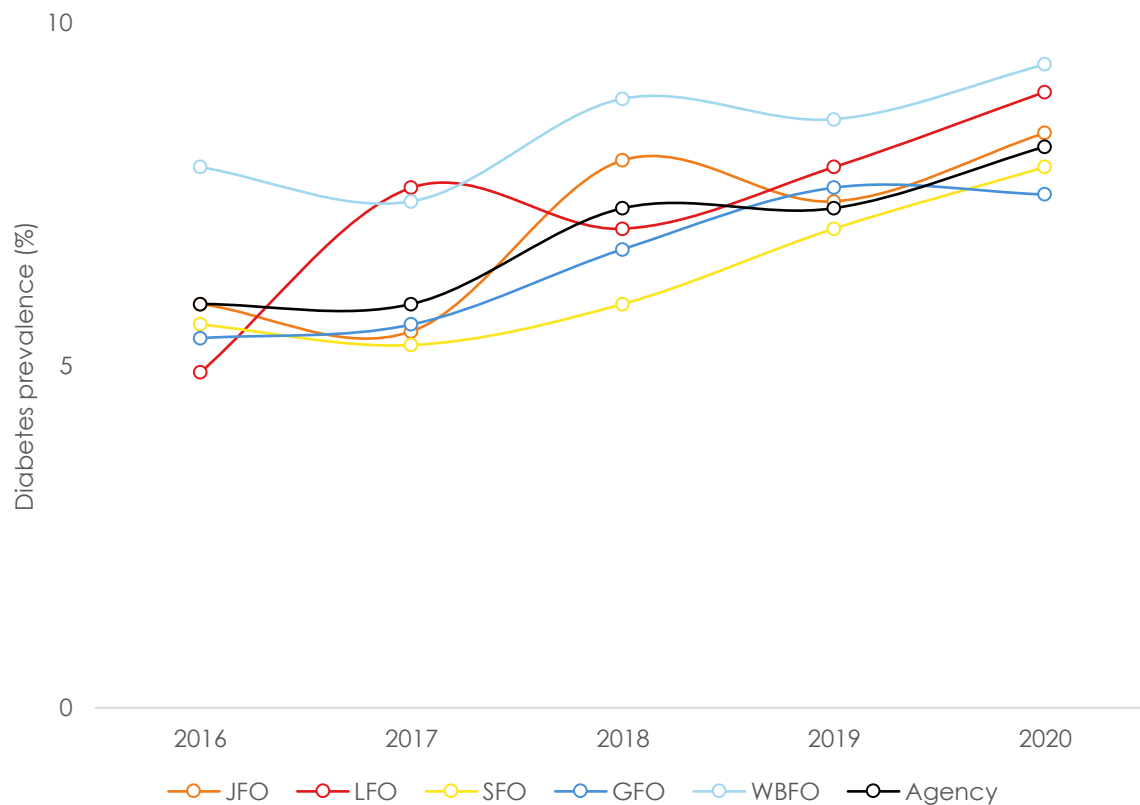
136. In terms of quality of services, while there is increased efficiency, improvements to the key indicators of number of consultations, contact time, antibiotic prescription rate and average daily consultations per doctor are not significant. This is driven by the funding and staff resource constraints in implementing the model to date. The FHT is, in many fields, already stretched as far as it can be without the model being suspended entirely, demonstrating that UNRWA would not be able to attain the same outputs with reduced costs.

137. It must however be noted that the reform did not intend to reduce costs but to improve quality of services and health outcomes for the Palestine refugee population. The extent to which the FHT has

<sup>51</sup> UNRWA, Health Annual Report, 2019

contributed to improved health outcomes for the refugee population has been limited as detailed further in this report. UNRWA is faced with a growing and ageing Palestine refugee population with increased health needs, as well as shocks and challenges in its wider operating context which challenge FHT implementation. The persistence and growth of these issues combined with little slack in the UNRWA operating budget, would prevent the organisation from achieving higher health outcomes with the same resources.

Figure 7. Percentage Prevalence of Diabetes Among Population Served, 18 Years and Older<sup>52</sup>



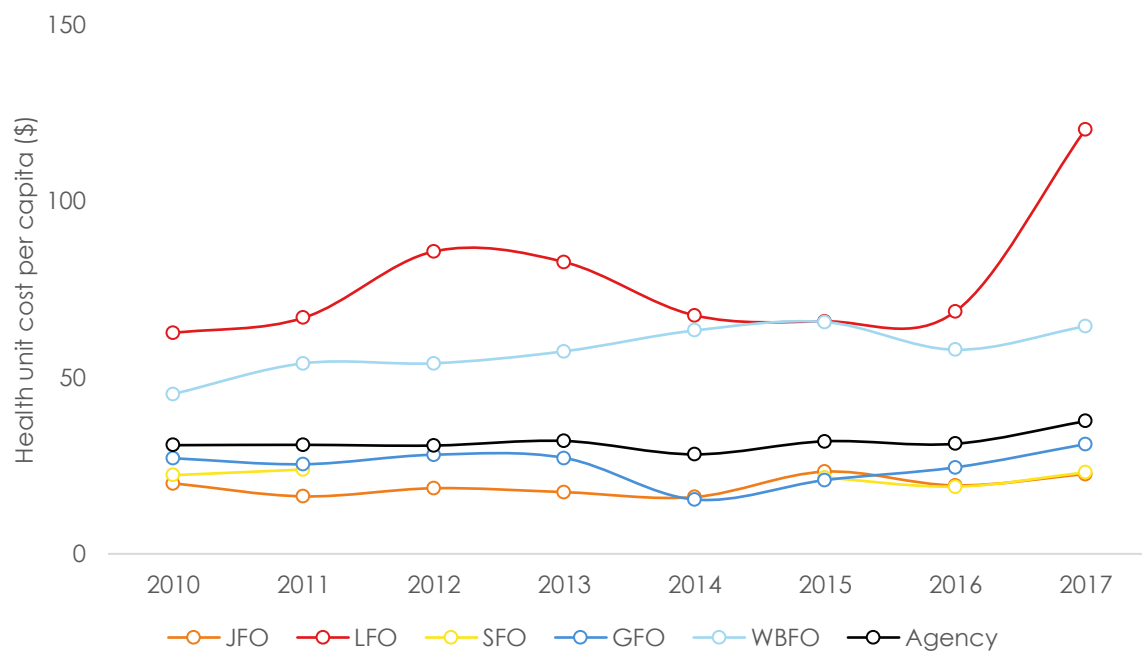
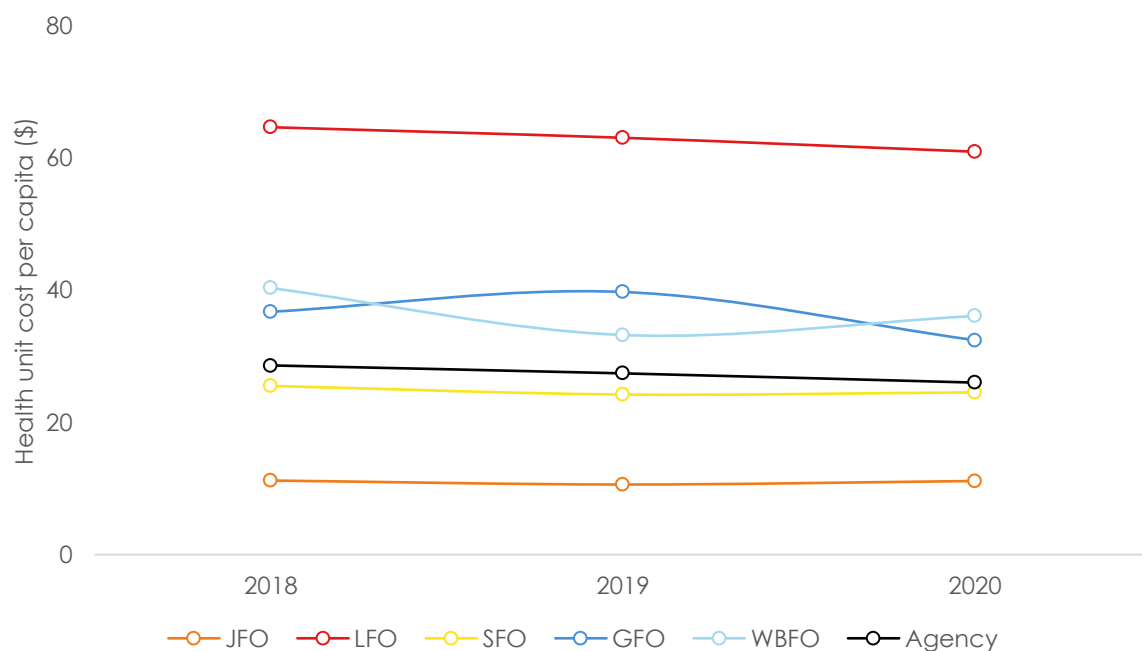
138. However, the FHT has been successful in containing the costs of providing services to a growing population for whom NCDs are increasing in prevalence in line with global trends (see Figure 7), whilst integrating additional services such as MHPSS. This development has helped to provide a more holistic approach to meet refugees' health needs and suggests that cost savings have been made while the FHT Approach has been enhanced.

139. This is reflected in the relatively stable health unit cost per capita<sup>53</sup> from 2011 to 2020.<sup>54</sup> As shown in Figure 8, health unit cost per capita in each field has fluctuated from 2010-2017, reflecting changes driven by context in each field. When comparing 2010 to 2017, health unit cost per capita showed small increases in Gaza, Jordan and Syria and larger increases in Lebanon and the West Bank, suggesting that the FHT Approach has supported UNRWA to provide a higher level of care to the served population.

<sup>52</sup> UNRWA, Health Annual Report 2011-2019

<sup>53</sup> Health unit cost per capita is calculated based on all funds (programme budget, projects, in-kind, emergency and restricted) allocated for the health department in all fields (programme management; Primary Health Care services including NCD, CD, MCH, MHPSS, Lab, Radiology etc.; school health services; pharmaceutical; hospitalization including Qalqilya hospital and referral to contracted hospitals) divided by total served population from 2010-2017 and total registered refugee population from 2019-2020

<sup>54</sup> It should be noted that it is not possible to directly compare figures from 2010-2017 with figures from 2018 onwards. From 2018-2020, UNRWA changed its calculation of health unit cost per capita from 'served population' to 'registered refugee population' which shifted the trends in expenditure

Figure 8: Health Unit Cost Per Capita (Served Population) USD<sup>55</sup>Figure 9: Health Unit Cost Per Capita (Registered Refugee Population) USD<sup>56</sup>

140. From 2018-2020 health unit cost per capita, calculated on total Palestine refugee population rather than served population, showed a slight decline in Gaza from \$36.7 to \$32.4 USD and in Lebanon from \$64.6 to \$60.0 USD respectively, while remaining relatively stable across all other fields. This reflects the heavy dependence of the Palestine refugee population on UNRWA services in Lebanon and Gaza, compared with other fields where they have better access to other service providers. This suggests that in most fields the FHT Approach has allowed UNRWA to contain the cost of providing health services

<sup>55</sup> Data requested from and provided by UNRWA on 11/04/21

<sup>56</sup> Data requested from and provided by UNRWA on 11/04/21

to a growing refugee population. However, in fields where they are highly dependent on UNRWA, the FHT Approach has not shown the benefits to the same extent.

141. The FHT faces multiple challenges: changing political contexts, socioeconomic decline in several fields, and the growing Palestine refugee population amongst whom NCD prevalence remains high, in line with increasing prevalence nationally and globally. Within this context the FHT Reform has been successful in containing increasing health problems. For example, the number of NCD patients, although growing is controlled.

142. When compared with the previous approach to health care provision, most beneficiaries are satisfied with the services, and UNRWA staff across all fields recognize that the FHT model has been essential in enabling continued service delivery. Consequently, while the model could not be stretched further with current resources, its achievements and relative efficiency should be recognized.

## 2.3 Effectiveness and Impact

Evaluation Question: To what extent has the FHT Approach improved health outcomes for refugees?

**Key finding:** Measuring the extent to which the FHT Approach has improved health outcomes for refugees is complex. Overall, health outcomes have not improved. Where changes have occurred, it is difficult to attribute this to the FHT Approach due to data constraints, changes to the refugee population and the wider operating context.

143. The World Health Organization defines an outcome measure as a “change in the health of an individual, group of people, or population that is attributable to an intervention or series of interventions.”<sup>57</sup> There are a number of ways in which measuring the extent to which the FHT Approach has contributed to improved health outcomes is challenging for this evaluation:

- The evaluation is reliant on UNRWA data regarding improvements in health outcomes over time, which are limited and lack baselines. Consequently, the findings presented below can only be triangulated with the perceptions of Palestine refugees and UNRWA staff as to whether health outcomes have improved.
- The evaluation team is reliant on the reliability and quality of UNRWA monitoring data to make its judgments. As noted later in the report, the e-Health system is credited with having supported improvements in UNRWA’s data quality, but some concerns regarding data quality and reliability were raised by UNRWA staff.
- It is important to recognize the impact of social determinants of health (SDH) (non-medical factors) on health outcomes. These are the conditions in which people are born, grow, work, live and age, and the wider set of forces and systems shaping the conditions of daily life.<sup>58</sup> In the context of UNRWA’s work, these include income and social protection, conflict and displacement, culture, education, food security, housing and the environment, social inclusion and non-discrimination and access to affordable, quality healthcare. WHO research and other studies show that the social determinants can be more important than health care or lifestyle choices in influencing health. Thus, any change, or lack thereof, in health outcomes must be understood within this broader context and it should be recognized that any changes to health outcomes cannot be attributed to the FHT Reform alone, but that the FHT Approach may have contributed to these changes.
- Health outcomes are by nature longitudinal; given that the FHT Approach has been underway since 2011, it could be expected that some impact of health outcomes could be observed. However, the reform has not taken place at the same pace in each of UNRWA’s fields of operations and there were no baselines at the start of the FHT Reform, and so any aggregate analysis of health outcomes achieved across UNRWA’s fields of operation would need to take this into account.
- In contexts where Palestine refugees can receive health services from both UNRWA and national or private health services, the quality of these latter services may have an impact on the health outcomes for Palestine refugees using UNRWA services. Additionally, in a number of UNRWA’s fields of operation, there is limited sharing of data between UNRWA and host authorities or national governments on health outcomes. Consequently, it may be challenging

<sup>57</sup> WHO Hanefeld, J. et al, ‘Understanding and Measuring Quality of care: Dealing with Complexity, 2017 Available at: <https://www.who.int/bulletin/volumes/95/5/16-179309/en/>

<sup>58</sup> WHO, Social Determinants of Health, accessed 02/06/2021. Available at: [https://www.who.int/health-topics/social-determinants-of-health#tab=tab\\_1](https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1)

to get an aggregate picture of health outcomes of Palestine refugees when these two data sources are not aligned.

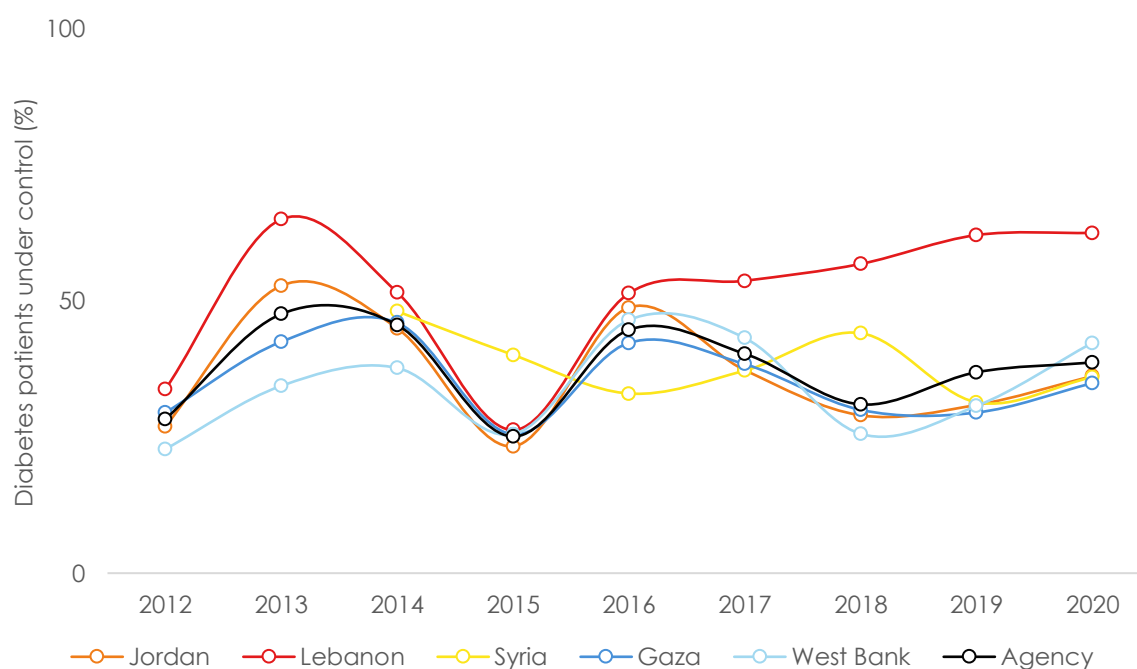
144. The key health outcomes UNRWA reports on an annual basis include NCD prevalence and maternal health indicators. These are reported on year by year in the UNRWA Health reports, although the health reports do not show improvements over time. The evaluation team has compiled these tables from across the annual reports to show changes in health outcomes over time.

145. As Figure 7 indicates, the prevalence of diabetes amongst the population has increased in each of UNRWA's field of operation over time. This could be due to an increase in incidence, a result of increased life expectancy or in part attributed to increased levels of diagnosis. A large number of UNRWA staff in interviews mentioned that the FHT Approach allowed for MOs to identify patients at high risk of developing NCDs more effectively based on their family history and risk factors and to do more pre-emptive or early detection screening.

146. Thus, as more screening is completed, more cases may be detected leading to increased prevalence. This was supported in interviews with Palestine refugees, many of whom expressed satisfaction in being provided care and follow up by the same team of health professionals, which resulted in increased continuity of care: *"Consulting with the same medical team is a good thing; it organizes the healthcare process, enhances follow-up, and increases the sense of familiarity between the provider and the beneficiary."* Participants stated that the allocation to a specific FHT has enabled better monitoring of their individual/family health needs and, in turn, ensured consistency in treatment plans as well as early detection of hereditary diseases, specifically NCDs.

147. The picture regarding the percentage of diabetes mellitus patients under control (Figure 10) is more mixed, with significant variations in some fields between years (i.e. 27% in Jordan in 2012, rising to 52.8% in 2013 and falling back down to 23.3% by 2015). Agency wide, there has been an improvement from 28.3% in 2012 to 38.7% in 2020, with the most significant improvement in Lebanon. The percentage in Syria has declined over the same period, which could be attributed to the challenging context and the weakened health system due to the conflict.

Figure 10: Percentage of Diabetes Patients Under Control Per Defined Criteria<sup>59</sup>

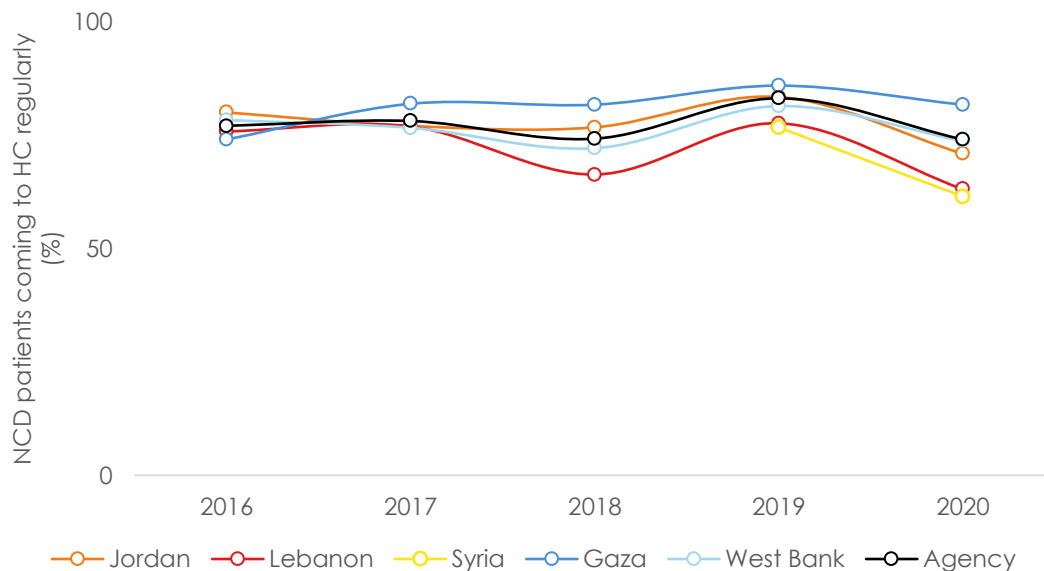


<sup>59</sup> UNRWA, Health Annual Reports, 2012-2020



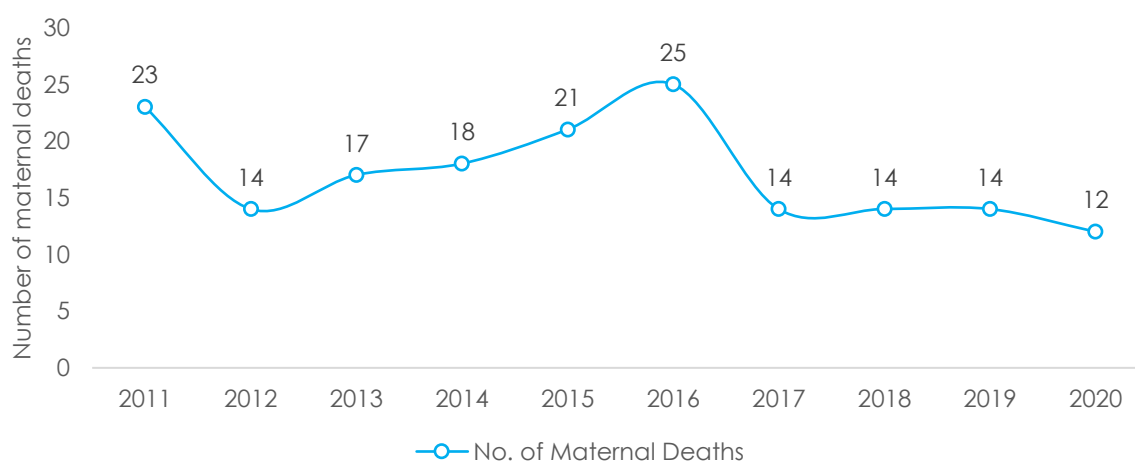
148. In terms of the percentage of NCD patients coming to Health Centres regularly (Figure 11), data is only available from 2016 onwards but increased in all fields between 2016-19.<sup>60</sup> The most significant increase was in Gaza, with an increase from 74.0% in 2016 to 85.9% in 2019.

Figure 11: Percentage of NCD Patients Coming to HC Regularly<sup>61</sup>



149. Regarding maternal health outcomes (Figure 12), this has improved across the agency since the start of the FHT Reform from 23 deaths in 2011 to 12 deaths in 2020. It is not clear whether the improvement in this health outcome can be attributed to the FHT Reform, as over the same period the percentage of women attending at least four antenatal clinic visits has remained static, with 87% in both 2011 and 2019 and a slight reduction to 76% in 2020, likely due to the disruption of services due to COVID-19. However, in interviews with Palestine refugees, there seemed to be a higher level of overall satisfaction and perception of improved quality of care for maternity health services and child immunizations (MCH), NCDs and general health services from both female and male respondents.

Figure 12: Number of Maternal Deaths<sup>62</sup>



150. Participants recognized that there is more emphasis on maternal health than before, especially regarding antenatal care visits (where women are followed up to take folic acid and iron supplements

<sup>60</sup> Figures in all fields of operation dropped in 2020 due to the disruption to services caused by COVID-19

<sup>61</sup> UNRWA, Health Annual Reports, 2012-2020

<sup>62</sup> UNRWA, Health Annual Reports, 2012-2020

and provided with health education). Services provided for new-borns and children were highlighted by many participants as being strong and well organized, *"There is special follow-up. Each child has his own booklet and information about him is well documented"*.

151. The Mother and Child Health mobile application (e-MCH App), which was rolled out in all fields in early 2019, also received a high level of satisfaction from many participants, *"I downloaded the application after I gave birth. It tells you how to feed the child, dates of vaccination, child appointments, all of these details exist...to have this in your hands is very nice."* The integral role that midwives effectively play in the provision of maternity care, family planning, and psychosocial support was noted by a substantial number of female respondents in all five fields, often indicating that they act as a source of *"comfort"* and *"guidance"*.

Evaluation Question: To what extent has the FHT led to improved quality of care and improved patient satisfaction?

**Key finding:** Most Palestine refugees indicated improvements with quality of care and conveyed a general satisfaction with UNRWA's health services. The FHT Approach has effectively increased continuity of care, enhanced the organization of services, and contributed to perceived improved quality of care by refugees and health staff. However, shortages in staff and medical commodities have undermined perceived improvement of care and patient satisfaction in all five fields.

152. UNRWA has not systematically conducted patient/staff satisfaction surveys nor utilized other effective tools to evaluate improved quality of care on an annual basis. As such, current institutional data regarding patient/staff satisfaction as well as assessments evaluating improved quality of care is lacking. Analysis of the data gathered through beneficiary interviews across UNRWA's five fields of operation, has revealed that the highest level of participant satisfaction was expressed by rights holders in the West Bank, followed by Jordan, Syria, Lebanon, and lastly Gaza, which yielded the lowest level of overall respondent satisfaction.

153. When assessing beneficiaries' perceptions towards improved quality of care, once again the West Bank had the largest number of participants noting improved quality and/or some improvements, followed by Jordan, Syria, Lebanon, and lastly, Gaza. Participants who stated that quality of care has improved cited the following in terms of noticeable improvements: a stronger relationship between health care providers and refugees, increased follow up by FHT, organized services, decreased waiting time for consultations, and provision of a holistic approach to care (in particular integration of MHPSS).

#### **a. Continuity of Care**

154. Continuity of care, a key aspect within the FHT Approach, is recognized as a vital component of quality of care whereby it improves patient-provider relationships, enables more effective treatment plans, and leads to better health outcomes. Established continuity of care between the FHTs and refugees enhances interpersonal relationships and allows the FHT to accumulate necessary medical knowledge concerning their patients, which has shown to effectively save time.

155. Palestine refugees and health staff interviewed stated that the FHTs gained knowledge about a patient's medical history has reduced the need for patients to repeat their medical history upon each visit and has freed more time for counselling and/or discussing other relevant issues that might be affecting the patient's health.

156. Increased *"sense of familiarity"* established between patients and their FHTs was observed as one of the main improvements brought forth by the implementation of the FHT Approach, whereby many

participants described the relationship as being “comfortable” and “familiar” and one that is built on “trust”, and “respect”. Strengthened trust is an essential aspect for a healthy patient-provider relationship, as it increases patient confidence in the capacity of the FHT to provide appropriate care and maintain medical confidentiality.

157. Participants stated that they believe that the care provided to them by their FHT is appropriate, and that the team is competent in addressing their health needs. They trusted the FHT to provide services because they had a strong understanding of what was best for the patient’s health. Furthermore, they feel more comfortable in disclosing and/or sharing personal information that is relevant to their overall health, in particular, feelings of psychosocial and/or emotional distress, *“Physicians became more knowledgeable about their patients’ conditions and patient-provider connections were built; thus, and as a result, patients who suffer from psychological and not physical conditions started to become more open about sharing their problems with their provider”*.

158. Health staff agreed that strengthened patient-provider relationships was a key achievement of the FHT Approach, resulting in better monitoring, treatment adherence and sharing of information. Furthermore, frontline staff stated that increased familiarity with their patients and their families has enhanced their ability to identify possible underlying MHPSS issues and/or protection concerns, and thus more effectively intervene with the necessary support and/or treatment.

159. Follow-up of patients by the FHT was recognized by Palestine refugees as being a noticeable improvement. Some NCD patients stated that regular follow-up allows for focused health education on lifestyle (smoking, diet, physical activity, etc.). Other than the implemented appointment system, refugees reported that nurses and midwives contact them to remind them of their next appointment, provide them with necessary instructions if they are undergoing specific tests, and even follow-up with patients if they missed a scheduled appointment.

160. For many participants, this level of follow-up was seen as an indication of how much the FHT cares about the individual well-being of each patient. Furthermore, some participants noted that communication between them and the FHT was easy, and that health staff are always available to respond to their needs, *“It’s as if I am taking my child to a private clinic...”*. Health staff stated that the FHT Approach has increased a greater sense of responsibility towards the well-being of the patients and their families because they have become their main health providers, therefore resulting in more meticulous follow-up.

## **b. Improved Organization**

161. To ensure programmatic efficiency and improved quality of care under the FHT Approach, UNRWA implemented electronic health records (e-Health), an appointment system, and reorganized the structure of HCs to better accommodate the patient flow. The majority of Palestine refugees across all five fields stated that UNRWA health services have become more organized, *“Previously, the service at the UNRWA Health Centre was chaotic, but the UNRWA Health Centre develops and improves regularly...I’ve been familiar with the UNRWA services since it was provided in caravans, when it was very chaotic; however, now the computerized system and services became more developed and comforting.”*

162. The distribution of families to FHTs was regarded by participants as having a positive effect on the organization of UNRWA health services. Under the old model, patients accessed multiple medical professionals for different medical conditions within the same centre. However, under the FHT Approach, each patient is allocated to a FHT that is responsible for her/his care and acts as the first point of contact to facilitate access to other health services. Some participants stated that having a designated FHT has clarified and simplified the processes of accessing and receiving care, *“Before, the process was not clear and the beneficiaries did not know anything; but now, when we arrive at the UNRWA Health Centre, we know exactly the steps to receive care and who to see.”*

163. Participants also noted that the restructuring/reorganization of HCs has led to better organized services because patients are able to navigate the HCs more easily depending on which service they

require, *"The renovation done on the clinic was very good, and they were able to divide the rooms very clearly, because now each room offers a specific service. The ground floor is for registration, measuring your weight, measuring blood pressure, and has the family doctor. The second floor houses the women's clinic, dentist...etc."*

164. The FHT Approach and its wider reforms (e-Health and the appointment booking system) aimed to improve efficiencies and in turn the improve quality of care. However, Palestine refugees' views on the success of these measures are mixed. Several participants mentioned that while UNRWA had increased the number of available HCs, particularly in the north of Gaza, they believed that the additional Health Centres have done little to accommodate the growing demand on UNRWA's services due to the worsening socio-economic conditions.

165. As such, respondents in Gaza characterized UNRWA's HCs as being overcrowded, and ailing from a shortage of available health professionals whereby *"patients wait 2-3 hours to meet the doctors for 1-3 minutes."* Although the average consultation time has seen an incremental increase over the years in Gaza, the increase is minimal to say the least. Some refugees may have either not noticed the slight improvement and/or still believe that the time provided within the consultation is not satisfying their needs.

166. In Syria, a substantial number of participants also stated that the FHT Approach has not led to noticeable *improvements* in reducing waiting time and increasing consultation time (see efficiency section above Figure 5). Participants in Syria attributed the overcrowded conditions of UNRWA's HCs to Syria's 10-year conflict, which has destroyed much of the country's public health infrastructure, including several UNRWA operated Health Centres and led to increased poverty rates amongst the Palestine refugee population.

167. In addition, due to the conflict, Syria was the last of the five fields to fully implement the FHT Approach within all its HCs. As can be observed through the other fields, any noticeable increase in consultation time has required a steady process. Additional views of Palestine refugees on improvements are discussed under Efficiency.

### **c. Shortage of staff & Medical Commodities**

168. The repercussions of UNRWA's financial crisis which has led to staff shortages, has greatly impacted upon the provision of continuity of care under the FHT Approach, and in turn, the level of perceived improvement in the quality of care and the level of satisfaction amongst a substantial proportion of interviewed Palestine refugees.

169. UNRWA's difficulty in employing the necessary Human Resources (medical officers, nurses and midwives) has either led to the composition of established FHTs being incomplete (i.e., sharing a physician amongst two FHTs), and/or has hampered the agency's ability to include additional FHTs to meet growing population needs. The shortage of essential health professionals within many of UNRWAs HCs across the five fields, has invariably led to gaps in the provision of services, and moreover, has increased the workload on FHTs and/or particular members of FHTs.

170. Furthermore, UNRWA's utilization of short-term employment contracts due to financial constraints (3-6 months) results in the constant rotation and/or changing of health professionals, which ultimately disrupts continuity of care. As one participant simply noted, *"They hire a physician and then three months later they change him with another physician."* The lack of available and/or consistent health professionals within some HCs is essentially reversing many of the benefits that have been derived from implementing the FHT Approach.

171. Patient satisfaction and perceived improvement of quality care amongst Palestine refugees was also influenced by the availability and quality of medication, laboratory tests, updated medical equipment, and UNRWA's financial coverage of secondary care. Participants across the five fields noted the quality and shortage of medication as well as the lack of certain diagnostic tests (in particular for NCDs) in UNRWA HCs as a major deficiency in the provision of quality services.

172. Furthermore, some participants stated that UNRWA provides *"ineffective"* and *"poor quality"* medication, and that physicians are only intent on prescribing *"Trufen and Acamol"*, no matter what a patient's medical needs might be. UNRWA has been exerting the necessary effort to curtail the over prescription and over consumption of antibiotics amongst the refugee communities.

173. Assumptions by participants that the withholding of certain medications is due to medical ineptness on behalf of the physician and/or UNRWA's inability to provide the needed medication, may indicate that more effort needs to be invested in community health awareness regarding the harmful effects of antibiotic overconsumption and other prescribed medication.

#### **d. Health Staff**

174. It was evident through the interviews conducted that a preference for consultations provided by specialists, in particular gynaecologists and cardiologists, is still predominant. The overall confidence of participants in the ability of family practitioners to appropriately identify, treat and manage all diseases/conditions is mixed. The lack of confidence in family practitioners, and/or articulated need towards more consultations provided by specialists, may be attributed to several factors.

175. Firstly, many of the beneficiaries across the five fields had very little and/or absolutely no knowledge about the FHT Approach, and what it entails in terms of processes and delivery of services. The concept of family members with different medical conditions, ages and sexes being treated by the same physician, is not a widespread practice in the region. Lack of community awareness and knowledge towards the evidence-based practice of family practitioners providing the necessary care to a community may unfairly affect the community's perception towards the family practitioner's capacity and ability.

176. Secondly, some of the participants noted that family practitioners need further capacity building and continued education to be able to develop their skill set and knowledge. Continued education and capacity building have also been stated as a need by many health staff interviewed. In fact, many health staff interviewed from across the board stated that it was difficult to adjust from being specialized under the old model to having to interact with and treat a wide array of patients with different medical needs.

177. Lastly, as a result of deteriorating socio-economic conditions, more participants are finding it increasingly difficult to access secondary care when properly referred by UNRWA. Therefore, the need communicated by some participants for more specialists to be provided at the Health Centres is primarily a result of their inability to financially afford specialists and/or secondary services outside of UNRWA's primary Health Centres.

178. Health staff were described by most Palestine refugees as being *"respectful"*, *"attentive"*, *"supportive"*, *"professional"* and *"kind"*. Participants stated that the health staff at UNRWA's HCs displayed a high level of good bedside manners. In Jordan and the West Bank, a number of participants stated that they prefer UNRWA's HCs to those provided by the MOH, because of the health staff's kind treatment and respect towards refugees.

179. Nonetheless, some participants raised concerns over the communication skills and attitude displayed by some health staff towards refugees. Syria had the highest number of participants noting the need for improved communication skills and bedside manners, *"The staff should be trained on how to deal and communicate properly with the beneficiaries"*.

180. In addition, some participants in Syria stated that MOs not only lack communication skills when dealing with refugees, but also, when communicating with their colleagues, *"Physicians communicate poorly and in a rude manner with other staff and sometimes they would burden the beneficiaries by referring them to other UNRWA centres or departments without providing them with the necessary documents."*

181. Dental services provided by UNRWA in selected HCs received the lowest satisfaction rate amongst all Palestine refugees across all five fields. Some participants alluded to the long waiting hours outside

the dental clinics, and even long waiting periods to be given an appointment. Participants stated that the dental services covered by UNRWA hardly met their needs and should be enhanced to cover more complex procedures. Furthermore, several participants mentioned that some dentists lacked communication skills and demonstrated an unfavourable attitude towards refugees accessing their services.

182. Some participants stated that UNRWA's health staff within the centres exhibit favouritism and nepotism, invariably affecting the quality of services provided. In Lebanon, allegations of favouritism and nepotism within UNRWA's HCs, as well as within the agency, was mentioned by several participants, *"For example, if the clerk knows someone, he will make him a priority over the 100 others waiting"*. Furthermore, some participants stated that depending on who you know, affects the extent of how much UNRWA would cover the financial cost of a surgical operation and/or procedure.

183. It is important to note that some participants were not very clear on what surgical procedures were covered as well as the selection criteria. This lack of clarity and awareness amongst the community can result in unnecessary misconceptions and misunderstandings regarding the services that UNRWA provides and the processes with which appeals are accepted.

#### **e. Integration of MHPSS**

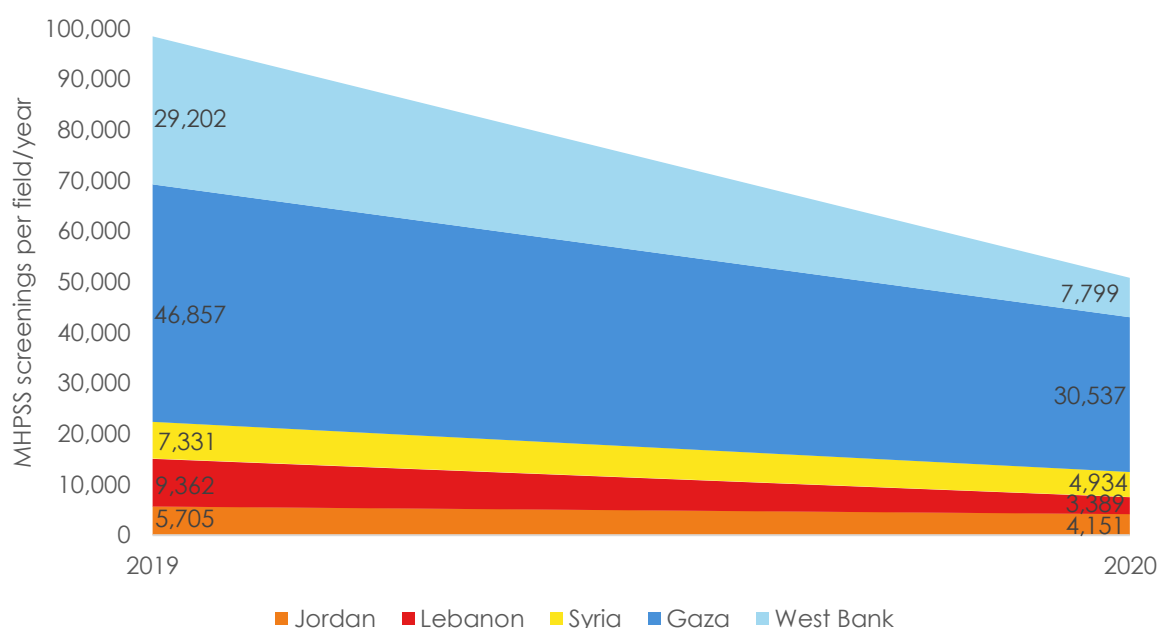
184. The integration of MHPSS services, was looked upon positively by the majority of health staff interviewed. Participants recognized that mental health problems were common amongst the Palestine refugee population, and that the need for MHPSS services/treatment is growing. Furthermore, participants stated that the integration of MHPSS services establishes a more holistic approach to care, and therefore provides better health outcomes for the community.

185. It was clear that the participants understood the important role that primary health care services, and in turn, primary healthcare professionals play within the provision of MHPSS services and where the FHTs intervention is placed within the WHO pyramid framework. Furthermore, intervention processes (Who, When, and How) and referral mechanisms for MHPSS are well established and follow a stepped-up approach to care.

186. All participants interviewed have stated that they have received MHPSS training (mhGAP, PFA, GHQ-12 screening) and believe that the training received has succeeded in providing them with the foundational knowledge and skills for MHPSS identification, basic intervention, and proper referral. Nonetheless, many participants stated that there is a need for refresher trainings and continued education in MHPSS.

187. Health staff utilize the General Health Questionnaire (GHQ-12), which is a validated questionnaire that assesses the severity of current mental health problems based on 12 items.<sup>63</sup> Midwives and nurses are tasked with using the GHQ-12 screening tool with patients who fall within high-risk categories (high risk of a comorbidity or perceived vulnerability) such as NCD patients, post-natal women, and primary care givers of children with disabilities.

<sup>63</sup> Aziz, Abdel & Vostanis, Panos. (2005). The validity and reliability of Arabic Version of General Health Questionnaire in the Gaza Strip. *Palestinian Med J.* 1. 33-36

Figure 13: Number of MHPSS Screenings Per Field Per Year<sup>64</sup>

188. MHPSS screening is also conducted on patients who exhibit symptoms and/or signs of psychosocial and/or emotional distress. Though the integration of MHPSS services within HCs began in 2017, documentation and data concerning MHPSS services within UNRWA HCs only began in 2019. Based on the MHPSS data retrieved from UNRWA (Figure 13), screening for MHPSS is active in all five fields. However, the data provided by UNRWA does not clarify who is providing MHPSS support/treatment (external MH specialist, in house PSS counsellor, visiting psychiatrist, or FHT member) nor does it provide disaggregated data concerning age, gender, and possible diagnosis if appropriate.

189. In assessing the data retrieved from the different Field Offices, it was identified that each field collects and reports on MHPSS data differently. As an essential component within the overall delivery of comprehensive services within UNRWA's HCs, there is a need to strengthen MHPSS data collection and proper reporting across all five fields of operation.

190. Health staff stated several challenges when having to provide the necessary support/treatment to patients in need of MHPSS. Some MOs noted that the provision of MHPSS requires time, which is not always afforded due to the high workload and demand of services by other patients. Time constraints in providing MHPSS services by MOs has mostly been communicated by FHTs in HCs that do not have in-house PSS counsellors and/or visiting psychiatrists.

191. Secondly, some participants stated that they find it difficult to provide support for refugees that experience psychological distress that is largely caused by surrounding social and environmental determinants and which the team has no power in changing or alleviating. It was noted that treating patients that are clinically diagnosed with more severe mental health disorders (bipolar, schizophrenia etc.) that are stable, is considered easier than providing PSS to those exhibiting symptoms of emotional distress.

192. It is evident through the interviews conducted that the level of MHPSS integration within the HCs is quite dependent on the presence and/or availability of "MHPSS specialists". The concerns and challenges communicated by some health staff are valid and understandable. It is necessary for UNRWA to ensure that the MHPSS need of beneficiaries do not go unattended due to the shortage of time and/or lack of professional capacity amongst FHTs.

<sup>64</sup> Data Requested and Provided by UNRWA on 11/04/21

193. Amongst interviewed Palestine refugees, there was a modest level of awareness regarding the provision of MHPSS services within HCs. This is true across all five fields, where a substantial number of participants had little knowledge with regards to the provision of MHPSS services and have never attended or observed any MHPSS community awareness sessions.

194. Several refugees interviewed from the West Bank and Lebanon have stated that they or a family member have accessed MHPSS services and reported being satisfied with the MHPSS support/treatment, *"I personally benefitted from the psychosocial support programme since my son used to cause so much trouble at the camp, until I took him to the counsellor who developed a treatment plan for him."*

195. In addition to individualized PSS sessions, some participants mentioned that group psychoeducation sessions are provided within the HCs and cover topics such as self-care, childcare, and depression. While those who need PSS are often referred to the counsellor, refugee interviews highlighted the integral and essential role that midwives play in the provision of PSS.

196. Some participants noted that they feel more comfortable speaking with the midwife than they do with a counsellor or family physician. Furthermore, it was observed through the interviews that although some participants were unaware of the provision of MHPSS services at the HC, they were however unofficially receiving an ongoing level of PSS from their attending midwives.

197. Whether intentional on behalf of the midwives or not, it does further demonstrate the positive influence that midwives are able to have on the overall wellbeing of Palestine refugees, *"I am not aware of the provision of such services (MHPSS) at UNRWA Health Centres, but when I used to visit the midwife during my last pregnancy, she used to support me. She used to tell me that I should not be stressed or angry, as this will affect my health negatively. I needed this support especially after finding out about my daughter's condition."*

198. Not all Palestine refugees that accessed MHPSS services were satisfied with the support provided, citing the incapacity and inability of the PSS counsellor and/or FHTs in providing proper care. Although Gaza has one of the oldest MHPSS programmes amongst the fields, several participants stated that some physicians are not interested in the *"psychological treatment"* and only concentrate on the *"medical issues"*.

199. Other participants from Gaza stated that they have not accessed MHPSS services because they are concerned about the level of confidentiality maintained, as well as the associated stigma surrounding mental health in the community. Though increased acceptance of MHPSS services amongst the community was mentioned by many of the refugees and health staff, it was evident that further efforts towards mental health awareness amongst the community is needed to increase MHPSS literacy, and in turn, decrease remaining stigma and/or barriers towards MHPSS support/treatment. In Syria, participants voiced concerns over the lack of privacy for MHPSS consultations within some HCs, where consultations are conducted in an open space setting outside of the HC due to a shortage of available rooms.

200. Interviews with Palestine refugees and health staff have highlighted many experiences where the MHPSS needs of refugees have been addressed and led to recovery. There is evidence to suggest that the integration of MHPSS services within UNRWA's primary healthcare services, has increased access to mental health care, and is contributing to the overall wellbeing of Palestine refugees.



Evaluation Question: To what extent has the UNRWA workforce/HR approach adapted to support the FHT Approach reform? (West Bank, Gaza, Syria, Lebanon)

**Key finding:** The reorganization of HR into FHTs, is regarded favourably by most health staff. However, this has been less effective in centres which have struggled to staff the FHT model. The financial crisis impacted UNRWA's ability to properly staff and train the FHTs, negatively impacting the FHT Approach's effectiveness and derived benefits.

201. At the onset of the reform, the establishment of FHTs was predominantly based on the reorganization of the existing workforce. Therefore, the number of FHTs within a given HC is dependent on the number of MOs functioning within the HC. The composition of an FHT, mainly includes a MO, practicing nurse and midwife, as well as clerks and pharmacists depending on available resources.

202. HCs have a Health Head Centre, who are senior MOs tasked with treating patients, providing trainings/supervision (for MOs, laboratory technicians, and pharmacists) and managing/overseeing the PHC and the designated FHT's within it. HCs are also provided with a staff and/or senior staff nurse, who like the Health Head Centre, is responsible for supporting, training and managing day to day activities of nurses, midwives, clerks, doorkeepers and cleaners within each HC.

203. External to the FHTs, HCs are supported by Area Officers who provide direct support and supervision to all HCs within their assigned area. Additional support positions within management Field Office/HQ were included in 2011 (FHT Coordinator, e-Health Project Coordinator, FHT Communications Officer, School Health Officer etc.), to support the rollout of the FHT Approach, and in turn, the FHTs on the field.

204. The majority of frontline health staff viewed the reorganization of HR to form FHTs as being a positive development within the provision of health services in UNRWA. Participants noted that forming multidisciplinary teams has effectively led to a better distribution of work, shared responsibilities, increased team comradery, and led to better health outcomes for Palestine refugees.

205. However, the organization of HR into FHTs was observed as being less effective in small HCs as well as within some larger HCs (i.e., Irbid-Jordan). Due to their catchment areas, smaller HCs are less prioritized in the distribution and allocation of HR. As such, some smaller HCs have one MO designated to support two FHTs, while also acting as the Health Head of Centre. While larger HCs are provided more HR, the reorganization of the staff has resulted in some HCs having several physicians rotating per FHT. Irbid-HC in Jordan is an example of a larger HC that has 3-4 physicians rotating weekly on one FHT.

206. As such, participants stated that the benefits achieved from implementing the FHT Approach (familiarity of patients, building of trust, continuity of care) is essentially lost, because depending on the week, a patient may end up consulting with a different doctor each visit. This was substantiated by PRJ participants accessing Irbid-HC whereby they described the HCs distribution of work and client flow as "*chaotic*" and "*disorganized*" and stated that they consult with a different physician each time who prescribe different medication and treatment plans.

207. UNRWA's financial crisis has resulted in the agency's inability to fill staff vacancies in both management and frontline health staff positions. Furthermore, UNRWA is also facing difficulties in recruiting and retaining highly trained health professionals due to its compensation packages, which are viewed as being less competitive than the surrounding markets. Thus, a large proportion of HCs across the five fields are not sufficiently staffed, and FHTs have remained incomplete.

208. In an effort to keep services running, UNRWA has deployed a number of tactics: sharing team members between two FHTs, deploying health professionals from one centre to another, and filling vacant positions with short term employee contracts. Though the aforementioned strategies essentially

succeed in sustaining service delivery, due to the constant rotation and/or changing of staff, they are less successful in sustaining the benefits derived from implementing the FHT Approach.

209. The integration of MHPSS, GBV and services for people with disabilities within UNRWA's HCs, has been deemed necessary by all UNRWA staff interviewed. Frontline health staff have been trained in MHPSS and GBV, and feel more confident in identification, provision of basic support, and referral for both MHPSS and GBV. Yet, it was observed that HCs are still heavily reliant on the presence of MH specialists and GBV focal points to provide the necessary support to Palestine refugees in need of such services.

210. In HCs that serve a large population with limited staff, frontline health staff find it difficult to provide the necessary care for both MHPSS and GBV due to time constraints. Thus, some participants noted that the additional tasks/responsibilities brought forth by the integration of MHPSS and GBV services has invariably caused added stress.

211. Frontline health staff exhibited strong resilience, dedication, and passion towards the work they are involved within. They understand the community they are servicing, and intrinsically believe that they have a responsibility to provide quality services to Palestine refugees. It was noted by some FHTs, that their ability to continue operating under such stressful environments, was largely attributed to peer support and the presence of good management.

212. However, not all FHTs were satisfied with the support being provided by their respective Field Offices. Several FHTs commented that Field Offices are slow to respond to requests from the HCs (IT, infrastructural renovations, damaged equipment etc.), which causes work related delays and increases frustration amongst frontline health staff.

213. In addition, some participants felt that Field Offices are indicator driven, with little regard and/or care to how these indicators are to be achieved. Moreover, frontline health staff feel that they bear the brunt when responding to emergencies, such as COVID-19, with little recognition and appreciation of their efforts. While short-term employee contracts were repeatedly mentioned as a problem throughout the fields, many of those interviewed lacked a clear understanding as to why UNRWA utilizes short term contracts to fulfil vacant positions.

214. Furthermore, participants stated that feelings of job insecurity were high amongst the teams, due to salary delays as well as the uncertainty of whether some positions will be continued or terminated, further indicating the need for strengthened internal communication. Strengthened channels of communication, development of training opportunities, and investment in motivational incentives are necessary initiatives that would support frontline health staff, and in turn, lead to more effective provision of services.

#### **a. Training & Family Medicine Diploma Programme (FMDP)**

215. Before the implementation of the FHT Approach, health staff received basic training on the new modality of care, that outlined the FHT Approach's principles (patient-centred, continuity of care, and comprehensive services), the new organization of services, and highlighted the new roles that team members will undertake. Staff orientation on the FHT Approach was further complemented with trainings focusing on the development of soft skills (i.e., teamwork, communication skills, etc.).

216. Initially, UNRWA did not provide specific technical trainings focused on building the capacity and skill set of MOs towards family practice. Different fields trained their medical staff through their own initiatives such as the collaboration between the American University of Beirut (AUB) and LFO in providing a 6-month on-the-job training programme by physicians from the university to selected MOs.<sup>65</sup> Frontline health staff stated that the lack of comprehensive technical training before implementation had caused additional stress because they felt undertrained, and consequently unprepared to assume all of their new tasks and responsibilities.

<sup>65</sup> UNRWA, Health Annual Report, 2014

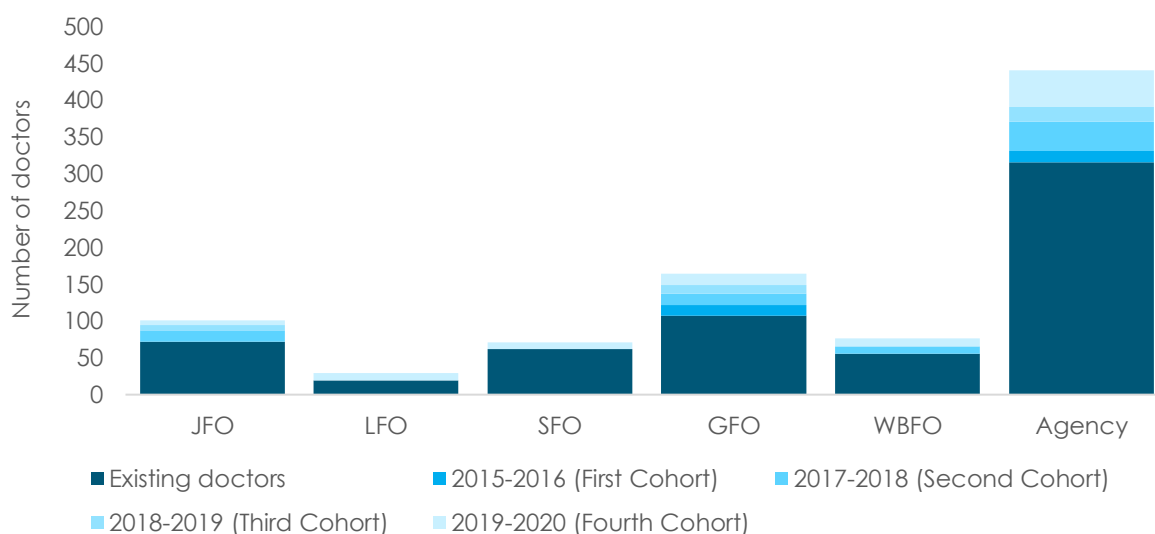
217. Recognizing the need to increase the knowledge and skill set of MOs, UNRWA initiated the Family Medicine Diploma Programme (FMDP) in 2015. The FMDP is a collaborative effort between UNRWA, the University of Westminster in UK, Rila Institute of Health Sciences, and Al Azhar University in Egypt. Utilizing different teaching modalities (face-to-face lectures, webinars, online resources, assessments, etc.) the FMDP is a 12-month course that allows MOs to gain necessary theoretical and practical knowledge as well as learnt skills without disrupting their daily work activities.<sup>66</sup>

218. Gaza was the first field to pilot the FMDP whereby 15 physicians were accepted into the FMDP. A mixed methods evaluation assessing the FMDP initial trial in Gaza found that the training programme can improve quality of care and is both cost-effective and scalable.<sup>67</sup>

219. Since 2015, UNRWA has extended the FMDP to all five fields (Figure 14), with the training extended to MOs across UNRWA's HCs. It is difficult to ascertain how much the FMDP has contributed to improved health outcomes. However, participants who have completed the FMDP stated that, based on their own experience, the training programme does lead to improved quality of care, and in turn, improved health outcomes.

220. According to participants, the FMDP sharpened their clinical knowledge and skills to address different medical conditions, enhanced provider knowledge and skills towards patient-centred care, improved communication skills and increased provider knowledge on psychosocial issues and appropriate intervention. All interviewed participants held very positive views towards the FMDP, and unanimously agreed that the training should be offered to all physicians operating within UNRWA HCs.

Figure 14: Total Number of Medical Officers Who Completed the FMDP 2015-2020<sup>68</sup>



221. UNRWA has not yet initiated a similar training programme like the FMDP for other health staff, primarily nurses and midwives. Although nurses are provided with different external training opportunities across the five fields of operation, the majority of those interviewed stated that most of their training was based on peer support/learning (nurse-to-nurse or MO-to-nurse) and/or team led initiatives like the rotation of nurses.

222. "Prior to the FHT, nurses were specialized in one of the services provided by the Health Centre. For example, a nurse who is specialized in immunization, and another who is specialized in NCDs. The rotation increased nurse's awareness of the different services provided at the Health Centre, and this

<sup>66</sup> UNRWA, Health Annual Report, 2015

<sup>67</sup> Lovell B, Dhillon R, Khader A, Seita A, Kitamura A, Al-Jadba G, Rawaf S, Newson R. Delivering and evaluating a scalable training model for strengthening family medicine in resource-limited environments: the Gaza experience. A mixed-methods evaluation. *BJGP Open*. 23;3(2), 2019. Available at: [bjgpopen19X101647](https://doi.org/10.3399/bjgpopen19X101647).doi: 10.3399/bjgpopen19X101647. PMID: 31366678; PMCID: PMC6662871

<sup>68</sup> Data Requested and Provided by UNRWA on 11/04/21

helped them in adapting to the FH.” Establishing a specific training programme for nurses and midwives like the FMDP, was a consistent request across the board.

223. Although the FMDP is seen as a necessary added value in the training and capacity building of UNRWA MOs, the FMDP is an UNRWA training programme and is not recognised as a formally accredited family health qualification by all host authorities in UNRWA’s fields of operation. As such, it fails to attract young candidates *who* are concerned with gaining recognized accreditation/certification as well as in ensuring that UNRWA’s MOs who have completed the programme can eventually practise family medicine outside of UNRWA.

224. Participants from HQ, Field Offices, and health staff have all cited training and capacity building opportunities as a gap in the different fields. UNRWA’s financial crisis, coupled with the emergence of COVID-19, have had a negative impact on the number of trainings provided to frontline health staff. Induction trainings as part of the FHT Approach as well as other focused trainings for new employees are not systematically implemented across the fields, creating inconsistencies in levels of capacity and knowledge amongst frontline health staff within and amongst different HCs.

225. Furthermore, short term employee contracts make it challenging to invest in necessary trainings due to the limited duration of their contracts (3-6 months). According to frontline health staff, most employees on short-term contracts are receiving on-the-job training by either the Senior MO or other MOs, which is increasing workload on the teams.

226. “In order to get a replacement they only hire them for 6 months and then terminate their contract and get another person for 6 months and then terminate...and this process goes on and on...and this causes a huge problem, with every new doctor that comes we have to train them, and we now are also training them on the new programme ICD11 which is not an easy programme to master especially for doctors who have little experience with working on a computer.”

Evaluation Question: To what extent has the FHT Approach been the/a ‘vital cog’ to addressing wider health issues and linking to other UNRWA service areas?

**Key finding:** Since 2001, some linkages have been established between UNRWA’s health programme and other departments to address cross-cutting issues including MHPSS, inclusion and protection, and health education. However, the FHT and other UNRWA service areas largely remain siloed and where linkages do exist, the FHT has not been a causal driver.

227. The FHT Reform process was designed to assist UNRWA in better identification of wider health issues and to form stronger linkages between the Health Programme and other UNRWA service areas.<sup>69</sup> In particular, the FHT Approach aimed to strengthen collaboration and referrals with Protection, RSS, Education and Infrastructure to provide Palestine refugees with more responsive, holistic services.<sup>70</sup> The FHT is intended to develop trust between service users and HC staff. If the FHT Approach is to be implemented effectively, there is indeed scope for greater assistance. If and when service users report wider concerns to Health Centre staff, they can be referred to other departments wherein there lies greater expertise.

228. There are some positive examples of the FHT acting as a ‘vital cog’ to address wider issues. On a programme level and across all fields, there has been particularly strong cooperation with the Education Department on the School Health Programme. This is supported by the FHT. Health Centres target schools in their catchment areas and provide vaccinations, identification of visual or hearing disabilities,

<sup>69</sup> UNRWA, Health Reform Strategy: Modern and Efficient UNRWA Health Services – Family Health Team Approach, 2011

<sup>70</sup> UNRWA Health Department, Report on the Second Family Health Team Retreat, 2011

classroom visits, health education, MHPSS support and teach capacity building amongst other activities. The WBFO stated that cooperation with the Education Department has been stronger during the COVID-19 pandemic and useful in detecting and referring cases in schools and providing COVID-19 awareness and hygiene kits for families.<sup>71</sup>

229. The FHT is a key part of integrating MHPSS across health, education, and RSS as the FHT Approach makes it easier to screen and refer service users who require MHPSS support. This has been driven by MHPSS focal points in Field Office health teams and other departments who liaise on MHPSS issues. This helps to ensure a consistent approach to MHPSS identification and referral approaches across UNRWA departments<sup>72</sup>.

230. UNRWA staff stated that the Protection Department has provided financial support for these mechanisms and has a strong working relationship with MHPSS focal points in Education. There is also cooperation on GBV across UNRWA programmes and in a similar manner, the FHT can identify GBV survivors who can be referred to the Protection Department. The health programme has GBV focal points and MHPSS coordinators who liaise with other UNRWA departments and Health Centre staff in Gaza, West Bank and Jordan reported good referral processes for GBV and MHPSS.

231. Some Health Centre staff reported having successfully referred a Palestine refugee to another department following a medical appointment, for example, referring children with malnutrition to the Education and RSS programmes. Similarly, Health Centre staff also reported receiving referrals on children of concern from other departments via schools or social workers. e-Health has also proved to be a useful tool in assisting with referrals to other departments. However, the lack of integration of e-Health with other programmatic data limits the ease with which these cross-programmatic linkages can be achieved.

232. At the implementation level, siloed working remains. Referral pathways for issues such as GBV are not consistent between the UNRWA fields or indeed between Health Centres within each field. They have been developed to meet the requirements of each field rather than being centrally designed.<sup>73</sup> Furthermore, referral mechanisms are contingent on individuals' actions and networks and are not systematic. Health Centre staff have a heavy workload and lack the capacity to proactively identify those at risk and make referrals. There are no follow-up mechanisms with other parts of UNRWA, meaning that for those who are referred, there is no feedback or link back to the FHT.

233. Palestine refugee participants did not make links between the FHT and other UNRWA services they received and discussed them as siloed programmes. For instance, some discussed the Protection and RSS Department's services for people living with disabilities but did not believe this support was linked with their health care. Social safety net participants in Lebanon and the West Bank were interviewed to understand how the provision of RSS support and health support were connected. In the majority of cases, there were no strong links between receipt of RSS and health services.

234. In Lebanon, social safety net participants were very critical of health provision. They did not think that UNRWA services were of high quality and stated that UNRWA did not provide them with support in buying medicine, which they could not afford. This suggests a potential area of overlap between RSS and Health that is not being addressed.

235. In the West Bank, social safety net participants spoke more highly of UNRWA health services and there appear to be stronger linkages with RSS. For example, one participant stated the *"UNRWA social services department covers 70% of the cost of the healthcare for my family and always follows up on our conditions"*. Another stated that UNRWA helped to cover the cost of medications that she could not afford.

<sup>71</sup> UNRWA Health Programme, West Bank Field Office: COVID Action, 2020

<sup>72</sup> UNRWA, Integrating Mental Health and Psychosocial Support within UNRWA's Primary Healthcare Model: Family Health Team – MHPSS Three Years Workplan (2016)

<sup>73</sup> UNRWA Protection Team, GBV Transition Plan, 2019

236. There is the potential to use the FHT as a platform to help vulnerable people and target services, but this is not implemented consistently because UNRWA does not have the requisite human or financial resources. If the FHT Approach is to deliver as a vital cog in addressing wider issues, the FHT must be implemented fully and staff across departments need to have the resources and understanding of processes to make and follow up on referrals.

237. An additional challenge for the FHT's role as a 'vital cog' is the fact that many Palestine refugees do not feel comfortable confiding in medical officers about wider issues including MHPSS and GBV. Given staff workload, they are dependent on service users self-reporting rather than the FHT proactively identifying those in need of assistance. If service users do not report issues to the FHT then they cannot be assisted.

238. There is not strong evidence to suggest that linkages between departments are directly a result of the FHT Reform itself. Coordination between departments is largely dependent on GBV and MHPSS focal points who liaise with other departments at the programme level. Furthermore, although cooperation on GBV is perhaps the strongest inter-departmental effort, this is driven by the Protection Division as opposed to the FHT.

239. Crucially, management staff at Field Office level and frontline health staff in Health Centres have very different understandings of referrals and linkages with other departments, with Field Office staff having a much stronger understanding than Health Centre staff. If Health Centre staff lack clear understanding of linkages with other departments, then the FHT Approach cannot be the 'vital cog' which drives inter-departmental links.

**Evaluation Question:** To what extent has the FHT Approach been able to adapt (absorbing shocks and stresses) to recent and projected changes in context?

**Key finding:** The FHT Approach's adaptability and resilience varies between fields. In Gaza, the FHT has proved effective in absorbing shocks and stresses, whereas in Syria, where the FHT Approach has had ongoing instability, the FHT is taking longer to embed. In both contexts the FHT does not bridge the humanitarian-development nexus. The FHT model was appropriate for responding to the COVID-19 pandemic.

#### **a. Conflict Response in Syria**

240. SFO has faced one of the most challenging operating contexts given the ongoing conflict and instability in the country throughout the FHT Reform period. Consequently, the reform has only been implemented from 2015 in Syria and has struggled to gain traction at the same rate as other fields.<sup>74</sup>

241. The FHT Reform in Syria has been implemented with limited resources and is heavily reliant on emergency rather than programme funds. While this has been essential in allowing SFO to integrate additional aspects of the FHT Approach such as MHPSS services, it means that the approach is less sustainable than in other fields. Although the FHT is beginning to offer potential development gains in terms of the long-term health for the population, the model remains disrupted.

242. Within this context, it is harder for the FHT model to be adaptable because it has not been as fully implemented as in other fields. Health Centres are not fit for purpose as many facilities were destroyed in the conflict. This has also delayed the rollout of e-Health which is only due to be completed in Syria in 2021.<sup>75</sup> The e-Health rollout has been impacted by the lack of reliable electricity supply in some areas.

<sup>74</sup> UNRWA, Reform Strategy Progress Report, 2015

<sup>75</sup> UNRWA, Health Annual Report, 2019

Brain drain of health staff is a key challenge for SFO and staffing shortages mean that the model cannot be fully implemented at all Health Centres.

243. During the height of conflict, staff reported that it was difficult to implement training and embed a reorganized work structure. Furthermore, due to conflict, Health Centre staff reported that service users are less likely to come to the Health Centre for preventative treatment and are more likely to access curative support. This limits the extent to which the FHT Approach and its aims have been embedded.

244. These issues do not necessarily reflect on the adaptability and resilience of the FHT model itself, but rather reflects the wider challenges of implementing a large-scale change management process in a conflict setting. It is therefore difficult to ascertain how resilient the FHT model has proved in this context or how agile it will be in the long run. However, there are some early warning signs in this regard.

245. Although Health Centre staff spoke more positively about the FHT than their counterparts in other fields, they reported that the training they had received focused on the approach itself and was not tailored to working in an emergency context. Indeed, they shared the sentiment that the model is not designed to operate in emergency situations. Additionally, given that it has been rolled out in an emergency context, Health Centre staff reported a gap in proper understanding of the FHT Approach and the e-Health system. There is a risk that poor roll-out could impact the effectiveness and agility of the model going ahead.

246. Service users' understanding of the FHT was very mixed, reflecting uneven implementation of the approach. They were also divided on the extent to which the needs of vulnerable people could be met by the FHT in an emergency setting, suggesting that this is inconsistent between Health Centres. SFO has an opportunity to learn from the experiences of other fields and develop the FHT model going forward. However, SFO could be faced with ongoing challenges in gaining traction with the FHT if implementation only occurs in an emergency context.

## **b. Conflict Response in Gaza**

247. In Gaza the FHT has shown resilience and enabled UNRWA to continue service delivery despite external circumstances. In contrast to Syria where the reform was delayed due to conflict, Gaza was a pilot field for the FHT Approach and has faced multiple protracted emergencies since its inception, most notably the 2014 war, 11-day conflict in 2021 and the ongoing blockade which has contributed to socioeconomic decline. Due to the situation in Gaza, the FHT here is the closest that UNRWA has achieved in bridging the humanitarian-development nexus<sup>76</sup> in its approach to healthcare.

248. There are many positives associated with the FHT Approach in Gaza and staff and Palestine refugees are highly committed to it. UNRWA is the primary health care provider for Palestine refugees in Gaza and as such the FHT model has had to adapt because of the high dependence on its services. The FHT Approach has been able to absorb increasing pressures in the Gaza context.

249. Although challenging to quantify, GFO staff and Health Centre staff maintain that they would not have been able to withstand the context's challenges without the FHT Approach. The FHT has created a more resilient system and despite a growing number of Palestine refugees, it has allowed the GFO to manage caseload and has reduced the need for repeat visits.<sup>77</sup>

250. Health Centre staff reported that they received training on how to adapt to emergency contexts during crises. In these situations, there has been a deliberate decision to temporarily suspend the FHT and instead to employ an emergency team approach focused on service delivery to NCD patients and the most vulnerable.

<sup>76</sup> OCHA, The Humanitarian-Development Nexus, available at <https://www.unocha.org/es/themes/humanitarian-development-nexus> (accessed 22/05/21)

<sup>77</sup> UNRWA, Health Annual Reports, 2011-2019

251. While this suggests that the FHT itself does not adapt to emergency, it lends a resilience to the overall system. This is because during the transition out of emergency, the FHT provides a strong and familiar structure to return to, speeding the system's shock recovery response. The system's resilience has also been strengthened by e-Health for which an emergency mode was developed in 2019.<sup>78</sup> This enables continued service delivery in the case of a large-scale transfer of service users during emergencies.

252. In times of acute emergency, notably during the 2014 war, the GFO has been able to pivot the FHT into emergency response mode. While this has necessitated some changes to the typical model, UNRWA staff stated that the FHT's clear structure and operations has driven resilience. During the 2014 war, only 65% of Health Centres remained open during the conflict and staff were encouraged to work from the Health Centre closest to their home.<sup>79</sup>

253. This caused uneven distribution of staff and high burnout levels.<sup>80</sup> In some instances, schools were used to provide health services. However, during this period the approach allowed them to deliver 348,070 consultations monthly, only a small decrease from normal average monthly consultations of 350,000.<sup>81</sup> Sixty-eight per cent of staff were able to work through the conflict, and essential services and medication stocks were maintained.<sup>82</sup>

254. In 2018, 23,000 Palestine refugees were injured during Great March of Return demonstrations. This caused increased workload for Health Centres, but the structure and resilience embedded by the FHT allowed UNRWA to expand provisions to meet Palestine refugees' need.<sup>83</sup>

### **c. COVID-19 Adaptions**

255. The COVID-19 pandemic has presented a far greater challenge in terms of the FHT's ability to absorb and respond to shocks than conflict. Across all fields, UNRWA decided at the outset of the pandemic that the FHT model was not appropriate for responding to the pandemic because of the high levels of patient contact involved in the approach and the lack of specialized triage services needed to identify and isolate infected patients. It has been suspended in order to continue to provide Palestine refugees with health services.

256. All fields, including Gaza and Syria, made the decision to suspend the FHT model in favour of emergency response and have shown agility in doing so. This has involved the establishment of triage systems and reducing the number of patients attending Health Centres. In Syria and the West Bank, a team rotation system has been implemented to better isolate staff and reduce the risk of infection.

257. Some HC staff reported that they had delivered medicines to the homes of the elderly, MHPSS and NCD patients, although this was not possible in all cases due to increasing workload over the course of the pandemic. In these instances, patients with easy access to HCs were able to collect their own medication.

258. Gaza's COVID-19 response plans were based on existing emergency response and business continuity plans which have aided its response. Notably, GFO was able to adapt easily to the pandemic response given the resilience built by the FHT and their prior experience of adapting the approach to emergency contexts.

259. In Gaza, a toll-free medical hotline for patients was established, and medicines were delivered to patients. GFO also employed telemedicine to make special provisions for some patients including online support groups for NCD patients and mobile teams to provide services for vulnerable, at-risk patients.<sup>84</sup>

<sup>78</sup> UNRWA, Health Annual Report, 2019

<sup>79</sup> UNRWA, Reform Strategy Progress Report, 2014

<sup>80</sup> UNRWA, Reform Strategy Progress Report, 2014

<sup>81</sup> UNRWA, Reform Strategy Progress Report, 2014

<sup>82</sup> UNRWA, Health Annual Report, 2014

<sup>83</sup> UNRWA, Health Annual Report, 2019

<sup>84</sup> UNRWA, Real Time Evaluation Report Three: Gaza Field Response to COVID-19 Emergency, 2020



In both Syria and Gaza, Health Centres have faced staff shortages as many staff members were infected with COVID-19.<sup>85</sup>

260. Staff in interviews noted that Health Centres have temporarily suspended services including dental preventative care, family planning, non-communicable disease screening, with a focus on responsive, rather than preventative healthcare provision. Whilst the temporary suspension of the model has been understandable in the current context, given that the challenges created by COVID-19 are likely to be felt in the longer-term, UNRWA will need to give consideration as to how to adapt the FHT model in the medium term to avoid potential negative impacts on health outcomes.

261. In fact, the suspension of the FHT model is believed to have already had a negative effect on health outcomes for vulnerable populations. In Syria, health staff believe that vulnerable groups and those facing protection issues have been adversely affected due to the sole focus on containing COVID-19 and treating high-risk cases. There has been little contact with service users who do not fall into this category.

262. Both Syria and Gaza Health Centre staff reported a rise in MHPSS needs and GBV cases which they have not been able to address. In Gaza, staff reported that they had felt the negative effects of suspending the FHT model and there is concern about how and when the model can be fully reinstated. This bodes poorly for future health outcomes if the FHT Approach cannot be reinstated in the near future.

#### **d. Responding to future shocks**

263. All Field Offices conduct strategic planning to respond to projected changes, both developmental and emergency. Emergency adaptations are underpinned by emergency and business continuity plans. While UNRWA has been able to expand and retract health services as needed, this has typically involved the suspension or partial suspension of the FHT model and is likely to do so in the future. Evidence around the FHT's ability to absorb and respond to shocks was primarily derived from interviews with staff. A more explicit approach to documenting lessons learned of applying the FHT in emergencies would be helpful to inform UNRWA's work going forward.

264. However, telemedicine connected with FHT is also improving, including the Mother and Child Health mobile app, the e-NCD mobile app, and hotlines for use in emergencies. If well-implemented, these can help UNRWA respond to future emergencies and focus on long-term health outcomes by maintaining a basic level of care and communication with regular patients. However, these are likely to take root more successfully in fields such as Gaza where the FHT is already well established. In Syria, where there are already infrastructure challenges in implementing the basic e-Health system, the potential is more limited.

Evaluation Question: To what extent has the reform supported the achievement of GEWE/protection results/results for people living with disabilities?

**Key finding:** The FHT Approach's original design did not focus on gender equality and women's empowerment (GEWE), protection results, or results for people living with disabilities. While there have been efforts to mainstream policies related to these issues, the design and implementation of the FHT has not been appropriately adjusted to achieve results in this area. GEWE and protection results were not achieved because the FHT Approach does not challenge traditional systems of oppression.

<sup>85</sup> UNRWA, Real Time Evaluation Report Three: Gaza Field Response to COVID-19 Emergency, 2020

265. The FHT Approach takes a holistic approach to providing healthcare for whole family units. As such, there is a clear assumption, both in documentation relating to the service's design and amongst UNRWA staff at all levels, that questions of empowerment, protection and equitable access to services are accounted for by the model by default. There is also an assumption at field and HQ level that the FHT has provided this because men and women have equal access to services. Consequently, gender, protection and inclusion are not areas of concern. This assumption is disproven through findings derived from interviews with frontline health staff and Palestine refugees.

#### **a. Maternal Health and Family Planning**

266. UNRWA's approach to gender mainstreaming has focused largely on improving women's health including maternal and child health. While this is not a gender issue in itself, access to these services is influenced by societal norms relating to women's autonomy over their reproductive health, such as the influence of husbands and mothers-in-law in decision-making and access to services.

267. The holistic approach of visiting one family doctor for all medical needs, including family planning, pre-conception care, antenatal care, and childcare means that women's health needs are better addressed. This is supported by the FHT life-cycle approach that supports and monitors women and children through all stages of life. Indicators show some improvements. This is reflected in the fact that the number of maternal deaths has consistently declined from 23 in 2011 to 12 in 2020.<sup>86</sup>

268. Health Centre staff, midwives in particular, stated that they had trusting relationships with women using maternal health and infant care services. In Lebanon, Jordan and Gaza, female and male Palestine refugee participants recognized the good care they, or female family members, had received from UNRWA. Particular praise was given to care for pregnant women, including the provision of medication and supplements, access to midwives, access to family planning services, vaccinations for children and health education.

269. As discussed under Health Outcomes, The Mother and Child Health mobile application was rolled out in 2019. This allows mothers to review their own and their children's health records, receive health advice and view appointment notifications.<sup>87</sup> Service users who had used the app found it useful in supporting their own and their children's health.

270. There remain some challenges in this area. Indicators do not show a significant change for the percentage of women attending at least four antenatal appointments. This increased from 87% in 2011 to 91% in 2018, declining to 87% in 2019 and to 75% in 2020. Similarly, while the percentage of pregnant women registered during the first trimester increased between 2011 and 2017, it has since declined.

271. While 2020 figures reflect barriers to access during the COVID-19 pandemic, declines in 2018 and 2019 are of concern. UNRWA also identified that girls under-18 remain particularly vulnerable to maternal death due to lack of information about services.<sup>88</sup> This is a particular issue where early marriage is a notable concern.

272. Many service users cited a shortage of midwives with the FHT as a barrier to effective follow-ups, as well as a lack of equipment for ultrasounds. Some female participants in Gaza stated that, where they could afford to, they preferred services provided by private Health Centres as this was more effective in identifying and supporting pregnancy complications.

273. In Lebanon, the main challenge raised by participants was the lack of gynaecologist appointments available. Across Lebanon, Jordan and Gaza, a lack of female medical officers was raised as an obstacle in interviews in terms of women accessing female health appointments. Female service users are not comfortable discussing issues, relating both to female reproductive health and GBV, with male doctors.

<sup>86</sup> UNRWA, Health Annual Reports, 2011-2019

<sup>87</sup> UNRWA, Health Annual Report, 2019

<sup>88</sup> UNRWA, Health Annual Report, 2019

274. As a result, communication about patient's conditions is directed to doctors via midwives. This raises two key repercussions. Firstly, midwives are burdened with providing support and services that they do not currently have the capacity to provide; they lack the training and mechanisms to address these issues alone. For example, women confide in them about GBV, MHPSS and other medical issues.

275. While this does support a survivor-led approach particularly with regard to survivors feeling comfortable discussing GBV, UNRWA needs to provide midwives and female nurses with the training, support, and referral mechanisms in order to fully support women. As it stands, midwives cannot provide this full support which in turn could be detrimental to women's health if they are not able to access appropriate care.

## **b. Women's Empowerment and Decision-Making**

276. The FHT Approach has had little impact on women's empowerment and decision-making. The FHT Reform has reinforced cultural norms, and by its very nature, has not challenged traditional family structures. Women can only access UNRWA services through a family unit with registration via their husbands or fathers.

277. In Lebanon and Jordan, a challenge was noted regarding service access for women with unregistered marriages. Women with unregistered marriages cannot be registered on e-Health as its design only allows for the registration of women as part of a family unit. While workarounds such as recording visits on paper have been implemented, the fact that these women cannot be formally entered into the e-Health system is highly problematic. It is more challenging for them to access appointments and for UNRWA staff to compile their medical records, meaning they may receive a less consistent and comprehensive level of service than other service users.

278. This is equally a challenge for unmarried women outside of a family unit who wished to access family planning services. UNRWA staff widely recognized that women in this position would be unlikely to visit UNRWA Health Centres because of the stigma women in this position would face in accessing a service firmly embedded in their community and because of the need to register through a male relative.

279. Additionally, UNRWA has experienced instances where UNRWA staff have refused care to unmarried women due to fears of retaliation from the community. Consequently, while incidence of unmarried women presenting to UNRWA to access these services is small, it remains a significant challenge for the FHT to provide them with care within the formal structures. Consequently, UNRWA is unable to fully provide quality and universally accessible primary healthcare to all Palestine refugees.<sup>89</sup>

280. Interviews with Palestine refugees and UNRWA staff confirmed men generally remain in charge of decisions around family health and family planning. Female participants reported ongoing heavy involvement by their mother-in-law in decisions on family planning. This is enabled by the fact that the FHT Approach is grounded in a family-based structure of health care provision.

281. However, the inclusion of men in family planning is a deliberate and priority policy decision by UNRWA<sup>90</sup> which has yielded some benefits. Including husbands in decision-making on family-planning has helped to communicate the importance of family planning and contraception, enabling women to have access to family planning that they may not otherwise have had.

282. The total number of family planning acceptors has grown from 150,000 in 2011 to 176,000 in 2020.<sup>91</sup> In Lebanon, Health Centre staff reported that younger men are more open to joining family planning appointments while those who have been married for longer do not see the relevance of men being involved. Service users reported that although UNRWA requires their husbands to be present in family planning appointments, this is not always enforced in practice and women can simply confirm they have their husband's consent.

<sup>89</sup> UNRWA, Medium Term Strategy 2016-2021, 2016

<sup>90</sup> UNRWA, Health Annual Report, 2018

<sup>91</sup> UNRWA, Health Annual Reports, 2011-2019

283. Several female service users reported that they felt more empowered to take control of their reproductive health as a result of UNRWA services and their relationship with midwives and nurses. They reported that it is easier for women to make decisions about family planning because they can access information they would not otherwise have had. Through this, they received all family planning information and can discuss mental health in a venue they would not otherwise have.

284. However, this finding was not reported by all female service users and cultural norms, such as the involvement of mothers in family planning and constraints for unmarried women, remain. Often family members who lack the requisite information, advise women on contraception and family planning.

285. UNRWA Health Centres are seen as a safe, social public space for women. The family and community nature of Health Centres allows extended families to feel comfortable in allowing women to visit the Health Centres alone. They are an important place for women to socialize and destress and are important in granting them greater independence.

### **c. Gender Parity in the Workforce**

286. UNRWA has prioritized gender parity in the workforce across the organization. Across all fields this is still a work in progress. UNRWA has set a target for the number of senior positions held by women: 43% for international staff and 40% for area staff. In 2020 UNRWA had achieved 39% and 31% respectively. Delays in meeting the target were attributed to austerity measures on recruitment and challenges in attracting suitably qualified female candidates.<sup>92</sup>

287. Within the health programme, gender parity is better with 61% of health staff being female across all fields. However, the health programme retains a traditional workforce structure with a majority of female nurses (85%) and a majority of male medical officers (65%).<sup>93</sup> Staff also reported that female medical officers tend not to be Palestinian themselves.

288. Both of these points pose a challenge for the FHT as service users repeatedly emphasized the importance of having a medical officer of their own gender and felt more comfortable speaking with staff who understood their background. There are some signs of improvement. The West Bank Field Office stated that as some male senior doctors have retired, they have been replaced with female staff and there are now two female area health managers. The Lebanon Field Office reported an increasing number of men represented in the nursing cadre.

289. UNRWA experiences challenges in recruiting women into senior positions, including as doctors and senior managers. Many UNRWA staff attributed to this to the small pool of qualified female candidates available across the fields. Several staff stated that they struggle to recruit the right women despite advertising widely, suggesting that there is a supply problem.

290. This is made more challenging by the fact that UNRWA's remuneration package is not as attractive as that of other employers. Staff raised the additional challenge that HCs may not be as accessible for female employees as male employees if they are not close to their homes, as there are high transaction costs associated with commuting.

291. Mobility within the workforce is also a challenge when recruiting women into senior positions. Although positions are advertised in an equitable manner, staff pointed to a non-inclusive recruitment process stemming from traditional attitudes towards women's roles. Some staff pointed to resistance towards women in some senior positions, strongly tied to the traditional hierarchy between male medical officers and female nursing staff.

292. Staff in both Jordan and the West Bank suggested that there are opportunities for experienced senior nurses to be HC managers. However, this notion has received pushback from senior male staff. There is also a clear need to provide mentorship for career advancement to women.

<sup>92</sup> UNRWA, Annual Results Review Information Package, 2020

<sup>93</sup> UNRWA, Health Annual Report, 2019

#### **d. Service Access for Persons with Disabilities**

293. Although not a part of the original design, the FHT Approach has improved access to services for persons with disabilities. Staff stated that the FHT model allows medical staff to understand the situation of a whole family including its most vulnerable members. Families with children with disabilities are more likely to bring them to UNRWA Health Centres now because of greater trust in medical staff who know their child's history. Service users reported that persons with disabilities are given priority appointments and are treated well.

294. The FHT Approach makes it possible to address disabilities in multiple ways, addressing both mental and physical health. Disability is now also tracked in e-Health providing more reliable medical records. Newer Health Centres built in Gaza have been designed to be physically accessible. Persons with disabilities can access home visits and medicine delivery. This has been a key part of service provision during the COVID-19 pandemic. For example, in Jordan, staff conducted 279 visits to older persons with disabilities and NCDs in 2019.<sup>94</sup>

295. Disability is an area of particular focus for the Gaza Field Office as many refugees now live with disabilities as a result of injury during the 2014 war and the Great March of Return. In 2020 alone, the GFO health department provided physiotherapy, assistive devices, and medical prosthesis to 1008 injured survivors, and glasses to 3453 children with visual impairments. 265 persons with disabilities also access MHPSS services.<sup>95</sup>

296. Medical staff have been trained on disability screening, although several noted that they have not been trained on treating persons with disabilities. In Jordan, 504 staff were trained on inclusive health services and in Lebanon frontline health staff have been involved in identifying barriers to access for their patients with disability, such as the need for adjustable examination tables.<sup>96</sup>

297. However, across the fields, persons with disabilities face a major challenge in accessing UNRWA HCs. Many HCs are located in rented or old buildings which do not have ramps and elevators. In Syria, Health Centres have been destroyed in the conflict and houses are being used as interim HCs. In Lebanon, Jordan, and Gaza, some HCs have been renovated to improve accessibility.

298. However, ongoing budget constraints have made it harder for UNRWA to make necessary changes to all buildings. Infrastructure was raised as an access barrier for persons with disabilities in Lebanon, where the location of UNRWA Health Centres in camps made it difficult for them to access. Compared with Jordan and Gaza, fewer Palestine refugees in Lebanon reported persons with disabilities using UNRWA services. Instead, they were more likely to attend specialist services provided by NGOs in camps.

299. A small number of service users reported that UNRWA did not cover health care for their children living with intellectual disabilities. In one instance, a participant reported that her daughter's dental care was refused by UNRWA due to the extra provisions required. In another instance a child was denied vaccinations as UNRWA staff were concerned about side effects. Although these examples were in the minority, it suggests that UNRWA staff may require additional training on treating persons with disabilities, in particular children or those with an intellectual disability.

#### **e. Gender-Based Violence**

300. Protection is the area where the FHT Approach has made the least impact, particularly with regards to GBV. Protection issues were not considered in the design of the FHT Approach owing to its strong focus on response to NCDs. However, identification and referrals for GBV survivors is now a clear priority within the health programme, with steps taken to integrate GBV services in healthcare as discussed below.<sup>97</sup> However, there is a disconnect between the GBV services provided at Health Centres and

<sup>94</sup> UNRWA, Disability Inclusion Report, 2020

<sup>95</sup> UNRWA, Disability Inclusion Report, 2020

<sup>96</sup> UNRWA, Disability Inclusion Report, 2020

<sup>97</sup> UNRWA, UNRWA Gender Equality Strategy 2016-2021, 2016

Palestine refugees' understanding of these services. Many Palestine refugees lacked an awareness of the services on offer to them, as discussed below.

301. Between 2016-2020 all HCs in Gaza, Jordan, Lebanon, and the West Bank, and 91% of HCs in Syria, had at least one member of staff trained on the detection and referral of GBV cases. Training on GBV is centralised through the protection department. During 2018 and 2019, staff, including health staff who are GBV focal points, received training on attitude change to GBV and developed competencies in core areas of: survivor-centred approach, communication and counselling, and case supervision.<sup>98</sup>

302. Management-level staff in Gaza, Jordan and Lebanon reported that there are clear referral pathways for GBV cases and found the role of the GBV focal point within each HC useful in ensuring UNRWA regulations are applied. Management-level staff also reported that the FHT Approach helped to identify GBV cases more easily because staff know their patients well and have high levels of trust.

303. The Health Programme has also run campaigns relating to GBV such as the 'Safety Capacity Building: Mainstreaming GBV Interventions into Prevention, Emergency Preparedness and Response' project and 'Prioritizing Reproductive Healthcare for Youth and Gender Based Violence' project<sup>99</sup> aimed at mainstreaming GBV awareness.

304. However, it is difficult to ascertain how effective GBV services within the FHT Approach are. Each Field Office has a different approach to collecting and reporting on GBV data. There is a lack of reliable, disaggregated data on GBV as this is not tracked in e-Health. Indeed, due to heavy workloads the management of GBV data collection and reporting is not systematised but implemented according to individual approach and capacity.

305. Consequently, it is not possible to ascertain from existing data how many cases are identified by the FHT or make comparisons between fields. Each field has a different approach for referring GBV cases. In Gaza, Lebanon and Jordan, frontline health staff reported that they had no way of following up on GBV cases once they had been referred. In contrast to the management staff, frontline health staff reported that GBV service provision is mainly reactive and only those who report cases are assisted. Frontline health staff reported a lack of time and capacity to actively identify and assist GBV survivors.

306. There is a clear question around how effective GBV training has been. The GBV Transition Plan assesses the return on GBV training in each field. While the West Bank shows a 75% return, returns in Jordan are as low as 25%, with Lebanon at 68%, Syria at 44% and Gaza at 50%.<sup>100</sup> GBV capacity in the health department was assessed in identification, referral, case management, coordination, capacity building and data collection.

307. There is significant variation in capacity between these areas and between fields of operation. Jordan and Lebanon have the weakest capacity across all the areas with Lebanon's capacity being of particular concern.<sup>101</sup> Capability to assist GBV survivors goes beyond training efficacy, with a clear weakness around processes and workloads. For example, frontline health staff in Lebanon reported that while they understood the functioning of the referral system, it was not always clear when and how they should intervene. In Jordan, frontline health staff lacked the capacity to assist GBV survivors due to heavy workloads and felt that there was a lack of options for referral.

308. Across Jordan, Lebanon and Gaza, many Palestine refugee participants were not aware of any GBV services provided at their local Health Centre. In Gaza, many participants stated their Health Centre had no active GBV counsellors and they had not received any awareness sessions on GBV or cross-cutting issues such as child marriage.

309. They also felt that UNRWA did not have any external referral process or support for assisting GBV survivors, which was contradictory to interviews with UNRWA staff. In Lebanon and Jordan, most

<sup>98</sup> UNRWA, GBV Transition Plan, 2019

<sup>99</sup> UNRWA, Health Annual Report, 2019

<sup>100</sup> UNRAW, GBV Transition Plan, 2019

<sup>101</sup> UNRAW, GBV Transition Plan, 2019

participants did not believe that UNRWA worked with GBV survivors. Only one refugee interviewed was aware of UNRWA's GBV services and stated that there was a need for more GBV support services, particularly raising awareness amongst children and men.

310. In Gaza, in instances where female Palestine refugees were aware of GBV services, they expressed concern around confidentiality. Given the family and community nature of the environment and being registered to health services through their husband, they were concerned about their problems being reported back to their husbands and mothers-in-law.

311. Another concern is the stigma associated with accessing GBV support, either by being referred to GBV services at area level or for MHPSS support within the HC. One participant stated that girls and women are unlikely to seek support on GBV from the FHT, because they are scared that this will be reported to their families. They further stated that the FHT cannot address social and psychological problems driving GBV within families.

312. The lack of confidential spaces to conduct GBV counselling appointments is a clear problem.<sup>102</sup> Others stated they were unlikely to speak to a Medical Officer or Counsellor about GBV because of fear and shame. Some expressed that they were comfortable discussing these issues with their midwives, emphasizing a clear need to midwives to be trained to identify and refer these cases. Beneficiary participants stated a clear desire for better GBV services at their Health Centres.

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<sup>102</sup> UNRWA, Health Annual Report, 2017

## 2.4 Sustainability

Evaluation Question: What are the major factors that have influenced the sustainability of the reform interventions and outcomes?

**Key finding:** Although the FHT model has continued to function for ten years, it has not always been implemented according to its design. In all fields the FHT has, at some point, been suspended or 'broken' to continue delivering services, limiting the reform's ability to meet its intended outcomes. Furthermore, two major factors impact the sustainability of the reform: financial and human resource constraints.

### a. Financial Crisis

313. UNRWA's financial crisis has had significant impacts on the FHT. The recruitment freeze, in place since 2018, has prevented UNRWA from filling positions as frontline health staff leave the organization or take sick or maternity leave, and has made it impossible for Field Offices to make temporary hires to fill vacancies. Where temporary hires are made, it is often not possible for UNRWA to train them and fully 'bring them on board' with the FHT Approach, which differs to that used by the health systems in UNRWA's fields of operations.

314. This has led to a breakdown of the FHT model because in many Health Centres, there are not enough trained staff to fill FHT posts. Consequently, available staff are shared between teams and redistributed amongst Health Centres. This directly undermines a core principle of the FHT: patients are not treated by the same team meaning that trust and knowledge of service users' medical history is lost.

315. Uncertainty around programme budget undermines the Field Office's ability to plan, leading many Field Office staff to raise concerns in interviews about workforce and medicine supplies in the future. The Jordan Field Office staff interviewed reported that they have suspended some treatments and services, such as follow ups on laboratory work as they cannot afford the nurses required for these activities.

316. Ensuring a capable and resilient workforce with the capacity to implement the FHT Approach is essential for the reform's sustainability. One staff member stated that the FHT model only works if teams are complete. If this cannot be achieved, it loses its benefits, meaning that the previous model would function as effectively.

317. The financial crisis has also created barriers to upgrading the infrastructure of Health Centres, leading to inadequate spaces to implement the FHT Approach and causing accessibility issues for some patients, such as the elderly, pregnant women and persons with disabilities. There is also a lack of appropriate space where Palestine refugees feel comfortable discussing issues relating to GBV and MHPSS.

318. All fields reported challenges with the internet and electricity at Health Centres which cannot be addressed due to budget constraints. This means that the e-Health system is often inaccessible to frontline health staff and there is no 'offline' version, meaning that staff have to enter the data at a later point.

### b. Workforce

319. Workforce-related challenges pose high risks for the future of the FHT. UNRWA has a high staff turnover rate, which is a significant problem as UNRWA cannot afford to replace staff. Before the financial crisis necessitated a hiring freeze, UNRWA already faced challenges in attracting the best medical professionals, as UNRWA salaries and opportunities for further qualification and specialization are not competitive compared with other health providers.



320. The challenge of recruiting and retaining staff is felt across Jordan, Syria, and the West Bank and is a particular problem in Lebanon, where labour market restrictions mean newly qualified frontline health staff are likely to emigrate to pursue specialization. The exception to the challenge is Gaza where UNRWA has stronger links with the wider health system and restrictions on mobility have reduced brain drain. This means that in terms of workforce, the FHT Approach in Gaza is potentially more sustainable than in other fields.

321. Training is also a risk to frontline health staff capability and retention. Due to financial constraints and the COVID-19 pandemic, many staff have not been trained on the concept of the FHT model. While the FMDP has been offered to Medical Officers, the lack of an equivalent qualification for other staff means family health knowledge is inconsistent across the team. This has also undermined motivation of staff who are not Medical Officers.

322. Consequently, there is a real risk that institutionalized knowledge and implementation of the model will decline. As detailed previously, the FHT diploma is not recognized outside of UNRWA. Consequently, in a situation where UNRWA health services are no longer necessary and its Medical Officers are 'absorbed' into a national health system, its staff trained in this way are not recognized as family-health trained physicians.

### **c. Responsiveness to Palestine Refugees' Needs**

323. Wider perception of the FHT model also threatens its sustainability. Both frontline health staff and Palestine refugee participants recognized that the FHT Approach has inherited negative characteristics of public health systems such as bureaucracy, poor management and communication and over-burdened services. Indeed, in Lebanon participants did not believe that UNRWA staff had a strong understanding of the FHT Approach itself.

324. Service users are very aware of UNRWA's financial challenges and were concerned about UNRWA's ability to meet the needs of a growing refugee population, particularly in camps. There is a clear perception amongst Palestine refugees across all five fields that UNRWA services are not the best on offer.

325. For example, there is a negative perception of UNRWA-provided medicines because they are provided free of charge. Rather than free medication being regarded a benefit, participants assumed that medicines were poor quality and generic. Participants stated that specialized medication had to be bought from the pharmacy or other healthcare providers, and that UNRWA does not provide and is continuously cutting the services they require.

326. Across all fields, participants requested more specialized services and treatments, such as laboratory tests, x-rays, acute and emergency health services, improved dental, gynaecology and mental health services, as opposed to the broader family health approach that UNRWA provides. These perceptions are likely linked to the fact that the evaluation identified limited evidence of Palestine refugee participation or consultation in the design of the FHT, limited community sensitization to the FHT Reform, limited analysis of the needs of specific stakeholder groups and a lack of systematic or frequent opportunities for refugees to provide feedback on the reform.

327. Palestine refugee participants across the fields shared the sentiment that they use UNRWA services, not because they are viewed as the best option, but because they are the only viable option for those who cannot afford to access services elsewhere. Frontline health staff have a clearer understanding of Palestine refugees' negative perception of services than senior staff.

328. However, given organizational dynamics, lack of engagement of beneficiary voice, and centralized decision-making within UNWRA, these perceptions are not communicated to senior staff. Consequently, there has been little consideration and discussion of how to address these negative perceptions on the ground. This undermines the stability and reputation of the reform.

**d. COVID-19**

329. As described previously, the COVID-19 pandemic has led to the suspension or alteration of the FHT Approach across all UNRWA fields. In some fields such as Lebanon, Jordan and Gaza, the model has been entirely suspended and patients redistributed according to curative and preventative clinics to protect those at greatest risk of infection. In the West Bank teams have worked on rotation to ensure that health services can be provided if frontline health staff come into contact with COVID-19.

330. For all fields it is unclear when the FHT Approach will be able to resume as normal. This poses a significant challenge to the sustainability of the FHT Approach. There is a risk that knowledge of the reform and ways of working will be lost as new staff recruited during the pandemic will not have been trained on the FHT and will lack experience in implementing it. Service users will also have lost familiarity with the FHT and may become more used to specialized curative and preventative services. This is a real risk, given the demand from service users that UNRWA provide specialized staff and services as opposed to a FHT Approach.

### 3. Conclusions

331. In terms of the design of the FHT, the evaluation finds that this has been a relevant and appropriate model to respond to the emerging needs of Palestine refugees, in terms of responding to the increased NCD burden of the Palestine refugee population, to establish continuity of care and to enable increased prevention, early intervention and management of diseases. Although not included in the original design of the FHT Approach, the integration of MHPSS, GBV, and Disability services over time has been appropriate and relevant, although gaps remain regarding the integration of GBV services.

332. The FHT Approach is aligned well with host authority and partner government health systems and policies. The use of e-Health is perceived as more advanced than the health systems of host authorities and partner governments, who themselves are moving toward an FHT Approach. Externally, the FHT has had good coordination and collaboration and is regarded as a valuable partner. Communications with local communities have been less effective and there is scope to strengthen local engagement and communication and raise refugees' awareness of the FHT Approach and the different services provided.

333. On the whole, the FHT Approach has been consistent with UNWRA internal policy commitments on cross-cutting issues of gender, protection, and disability, although these are not always operationalized in practice. There is strong evidence that whilst the FHT Approach responds to the needs of Palestine refugees as a whole, a more disaggregated and tailored approach is needed which considers the needs of specific groups.

334. The FHT Approach's original design did not focus on gender equality and women's empowerment, protection results, or results for persons with disabilities. While there have been efforts to mainstream policies related to these issues, the design and implementation of the FHT Approach has not been underpinned by gender and vulnerability analysis, reinforcing traditional gender dynamics.

335. The FHT Approach has created a more efficient health service. The appointment system and use of e-Health has streamlined workloads through planned allocation. FHT has also enabled the redistribution of tasks from medical officers to nurses and midwives and has reduced the burden on medical officers. Integration with MPHSS, Disability services and, to a lesser extent, GBV services under one HC management is an efficiency gain. There have also been improvements in service user contact time with medical staff, indicating higher quality of care.

336. A significant weakness of the FHT Approach from the outset has been its planning, monitoring and evaluation. M&E was insufficiently considered in its planned design, with no underlying Theory of Change articulating the intended outcomes of the FHT Reform. As a result, it is difficult to assess if the FHT Approach has achieved what was intended. Using health outcomes as the key indicator of the success of the FHT Approach is problematic since their achievement or non-achievement cannot be solely attributed to UNRWA.

337. There remains a need for systematic evaluation and use of the qualitative learning about the reform process and its implementation to inform continuing improvement. While e-Health has significantly improved the gathering and reporting of data, challenges remain around data accuracy, e-Health infrastructure, and the use of data in decision-making.

338. The Palestine refugee's voice has been insufficiently and inconsistently included in the FHT Approach M&E. Patient and/or staff satisfaction surveys and annual assessments evaluating improved quality of care throughout the five fields of operation have not been conducted systematically or aggregated to gain an agency wide perspective on progress. The data gathered is not sufficiently disaggregated to show the impact of the FHT Reform on particular groups (e.g., youth, men, women, disability).

339. Assessing the extent of the FHT Approach's contribution to improved health outcomes for refugees is complex, given many other factors affecting health outcomes and weaknesses in the process and outcome indicators monitored. A key driver for the FHT Reform was to address NCDs more effectively.

340. There is some evidence that the FHT Approach has supported the better management of NCDs, using diabetes as a tracer indicator. There has been an increase in the proportion of diabetes patients controlling their illness with FHT support between 2012 and 2020 agency wide. NCD patients are attending Health Centres more regularly. Maternal health outcomes have improved across the agency since 2011, but it is not clear whether the improvement can be wholly attributed to the FHT Reform, as women's take up of antenatal care has recently decreased.

341. Gains of the reform have included progress against key system operating indicators (e.g., increased patient consultation times and a reduction in the number of consultations per MO per day). Integration of the MPHSS and GBV support has also been cost effective since these are provided alongside other health services.

342. UNRWA's approach to gender mainstreaming in the FHT has focused largely on improving women's health including maternal and child health. However, the FHT Approach has had little impact on women's empowerment and decision-making. The FHT Reform has reinforced cultural norms and by its very nature has not challenged traditional family structures. There also remain gaps in how men access and are included in services and the provision of male-specific services. Whilst UNRWA has prioritized gender parity in the workforce across the organization, this is still a work in progress across all fields.

343. Protection is the area where the FHT Approach has made the least impact, particularly with regard to GBV. There is a disconnect between the GBV services provided at Health Centres and Palestine refugees' understanding of these services. GBV services are not always well understood or delivered by frontline health staff, and services are reactive. There were some refugee concerns about confidentiality in reporting GBV.

344. Despite the mixed improvements in health outcomes, Palestine refugees generally indicated that the quality of care has improved and conveyed a general satisfaction with UNRWA's health services. The FHT Approach has enabled an increased continuity of care, enhanced the organization of services, and contributed to a perceived improved quality of care by refugees and frontline health staff.

345. The integration of MHPSS has been welcomed and has improved Palestine refugee's access to mental health care and contributed to overall wellbeing. However, shortages in frontline health staff and medical commodities have undermined perceived improvement of care and patient satisfaction in all five fields. There is a perception amongst Palestine refugees across all five fields that UNRWA services are not the best on offer and because medications are free of charge, they are perceived as poor quality and generic.

346. It is also evident that the FHT Approach's adaptability and resilience varies between fields. In Gaza, the FHT has proved effective in absorbing shocks and stresses whereas in Syria, where the FHT Approach is less established, it has not shown the same resilience. In these contexts, the FHT does not bridge the humanitarian-development nexus.

347. It has been challenging for the health programme to respond to the COVID-19 pandemic using the FHT model as envisaged. HCs reverted to separate curative and preventative services to ensure protection from infection, with the Agency needing to use a 'trial and error' approach to explore how to effectively deliver services in this challenging context.

348. It is unclear for all fields when 'normal' delivery of services post-pandemic will resume, but there is a need for ongoing planning across the agency regarding what the FHT Approach will look like post-pandemic. There is a risk that it will not 'bounce' back given the ongoing resource issues and that knowledge of the reform and ways of working will be lost as new staff recruited during the pandemic will not have been trained on the FHT and will lack experience in implementing it. Service users may also have lost familiarity with the FHT integrated model.

349. The reorganization of frontline health staff into FHTs is regarded favourably by most frontline health staff. However, UNRWA's inability to recruit adequate numbers of staff in terms of delivering the training necessary to support such a large-scale reform across the agency has negatively impacted the FHT Approach's effectiveness and derived benefits. UNRWA has a high staff turnover rate and cannot afford to easily replace and train staff. Staff shortages mean that staff often shoulder increased burdens with a risk of burnout.

350. The focus of training on the FHT Approach model on MO rather than more broadly across the FHT has meant that there is inconsistent knowledge across the FHT. There is a real risk that institutionalized knowledge and implementation of the model will decline due to turnover and short-term contracts. Investment in supportive infrastructure (e.g., e-Health, training for non-MO staff) has been insufficient.

351. Throughout the current medium-term strategy period, UNRWA has experienced acute financial crisis across the Agency which has affected all its programme areas. Coupled with growing demands through an increasing and ageing PR community and higher expectations and needs for health care, this has placed a real strain on UNRWA's provision of primary health care, which undermines the reform's sustainability.

352. The evaluation observes that in all fields the FHT has, at some point, been suspended or 'broken' to continue delivering services, limiting the reform's ability to meet its intended outcomes. Negative refugee perceptions of the FHT model may also affect its sustainability.

353. The FHT Approach provides a highly relevant and effective model for providing health services in a holistic and efficient manner. Ensuring adequate resourcing, staffing, and prioritizing effective communication on what it offers to Palestine refugees will all be key to its future success.

## 4. Recommendations

354. The recommendations below are presented in order of priority, as are the accompanying 'sub-recommendations'. Each recommendation is targeted to an institutional owner within UNRWA who will be responsible for its implementation.

|   |  |
|---|--|
| 1 | <p><b>The UNRWA Health Department should develop a needs-based budget request for the Programme Budget to fully support the effective implementation of the FHT Approach and the core health programme in all fields, including:</b></p> <ul style="list-style-type: none"> <li>▪ Requesting that the FHT as UNRWA's core health programme is supported by the Programme Budget in all fields, rather than the ongoing reliance on Emergency Appeal Funding.</li> <li>▪ Requesting that adequate resources are available to fully deliver a prevention-focused approach to NCD management, rather than primarily a curative one.</li> <li>▪ Ensuring that up-to-date workforce analyses are completed to allow UNRWA to fundraise and recruit for the number of positions needed to deliver the FHT in relation to need/demand.</li> <li>▪ Raise/allocate funds to ensure that training on the FHT Approach goes beyond MOs, to include nurses and the broader FHT.</li> <li>▪ Plan and allocate funding for training that institutionalises knowledge of the FHT Approach, ensuring all frontline health staff have access to initial and refresher training of the FHT concept.</li> </ul> <p><i>(Responsible: Health Department and HQ and Field Office Level, Planning and Front Office)</i></p> |
| 2 | <p><b>Invest in attracting and retaining high-quality staff, and maximizing the potential of existing staff:</b></p> <ul style="list-style-type: none"> <li>▪ Identify and promote a course equivalent to the FMDDP which can be offered to other FHT members including nurses and midwives to embed FHT understanding and support career advancement.</li> <li>▪ Recognizing that supply of adequately trained staff is an issue, ensure that the Health Programme continues to expand recruitment of female doctors and women in management positions, including the development of leadership training opportunities for women.</li> <li>▪ Establish support and supervision units comprised of mental health specialists (psychiatrists and psychotherapists) to provide ongoing MHPSS technical training, supervision, and support to FHTs.</li> <li>▪ Develop clear and defined support structures to help women progress up the hierarchy in UNRWA's Health Programme, both at the level of HC management and programme management.</li> <li>▪ Ensure that qualifications offered are recognised by providers beyond UNRWA.<sup>103</sup></li> </ul> <p><i>(Responsible: Health Department, Human Resources)</i></p>  |
| 3 | <p><b>Ensure that strong planning processes support the sustainability of the FHT Approach and the gains it has achieved including:</b></p> <ul style="list-style-type: none"> <li>▪ Recognising UNRWA's financial challenges and investing in developing strong partnerships within the health sector. Strengthen coordination efforts and seek joint collaborations/initiatives with CSOs, other UN agencies and other partners, and utilize the experience and capacity of these organisations to fill existent and/or emerging gaps.</li> </ul>  |

<sup>103</sup> We note that this may not be possible in all the contexts UNRWA operates in, i.e. in Lebanon, Palestinian Doctors are not recognized by the Host government due to restrictions on some professions by the Lebanese Government.

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|   | <ul style="list-style-type: none"> <li>Ensuring all fields have clear plans to reimplement the reform after COVID-19, including solid training for frontline health staff who have joined the workforce in the interim and will not have worked in the FHT model, and refresher training for other FHT staff.</li> <li>Continue to support the FHT through the use of telemedicine but ensure continued investment in usual services, facilities, and staff, recognizing that telemedicine does not displace usual service provision.</li> </ul> <p><i>(Responsible: Health Department and HQ and Field Office Level, Planning and Front Office)</i></p>  |
| 4 | <p><b>Ensure the FHT Approach is underpinned by robust gender and vulnerability analysis, which considers the needs of specific groups and enables UNRWA to deliver gender and vulnerability/disability-sensitive health services. This should include:</b></p> <ul style="list-style-type: none"> <li>Moving beyond a 'women's health' approach e.g., maternal care, breast screening and examining the barriers to women accessing their services, societal norms impacting how women access services and what UNRWA can do to address these.</li> <li>Analysis of how men access services including Health Centre opening times, availability of male doctors, supporting men to access preventative care (i.e. for NCDs) rather than largely curative.</li> <li>Ensuring the provision of family planning and other health care services for women outside of the traditional 'family' construct.</li> </ul> <p><i>(Responsible: Health Department and Gender Unit)</i></p>   |
| 5 | <p><b>Revise the M&amp;E of the FHT in line with the development of the new MTS, to ensure:</b></p> <ul style="list-style-type: none"> <li>M&amp;E of the FHT includes the perspectives and perceptions of Palestine refugees, promoting community participation in shaping health services and enhancing responsiveness to Palestine refugees' needs.</li> <li>There are clear M&amp;E processes for assessing the effectiveness and impact of the reform as a change process rather than conflating process change with progress against broader health outcomes.</li> <li>That evidence and lessons are documented, disseminated, and used actively to make improvements to the FHT Approach.</li> <li>That standardised approaches are in place across all fields to gather data on the services integrated with the FHT Approach, including GBV and MHPSS.</li> <li>That data against all indicators can be disaggregated according to gender and other protection/vulnerability factors.</li> <li>That e-Health is upgraded to capture data collection and segregation of different vulnerable groups as well as the ability to provide area/field level aggregation.</li> <li>Recognising that strong M&amp;E is contingent on high-quality data, maintain frontline health staff training on using e-Health and strengthen levels of communication and engagement on e-Health upgrades.</li> <li>Consistency and quality of MHPSS data collected across fields of operation (i.e., who is providing MHPSS support/treatment, disaggregated data concerning age, gender, and possible diagnosis).</li> </ul> <p><i>(Responsible: Health Department and HQ and Field Office Level, Planning and Front Office)</i></p> |
| 6 | <p><b>Raise awareness and improve accessibility of GBV services available at Health Centres. Mainstream UNRWA health staff's understanding of GBV support through ensuring that staff are adequately trained to identify GBV survivors and that there are clear and consistent referral mechanisms:</b></p> <ul style="list-style-type: none"> <li>Across all fields, ensure that UNRWA has a uniform approach to identifying, assisting, and referring GBV survivors, either internally to the Protection department or externally to other service providers. Train staff so that knowledge of referral processes is understood and institutionalised.</li> </ul>   |

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|          | <ul style="list-style-type: none"> <li>▪ Provide all Health Centre staff with training on identifying GBV survivors to make services proactive rather than reactive. Ensure that at Health Centre level the responsibility for identifying and assisting GBV survivors does not rest with sole individuals such as midwives.</li> <li>▪ Conduct a review to examine the cultural barriers GBV survivors may face in accessing UNRWA GBV services at HC.</li> <li>▪ Ensure confidential spaces for accessing GBV support either through the Health Centre MHPSS counsellor or in referrals to GBV focal points.</li> <li>▪ Run clear communication campaigns targeting Health Centre users and the wider community to raise awareness of the GBV services at HC, with a focus on confidentiality and understanding of how referral and assistance processes work.</li> </ul> <p><i>(Responsible: Health Department and Gender Unit)</i></p>  |
| <b>7</b> | <p><b>Invest in integrated services that help the FHT to better address beneficiaries cross-cutting needs such as MHPSS and Disability, including:</b></p> <ul style="list-style-type: none"> <li>▪ Provide staff with additional training to assist PLWD that goes beyond screening and focuses on treatment and support.</li> <li>▪ Map and identify external MHPSS actors that could effectively support HCs in providing the needed support and treatment for identified MHPSS beneficiaries.</li> <li>▪ Clarify referral mechanisms between UNRWA departments and external actors. Train all FHT staff on these referral pathways to ensure responsibility does not rely solely on individual focal points.</li> <li>▪ Increase MHPSS community awareness activities, psychoeducation sessions and engage with communities to understand and target barriers to accessing MHPSS services.</li> <li>▪ Continue to invest in Health Centre infrastructure to promote accessibility and confidentiality for MHPSS service users.</li> <li>▪ Undertake an accessibility audit of all UNRWA HCs to assess how they can be made more accessible for persons with disabilities, pregnant women, and the elderly.</li> </ul> <p><i>(Responsible: Health Department and Protection)</i></p> |
| <b>8</b> | <p><b>Improve community engagement with Palestine refugees and communication of the FHT Approach</b></p> <ul style="list-style-type: none"> <li>▪ Improve opportunities for feedback and refugee voices to be included in M&amp;E of health programmes.</li> <li>▪ Increase efforts to raise awareness of GBV services to Palestine refugees.</li> <li>▪ Strengthen engagement with HCFCs through regular meetings and strong two-way communication channels.</li> <li>▪ Developing materials and processes to raise awareness of what FHT offers to Palestine Refugees and how to access FHT services to increase understanding and reduce negative perceptions (e.g., effort needs to be invested in community health awareness regarding the harmful effects of antibiotic overconsumption and other prescribed medication, selection criteria for the funding of medical procedures).</li> </ul> <p><i>(Responsible: Health Department and Camp Improvement)</i></p>  |



## Annexes

### Annex A: Management Response

**General Response:** The Health Department highly appreciates the detailed evaluation report and the set of recommendations provided. The HD finds the recommendations very valuable in setting its direction for a new Universal Primary Health Care (FHT V2) strategy and will consider all the recommendations during the development of this strategic plan. The HD also realizes that some of the identified key gaps are directly linked with funding availability and the overall Agency's financial situation will remain an important factor in the implementation of planned actions.

### Response to specific recommendations

| recommendation  | management response (agree, partially agree, disagree): | action planned / taken / reason for partially agreeing or disagreeing   | planned date for implementation |
|---|---|---|---------------------------------|
| <p>Recommendation 1:</p> <p>The UNRWA Health Department should develop a needs-based request for the Programme Budget to fully support the effective implementation of the FHT Approach and the core health programme in all fields. This should include a thorough workforce analysis for each field, elaboration of resources to address training needs, and resources to apply a prevention-focused approach to NCD management. The needs-based budget should also be used for advocacy purposes and to work towards a fully funded family health team approach.</p> | Agree   | <p>HD together with other relevant department to develop needs-based funding request document. This document will be used for annual budget preparation plan and advocate for the required resources to fully fund the FHT by the Programme Budget. HD to complete workforce analysis (HRH norms and standards) for all cadre of health staff working in 140 health centres. HD together with HR department to complete training needs analysis for the universal PHC/FHT V2.</p> | October 2022                    |

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| <p>Recommendation 2:<br/>Invest in attracting and retaining high-quality staff and maximizing the potential of existing staff through the provision of training and support.</p>   | Agree | <p>HD to produce the HR recruitment and retention plan in 2022 and start implementing from 2023. The plan will include training needs assessment and training plan, plan to increase the female staff capacity.</p> <p>HD to continue FMD (family medicine diploma) course for medical officers and start from 2022 an FMD equivalent course for nursing cadre.</p>  | <p>October 2022 for draft plan.</p> <p>2023 onwards – implementation</p> <p>June 2022 for FMD equivalent course for nursing Cadre</p> |
| <p>Recommendation 3:<br/>Ensure the FHT Approach is underpinned by robust gender and vulnerability analysis, which considers the needs of specific groups, and enables UNRWA to deliver gender and vulnerability/disability-sensitive health services.</p>   | Agree | <p>HD to work with RSS and other department to prepare and conduct gender and vulnerability analysis in 2022, which will be translated in the updated technical guidelines on GBV, disability and others in 2022/3.</p>  | <p>October 2022 for vulnerability analysis</p> <p>June 2023 for updated TIs</p>   |
| <p>Recommendation 4:<br/>Ensure strong planning processes support the sustainability of the FHT Approach and the gains it has achieved including planning for post-Covid-19 and developing strong partnerships.</p>  | Agree | <p>HD to develop a new PHC (Universal PHC OR FHT v.2) strategic plan in 2021/2022, followed by key strategic documents development (including HR plan, ME plan etc.) in 2022.</p> <p>All processes are inclusive and joint work with field offices, other UNRWA departments, refugee communities, and host and donor countries.</p>  | <p>June 2022 FHT V.2 strategic plan</p>   |
| <p>Recommendation 5:<br/>Revise the M&amp;E of the FHT in line with the development of the new MTS: to ensure the impact of the FHT Reform can be measured, that there is better integration of the perspectives and perceptions of Palestine refugees in M&amp;E, that there is better documentation and dissemination of lessons learned regarding the FHT Approach, that there is quality and consistency of data gathered, that data against all indicators can be disaggregated according to gender</p> | Agree | <p>HD to develop a new PHC (Universal PHC or FHT v.2) strategic plan in 2021/2022 which defines and follows the theory of change. Based on the new plan, M &amp; E plan will be developed in 2022 which will be incorporated in the new MTS plan (2023 to 2028).</p> <p>HD to organise a yearly knowledge exchange event for sharing lessons learned across the fields and adapting best practices across all fields</p> <p>HD to introduce Power BI dashboard for improving data analysis</p> | <p>June 2022 FHT V.2 strategic plan</p> <p>June 2022</p> <p>June 2022</p>   |

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| and other protection/ vulnerability factors, and that necessary upgrades to e-Health are put in place.  |       | capacities at various levels of health service providers and training of staff on Power BI.  |   |
| Recommendation 6:<br>Raise awareness and improve accessibility of GBV services available at Health Centres. Mainstream UNRWA health staff's understanding of GBV support through ensuring staff are adequately trained to identify GBV survivors and that there are clear and consistent referral mechanisms for GBV cases. | Agree | HD to develop a new PHC (universal PHC or FHT v.2) strategic plan in 2021/2022 which gives special attention to GBV and other vulnerability services.<br><br>This will be followed by updating of the GBV technical guidelines in 2022, which will be in full implementation from 2022/2023 with new EMR.  | October 2022<br><br>October 2023                        |
| Recommendation 7:<br>Invest in integrated services that help the FHT to better address beneficiaries' cross-cutting needs such as MHPSS and disability, including partnerships and referral mechanisms, community awareness, staff training, infrastructure and needs analysis.   | Agree | HD to develop a new PHC (universal PHC or FHT v.2) strategic plan in 2021/2022 in close collaboration with other UNRWA departments (RSS, Protection, etc.) to address MHPSS and disability needs. This will be followed by the development of technical guidelines relevant in 2022, so that the services are implemented in 2022/2023.<br><br>Expand partnership (external) for MHPSS and disability related services, identify the referral pathways (internal and external) in all fields and train the staff (refreshers). | June 2022<br>June 2023<br>implementation<br><br>Ongoing |
| Recommendation 8:<br>Improve community engagement with Palestine refugees and communication of the FHT Approach   | Agree | HD to develop a new PHC (universal PHC, or FHT v.2) strategic plan in 2021/2022 through inclusive engagement of refugee communities leading to development of a communication plan for refugee communities in 2022. HD to conduct community satisfaction surveys regularly in every 2 years.   | June 2022   |

## Annex B: Terms of Reference

### 1. Introduction

- 1.1 In 2011, The United Nations Relief and Works Agency for Palestine Refugees (UNRWA, the Agency) health programme began the design and implementation of a major reform process based on a Family Health Team (FHT) approach and the development of electronic medical records (e-Health). The Health Reform Strategy<sup>104</sup> aimed to modernize the Agency's primary health services, making them more person-centred and more efficient. Based on World Health Organization (WHO) principles, the FHT approach is a patient/family centred, continuous and holistic primary health-care delivery model. The FHT focuses not only on quality curative care but also on household-based health education and promotion interventions, covering the full health continuum, from protection and prevention to treatment and disease management to psychosocial well-being. The introduction of e-Health aimed to improve the efficiency of care, reduce medical errors, and facilitate timely and reliable needs-based decision-making.
- 1.2 Considering the scope and criticality of the health reform agenda, and the importance of health in the overall strategic framework of UNRWA, the Medium-Term Strategy 2016–2021 highlighted the need for an evaluation of the health reform. As such, the Evaluation Division of the Department of Internal Oversight Services (DIOS) is seeking to retain an evaluation team with expertise in public health, and outcome and impact analysis to assess the UNRWA health reform and the FHT approach as part of the DIOS evaluation work plan for 2020–2021.
- 1.3 The results of the evaluation will come at a valuable time when the Agency will be looking forward and preparing its next Medium-Term Strategy due in 2022. The evaluation should provide UNRWA with information on what outcomes the reform has contributed to, as well as insight into how and why the reform programme contributed to those outcomes. Conversely, it should provide insight into the challenges encountered and the circumstances that hindered achievement.
- 1.4 These terms of reference outline the evaluation context, scope, key questions, and the parameters of the assignment.

### 2. Background, context, and programme/reform objectives

- 2.1 UNRWA is a United Nations agency established by the General Assembly in 1949 and mandated to provide assistance and protection to a population of some 5.6 million registered Palestine refugees. Its mission is to help Palestine refugees in Jordan, Lebanon, Syria, West Bank, and the Gaza Strip to achieve their full human development potential, pending a just solution to their plight. UNRWA services encompass education, health care, relief and social services, camp infrastructure and improvement, microfinance, and emergency assistance.
- 2.2 In line with the UN human development approach, UNRWA recognises that health influences achievements in human development – educational outcomes, cognitive development, employment opportunities and income-earning potential – and is a fundamental human right that encompasses physical, mental and social well-being. As such, the protection of refugee health and the provision of universally accessible quality primary health care services is a core programme of UNRWA, and it plays a strategic part in fulfilling UNRWA's mission (Strategic Outcome 2: Refugees' Health is Protected and the Disease Burden is Reduced).

<sup>104</sup> <http://www.unrwa.org/userfiles/file/publications/Health%20Reform%20Strategy.pdf>

## UNRWA health services

- 2.3 Operationally, UNRWA runs 141 primary health care facilities (PHCFs or HCs) across its five fields of operation and employs 2986 health care staff (1811 female and 1175 male). In 2019, the programme supported 8.7 million patient visits.<sup>105</sup> The organizational structure includes several levels: i) a headquarters structure which handles policy and strategy development, progress monitoring and evaluation, ii) a field management structure that supports and supervises operational and workforce management, as well as results monitoring and reporting, iii) the installation level, which includes the 141 HCs (69 HCs operating inside official UNRWA camps, 72 outside official camps) and staff delivering services.
- 2.4 UNRWA health services include preventive and curative health services, from preconception care through pregnancy, childhood, adolescence and adulthood and active ageing. These services include family planning, pre-conception care, antenatal care and postnatal follow-up, infant care (growth monitoring, medical check-ups and immunizations), school health, oral health, outpatient consultations, diagnostic or laboratory services, the management of chronic non-communicable diseases, management of communicable diseases, Mental Health and psychosocial support (MHPSS) and health promotion. Through mobile health clinics, UNRWA works to improve access for Palestine refugees to health services where access is restricted by a lack of rights or restrictions on movement.
- 2.5 Additionally, through a hospitalization sub-programme, UNRWA provides focused support to refugees who have life-threatening illnesses requiring lifesaving/life-supporting medical care, and lack the necessary financial assets or insurance coverage to attain such treatment. The majority of hospitalization services are provided by public or private hospitals through different means of contracts. Furthermore, UNRWA runs one hospital in the West Bank – Qalqilya Hospital.

## Context and components of the health reform

- 2.6 In 2009 and 2010, comprehensive reviews of the UNRWA health programme identified a number of challenges and opportunities for the programme. The reviews highlighted a need to expand NCD and preventative care services, and address issues of over-crowded and over-used HCs. As well, the studies emphasized a need to foster partnerships with key health actors and reflected on negative effects of vertical reporting lines within the programme, recommending changes to increase responsibility at the installation level.
- 2.7 Further, reviews stressed the need for a database and the systematic use of data to inform knowledge on refugee health, health seeking behaviours, and programme/HC expenditures and workforce activities. A strengthened use of data related to the hospitalization sub-programme was also suggested, to further knowledge on the types and quality of services delivered to refugees and to enable negotiation of service costs.

## Key reform components:

- 2.8 The health reform strategy was designed to address these challenges, and a core component of the reform was the FHT approach. The FHT represented a shift in focus, and a reorganization of the programme's workforce into teams with an aim to improve the quality of health care for Palestine refugees. Previously, care was provided to treat specific ailments without taking into consideration the comprehensive health status or the family history of an individual. With the FHT, care has been delivered by multidisciplinary medical teams, who provide comprehensive,

<sup>105</sup> Annual Results Review 2019, and Health Department Annual Report 2019  
<https://www.unrwa.org/2019UNRWAHealthAnnualReport>

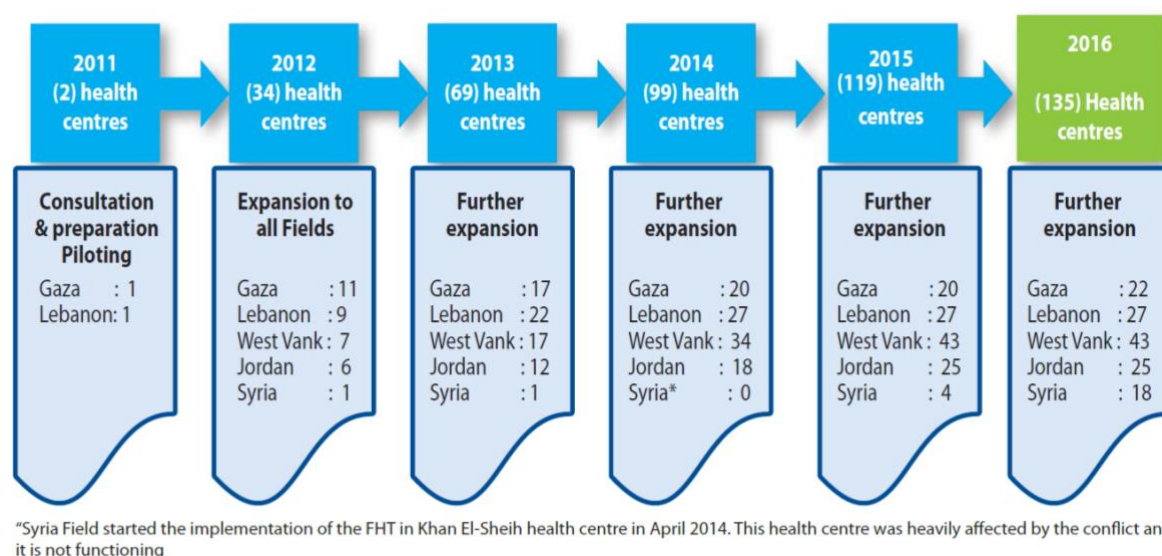
continuous care to the patients and families registered with them. Each FHT is made up of at least one doctor, a nurse, and a clerk.

#### Other key reform components and activities included:

- introduction of an electronic management system for patient files – e-Health.
- introducing an appointment system.
- developing FHTs, creating family folders and registering families with FHTs.
- physical modifications to HCs to facilitate patients' access, upgrading and standardizing HC infrastructure, equipment, medicines, and supplies.
- improving referral and feedback systems for higher-level, specialist health services; and,
- strengthening of Field Office support capacity.

2.9 The reforms were implemented incrementally, with essential services continued, and the use of a pilot approach to support learning and the use of experience gained. The implementation schedule for e-Health and the FHT varied, with e-Health introductions starting in 2009, and the FHT approach piloted beginning in late 2011. Figure 1 below reflects on FHT implementation. By the end of 2013, 69 HCs had implemented the FHT approach although just 44 HCs<sup>106</sup> had both eHealth and the FHT approach in place.

Figure 1. Illustration from 2016 UNRWA Health Department Annual Report on FHT implementation progress.



2.10 Later, additional reform components were introduced. In 2015, the Agency launched an in-service training - the Family Medicine Diploma Programme (FMDP). The main goal of the FMDP has been to build on the knowledge, skills, and experience of doctors to improve their clinical management of patients and the standards of clinical care.

2.11 UNRWA has also started to integrate mental health and psychosocial support services (MHPSS) into the health programme based on the WHO mental health Global Action Programme (mhGAP). Medical Officers, staff nurses and midwives have been trained and a total of 129 HCs have integrated MHPSS into the FHT<sup>107</sup> approach as of year-end 2019.

<sup>106</sup> [http://www.unrwa.org/sites/default/files/2013\\_health\\_reform\\_report.pdf](http://www.unrwa.org/sites/default/files/2013_health_reform_report.pdf)

<sup>107</sup> Annual Results Review 2019.

### Anticipated outcomes:

- 2.12 The reforms were expected to lead to a range of intermediate outcomes:
- improved patient access and flow in the clinic, and equalized workload among staff (average daily medical consultations per doctor).
  - comprehensive information on patient health, deeper knowledge of patients to support follow-up, curative and preventive care.
  - improved medical consultation quality (increased contact time per patient, improved doctor-patient trust and communication, and technical quality of consultations).
  - rationalization of prescription rates and hospitalization referrals.
  - greater data use to inform on patterns of disease and cohort monitoring; and
  - simplified reporting and referral processes.
- 2.13 In the longer-term, the FHT approach was expected to improve patient satisfaction, staff satisfaction and quality of care. The modernization of the health programme, and the use of teams, was expected to contribute to staff satisfaction, growth in skills and competencies, motivation, and accountability. Improved quality of care was expected to contribute to the prevention and management of non-communicable diseases (NCDs), as well as improvements on cross-cutting issues impacting health such as diet, physical activity, gender-based violence and child protection.
- 2.14 2013 and 2014 Reform Strategy Progress Reports<sup>108</sup> reflected on a results framework for the reform, including one outcome indicator (improved effectiveness - % of patients with controlled diabetes out of all diagnosed patients with diabetes), and 10 output indicators (improved efficiency – e.g. # of consultations per doctor, per day; cost per capita; antibiotic prescription rate).

## 3. Evaluation purpose, objectives, scope, and key questions

### Purpose and objectives:

- 3.1 In accordance with the United Nations Evaluation Group (UNEG) norms and standards, the evaluation will serve a dual purpose of accountability and learning. The evaluation needs to assess and report on the quality and results of the reform relative to its outcome objectives. The evaluation should also determine the reasons why certain changes occurred or did not to draw lessons and to assist in decision-making and preparations by the health programme for the 2023-2028 Medium Term Strategy. Evaluation results will be actively disseminated by DIOS and the evaluation team will be asked to present the evaluation results in a briefing to internal stakeholders.
- 3.2 Guided by the standard criteria for evaluation for development assistance<sup>109</sup> including relevance and coherence, efficiency, effectiveness and impact, and sustainability, the evaluation should examine the design, implementation, objectives, and results of the reform and FHT activities.

### Scope:

- 3.3 The primary scope of the evaluation is the FHT approach, including the activities and processes dependent on its development, implementation, resourcing, monitoring, and reporting until now. The evaluation should closely consider the 2011 Health Reform Strategy of which the FHT was the core component of the reform. The evaluation scope should include all five fields of operation,

<sup>108</sup> <https://www.unrwa.org/resources/reports/health-reform-strategy-%E2%80%93-2014-progress-report>

<sup>109</sup> <https://www.oecd.org/dac/evaluation/daccriteriaforevaluatingdevelopmentassistance.htm>



although the timelines for the implementation of the FHT and e-Health system differed across fields.

#### Key evaluation questions:

- 3.4 The contractor is expected to update the evaluation questions and formulate sub-questions at inception. Sub-questions should be adapted as needed for each field of operation, while ensuring that evidence useful for synthesis at the Agency level is generated. The consultant is expected to use an evaluation matrix to express the methodology planned to address evaluation questions and sub-questions.
- 3.5 The line of inquiry should be guided by the standard OECD-DAC criteria for evaluation in the UN system. The evaluation is expected to fully integrate dimensions of gender, human rights, and disability inclusion into its analysis,<sup>110</sup> giving attention to humanitarian principles, protection, and accountability to affected populations. A consistent gender and human rights analysis should be applied across each criteria to assess in detail the extent to which the different needs and vulnerabilities of women, men, boys and girls, the disabled and elderly have been considered in the design, implementation and monitoring of the FHT approach. A gender and vulnerability analysis should also be applied to the contribution's analysis.
- 3.6 In order to evaluate the reform strategy and FHT approach based on the aforementioned criteria, the following key questions should be explored:

#### ✓ **Relevance and coherence:**

[The extent to which the reform and FHT approach aligns to the needs of Palestine refugees, and complementary to the strategic framework of UNRWA, the health systems of host countries, and other relevant actors]

- To what extent was the health reform strategy and FHT approach coherent to relevant Agency policies and commitments as well as those of UNRWA health partners and host governments?
- To what extent has the health reform strategy and FHT approach reflected good practice and aligned to the needs of Palestine refugees in the five fields of operation and the evolving contexts within them?

#### ✓ **Efficiency:**

[How economically were resources/inputs (funds, expertise, time, etc.) converted into outputs]

- To what extent have the resources available to implement the reforms been adequate, including the enabling organizational frameworks (governance, policies, monitoring and feedback mechanisms)?
- Could the same outputs be attained at lower costs, or higher outcomes be achieved with the same resources?

#### ✓ **Effectiveness and impact (contribution):**

[The extent to which the FHT approach has met its objectives, and what positive or negative outcomes, intended or unintended has the programme contributed to]

<sup>110</sup> UNEG guidance: 'Integrating Human Rights and Gender Equality in Evaluations'.  
<http://www.uneval.org/document/download/1294>



- To what extent have changes introduced through the reform met their specific objectives?
- Did the additions of the Family Medicine Diploma Programme (FMDP), and the Mental Health and Psychosocial Support (MHPSS) activities have additional effects on health programme outcomes (e.g. on protection, psycho-social well-being, quality of care)?
- What contributions can be linked to the reforms and the FHT approach (e.g. improved quality of care, improved programme efficiency, improved staff and patient satisfaction, improved Hospitalization Support Programme (HSP), and improved health outcomes for refugees)?

✓ **Sustainability:**

[What are the major factors that influence the sustainability of the reform interventions and outcomes]

- What are the major factors influencing the sustainability of the health reform outputs and outcomes?

#### 4. Evaluation approach and methods

##### Evaluation approach and methodology:

- 4.1 The overall approach to the evaluation should be rigorous, transparent, and consultative. The contractor is encouraged to propose a theory-based, adaptive, and innovative methodology for the evaluation, and will have scope to influence and adapt the design during the inception phase. The UNRWA Evaluation Division and Health Department will work closely with the contractor in this process.
- 4.2 The contractor is expected to produce a coherent set of assessments across all fields of operation as well as a synthesis on results using the field studies as the principal evidence base. Together, the field studies should tell a coherent story, answer the overarching questions, as well as the synthesis.
- 4.3 The evaluation should use mixed methods (quantitative, qualitative, and participatory) to answer the evaluation questions, to ensure triangulation of information through a variety of means. The following methods and data sources are expected to be used to inform the evaluation:
  - **Literature review:** The UNRWA Health Reform Strategy and FHT formation documents, policies and procedures related to the reform activities, programme guidance, budget and human resources information, progress reports, monitoring documents, and any self-evaluative research and assessments should be considered. Moreover, relevant policies and frameworks of host authority health systems, and the World Health Organization (WHO) should be considered, e.g. WHO family health approach and MHPSS guidance.
  - **Stakeholder interviews:** Informed through a stakeholder analysis, one to one and group interviews, both structured and semi-structured, should be used as a main source for collecting data and information. The evaluation team should gather views from as many internal and external stakeholders as possible, including for example: relevant staff across the organizational hierarchy and fields of operation (headquarter, field management teams and HC staff); beneficiaries and members of beneficiary committees; referral partners and host authorities (Ministries of Health); and donors as UNRWA operations are voluntarily funded.

- **Surveys:** Surveys should also be considered to reach as wide an audience as possible, targeted at both staff and beneficiaries. Beneficiary surveys may be used to support the assessment of how UNRWA health services are used and valued, as well as beneficiary use of government health centres. Although beneficiary survey research may best be administered through face-to-face interviews, given the COVID 19 pandemic, research may need to be supported through locally employed enumerators or online/mobile applications.
- **Impact assessments:** Using qualitative and quantitative data, impact assessments should aim to identify general outcomes delivered through the reform (e.g., beneficiary and staff satisfaction with improvements in quality and depth of care) and specific outcomes delivered through the reform (e.g. improvements in rational use of health services and pharmaceuticals, and referral processes). The evaluation team will need to make use of healthcare data within the Agency's eHealth information management system to inform its efficiency, effectiveness, and impact assessments.
- **Secondary data:** The Health Department has conducted assessments of programme performance over the period in scope (e.g. 2013 efficiency study). Additionally, doctoral and master students have reviewed the UNRWA health programme through a number of research projects. The secondary data from these studies may help to validate findings arising from this evaluation.
- **Health cluster and host authority data sets:** Administrative and utilization data on the health care systems in the fields of operation should be considered as part of a comparative analysis.

## 5. Phases, timing, and deliverables

5.1 It is expected that the contractor / evaluation team will complete work in three broad phases:

- **Planning/inception:** Preliminary research should commence by October 2020, with the development of a theory of change, a final term of reference and inception report. Methodologically, the evaluation should draw on a theory of change approach to identify the key elements and assumptions that should be the focus of the assessment. The theory of change should express the overarching logic behind the reform, describing the interventions, the intended results, how the interventions work towards those results, and the main assumptions that underpin the intervention's logic. The inception report should refine the evaluation questions and sub-questions and provide specific information on the evaluation design, methodology, data collection techniques and tools in an evaluation matrix.
- **Data collection and data analysis:** The contractor should complete data collection for all fields of operation by February 2021, completing field-specific analysis and syntheses, and an Agency-level synthesis by the end of the April 2021.
- **Reporting:** A draft report should be produced including field-level components and a synthesis on cross-cutting findings at the Agency-level in May 2021. The draft report will be circulated within UNRWA for comment. A comments matrix for the report that records comments and how each is addressed should be provided. Once the report is finalised, the evaluation team should present, through an informal presentation, the findings, conclusions, and recommendations with internal stakeholders (expected to be presented through an MS Teams or other online forum). Once the management response is prepared, the final report will be submitted to the Agency's Commissioner General and shared externally through the Agency's website (June – July 2021).

- 5.2 As noted earlier, the evaluation team may need to rely on distance methods to complete activities, and the use of local enumerators to support evaluation activities given the COVID-19 pandemic and travel/quarantine restrictions. If travel to the region becomes possible during the data collection phase, or an evaluation team member is based in an UNRWA field of operation, the Agency will facilitate travel and provide for local security arrangements, as provided for UNRWA staff members.

| Activity / deliverable   | Timing                        |
|--|-------------------------------|
| <b>1. Planning/inception phase activities and deliverables</b> <ul style="list-style-type: none"> <li>a) Desk review of existing documents and secondary data.</li> <li>b) Orientation for evaluation team with Health staff at Headquarters and Fields of Operation (virtual meetings); scoping interviews completed with area and installation level staff across at least two fields of operation.</li> <li>c) Inception discussions with Evaluation Reference Group (ERG) members</li> <li>d) Presentation / briefing with ERG on planned evaluation approach</li> <li>e) Draft and final inception report including a Theory of Change for the reform strategy, an evaluation matrix and a bibliography of literature reviewed</li> </ul> | October to mid-November 2020  |
| <b>2. Data collection activities</b> <ul style="list-style-type: none"> <li>a) Field work</li> <li>b) Field work debriefings</li> </ul>  | November 2020 - February 2021 |
| <b>3. Data analysis and synthesis</b> <ul style="list-style-type: none"> <li>a) Analysis of data</li> <li>b) Preparations of field-level reports</li> <li>c) Synthesis of cross-cutting findings</li> <li>d) Online workshop with ERG and key internal stakeholders on findings, conclusions</li> </ul>  | March – April 2021            |
| <b>4. Reporting</b> <ul style="list-style-type: none"> <li>a) Final synthesis, preparation, and submission of draft work</li> <li>b) Circulation of draft report for review, including quality assurance review</li> <li>c) Revise draft report / preparation of final report with comment tracker</li> <li>d) Preparation of final report</li> <li>e) Online informal briefing on evaluation results with internal stakeholders</li> </ul>  | April – June 2021             |
| <b>5. Management Response, publication of final report<br/>Project Closure</b>   | June - July 2021              |

## 6. Arrangements for managing the evaluation

- 6.1 The lead evaluator (team leader) for the contracted evaluation team will report to the Evaluation Manager in UNRWA. The Evaluation Manager will provide all documents, information and logistical support required of the contracted team and will be a first point of review for team outputs.
- 6.2 An Evaluation Reference Group will be established to provide technical input and guidance to the contracted evaluation team.

- 6.3 Based on UNEG norms and standards, the UNRWA Standard and Procedures for Quality Assurance in Evaluation define the quality standards expected from this evaluation and sets out the processes for quality assurance. The Evaluation Division of DIOS will apply these guidelines to quality review the inception report, draft, and final evaluation report.

## 7. Evaluation team composition and required experience:

- 7.1 The evaluation team should not have been involved in the design or implementation of the health reform strategy or its components or have any other conflicts of interest. Further, they will act impartially and conform to UNEG ethical standards and norms in all parts of the evaluation process.
- 7.2 The evaluation team should provide a balance of expertise and practical knowledge in the following areas:
- ✓ Skills and experience in mixed methods evaluation and impact assessments, including qualitative evaluation consulting local communities, preferably in humanitarian contexts.
  - ✓ Experience in evaluating health programming.
  - ✓ Experience in the use of data from information management systems to analyse programme results, ideally the use of medical use / health data.
  - ✓ Expertise in applying gender and human rights dimensions in evaluation.
  - ✓ All team members should have strong analytical and communications skills, evaluation experience and familiarity with the region and UNRWA fields of operation.
  - ✓ The inclusion of regional and/or national consultants is encouraged, and to the extent possible, the evaluation team should be gender balanced.
  - ✓ The technical proposal should be no more than 12 pages including i) a cover letter of no more than 3 pages that demonstrates the capabilities and past history of the consulting firm(s)/team leader in conducting similar assignments, and highlights the past experience, skills and competencies of evaluation team members; ii) a proposed methodology in no more than 9 pages to reflect an understanding of the scope of the assignment and to elaborate on the approach and methods the team would use to address the evaluation questions, including strategies for impact analysis and how the team will use the data within the Agency's eHealth information management system. Additionally, the technical proposal should elaborate on how the team will conduct work and use distance methods if COVID travel restrictions limit team member movement, using for example local enumerators. A high-level timeline and work plan that reflects the three broad phases of planning, data collection and analysis, and reporting, should also be included within the technical proposal.
  - ✓ Respondents are requested to submit a financial proposal based on the following scenarios:
    - i) **a remote evaluation** – pricing model based on full travel restrictions for the evaluation team members, and the use of locally based team members or enumerators.

- ii) **a hybrid evaluation** – pricing model based on remote collection for Syria and one additional field, and travel to Headquarters Amman and three fields of operation (including for example Jordan, Lebanon, West Bank and/or Gaza).

## 8. Security considerations

- 8.1 UNRWA acknowledges the security constraints involved in carrying out evaluations in several fields of operation including Lebanon, Syria and Gaza, and if movement restrictions due to the COVID-19 pandemic are lifted across fields, UNRWA will provide support to the contractor in making travel and visit arrangements. This support would include liaising with authorities for field visits.
- 8.2 However, the contractor should indicate in the proposal how the evaluation research can be successfully carried out and managed through a remote management approach.

## Annex C: Evaluation Matrix

| Evaluation criteria                     | Evaluation questions   | Evaluation sub-questions   | Data collection tool(s)            |
|---|--|--|------------------------------------|
| Relevance and coherence                 | To what extent was the FHT Reform strategy and FHT Approach coherent to relevant Agency policies and commitments as well as those of UNRWA health partners and host governments?   | How has UNRWA partnered with Host Authorities / Palestinian Authority to deliver the FHT Reform effectively? (West Bank, Jordan)   | Documentary review<br>KIIs         |
|   | To what extent has the FHT Reform strategy and FHT Approach aligned to the needs of Palestine refugees in the five fields of operation and the evolving contexts within them?  | To what extent has the FHT Approach reform considered gender, inclusion, age, disability, and protection aspects in its design? (Cross-cutting)  | FGDs<br>KIIs<br>Documentary review |
| Efficiency                              | To what extent have the appropriate resources/internal and external communication/ been in place to efficiently implement the FHT Reform?  |  | KII<br>Document review             |
|   | How could the same outputs be attained at lower costs, or higher outcomes be achieved with the same resources?   |  | Document review<br>KIIs            |
|   | To what extent has the monitoring and evaluation of the FHT been effective and improved data use?  |  | Document review<br>KIIs            |
| Effectiveness and impact (contribution) | To what extent has the FHT Approach met its intended objectives?   |  | Documentary review<br>KIIS         |
|   | What have been the unintended impacts/consequences of the FHT Reform?  | To be identified from aggregated analysis  | KIIs<br>FGDs                       |
|   | What contributions/outcomes can be linked to the reforms and the FHT Approach? (e.g., improved quality of care, improved programme efficiency, improved staff and patient satisfaction, improved Hospitalization Support Programme (HSP), and improved health outcomes for refugees, GEEW results, HR and workforce management, partnerships)? | To what extent has the FHT Approach reform supported the achievement of GEWE/protection results/results for people living with disability (Access to services, women's decision making, gender equity in the workforce)? (Gaza, Lebanon, Jordan) | KIIs<br>FGDs                       |
|   |  | To what extent has the UNRWA workforce/HR approach adapted to support the FHT Approach   | KIIs<br>FGDs                       |

|                |  |  |              |
|----------------|--|--|--------------|
|                |  | reform? (West Bank, Gaza, Syria, Lebanon)  |              |
|                |  | Did the additions of the Family Medicine Diploma Programme (FMDP), and the Mental Health and Psychosocial Support (MHPSS) activities have additional effects on health programme outcomes (e.g., on protection, GBV, psycho-social well-being, quality of care)? | KIIs<br>FGDs |
|                |  | To what extent has the FHT Approach been the/a 'vital cog' in addressing wider health issues and linking to other UNRWA service areas?   | KIIs<br>FGDs |
|                | To what extent has the FHT Approach been able to adapt (absorbing shocks and stresses) to recent and projected changes in context? | To what extent does the FHT Reform reflect the nexus between humanitarian and development assistance? (Cross-cutting)<br><br>To what extent has the FHT Approach adapted and been able to achieve results in emergency contexts? (Syria, Gaza)                   | KIIs<br>FGDs |
|                | What factors have enabled or hindered the achievement of results?  |  | KIIs<br>FGDs |
| Sustainability | What are the major factors that have influenced the sustainability of the reform interventions and outcomes?                       | What would be necessary to further embed the sustainability of gains made from the FHT Approach?   | KIIs<br>FGDs |

## Annex D: Bibliography

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Patient Satisfaction Surveys from 2011 Onwards

Training Materials for 3-Day Introduction for Staff on the Concept of the FHT

Instructions for HC Implementation of the FHT including Patient Flow Analysis

Numbers of Staff Taking the Family Medicine Health Diploma Per Field Per Year

Number of Staff Trained on GBV Per Field Per Year

Work Force Plans and WHO WISN Analysis

Sample of Quarterly Health Reports Per Field (2016 Onwards)

Emergency Appeal Budget and Expenditure

Project Budget and Expenditure

Health Expenditure Per Registered Palestine Refugee, Regular Budget 2010, 2011, 2012, 2013, 2014, 2015, 2016, Per Field and Agency Level

Total Health Program Expenditure, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017 at Agency Level

Average Cost Per Registered Refugee USD (Agency-Wide), 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017 at Agency Level

Total Costs Spent on Health Staff Salaries - 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020 at Agency Level

Health Personnel Per 100,000 Registered Refugees (Doctors and Nurses): 2011, 2012, 2013, 2014, 2015 and 2020, Per Field and at Agency Level

Percentage of Health Centres with At Least one Staff Member Trained on Detection and Referral of GBV cases: 2016, 2017, 2018, 2019 and 2020, Per Field and at Agency Level

Number of Patients Screened for MHPSS Each Year 2011-2020, Per Field and at Agency Level

Number of MHPSS Referrals Each Year 2011-2020, Per Field and at Agency Level

Percentage of Male vs Female Staff in Each Role Type (e.g., Medical Officer, Nurse, Midwife) Per Field

## Annex E: List of Interviewees

| UNRWA HQ Health Staff                                  |   |
|--|---|
| Name   | Position  |
| Dr. Akihiro Seita                                      | Director of Health Department                                   |
| Dr. Majed Habadeh                                      | Consultant, Former Chief of Health and Protection and Promotion |
| Dr. Yousef Shahin                                      | Chief, Disease Control and Prevention                           |
| Dr. Rami Habash  | Chief, Health Protection and Promotion                          |
| Dr. Yassir Turki                                       | Health Communication and Community Based Initiative Officer     |
| Ghada Ballout  | e-Health Project Coordinator                                    |
| Dr. Sayed Shah   | Health Planning and Policy Officer                              |
| UNRWA Management from Other Departments and Programmes |   |
| Sam Rose   | Director of Planning  |
| Edwin Berry  | Deputy Director of Planning                                     |
| Sana Jelassi   | Head of Gender and Protection                                   |
| Dr. Caroline Pontefract                                | Direction of Education Department                               |
| Valeria Cetorelli                                      | Head, Refugee Registration and Eligibility Services             |
| WHO/Other Partners                                     |   |
| Hassan Salah   | WHO   |
| Paul Wallace   | FIDFMP  |
| UNRWA Health Donors                                    |   |
| Asaka Ishiguro   | UNRWA Focal Point at Japanese Representative Office in Ramallah |
| Reem Ghattas   | Austria Representative  |
| Astrid Wein  | Austria Representative  |
| Christopher Gooch                                      | USA Representative  |
| Gaza   |   |
| Zohair El Khateeb                                      | Deputy Chief, Field Health Programme                            |
| Hala Mughari   | FNO   |
| Rehab Qouqa  | AHO/DCHP Assistant  |
| Khalil Hamad   | FDCO  |
| Randa Zaqout   | Field Family Health Officer                                     |
| Dr. Faten Abu Amra                                     | Medical Officer, Al-Maghazi Health Centre                       |
| Dr. Marwa Abu Amer                                     | Deputy Director, Sheikh Ridwan Health Centre                    |

|                          |   |
|--------------------------|---|
| Dr. Mohammed Al-Khalidi  | Director, Gabaliya Health Centre                      |
| Dr. Nahla A-Asadi        | Midwife, Al-Remal Nasser Health Centre                |
| Rania Al-Najar           | Midwife, Khan Younis Health Centre                    |
| Dr. Hasan Diab           | Medical Officer                                       |
| Dr. Somaya Jasn          | Medical Officer                                       |
| Ashraf Abu Muawad        | Practical Nurse                                       |
| Abeer Al Khateeb         | Practical Nurse                                       |
| Souad Radwan             | Midwife   |
| Amal Syam                | Director, Women's Affairs Centre                      |
| Etisalat Aziz            | Local Committee Member, Jabalia Health Centre         |
| Zahra Khalaf             | Local Committee Member, Rafah Health Centre           |
| Dr. Moussa Aabed         | Family Physician-Head of FH Model (MOH)               |
| Jordan                   |   |
| Vickram Chhetri          | Field Programme Support Officer                       |
| Dr. Mustafa Ammoura      | Chief, Field Health Programme                         |
| Manar Hussein            | Field Nursing Staff Officer                           |
| Dr. Reham Jaffal         | Deputy Chief, Field Health Programme                  |
| Fatimah Abdel Hafeth     | Senior Staff Nurse                                    |
| Dr. Hasan Ahmed Kahlifeh | Head Health Centre                                    |
| Mariam Alawadeh          | Senior Staff Nurse                                    |
| Dr. Nabil Abo Obeid      | Head Health Centre                                    |
| Sahar Tamimi             | Senior Staff Nurse                                    |
| Dr. Dua Al Smadi         | Medical Officer                                       |
| Nariman Abu-Bakr         | Senior Staff Nurse                                    |
| Lubna Abu Ziad           | Midwife   |
| Nour Al-Hawwari          | Clerk   |
| Suzan Nasr               | Senior Staff Nurse                                    |
| Sousan El Alty           | Midwife   |
| Souad Mohammad Abed      | Practical Nurse                                       |
| Ihlam Abu Matawa         | Lab Technician  |
| Abeer Elewa              | Director, Women Programme Centre - Baqa'a Camp        |
| Bashar Azza              | Head of Rehabilitation Centre, Baqa'a Camp            |
| Hanan Abed Daoud Ibrahim | Director, Women's Programme Centre in Al-Hussein camp |

|                           |  |
|---------------------------|--|
| Dr. Alaa Hodib            | Epidemiologist in the Communicable Diseases Department (MOH) |
| Dr. Zeina Kreisat         | Head of Family Planning Department-MCH, (MOH)                |
| Lebanon                   |  |
| Mera Thompson             | Deputy Director, UNRWA Operations Lebanon Field              |
| Dr. Suha Ismail           | Deputy Chief, Field Health Programme                         |
| Dr. Abed Chanaa           | Chief, Field Health Programme                                |
| Bahija El Ghazal          | Midwife  |
| Hussein Jreidi            | Practical Nurse  |
| Dr. Mahmoud El Sleiman    | Senior Medical Officer                                       |
| Randa El Khateb           | Midwife  |
| Ayman El Haj Mohammad     | Senior Staff Nurse   |
| Dr. Nada Maarouf          | Medical Officer  |
| Suzan Al Lahham           | Senior Staff Nurse   |
| Layal Bisher              | Senior Staff Nurse   |
| Mohammad Hamoudeh         | Area Nursing Officer   |
| Dr. Khaled Abou Chakra    | Senior Medical Officer                                       |
| Yousef Abed El Aziz       | Staff Nurse  |
| Zeinab Ismail             | Midwife  |
| Abdel Nasar Kanaan        | Local Committee Member/ Tyre                                 |
| Almaza Sharkawi           | Director, Women's Programme Centre/ Ain El Helwa Camp        |
| Hanan Al khatib Al Assadi | Programme Manager, Human Call Association/ Ain El Helwa Camp |
| Syria                     |  |
| Prafulla Mishra           | Deputy Director of UNRWA Affairs                             |
| Dr. Kinan Fanous          | Deputy Chief, Field Health Programme                         |
| Dr. Suzan Al-Abyad        | Field Family Health Officer                                  |
| Dr. Husain Shihabi        | Field Disease Control Officer                                |
| Dr. Khaled Hamdan         | Damascus Area Health Officer                                 |
| Ali Saadaldin             | Field Nursing Officer  |
| Issa Aahed                | Clerk  |
| Dr. Ghaleb Alrantisi      | Head Health Centre   |
| Hiba Hamid                | Practical Nurse  |
| Dr. Mahmoud Al Faysal     | Head Health Centre   |
| Dr. Salwa Al Noqari       | Head Health Centre   |

|                          |  |
|--------------------------|--|
| Dr. Rana Darwish         | Head Health Centre                         |
| Layla Mousa              | Senior Staff Nurse                         |
| Fawzieh Nasrallah        | Midwife                                    |
| Fathieh Mohammad         | Practical Nurse                            |
| Dr. Ghada Nofal          | Medical Officer                            |
| Iman Mohammad            | Senior staff nurse                         |
| Maisaa Darwish           | Midwife                                    |
| Nisreen Mohammad         | Practical nurse                            |
| West Bank                |  |
| Gwyn Lewis               | Director, UNRWA Operations West Bank Field |
| Dr. Adnan Qamash         | Chief, Field Health Programme              |
| Dr. Mahmoud Wohoush      | Deputy Chief, Field Health Programme       |
| Najwa Eissa              | Field Nursing Services Officer             |
| Dr. Ahmad Al Hoor        | Field Family Health Officer                |
| Jehad Sabbah             | Area Nursing Officer                       |
| Khawla Kawamreh          | Midwife                                    |
| Dr. Khaled Shelbayeh     | Medical Officer/Focal Point e-Health       |
| Suzan Qaddoura           | Acting Area Nursing Officer                |
| Dr. Remonda Hasounah     | Medical Officer                            |
| Laila Al-Baw             | Senior Staff Nurse                         |
| Dr. Ansar Saada          | Senior Medical Officer                     |
| Amani Amarneh            | Midwife                                    |
| Hiba Adawi               | Practical Nurse                            |
| Bosaina Malah            | Midwife                                    |
| Suher Khazaimah          | Responsible for Jenin Camp/UNRWA           |
| Yacoub Assaf             | Local Committee Member/Kalandia            |
| Abed Al Latif Abu Safiye | Responsible for Arroub Camp/UNRWA          |

## Annex F: Team Composition

### Team Leader – Julian Gayfer

Julian Gayfer will be responsible for managing the team and shaping the evaluation. He will be the key point of contact for the UNRWA evaluation management team and the Evaluation Reference Group. Julian will lead on the Jordan, West Bank and Gaza components of the evaluation, leading on remote KIIs with FHT senior management at Headquarters and Field Offices as well as external donors and host governments.

### Senior Health Evaluator – Naomi Blight

Naomi will lead on the development of methodology; the retrospective Theory of Change and the data collection tools. They will lead on the Lebanon and Syria components of the evaluation, conducting remote KIIs with senior UNRWA stakeholders, external donors, and host governments.

### Migration and Refugee Expert – Ima Bishop

Ima will input knowledge on migration and protracted refugee situations to the team. She will work closely with Julian on the Jordan, West Bank and Gaza components of the evaluation and undertake remote data collection. She will also be responsible for analyzing e-Health data and inputting to all deliverables. Ima will also provide project management support for the project and coordinate meetings with UNRWA and the field research logistics.

### Senior Data Collector – Zeina Hassan

Zeina will work across the evaluation in all fields and lead on field data collection and manage the team of national data collectors. Zeina will be responsible for conducting KIIs with frontline FHT staff and will oversee the rollout of the survey and data collection with beneficiaries. She will be supported by national data collectors based in Jordan, Lebanon and Syria who will conduct FGDs or remote interviews with beneficiaries. She will lead on the development of field level reports.

### Wider Team

The core team will be supported by national data collectors in Jordan, West Bank, Gaza, Lebanon, and Syria who will remotely conduct beneficiary surveys and FGDs. Quality Assurance will be provided by IOD PARC Principal Consultant and Director, Nick York.



## Annex G: Indicator Tables

| Health Programme Budget and Staff Costs (Thousands of USD) <sup>111</sup> |        |        |        |        |        |
|---|--------|--------|--------|--------|--------|
| Field   | 2016   | 2017   | 2018   | 2019   | 2020   |
| Gaza Field Office   | 30,554 | 30,398 | 32,125 | 30,604 | 38,212 |
| Of which is staff cost  | 19,547 | 20,803 | 22,639 | 21,155 | 25,427 |
| Staff cost as % of Programme Budget                                       | 64%    | 68%    | 70%    | 69%    | 66%    |
| Jordan Field Office   | 19,238 | 20,813 | 21,143 | 19,358 | 19,054 |
| Of which is staff cost  | 13,535 | 13,699 | 15,250 | 14,108 | 12,860 |
| Staff cost as % of Programme Budget                                       | 70     | 65     | 72     | 72     | 67     |
| Lebanon Field Office  | 22,849 | 26,088 | 25,059 | 24,529 | 25,315 |
| Of which is staff cost  | 8,327  | 8,690  | 8,985  | 8,934  | 9,509  |
| Staff cost as % of Programme Budget                                       | 36     | 33     | 35     | 36     | 37     |
| Syria Field Office  | 9,275  | 8,825  | 8,511  | 7,826  | 9,860  |
| Of which is staff cost  | 5,662  | 4,660  | 4,723  | 4,410  | 4,293  |
| Staff cost as % of Programme Budget                                       | 61     | 52     | 55     | 56     | 43     |
| West Bank   | 22,211 | 26,003 | 28,067 | 27,863 | 28,631 |
| Of which is staff cost  | 14,843 | 16,882 | 18,004 | 18,294 | 19,116 |
| Staff cost as % of Programme Budget                                       | 57     | 64     | 64     | 65     | 66     |
| HQ  | 715    | 713    | 703    | 951    | 828    |
| Of which is staff cost  | 539    | 580    | 662    | 906    | 706    |
| Staff cost as % of Programme Budget                                       | 75     | 81     | 94     | 95     | 85     |

| Total Number of Medical Consultations Per Field, Per Year <sup>112</sup> |           |           |           |           |           |           |
|--|-----------|-----------|-----------|-----------|-----------|-----------|
| Field  | Jordan    | Lebanon   | Syria     | Gaza      | West Bank | Agency    |
| 2012   | 1,943,057 | 979,993   | 414,993   | 4,515,248 | 1,798,961 | 9,652,066 |
| 2013   | 1,765,335 | 1,082,427 | 635,754   | 4,300,637 | 1,506,044 | 9,290,197 |
| 2014   | 1,721,440 | 1,276,153 | 983,635   | 4,181,967 | 1,293,960 | 9,457,155 |
| 2015   | 1,598,989 | 1,218,279 | 1,051,195 | 4,010,882 | 1,312,576 | 9,191,921 |
| 2016   | 1,552,936 | 1,104,705 | 927,913   | 3,810,791 | 1,157,173 | 8,553,518 |

<sup>111</sup> Data requested from and provided by UNRWA on 21/04/21<sup>112</sup> UNRWA Annual Health Reports 2012 to 2020 and data requested and received from UNRWA on 11/04/21

| Total Number of Medical Consultations Per Field, Per Year <sup>112</sup> |           |           |         |           |           |           |
|--|-----------|-----------|---------|-----------|-----------|-----------|
| Field  | Jordan    | Lebanon   | Syria   | Gaza      | West Bank | Agency    |
| 2017   | 1,570,044 | 1,037,962 | 831,015 | 3,858,497 | 1,066,984 | 8,364,502 |
| 2018   | 1,597,015 | 1,019,967 | 856,024 | 4,051,604 | 1,041,481 | 8,556,091 |
| 2019   | 1,695,966 | 881,064   | 804,542 | 4,215,247 | 1,126,299 | 8,723,118 |
| 2020   | 1,127,805 | 556,511   | 672,008 | 2,683,834 | 758,746   | 5,798,904 |

| Average Medical Consultations per MO per Day <sup>113</sup> |        |         |       |      |           |        |
|---|--------|---------|-------|------|-----------|--------|
| Field   | Jordan | Lebanon | Syria | Gaza | West Bank | Agency |
| 2011  | 96.2   | 117     | 95    | 103  | 104       | 104    |
| 2012  | 87     | 103     | -     | 113  | 107       | 105    |
| 2013  | 81     | 92      | -     | 109  | 116       | 99     |
| 2014  | 84     | 108     | 80    | 96   | 111       | 95     |
| 2015  | 81     | 98      | 80    | 87   | 86        | 86     |
| 2016  | 82     | 100     | 82    | 82   | 78        | 85     |
| 2017  | 79     | 83      | 77    | 77   | 74        | 78     |
| 2018  | 86     | 84      | 82    | 82   | 76        | 82     |
| 2019  | 86     | 73      | 73    | 81   | 76        | 78     |
| 2020  | 62     | 51      | 54    | 64   | 64        | 59     |

| Ratio of Repeat to First Visits <sup>114</sup> |        |         |       |      |           |        |
|--|--------|---------|-------|------|-----------|--------|
| Field  | Jordan | Lebanon | Syria | Gaza | West Bank | Agency |
| 2013   | 3.8    | 4.1     | 1.1   | 3.6  | 2.5       | 3.1    |
| 2014   | 3.4    | 4.8     | 1.8   | 2.7  | 2.8       | 3.1    |
| 2015   | 3.2    | 4.3     | 2.2   | 3.9  | 2.7       | 3      |
| 2016   | 3.2    | 5.1     | 2.5   | 3.4  | 2.6       | 3      |
| 2017   | 2.7    | 3.1     | 2.5   | 3.2  | 2.6       | 3.2    |
| 2018   | 2.7    | 3.1     | 2.5   | 3.2  | 2.6       | 3.3    |
| 2019   | 2.6    | 3.3     | 3.3   | 3.5  | 2.8       | 2.9    |
| 2020   | 2      | 2.6     | 2.6   | 3.2  | 3.8       | 3.1    |

| Health Unit Cost Per Capita (Served Population) US\$ <sup>115</sup> |     |     |     |     |      |        |
|---|-----|-----|-----|-----|------|--------|
| Year  | GFO | JFO | LFO | SFO | WBFO | Agency |

<sup>113</sup> UNRWA Annual Health Reports 2011 to 2020 and data requested and received from UNRWA on 11/04/21

<sup>114</sup> UNRWA Annual Health Reports 2013 to 2020 and data requested and received from UNRWA on 11/04/21

<sup>115</sup> Data requested from and provided by UNRWA on 11/04/21

|      |       |      |       |       |       |      |
|------|-------|------|-------|-------|-------|------|
| 2010 | 27.1  | 20   | 62.6  | 22.3  | 45.3  | 30.8 |
| 2011 | 25.4  | 16.3 | 66.9  | 23.9  | 54.0  | 30.9 |
| 2012 | 28.1  | 18.6 | 85.7  | NA    | 54.0  | 30.7 |
| 2013 | 27.2  | 17.5 | 82.7  | NA    | 57.4  | 32.0 |
| 2014 | 15.4  | 16.1 | 67.6  | NA    | 63.3  | 28.2 |
| 2015 | 20.9  | 23.3 | 65.9  | 21.7  | 65.7  | 31.9 |
| 2016 | 24.51 | 19.4 | 68.64 | 19.05 | 57.84 | 31.2 |
| 2017 | 31.1  | 22.6 | 120.3 | 23.1  | 64.5  | 37.6 |

| Health Unit Cost Per Capita (Registered Refugee Population) US\$ |       |       |       |       |       |        |
|--|-------|-------|-------|-------|-------|--------|
| Year   | GFO   | JFO   | LFO   | SFO   | WBFO  | Agency |
| 2018   | 36.7  | 11.2  | 64.6  | 25.5  | 40.3  | 28.6   |
| 2019   | 39.7  | 10.6  | 63    | 24.2  | 33.2  | 27.4   |
| 2020   | 32.42 | 11.13 | 60.90 | 24.53 | 36.07 | 26     |

## Annex H: FHT Context by Field Office

### A. Gaza

355. Gaza hosts 1.4 million Palestine refugees. 43% live in official UNRWA camps<sup>116</sup>. 80% of Gaza's population depends on international assistance. Gaza has been under land, air, and sea blockade since 2007. Combined with the 2014 war and ongoing violent incidents, this has created economic and social decline throughout the UNRWA health reform period and therefore had negative implications on refugees' health needs.

356. UNRWA operates 22 Health Centres in Gaza and refers to partner hospitals for secondary and tertiary care.<sup>117</sup> This is UNRWA's biggest health operation and provides nearly half of all UNRWA medical consultations. The implementation of the FHT Approach was completed in Gaza by 2016. Gaza was the first field of operation where the Family Health Team approach was fully implemented, and field staff recognise that health professionals were open to the reform programme. Since 2018 there have been ongoing challenges to the implementation of the FHT Approach. Due to the agency's budget crisis, it has not been possible to retain a full workforce and matching the workforce to the structural requirements of the FHT remains a challenge. While time spent per patient increased in 2018 it has been under pressure since.

357. Alongside NCDs, disability and mental health are important considerations in the Gaza context. Since the Great March of Return in 2018 there has been an increase in violence and injuries. In 2018 alone there were 113 amputations, 21 people left paralysed and 9 people left permanently blind.<sup>118</sup> This has added pressures to health services around their inclusion and meeting their needs. Mental health is a major concern in Gaza given the extreme stresses of the context. Mental health has been integrated into UNRWA health services as a priority and there are now 1000 staff trained in mental health care.

358. Palestine refugees also have access to public health services provided by the Palestine Authority's Ministry of Health. Palestine refugees are eligible for government health insurance that covers primary services, secondary care, and tertiary care. The Ministry of Health provides roughly 33% of primary Health Centres. UNRWA and other non-state actors are the majority primary health care providers<sup>119</sup>. There are 30 hospitals in Gaza provided primarily by the Ministry of Health and the Military Medical Services.<sup>120</sup> However, Gaza continues to experience deep strain on public health systems including poor infrastructure and lack of supplies and medicine. This in turn places greater strain on UNRWA services.

359. COVID-19 has placed significant strain on the health system in Gaza, which was already under significant pressure as a result of war and the deteriorating social and economic context. COVID-19 has increased PSS needs and staff have also observed a rise in gender-based violence (GBV). In order to respond to the pandemic, a triage system was created across the 22 Health Centres with those displaying symptoms directed to 18 converted school spaces that served as COVID-19 medical points. A medical hotline and online support groups for NCD patients were also established.

360. The Family Health Team structure has been broken down during the pandemic response with re-distribution of staff across 22 Emergency Response teams.<sup>121</sup> It will take time to re-establish the Family Health Team structure. Adapting to COVID-19 has been more challenging than adapting to the 2014 war and ongoing blockade Gaza has experienced but the structure and processes of the Family Health Team approach has increased the system's resilience, in particular the e-Health system which allowed a clear understanding of patient needs.

<sup>116</sup> UNRWA, Annual Health Report 2018 (2018)

<sup>117</sup> UNRWA, Annual Operating Report (2018)

<sup>118</sup> WHO – Health Conditions in the Occupied Palestinian Territory, Including East Jerusalem and in the Occupied Syrian Golan (2019)

<sup>119</sup> *ibid*

<sup>120</sup> *ibid*

<sup>121</sup> UNRWA, Real Time Evaluation Reports on COVID-19 Response – Gaza (2020)

## B. The West Bank

361. Around one million registered Palestine refugees reside in the West Bank, around 500,000 of whom use UNRWA health services.<sup>122</sup> Around 24% of the Palestine refugee population live in 19 official UNRWA camps and 80% of the camps populations are dependent on UNRWA health services within their camps.<sup>123</sup> The West Bank remains under Israeli occupation and refugees are often displaced or disposed. They continue to suffer from a stagnant economy.<sup>124</sup> Palestine refugees living in the central areas of the West Bank suffer violence and harassment from the Israeli military and settler community which hinders their access to essential services including health.

362. The UNRWA services in these areas provide primary health care for Palestine refugees living in camps as well as in urban settings. Unlike their counterparts situated in central-West Bank, those situated in the west have limited to no daily contact with Israeli authorities and/or settlers. However, in the west areas of the West Bank dependence on UNRWA is significant due to limited public health infrastructure. This additionally presents challenges in referring patients for specialist care. In addition to NCDs and maternal health, a major challenge is mental health as a result of the insecure context. This is a particular concern for those living in Area C and near the barrier.

363. UNRWA runs 43 health establishments in the West Bank consisting of 24 Health Centres and 19 Health Points. In 2018, these provided 1,041,481 medical consultations.<sup>125</sup> Health Centres are also smaller and more crowded than in fields of operation such as Gaza, and the Field Programme plans to reconstruct the smaller Health Centres over the next two years to allow better service delivery.

364. UNRWA also struggles to recruit high-quality doctors in the West Bank because of labour market competition and higher salaries offered by other service providers. UNRWA also runs one hospital at Qalqilya and six mobile Health Centres. These mobile Health Centres reach 13,000 patients per month in hard-to-reach areas such as Area C and areas near the barrier. UNRWA works in partnership with other service providers to make referrals for secondary and tertiary care.

365. The Agency's partners include Ministry of Health, Augusta Victoria Hospital, and the Juzoor Foundation for Social Development.<sup>126</sup> In contrast to Gaza, the Ministry of Health provides the majority of primary health care services in the West Bank, providing over 71% of Health Centres. The Ministry of Health also provides 43% of hospital bed capacity and Palestine refugees are eligible for government health insurance for primary, secondary, and tertiary care.

366. Non-state actors also play a large role in the provision of mobile Health Centres in the West Bank, in particular in Area C.<sup>127</sup> Palestine refugees are eligible for health care with both UNRWA and the host authority who coordinate on areas such as vaccinations. Patients who can afford to do so can also access private health care. However, there remains a high dependence on UNRWA services, particularly for those living in camps or hard to reach areas.

367. The COVID-19 pandemic has strained UNRWA's health services. UNRWA adapted its health service approach to align with the Ministry of Health and through coordination meetings to ensure that refugees were included in the Palestinian authority's response. UNRWA was able to provide NCD patients with 2-months of medication to reduce the need for visits to Health Centres. Mobile Health Centres enabled home visits and telemedicine was used to provide ongoing services.<sup>128</sup>

368. Field staff suggested their relationship with the Ministry of Health was strengthened during the response with UNRWA playing a key role in establishing ten isolation centres. The disbanding of the FHT Approach during this time presents opportunities, such as further integrating MHPSS services

<sup>122</sup> website

<sup>123</sup> UNRWA MTS, 2016

<sup>124</sup> UNRWA MTS

<sup>125</sup> UNRWA, 2018 Annual Operating Report, (2019)

<sup>126</sup> UNRWA, 2019 Annual Health Report (2019)

<sup>127</sup> WHO – Health Conditions in the Occupied Palestinian Territory, Including East Jerusalem, and Occupied Syrian Golan (2019)

<sup>128</sup> West Bank C19 RTE

across Health Centres, and challenges, including training the 107 newly recruited staff who are not familiar with the FHT Approach.

### C. Jordan

369. Jordan is second only to Lebanon in accommodating the largest ratio of refugees to host population in the world, with the majority of the refugee population comprising of Palestine refugees. The two major waves of Palestine refugees in Jordan (PRJ) were caused first by the 1948 war with Israel, which led to the mass expulsion of an estimated 700,000-800,000 Palestinians to neighbouring countries, and the second was the Six-Day-War in 1967 which resulted in Israel's occupation of East Jerusalem, the West Bank and Gaza Strip, and in turn, the displacement of more Palestinians.

370. In 2020, the population of registered Palestine refugees in Jordan is estimated at more than two million, of whom around 13,836 individuals are Palestine refugees from Syria (PRS).<sup>129</sup> The PRS began to arrive in Jordan from Syria in 2011; however, by January 2013, the Jordanian government (GOJ) issued a policy prohibiting the entry of PRS into Jordan. There are 10 official and 3 unofficial refugee camps established across Jordan, housing only 18% or around 325,000 of the overall combined population of PRJ and PRS, with the majority opting to live in urban centres.<sup>130</sup>

371. In Jordan, UNRWA provides comprehensive primary health care services for 1.1 million Palestine refugees. The services are provided through 25 health facilities whereby 12 are located within refugee camps, and 13 are located outside the camps. By the end of 2015, the Jordan team had fully implemented the FHT Approach as well as e-Health within all 25 of its Health Centres.

372. Although Jordan has not signed the 1951 Geneva Convention on Refugees, it has under Law No. 6 of the 1954 Convention granted Jordanian citizenship to Palestine refugees.<sup>131</sup> As such, the majority of PRJ have become nationalized and are benefiting from the same civil and social rights as natural born Jordanians.

373. However, not all Palestine refugees are granted the right and/or option for Jordanian citizenship. 150,000 Palestine refugees who were originally displaced from Gaza after the 1967 war, and who are commonly referred to as "ex-Gazans" are barred from obtaining Jordanian citizenship.<sup>132</sup> Instead, the government provides ex-Gazans with a temporary Jordanian passport that does not include a national ID number and is valid for only two years at a time. The lack of Jordanian citizenship hampers their access to public universities, employment opportunities, property ownership and social services.<sup>133</sup>

374. As such, Palestine refugees originating from Gaza are considered as being a highly marginalized group that is "three times more likely to be amongst the poorest" communities in Jordan.<sup>134</sup> PRS are placed in an even more precarious and vulnerable situation than that of the ex-Gazans. Not only are PRS denied the benefits of Jordanian citizenship, but moreover, their lack of a clear and defined legal status within Jordan leaves them prone to a multitude of protection risks including detention and deportation.

375. Over the past decade, the Ministry of Health (MOH) concentrated its efforts towards the expansion

<sup>129</sup> UNRWA PRS in Jordan. (n.d.). UNRWA. Retrieved December 5, 2020, from <http://www.unrwa.org/prs-jordan>

<sup>130</sup> United Nations Relief and Works Agency for Palestinian Refugees in the Near East (UNRWA). (2019), Health Department Annual Report

<sup>131</sup> UNRWA Jordanian nationality. (n.d.). UNRWA. Retrieved December 5, 2020, from <https://www.unrwa.org/content/jordanian-nationality>

<sup>132</sup> United Nations Relief and Works Agency for Palestinian Refugees in the Near East (UNRWA). (2018), Health Department Annual Report

<sup>133</sup> Dal Pra, Amelia Marie (2017) "A Refuge for Refugees: The Historical Context and Socioeconomic Impact of Palestinian Refugees in Jordan," *Global Tides*: Vol. 11, Article 4.

<sup>134</sup> Tiltne, Å., & Zhang, H. (2013). Progress, challenges, diversity Insights into the socio-economic conditions of Palestinian refugees in Jordan (No. 237). Fafo. <https://www.fafo.no/zoo-publikasjoner/fafo-rapporter/item/living-conditions-among-palestinian-refugees-and-displaced-in-jordan>

of health facilities as well as better-quality services across Jordan.<sup>135</sup> As a result, Jordan is becoming a leading destination for medical tourism for the Middle East. A study conducted in 2013 found that half of all PRJ living outside of camps were covered by some type of insurance, with the most common one being the Civil Insurance Programme (CIP) – a government afforded insurance scheme – while ex-Gazans had the lowest health coverage outside of camps (30%) and inside camps (17%).<sup>136</sup>

376. With regard to the utilization of health services by PRJ, the same study found that those outside the camps utilized governmental hospitals (42%) and Health Centres (23%) the most, with 12% utilization rates for UNRWA's services; however for those residing in the camps UNRWA remained their main service provider, citing accessibility as the primary reason.<sup>137</sup>

377. In many regards, Jordan enjoys a strong level of stability in comparison to its neighbours in the region. However, there are indications that this stability is becoming quite precarious, with the country suffering from a high level of unemployment coupled with high costs of living. Furthermore, the large population of refugees have increased the burden on the country's limited resources and infrastructure.

#### **D. Lebanon**

378. Palestine refugees in Lebanon (PRL) are the oldest refugee population residing in Lebanon whereby their presence within the country dates to the Palestinian exodus of 1948, after the establishment of the state of Israel. PRLs can be divided into three categories: refugees who are both registered with UNRWA as well as the Lebanese authorities; refugees registered with the Lebanese authorities but who are not registered with UNRWA, referred to as unregistered refugees; and lastly refugees who are neither registered with UNRWA nor the Lebanese authorities, referred to as non-ID refugees.

379. By 2011, a new wave of Palestine refugees arrived in Lebanon from Syria (PRS) seeking safe refuge from the crisis. After the initial wave, and by the end of 2013, new governmental restrictions towards the border entry of PRS were enforced consequently curbing the number of new arrivals by 2014. Today the Palestine refugee population in Lebanon is estimated to be around 538,692 (PRS are estimated at 29,145), of whom 233,827 are reliant on UNRWA's services<sup>138</sup>. A sizable 46% of the PRL population and 54.8% of the PRS live in 12 official refugee camps located across 4 governorates (Beqaa, North Lebanon, South Lebanon, Beirut) while the rest of the population is largely situated in 27 informal gatherings that are close to and/or surrounding the camps.

380. Although Lebanon hosts the highest number of refugees (Palestinian, Syrian, Iraqi) in the world in relation to its own population, as a non-signatory to the 1951 United Nations (UN) Convention regarding the Status of Refugees as well as the Convention's 1967 Protocol, Lebanon has legally evaded any responsibility and/or liability for all refugee populations residing within its territory.

381. As such, all Palestine refugees are regarded as "foreigners" under Lebanese law and are denied, by policy, their basic civil and social rights, access to public health facilities and education as well as the right to work in specified professions (medicine, law, engineering, etc.).<sup>139</sup> Due to their lack of valid documentation, approximately 3,000-5,000 non-ID refugees are denied registration by the Lebanese authorities, invariably placing them in a highly precarious situation whereby they are prohibited from the few civil and social rights granted to other categories of PRLs.<sup>140</sup>

382. Moreover, government policies pertaining to the legal status of PRS within Lebanon stipulate that

<sup>135</sup> Nazer, L. H., & Tuffaha, H. (2017). Health Care and Pharmacy Practice in Jordan. *The Canadian journal of hospital pharmacy*, 70(2), 150–155. <https://doi.org/10.4212/cjhp.v70i2.1649>

<sup>136</sup> Tiltne, Å., & Zhang, H. (2013). Progress, challenges, diversity Insights into the socio-economic conditions of Palestinian refugees in Jordan (No. 237). Fafo. <https://www.fafo.no/zoo-publikasjoner/fafo-rapporter/item/living-conditions-among-palestinian-refugees-and-displaced-in-jordan>

<sup>137</sup> Ibid

<sup>138</sup> United Nations Relief and Works Agency for Palestinian Refugees in the Near East (UNRWA). (2019), Health Department Annual Report

<sup>139</sup> Khalidi, A., & Tabbarah, R. (2009), Contributions of Palestinian refugees residing in camps and some gatherings to the Lebanese economy.

<sup>140</sup> UNRWA, Protection Brief Palestine Refugees Living in Lebanon, (2018)

individuals must hold a valid visa to legally remain in the country with annual renewal fees for residency permits set at a cost of US Dollars 200 per person. Even though the large majority of PRS entered Lebanon legally, by 2015 more than half of all PRS surveyed had lost their legal status due to an inability to pay the residency renewal costs.<sup>141</sup>

383. These policies have played a primary role in the high levels of poverty and mass deprivation existent amongst both the PRL (non-ID refugees in particular) and PRS communities. A survey conducted in 2015, found that 65% of PRL and 89% of PRS were unable to meet their basic needs for food and non-food items (NFI), citing low income as the main cause of elevated poverty levels.<sup>142</sup> The same survey also identified higher rates of poverty amongst those residing in camps (PRL-73.2%, PRS-92.1%) compared to those outside the camps (PRL-55%, PRS-83.6%).

384. The general characterization of the living conditions within camps includes severe overcrowding, weak infrastructure, limited access to clean water and electricity, and inadequate sewage systems. As such, the overall well-being of both the PRL and PRS populations is further exacerbated by the impoverished conditions of the camps. In addition, the arrival of PRS and Syrian refugees to Lebanon has stirred community tensions with their PRL counterparts over access to limited resources, services, living space, and employment opportunities.

385. As demonstrated in UNRWA's Annual Health report of 2019, a high demand on its health services continued throughout the year whereby the total number of consultations (first time visits, repeat visits, specialist consultations) provided at all 27 UNRWA health facilities was 881,064. The exclusion of PRL and PRS communities from coverage under public and/or social insurance schemes by Lebanese law, has consequently increased both these communities' reliance and dependency on UNRWA's health services (PRL-95%, PRS-99%).<sup>143</sup>

386. With regards to non-ID refugees, UNRWA officially extended its primary health care (PHC) services to non-ID refugees, however, support for tertiary care is more complicated and limited. To address the health needs of the PRL and PRS, UNRWA has established 27 health facilities across Lebanon (14 in camps and 13 outside camps) providing free-of-charge primary health care services: general medical consultations, mother & child health (MCH), non-communicable disease services (NCD), and provision of essential medicines.

387. In addition to the standard package of care provided in all health facilities, some health facilities also offer specialist consultations –gynaecology, cardiology, ophthalmology, oral health, basic laboratory services, and radiology tests. To better address the growing needs and increased demand placed on its health services, the Lebanon Field Office (LFO) piloted the Family Health Team (FHT) approach in 2011, and by 2014 they succeeded in implementing the FHT Reform within all 27 health facilities.

388. During the past several years, UNRWA has confronted numerous challenges while trying to provide the needed health services to PRL and PRS, namely: an increasing population size that is coupled with growing needs and lesser economic opportunities; arrival of PRS; restrictive governmental policies directed at exclusion; instability and lack of security within camps and Lebanon as a whole; and the economic and political ramifications of the Syrian conflict on Lebanon.

389. With that being said, 2020 brought forth a whole new set of challenges that in many ways continues to test the resilience of the PRL and PRS communities as well as UNRWA's health department. Lebanon is currently experiencing its worst financial crisis with the economy nearing total collapse. Moreover, the disintegration of the Lebanese economy has been further affected by the COVID-19 pandemic which

<sup>141</sup> United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA). (2015), *Profiling the Vulnerability of Palestine Refugees from Syria Living in Lebanon*.

<sup>142</sup> Chaaban, J., Salti, N., Ghattas, H., Irani, A., Ismail, T., Batlouni, L. (2016), *Survey on the Socioeconomic Status of Palestine Refugees in Lebanon 2015*, the American University of Beirut (AUB) and the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA)

<sup>143</sup> Ibid



has necessitated numerous nationwide lockdowns, and the explosion at Beirut's port on the 4<sup>th</sup> of August, which destroyed a large part of the port and the country's main grain silo.

390. Although there is currently no official data regarding the direct affects that all these crises are having on PRL and PRS communities, anecdotal data suggests that both communities are experiencing increased financial and social vulnerability due to loss of employment, decrease in purchasing power due to the decline of the Lebanese Pound, decrease in US funding to UNRWA due to the policy of the former Trump administration in the Middle East, decrease in international donor funding to UNRWA and other NGOs due to COVID-19, and difficulty in receiving relied upon remittances from family/friends living outside of Lebanon.

## E. Syria

391. Like their Palestinian counterparts who fled Palestine for Lebanon, the first wave of Palestine refugees arrived in Syria in 1948. However, unlike Palestine refugees who settled in Lebanon (PRL), Palestine refugees residing in Syria have been granted the same civil rights (with exception to voting and holding parliamentary seats) as Syrian nationals. Palestine refugees under Law No. 260 of July 10, 1956 are given full and equal access to all public and social services, the right to employment, trade, travel, and residence in Syria.<sup>144</sup>

392. As a result of favourable governmental regulations and laws pertaining to the status and rights of Palestine refugees, the general Palestine refugee population prior to the Syrian crisis were more socially integrated within Syrian society, and in turn, benefited from lower levels of poverty and unemployment compared to those residing in Jordan and Lebanon.<sup>145</sup> Nevertheless, Palestine refugees continued to be the most vulnerable group within Syria with 23% of all those residing in camps earning less than two USD per day and 5% falling under extreme poverty earning less than one USD per day.<sup>146</sup>

393. Prior to the Syrian crisis, it was estimated that there were 495,970 Palestine refugees registered with UNRWA, of whom 75% lived in or around Damascus. There are 12 Palestine refugee camps in Syria, nine of which are official (established by UNRWA), while the remaining three are considered unofficial (established by Syrian authorities). In addressing the health needs of Palestine refugees in Syria, UNRWA established 23 primary health care facilities of which 12 were operating within the camps, and 11 servicing the communities outside the camps.

394. By March 2011, the Syrian conflict escalated drastically causing unprecedented destruction to both Syria's infrastructure and, moreover, the communities that reside within it. Though the majority of Palestine refugees (including leaders of political movements) had initially taken a neutral stance towards the spiralling conflict, the politically entangling nature of the conflict was ultimately too difficult to avoid and/or escape.<sup>147</sup> As a result, many of the Palestine refugee camps found themselves thrown in the midst of the conflict whereby displacement became the new norm.

395. At the end of 2012, Yarmouk, Syria's largest Palestine refugee camp located eight kilometres from Damascus, and which housed around 160,000 Palestinians, became the new designated battlefield between armed opposition groups and the Government of Syria (GOS). According to field reports, an estimated 150,000 people fled Yarmouk in a four-day period, causing the displacement of thousands of Palestine refugees and Syrians.<sup>148</sup> By 2013, the siege of Yarmouk began, whereby the Palestinians left behind found themselves barricaded within the confines of the camp with little to no access to food,

<sup>144</sup> Khalil, A. (2010). Socioeconomic Rights of Refugees: The Case of Palestinian Refugees in Egypt, Jordan, Lebanon, and Syria. American University of Cairo. <https://documents.aucegypt.edu/Docs/GAPP/KHALIL.pdf>

<sup>145</sup> Mawed, H. (1999). The Palestinian Refugees in Syria Their Past, Present and Future. International Development Research Centre. <http://prn.mcgill.ca/prn/al-mawed.pdf>

<sup>146</sup> Tiltne, A. A. (2007). Keeping Up A Brief A Brief on The Living Conditions of Palestinian Refugees in Syria (No. 13). Fafo. [https://www.fafo.no/media/com\\_netsukii/20013.pdf](https://www.fafo.no/media/com_netsukii/20013.pdf)

<sup>147</sup> Hassan, S. (2012, October). Palestinians in Syria and the Syrian Uprising: Case Analysis. Arab Centre for Research and Policy Studies. [https://www.dohainstitute.org/en/lists/ACRPS-PDFDocumentLibrary/Palestinians\\_in\\_Syria\\_and\\_the\\_Syrian\\_Uprising.pdf](https://www.dohainstitute.org/en/lists/ACRPS-PDFDocumentLibrary/Palestinians_in_Syria_and_the_Syrian_Uprising.pdf)

<sup>148</sup> UNRWA and SARC. (2010, December 20). Syrian Arab Republic Yarmouk Camp - Situation update [Press release]. <https://www.unrwa.org/where-we-work/syria/yarmouk-unofficial-camp>

water, and other necessary supplies. By 2018, the government regained control of the camp and UNRWA was able to conduct a full needs assessment and found that all three of its Health Centres were destroyed. Several official and unofficial refugee camps (i.e., Lattakia camp, Ein EL Tal camp, Dera'a camp, Sbeineh camp) have also been the target of direct hostilities leading to the destruction of facilities, casualties, and mass displacement of Palestine refugees.

396. A vulnerability assessment conducted by UNRWA in 2017, found that 95% of all Palestine refugees in Syria were dependent on UNRWA's services. Furthermore, a staggering 90% of Palestine refugees in Syria are living in absolute poverty surviving on less than two US dollars a day in comparison to 23% prior to the crisis.<sup>149</sup> By 2018, almost half of all registered Palestine refugees (254,000) have been internally displaced at least once, whilst another 34,200 are situated in "hard-to-reach areas".<sup>150</sup>

397. Though universal health coverage is a notable characteristic of the Syrian public health system, the crisis has largely impeded access to healthcare. Years of conflict have eroded the health infrastructure and consequently led to a sizable decrease in human resources, destruction of public health facilities, and irregular supply of medication. Furthermore, the deteriorating socioeconomic capabilities of the population, coupled with a scarcity of medical services, has further rendered access more difficult due to rising costs.

398. In addressing the health needs of the Palestine refugees in Syria, UNRWA's health team continues to provide primary health care services through 17 Health Centres, 6 health points, and two mobile teams. The services provided by UNRWA include the basic package of care (general medical consultations, mother and child health, non-communicable disease care, provision of essential medication) as well as gynaecology consultations, laboratory services, dental care, and MHPSS. It is important to note that conflict related incidents and/or events pose a continuous challenge for the health teams operating in Syria, at times impeding access to certain communities as well as their own access to UNRWA health facilities subsequently causing delays to service delivery.

399. The recent increase of COVID-19 confirmed cases amongst frontline health staff has substantiated a reasonable level of concern.<sup>ii</sup> Although the total number of confirmed cases are relatively low in Syria, the ability of Syria's depleted and fragmented health care system to withstand a full-scale pandemic is questionable to say the least. Therefore, the emergence of COVID-19 has compelled UNRWA's health teams to restructure, adopt, and adapt new modalities of service delivery that would provide the needed services to the community, while also protecting the patients and the frontline health staff. Newly adopted modalities of work included: the utilization of telemedicine, reorganizing facilities to provide triage for proper screening, organization and distribution of two to three months of NCD medication, community awareness, and proper utilization and reliance on the e-Health system for monitoring and organization of service delivery.

400. The Syrian economy is undergoing an acute economic crisis that is fuelled by almost a decade of fighting that has left the country devastated, Western sanctions, COVID-19 pandemic, the financial crisis in neighbouring Lebanon, and widespread allegations of corruption. High inflation rates have grappled the country, as Syria continues to witness the rapid devaluation of its currency. Accordingly, public frustration with the government's lack of clear economic policy/strategy has begun to increase across the country.<sup>151</sup>

<sup>149</sup> UNRWA Syria Regional Crisis Emergency Appeal (2020, January). United Nations Relief and Works Agency for Palestine Refugees in the Near East. <https://www.unrwa.org/resources/emergency-appeals/2020-syria-regional-crisis-emergency-appeal>

<sup>150</sup> UNRWA. (2020, October 7). Syria: - Humanitarian Snapshot [Press release]. <https://www.unrwa.org/resources/reports/syria-unrwa-humanitarian-snapshot-august-2020>

<sup>151</sup> Makki, D. M. (2020, June 2). Rampant Inflation Adds to Syria's Economic Turmoil. Middle East Institute. <https://www.mei.edu/publications/rampant-inflation-adds-syrias-economic-turmoil>

## Annex I: Data Collection Tools

| Overarching evaluation questions  | Sub-questions   | Stakeholder group   |  |   |   |   |  |  |  |
|---|---|---|--|---|---|---|--|--|--|
|   |   | UNRWA Health Department Staff   | Field Office Health Staff  | Frontline Health Staff  | Other UNRWA program areas   | Host Authority Representatives  | CSOs   | WHO and Donor representatives  | Palestine refugees   |
| <b>To what extent was the FHT Reform strategy and FHT Approach coherent to relevant Agency policies and commitments as well as those of UNRWA health partners and host governments?</b> |   | <p>How did the UNRWA policy framework (MTS, gender) inform the design of the FHTA? And how did the FHTA inform subsequent policies (MTS, gender?)</p> <p>How did UNRWA involve different stakeholders in the design/conception of the FHT reform?</p> | How were Field Office staff consulted in the design of the FHT reform?   | How were frontline staff consulted in the design of the FHT reform? | How were other programme areas consulted in the design of the FHT Reform? | <p>How has the UNRWA FHT Reform aligned with the primary health care priorities/ policies of your own government?</p> <p>How were you consulted in its design?</p>  | How has the UNRWA FHT Reform aligned with the primary health care priorities/ policies of your organization? | How has the UNRWA FHT Reform aligned with the primary health care priorities/ policies of your organization? |  |
|   | How has UNRWA partnered with the Palestinian Authority to deliver the FHT Reform effectively? | <p>What are the lines of communication between UNRWA and the PA regarding health? How have these changed under the FHT Reform? How could these be improved?</p> <p>To what extent is there joint planning/decision-making with PA?</p>                | <p>What are the lines of communication between UNRWA and the PA regarding health? How have these changed under the FHT Reform? How could these be improved?</p> <p>To what extent is there joint planning/decision-making with PA?</p> |   |   | <p>What are the lines of communication between UNRWA and the PA regarding health? How have these changed under the FHT Reform? How could these be improved?</p> <p>How is data shared between UNRWA/your health system? How is the shared</p> |  |  | <p>What are the considerations for Palestine refugees about the types of health services they use? How is the UNRWA FHTA different to other health services available?</p> |

| Overarching evaluation questions | Sub-questions | Stakeholder group  |   |                        |                           |   |      |                               |                    |
|----------------------------------|---------------|--|---|------------------------|---------------------------|---|------|-------------------------------|--------------------|
|                                  |               | UNRWA Health Department Staff  | Field Office Health Staff   | Frontline Health Staff | Other UNRWA program areas | Host Authority Representatives  | CSOs | WHO and Donor representatives | Palestine refugees |
|                                  |               | <p>How does UNRWA share data with the PA? What data does UNRWA receive from the PA? How could this be improved?</p> <p>Are there clear accountabilities in terms of what UNRWA is responsible for and the PA?</p> <p>How do you ensure that the needs of vulnerable Palestine refugees are met through your partnership with the PA?</p> <p>How are the social determinants of health addressed in your partnership with UNRWA? How could this be improved?</p> <p>How has public health messaging been coordinated with UNRWA</p> | <p>How does UNRWA share data with the PA? What data does UNRWA receive from partners? How could this be improved?</p> <p>Are there clear accountabilities in terms of what UNRWA is responsible for and the PA?</p> <p>How do you ensure that the needs of vulnerable Palestine refugees are met through your partnership with the PA?</p> <p>How are the social determinants of health addressed in your partnership with UNRWA? How could this be improved?</p> |                        |                           | <p>data used? Is this of sufficient frequency? Is the data reliable? How could data sharing be improved? How do you ensure that the needs of vulnerable Palestine refugees are met through your partnership with UNRWA?</p> <p>What have been the successes of the FHT Reform from your perspective? How has it improved services/health outcomes?</p> <p>What would make the FHT Reform more effective from your perspective?</p> <p>How are the social determinants of health addressed in your partnership with UNRWA? How</p> |      |                               |                    |

| Overarching evaluation questions   | Sub-questions   | Stakeholder group  |   |  |   |  |  |  |   |
|--|---|--|---|--|---|--|--|--|---|
|  |   | UNRWA Health Department Staff  | Field Office Health Staff   | Frontline Health Staff   | Other UNRWA program areas   | Host Authority Representatives   | CSOs   | WHO and Donor representatives  | Palestine refugees  |
|  |   | (COVID-19)? How could this be improved?  | How has public health messaging been coordinated with UNRWA (COVID-19)? How could this be improved?   |  |   | could this be improved?<br><br>How has public health messaging been coordinated with UNRWA (COVID-19)? How could this be improved?   |  |  |   |
| <b>To what extent has the FHT Reform strategy and FHTA aligned to the needs of Palestine refugees in the five fields of operation and the evolving contexts within them?</b> | To what extent has the FHTA reform considered gender, disability, and protection aspects in its design? (Cross-cutting) | What needs analyses/ evidence was used to design/justify the need for a reform of UNRWA's primary healthcare services?<br><br>To what extent does the FHTA allow UNRWA to better respond to the needs of Palestine refugees? How/has this changed over time? | To what extent has the design of the FHTA better enabled UNRWA to meet the needs of Palestine refugees?<br>To address gender/protection/disability concerns/needs of the most vulnerable? | To what extent has the design of the FHTA better enabled UNRWA to meet the needs of Palestine refugees?<br>To address gender/protection/disability concerns/ needs of the most vulnerable? | How were other program areas engaged in the design of the FHT Reform?<br><br>To what extent does the FHT Reform allow UNRWA to better meet the needs of Palestine refugees? | To what extent has the design of the FHTA better enabled UNRWA to meet the needs of Palestine refugees?<br>To address gender/protection/disability concerns/ needs of the most vulnerable? | To what extent has the design of the FHTA better enabled UNRWA to meet the needs of Palestine refugees?<br>To address gender/protection/disability concerns/ needs of the most vulnerable? | To what extent has the design of the FHTA better enabled UNRWA to meet the needs of Palestine refugees?<br>To address gender/protection/disability concerns/ needs of the most vulnerable? | How has the FHTA enable UNRWA to better address the needs of the most vulnerable/the disabled/ protection issues/ women's health and gender issues? |
| <b>To what extent have the resources available to implement the</b>  |   | To have extent has UNRWA's financial crisis affected the implementation of   | To have extent has UNRWA's financial crisis affected the implementation of the FHTA? What   | To have extent has UNRWA's financial crisis affected the implementation of the FHTA? What  |   | From your perspective, what impact have UNRWA's resource constraints had on  | From your perspective, what impact have UNRWA's  |  | How have the primary health care services provided by UNRWA been  |

| Overarching evaluation questions  | Sub-questions | Stakeholder group   |   |   |  |  |  |  |   |
|---|---------------|---|---|---|--|--|--|--|---|
|   |               | UNRWA Health Department Staff   | Field Office Health Staff   | Frontline Health Staff  | Other UNRWA program areas                              | Host Authority Representatives                         | CSOs   | WHO and Donor representatives                          | Palestine refugees  |
| <b>FHT Reform been adequate, including the enabling organizational frameworks (governance, policies, monitoring and feedback mechanisms)?</b> |               | the FHTA? What have been the gaps?  | have been the gaps?   | have been the gaps?   |  | its ability to deliver the FHT Reform?                 | resource constraints had on its ability to deliver the FHT Reform? |  | affected by its recent financial struggles?   |
| <b>Could the same outputs be attained at lower costs, or higher outcomes be achieved with the same resources?</b>                             |               | To what extent has the FHT led to efficiencies in the cost/delivery of services? What evidence is there for this? | To what extent has the FHT led to efficiencies in the cost/delivery of services? What evidence is there for this? | To what extent has the FHT led to efficiencies in the cost/delivery of services? What evidence is there for this? |  |  |  |  |   |
| <b>To what extent has the FHTA met its intended objectives?</b>   |               | What have been the key achievements of the FHT Reform?  | What have been the key achievements of the FHT Reform?  | What have been the key achievements of the FHT Reform?  | What have been the key achievements of the FHT Reform? | What have been the key achievements of the FHT Reform? | What have been the key achievements of the FHT Reform?             | What have been the key achievements of the FHT Reform? | What improvements has the FHT Reform led to for the health of Palestine refugees (access, quality, health outcomes) |
| <b>What have been the unintended</b>  |               | What have been the unintended/  | What have been the unintended/  | What have been the unintended/ surprising impacts   |  |  |  |  |   |

| Overarching evaluation questions  | Sub-questions   | Stakeholder group   |  |  |                           |   |   |  |  |
|---|---|---|--|--|---------------------------|---|---|--|--|
|   |   | UNRWA Health Department Staff   | Field Office Health Staff  | Frontline Health Staff   | Other UNRWA program areas | Host Authority Representatives  | CSOs  | WHO and Donor representatives  | Palestine refugees   |
| <b>impacts of the FHT Reform?</b>   |   | surprising impacts of the FHT Reform?   | surprising impacts of the FHT Reform?  | of the FHT Reform?   |                           |   |   |  |  |
| <b>What contributions/outcomes can be linked to the reforms and the FHT Approach? (e.g., improved quality of care, NCD reduction improved programme efficiency, improved staff and patient satisfaction, improved Hospitalization Support Program (HSP), and improved health outcomes for refugees, GEEW results, HR and workforce management, partnerships)?</b> | To what extent has the FHTA reform supported the achievement of GEEW/ protection results/results for people living with disability (Access to services, women's decision making, gender equity in the workforce)? (Gaza, Lebanon, Jordan) | <p>To what extent has the FHT Reform improved UNRWA's ability to address NCDs/led to better NCD outcomes for Palestine refugees?</p> <p>To what extent has the FHT Reform improved UNRWA's maternal health and infant care?</p> <p>What gender/disability/ protection analyses have been used to inform the design of the FHT Reform?</p> <p>To what extent was gender/disability/ protection considered in the design process?</p> <p>What training have staff had on gender/disability/</p> | <p>To what extent has the FHT Reform improved UNRWA's ability to address NCDs/led to better NCD outcomes for Palestine refugees?</p> <p>To what extent has the FHT Reform improved UNRWA's maternal health and infant care?</p> <p>What gender/ disability/ protection analyses have been used to inform the design of the FHT Reform?</p> <p>To what extent was gender/disability/ protection considered in the design process?</p> <p>What training have staff had on gender/disability/ protection as part of the reform?</p> | <p>To what extent has the FHT Reform improved UNRWA's ability to address NCDs/led to better NCD outcomes for Palestine refugees?</p> <p>To what extent has the FHT Reform improved UNRWA's maternal health and infant care?</p> <p>What training have staff had on gender/disability/ protection as part of the reform?</p> <p>To what extent has the FHTA allowed UNRWA to get closer to communities to identify/ intervene in protection/GBV cases? What are</p> |                           | <p>To what extent has the FHT Reform improved UNRWA's ability to address NCDs/led to better NCD outcomes for Palestine refugees?</p> <p>To what extent has the FHT Reform improved UNRWA's maternal health and infant care?</p> <p>To what extent has the FHTA enabled UNRWA to better address gender/protection/ disability issues?</p> <p>Have the referral pathways for protection/GBV cases improved under the FHTA? How could these be improved?</p> | <p>To what extent has the FHT Reform improved UNRWA's ability to address NCDs/led to better NCD outcomes for Palestine refugees?</p> <p>To what extent has the FHT Reform improved UNRWA's maternal health and infant care?</p> <p>To what extent has the FHTA enabled UNRWA to better address gender/ protection/ disability issues?</p> | <p>To what extent has the FHT Reform improved UNRWA's ability to address NCDs/led to better NCD outcomes for Palestine refugees?</p> <p>To what extent has the FHT Reform improved UNRWA's maternal health and infant care?</p> <p>To what extent has the FHTA enabled UNRWA to better address gender/protection/ disability issues?</p> | <p>To what extent has the FHT Reform improved UNRWA's ability to address NCDs/led to better NCD outcomes for Palestine refugees?</p> <p>To what extent has the FHT Reform improved UNRWA's maternal health and infant care?</p> <p>Probe whether: the UNRWA FHT Reform made it easier for Palestine refugees to: Report protection and GBV cases</p> |

| Overarching evaluation questions | Sub-questions | Stakeholder group  |   |  |                           |                                |  |                               |   |
|----------------------------------|---------------|--|---|--|---------------------------|--------------------------------|--|-------------------------------|---|
|                                  |               | UNRWA Health Department Staff  | Field Office Health Staff   | Frontline Health Staff   | Other UNRWA program areas | Host Authority Representatives | CSOs   | WHO and Donor representatives | Palestine refugees  |
|                                  |               | <p>protection as part of the reform?</p> <p>How has the FHTA better enabled the disaggregation of data gathered and gendered/disability/protection analysis of data?</p> | <p>How has the FHTA better enabled the disaggregation of data gathered and gendered/disability/protection analysis of data?</p> | <p>the disadvantages of this?</p> <p>Are the referral pathways for protection /GBV cases clearer/more accessible under the FHTA?</p> <p>How has the FHTA better enabled the disaggregation of data gathered and gendered/disability/protection analysis of data?</p> |                           |                                | <p>Have the referral pathways for protection/GBV cases improved under the FHTA? How could these be improved?</p> |                               | <p>Address child marriage<br/>9recognising the sensitivity of this issues in a direct question)</p> <p>Has the FHT Reform enabled men to access health services more/less/the same? In ways that are convenient/accessible to them?</p> <p>Has the FHTA supported women to have more/les control over their health (i.e., reproductive health)? What are the drawbacks?</p> |



| Overarching evaluation questions | Sub-questions   | Stakeholder group  |  |  |   |   |   |  |   |
|----------------------------------|---|--|--|--|---|---|---|--|---|
|                                  |   | UNRWA Health Department Staff  | Field Office Health Staff  | Frontline Health Staff   | Other UNRWA program areas   | Host Authority Representatives  | CSOs  | WHO and Donor representatives  | Palestine refugees  |
|                                  |   |  |  |  |   |   |   |  | <p>Are Palestine refugees/more /less able to access the services they require?</p> <p>Does the FHTA enable PLWD to better access services? Improve the services they can access?</p>              |
|                                  | To what extent has the FHTA reform supported the improvement of and use of data? (West Bank, Syria) | <p>How has the FHTR (E-Health) improved the accuracy/reliability of the health data UNRWA gathers?</p> <p>How is the data tested/validated for accuracy?</p> <p>How is the health data gathered used to inform decision-making/learning (give examples)?</p> | <p>How has the FHTR (E-Health) improved the accuracy/reliability of the health data UNRWA gathers?</p> <p>How is the data tested/validated for accuracy?</p> <p>What training have staff had on data use/data analysis? Are there still gaps in this area?</p> | <p>How has the FHTR (E-Health) improved the accuracy/reliability of the health data UNRWA gathers?</p> <p>How is the data tested/validated for accuracy?</p> <p>What training have staff had on data use/data analysis? Are there still gaps in this area?</p> | <p>How is health data shared with other UNRW program areas? How could this be improved?</p> | <p>How is health data shared by UNRWA with host authorities/PA? Is this data reliable/of sufficient quality? How is it used? How could data sharing be improved? Is there joint analysis?</p> <p>What are the feedback pathways for cases referred to/from UNRWA?</p> | <p>How is health data shared by UNRWA with partners?</p> <p>Is this data reliable/of sufficient quality? How is it used?</p> <p>How could data sharing be improved?</p> <p>Is there joint analysis?</p> | <p>How is health data shared by UNRWA with WHO/donors?</p> <p>Is this data reliable/of sufficient quality? How is it used?</p> <p>How could data sharing be improved? Is there joint analysis?</p> | <p>Are you aware of the health data gathered by UNRWA?</p> <p>Are you aware of how this is used/stored?</p> <p>Are there any concerns about data privacy? If so, how could this be addressed?</p> |

| Overarching evaluation questions | Sub-questions | Stakeholder group   |   |   |                           |                                |   |   |                    |
|----------------------------------|---------------|---|---|---|---------------------------|--------------------------------|---|---|--------------------|
|                                  |               | UNRWA Health Department Staff   | Field Office Health Staff   | Frontline Health Staff  | Other UNRWA program areas | Host Authority Representatives | CSOs  | WHO and Donor representatives   | Palestine refugees |
|                                  |               | <p>How useful is the data gathered to understanding health/outcomes/trends? How could this be improved? (too much? Right indicators etc.?)</p> <p>Are there any other weaknesses in how UNRWA gathers/records/analyses/uses data?</p> <p>How is data shared with other UNRWA program areas? How could this be improved?</p> <p>How is data gathered/disaggregated/analyses to ensure the gender/protection/disability are considered?</p> <p>Are UNRWA data collection systems/mechanisms for health data fit for</p> | <p>How is the health data gathered used to inform decision-making/learning (give examples)?</p> <p>How useful is the data gathered to understanding health/outcomes/trends? How could this be improved? (too much? Right indicators etc.?)</p> <p>Are there any other weaknesses in how UNRWA gathers/records/analyses/uses data?</p> <p>How is data gathered/disaggregated/analyses to ensure the gender/protection/disability are considered?</p> <p>Are UNRWA data collection systems/mechanisms for health data</p> | <p>How is the health data gathered used to inform decision-making/learning (give examples)?</p> <p>How useful is the data gathered to understanding health/outcomes/trends? How could this be improved? (too much? Right indicators etc.?)</p> <p>Are there any other weaknesses in how UNRWA gathers/records/analyses/uses data?</p> <p>How is data gathered/disaggregated/analyses to ensure the gender/protection/disability are considered?</p> <p>Are UNRWA data collection systems/mechanisms</p> |                           |                                | <p>What are the feedback pathways for cases referred to/from UNRWA?</p> | <p>What are the feedback pathways for cases referred to/from UNRWA?</p> |                    |

| Overarching evaluation questions | Sub-questions  | Stakeholder group  |  |   |                           |  |  |  |   |
|----------------------------------|--|--|--|---|---------------------------|--|--|--|---|
|                                  |  | UNRWA Health Department Staff  | Field Office Health Staff  | Frontline Health Staff  | Other UNRWA program areas | Host Authority Representatives   | CSOs   | WHO and Donor representatives  | Palestine refugees  |
|                                  |  | purpose? (Coherence of systems, infrastructure etc.)<br><br>To what extent does the data gathered enable UNRWA to understand efficiencies/cost savings since the FHT Reform?   | fit for purpose? (Coherence of systems, infrastructure etc.)<br><br>To what extent does the data gathered enable UNRWA to understand efficiencies/cost savings since the FHT Reform?   | ms for health data fit for purpose? (Coherence of systems, infrastructure etc.)   |                           |  |  |  |   |
|                                  | To what extent has the UNRWA workforce/HR approach adapted to support the FHTA reform? (West Bank, Gaza, Syria, Lebanon) | What workforce planning/analyses were undertaken in the design of the FHT Reform? Have these been repeated? What adjustments have been made?<br><br>To what extent has the FHT Reform supported or been accompanied by the development of 'soft skills' for staff (ability to work in teams etc.). | To what extent has the FHT Reform supported or been accompanied by the development of 'soft skills' for staff (ability to work in teams etc.).<br><br>What training Have staff had to adapt to the FHTA? Has this been adequate/goods quality? What are the gaps?<br><br>How have staff been supported to better address | To what extent has the FHT Reform supported or been accompanied by the development of 'soft skills' for staff (ability to work in teams etc.).<br><br>What training Have staff had to adapt to the FHTA? Has this been adequate/goods quality? What are the gaps? |                           | To what extent have the changes to the UNRWA health workforce supported the implementation of the FHT Reform? What are the workforce gaps (skills, volume...)? | To what extent have the changes to the UNRWA health workforce supported the implementation of the FHT Reform? What are the workforce gaps (skills, volume...)? | To what extent have the changes to the UNRWA health workforce supported the implementation of the FHT Reform? What are the workforce gaps (skills, volume...)? | To what extent has the UNRWA FHTA led to better staffing for delivering health care for Palestine refugees? |

| Overarching evaluation questions | Sub-questions | Stakeholder group   |  |  |                           |                                |      |                               |                    |
|----------------------------------|---------------|---|--|--|---------------------------|--------------------------------|------|-------------------------------|--------------------|
|                                  |               | UNRWA Health Department Staff   | Field Office Health Staff  | Frontline Health Staff   | Other UNRWA program areas | Host Authority Representatives | CSOs | WHO and Donor representatives | Palestine refugees |
|                                  |               | <p>What training Have staff had to adapt to the FHTA? Has this been adequate/goods quality? What are the gaps?</p> <p>How have staff been supported to better address gender/protection/di sability issues under the FHTA? Has this been effective? How could it be improved?</p> <p>How has UNRWA's health workforce responded to shocks (COVID-19, emergencies)?</p> <p>How has UNRWA's financial situation/austerity affected the agency's ability to meet the workforce requirements to deliver the FHTA?</p> | <p>gender/protection/ disability issues under the FHTA? Has this been effective? How could it be improved?</p> <p>How has UNRWA's health workforce responded to shocks (COVID-19, emergencies)?</p> <p>How have UNRWA staff been supported to include psychosocial support under the FHTA? Did this have additional effects on health program outcomes (e.g., on protection, psycho-social well-being, quality of care)?</p> <p>How has UNRWA's financial situation/austerity affected the</p> | <p>How have staff been supported to better address gender/protection /disability issues under the FHTA? Has this been effective? How could it be improved?</p> <p>How has UNRWA's health workforce responded to shocks (COVID-19, emergencies)?</p> <p>How have UNRWA staff been supported to include - psychosocial support under the FHTA? Did this have additional effects on health program outcomes (e.g., on protection, psycho-social well-being, quality of care)?</p> |                           |                                |      |                               |                    |

| Overarching evaluation questions | Sub-questions | Stakeholder group  |  |   |                           |                                |      |                               |                    |
|----------------------------------|---------------|--|--|---|---------------------------|--------------------------------|------|-------------------------------|--------------------|
|                                  |               | UNRWA Health Department Staff  | Field Office Health Staff  | Frontline Health Staff  | Other UNRWA program areas | Host Authority Representatives | CSOs | WHO and Donor representatives | Palestine refugees |
|                                  |               | <p>How have changes to the workforce under the FHTA supported the achievement of health outcomes?</p> <p>Have the adaptations to the workforce model under the FHT Reform created efficiencies?</p> <p>Have the adaptations to the health workforce model under the FHT Reform supported/enabled/inhibited gender equality in the workforce (roles by gender, women in leadership.)</p> <p>What further changes to the workforce are needed to support the effective implementation of the FHTA?</p> | <p>agency's ability to meet the workforce requirements to deliver the FHTA?</p> <p>How have changes to the workforce under the FHTA supported the achievement of health outcomes?</p> <p>Have the adaptations to the health workforce model under the FHT Reform supported/enabled/inhibited gender equality in the workforce (roles by gender, women in leadership.)</p> <p>What further changes to the workforce are needed to support the effective implementation of the FHTA?</p> | <p>How has UNRWA's financial situation/austerity affected the agency's ability to meet the workforce requirements to deliver the FHTA?</p> <p>How have changes to the workforce under the FHTA supported the achievement of health outcomes?</p> <p>Have the adaptations to the health workforce model under the FHT Reform supported/enabled/inhibited gender equality in the workforce (roles by gender, women in leadership.)</p> <p>What further changes to the workforce are</p> |                           |                                |      |                               |                    |

[illegible]

| Overarching evaluation questions                      | Sub-questions   | Stakeholder group   |  |  |                           |  |   |  |   |
|---|---|---|--|--|---------------------------|--|---|--|---|
|   |   | UNRWA Health Department Staff   | Field Office Health Staff  | Frontline Health Staff   | Other UNRWA program areas | Host Authority Representatives   | CSOs  | WHO and Donor representatives  | Palestine refugees  |
| stresses) to recent and projected changes in context? | and development assistance?<br>(Cross-cutting)  |   |  |  |                           |  |   |  |   |
|   | To what extent has the FHTA adapted and been able to achieve results in emergency contexts? (Syria, Gaza) | <p>How has the FHTA model been adapted to emergency contexts? Which aspects have been prioritized/deprioritized?</p> <p>How has the FHT workforce model been different in an emergency context? What have been the challenges with this?</p> <p>How have the needs of vulnerable groups/gender/disability/protection issues been addressed under the FHT Reform in emergency contexts? How could this be improved?</p> <p>How have UNRWA funding mechanisms (Emergency Appeals)</p> | <p>How has the FHTA model been adapted to emergency contexts? Which aspects have been prioritized/deprioritized?</p> <p>How has the FHT workforce model been different in an emergency context? What have been the challenges with this?</p> <p>How have the needs of vulnerable groups/gender/disability/protection issues been addressed under the FHT Reform in emergency contexts? How could this be improved?</p> | <p>How has the FHTA model been adapted to emergency contexts? Which aspects have been prioritized/deprioritized?</p> <p>How has the FHT workforce model been different in an emergency context? What have been the challenges with this?</p> <p>How have the needs of vulnerable groups/gender/disability/protection issues been addressed under the FHT Reform in emergency contexts? How</p> |                           | <p>How has the UNRWA FHT model been adapted to emergency contexts? How could this be improved?</p> <p>How have the needs of vulnerable groups/gender/disability/protection issues been addressed under the FHT Reform in emergency contexts? How could this be improved?</p> <p>How has UNRWA collaborated with host authorities/PA to deliver primary health services in emergencies?</p> | <p>How has the UNRWA FHT model been adapted to emergency contexts? How could this be improved?</p> <p>How has UNRWA collaborated with partners to deliver primary health services in emergencies?</p> | <p>How has the UNRWA FHT model been adapted to emergency contexts? How could this be improved?</p> | <p>How have the FHT services available to you been affected by the emergency context?</p> <p>To what extent is UNRWA able to address the needs of the most vulnerable/disabled/gender in emergencies? How could this be improved?</p> |

| Overarching evaluation questions | Sub-questions | Stakeholder group  |  |  |                           |                                |      |                               |                    |
|----------------------------------|---------------|--|--|--|---------------------------|--------------------------------|------|-------------------------------|--------------------|
|                                  |               | UNRWA Health Department Staff  | Field Office Health Staff  | Frontline Health Staff   | Other UNRWA program areas | Host Authority Representatives | CSOs | WHO and Donor representatives | Palestine refugees |
|                                  |               | <p>supported the rollout of the FHTA?</p> <p>Have the health outcomes achieved by the FHT Reform been different/worse/better in emergencies?</p> <p>How has UNRWA been able to adapt and be agile whilst undertaking a long-term reform?</p> <p>Has the emergency context led to any delays in the FHT Reform? How/have these been overcome?</p> | <p>How have UNRWA funding mechanisms (Emergency Appeals) supported the rollout of the FHTA?</p> <p>Have the health outcomes achieved by the FHT Reform been different/worse/better in emergencies?</p> <p>How has UNRWA been able to adapt and be agile whilst undertaking a long-term reform?</p> <p>Have staff working in emergencies received training on the FHTA and how to deliver this in emergencies?</p> <p>Has the emergency context led to any delays in the FHT Reform? How/have</p> | <p>could this be improved?</p> <p>Have the health outcomes achieved by the FHT Reform been different/worse/better in emergencies?</p> <p>How has UNRWA been able to adapt and be agile whilst undertaking a long-term reform?</p> <p>Have staff working in emergencies received training on the FHTA and how to deliver this in emergencies?</p> |                           |                                |      |                               |                    |



| Overarching evaluation questions   | Sub-questions  | Stakeholder group                                      |                           |                        |                           |                                |      |                               |                    |
|--|--|--|---------------------------|------------------------|---------------------------|--------------------------------|------|-------------------------------|--------------------|
|  |  | UNRWA Health Department Staff                          | Field Office Health Staff | Frontline Health Staff | Other UNRWA program areas | Host Authority Representatives | CSOs | WHO and Donor representatives | Palestine refugees |
|  |  |  | these been overcome?      |                        |                           |                                |      |                               |                    |
| What are the major factors that have influenced the sustainability of the reform interventions and outcomes? | What would be necessary to further embed the sustainability of gains made from the FHTA? | To be addressed implicitly through other enquiry areas |                           |                        |                           |                                |      |                               |                    |

## Annex J: Methodological Approach

### Approach

A mixed-methods approach has been used to undertake this evaluation. It was determined in the inception phase that the evaluation would take a primarily qualitative approach to data collection, gathering evidence to 'tell the story' of the UNRWA FHT Reform and the difference it has made. Qualitative evidence has been triangulated where possible with secondary quantitative data from UNRWA to develop evaluation findings and recommendations.

The evaluation team also developed a retrospective Theory of Change for the FHT which has informed our understanding of the FHT Reform's intended results. An evaluation matrix was developed setting out the evaluation questions criteria and the intended methods and stakeholders to address each evaluation question.

The evaluation has taken a primarily qualitative approach to data collection, gathering evidence to 'tell the story' of the UNRWA FHT Reform and the difference it has made. Qualitative evidence has been triangulated where possible with secondary quantitative data from UNRWA (i.e., annual reports, e-Health) to develop evaluation findings and recommendations.

### Gender and Cross-Cutting Issues

The evaluation sought to ensure that cross-cutting issues of gender, protection, disability and human rights were well-integrated into the evaluation's design, implementation, and analysis and that data collection tools and sampling were gender and conflict sensitive, considering tensions between different groups of Palestine refugees and applying careful consideration to those who have been doubly displaced and may experience heightened vulnerability. Focus groups were disaggregated by nationality (i.e., between PRS and PRL/J) and were disaggregated where possible by gender and age, creating safe spaces for engagement for women and accounting for power relations between different family members such as mothers-in-law and daughters-in-law.

### Data Collection

The key data collection methods for this evaluation were remote key informant interviews (KIIs) which were conducted using semi-structured questionnaire guides to gather views and perceptions from key informants. Interviews were undertaken with UNRWA HQ Health Staff, as well as senior management from other UNRWA programme areas and external stakeholders such as UNRWA health donors and WHO representatives. In each field of operation, the evaluation team completed interviews with Senior Health Staff, UNRWA Area and Health Centre staff, UNRWA partners, and host government representatives, as well as individual interviews and (where possible) focus groups with Palestine refugees.

Interview guides were designed using the evaluation matrix tailored to each stakeholder group, using knowledge of their context to elicit detailed descriptions that respond to the review questions. In total, the evaluation completed 225 interviews and 16 focus groups.

### Limitations

A key limitation for this evaluation was the fact that it was completed during the COVID-19 pandemic, which affected the availability of stakeholders for interview and the evaluation team's ability to undertake field work as planned, given the worsening situation in several of UNRWA's fields of operation and the restrictions on travel across the different fields.

The evaluation team originally planned to conduct face-to-face methods of data collection with Palestine refugees through focus groups, ensuring separate engagement with men and women, with a range of ages, and with NCD and MCH patients. However, given the changing COVID-19 context, this was only possible in Gaza and Syria during the time of the field work timeframe and individual remote interviews of Palestine refugees were completed in other fields.

This meant that the evaluation was unable to engage with as many Palestine refugees as intended to ensure the inclusion of their views in this evaluation. Extra resources were made available by UNRWA to increase the number of individual interviews to mitigate this. However, the format of individual phone interviews with Palestine refugees was suboptimal in terms of the logistics of arranging these which may have affected the frankness of responses.

The evaluation team was unable to obtain the requisite permissions to undertake primary data collection with Palestine refugees and UNRWA partners in Syria. Instead, the evaluation engaged with staff from different UNRWA departments (Education, Relief and Social Services (RSS), etc.) who are themselves Palestine refugees and UNRWA service health users. While this has added the voices of Palestine refugees in Syria to the evaluation, engagement with this group was not as extensive as that with Palestine refugees in UNRWA's other four fields.

A limitation to the evaluation is the lack of an existing Theory of Change or results framework for the FHT Approach. A time series of monitoring data that would permit an analysis of the FHT process, quality and outcome indicators over time is not available, and there is no baseline data. For example, UNRWA has not systematically conducted patient/staff satisfaction surveys nor utilized other effective tools to evaluate improved quality of care on an annual basis. As such, it is not possible to observe changes over time. Available data which can be construed as outcomes or process improvement indicators have been used where possible to triangulate qualitative data collected by the evaluation.

An additional limitation was the reliance on UNRWA quantitative data for outcomes. This evaluation did not collect primary data on health outcomes and is thus reliant on secondary data from UNRWA documentation regarding improvements in health outcomes over time. The only health outcomes reported by UNRWA are on NCD prevalence and maternal health. To mitigate this, the evaluation team has ensured that its findings, conclusions, and recommendations for this evaluation are derived from multiple sources and triangulated.

### **Phase 1: Inception Phase**

In the inception phase, the evaluation team conducted 25 individual interviews and undertook a review of key documentation relevant to the FHT Reform (see Annex D) to inform the development of a retrospective Theory of Change, a timeline of key events relevant to the FHT Reform and a context analysis, and refined the evaluation questions and developed the methodology in the inception report. The inception report was finalized based upon comments received from the Evaluation Reference Group (ERG).

### **Phase 2: Data Collection**

The evaluation team used a mixed methods approach to collect data linked to the overarching and sub-evaluation questions. It developed a 'data collection plan' with Q Perspective to ensure that logistical arrangements were in place to manage data collection processes. There was a clear division of work between Q Perspective and the core evaluation team regarding different data collection methods and sources. It also held a session where the core evaluation team took Q Perspective staff and national data collectors through the data collection tools to ensure a shared understanding of the evaluation lines of enquiry. Once data collection began, it 'tested' a random sample of the data gathered to check for consistent approaches/depth etc.

The key data collection methods include:

Key Informant Interviews (KIs): The core evaluation team conducted remote KIs with FHT senior management at Headquarters and Field Offices, as well as selected senior clinical staff and external stakeholders such as UNRWA health donors and host governments. KIs were also completed by Q

Perspective and national data collectors with UNRWA field staff and partners. Semi-structured questionnaire guides were used to gather views and perceptions from key informants.

Interview guides were designed using the evaluation matrix, tailored to each stakeholder group, using knowledge of their context to elicit detailed descriptions that respond to the review questions. Interviews lasted approximately one hour. Interview findings were recorded using a standardized analytical tool derived from the evaluation matrix, questions and criteria and triangulated against other data sources to generate robust findings.

Focus groups: Sixteen focus groups took place with groups of Palestine refugees and with UNRWA field staff. Each focus group was conducted using a structured tool based upon the comparative enquiry area relevant. To allow for a breadth of opinion without over-crowding the discussion, the ideal number of participants for an FGD was between 6 and 8 (5 when remote). The convening member of the review team guided the FGD to ensure the discussion remained relevant but encouraged participants to elaborate on points they made to achieve depth in the responses.

The convener encouraged the participation of all members and ascertained if opinions were representative of the whole group or individual perspectives, rather than relying on the most vocal. Ethical protocols were considered in the design and undertaking of FGDs. FGD findings were recorded using a standardized analytical tool derived from the evaluation matrix, questions and criteria and triangulated against other data sources to generate robust findings.

Document review: The core evaluation team conducted further document reviews (which supplemented and went deeper than the document reviews conducted during inception) and extracted relevant data from the e-Health system at facility and field levels. Document review was used to map the reform trajectory and contextualize other qualitative data collected. Document review was particularly important in examining the reform period before 2016 where there was less institutional memory compared with the 2016-2021 strategic period, helping to map and deep dive into the stages of reform.

Here the evaluation team drew upon sources, including but not limited to, UNRWA strategic plans such as the UNRWA Medium Term Plan 2005-2009, the UNRWA Medium Term Strategy 2010-2015 and the 2011 Health Reform Strategy, project and implementation documents, human resources documents including revised job descriptions, reform progress reports, Annual Health Reports and independent reviews of the Family Health Team. The evaluation team worked with the Evaluation Manager and key stakeholders to iteratively add to the list of documents under review as data collection progressed. Documentary review findings were recorded using a standardized analytical tool derived from the evaluation matrix, questions and criteria and triangulated against other data sources to generate robust findings.

Data collected from all sources was captured and systematized in a framework based on tailored field-specific Evaluation Matrices, i.e., according to sub-questions against key evaluation questions that pertain to the different evaluation criteria for each field. The framework was held in an electronic platform accessible to all evaluation team members.

### **Phase 3: Data Analysis and Synthesis**

Recognizing that a proportion of the field-level data was gathered by national data collectors, the core evaluation team received a debriefing on the data gathered in the field to orientate themselves into the findings. It conducted analysis of data gathered individually and as a team to 'test' emerging findings to ensure they were both validated and triangulated.

The evaluation team took an aggregate view of evidence across the comparative enquiry area and the high-level interviews to assess the overarching evaluation questions and criteria to develop robust findings and recommendations, ensuring that findings are derived from multiple sources to ensure triangulation or noting explicitly where this is not the case.

Relevance, coherence, efficiency, effectiveness, and sustainability guided the identification of enablers and constraints that affected impact in different cases, and for different groups. This included changes that were introduced to the FHT Approach at various times in different fields and informed preliminary context and/or service-specific findings, conclusions, lessons, and recommendations.

Secondly, and based on the Theory of Change, a contribution analysis lens was used to form a view on where reforms within the FHT Approach have had/are having a demonstrable effect, the significance of this (in context) and the prospect for such gains to be sustained and built on further. The evaluation team applied dedicated gender- and rights- based analyses to identify where and how a gendered and rights-based approach (or lack thereof) may have affected service delivery, quality, utilization, and outcomes. This helped to explain the possible contribution of the FHT Approach to identified trends and differences in service availability, delivery and utilization, staff and beneficiary satisfaction, as well as outcomes in selected cases, including planning and resourcing of services.

The evaluation team also analyzed the evidence collected from the perspective of what insights can be taken from the FHT Reform experience regarding the change management aspects of the reform/continuous improvement process. Once emerging findings and outline conclusions were identified, they were validated and refined during a virtual workshop with the ERG and key internal stakeholders.

#### **Phase 4: Reporting**

Following the workshop with ERG and key stakeholders, the evaluation team conducted a final data analysis and synthesis of its findings, conclusions, and recommendations in the draft Evaluation Report. It considered all feedback received from the ERG workshop. The report adhered to the UNEG guidelines and UNRWA QA standards.

The draft Evaluation Report was quality assured following the evaluation team's rigorous quality assurance processes. The report was then circulated by DIOS for stakeholder review and underwent DIOS's own quality assurance. The evaluation team revised the report based on feedback from UNRWA, collaborating via a comment tracker to produce the Final Evaluation Report.

Finally, the evaluation team delivered a virtual informal briefing on the evaluation results to internal stakeholders.

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