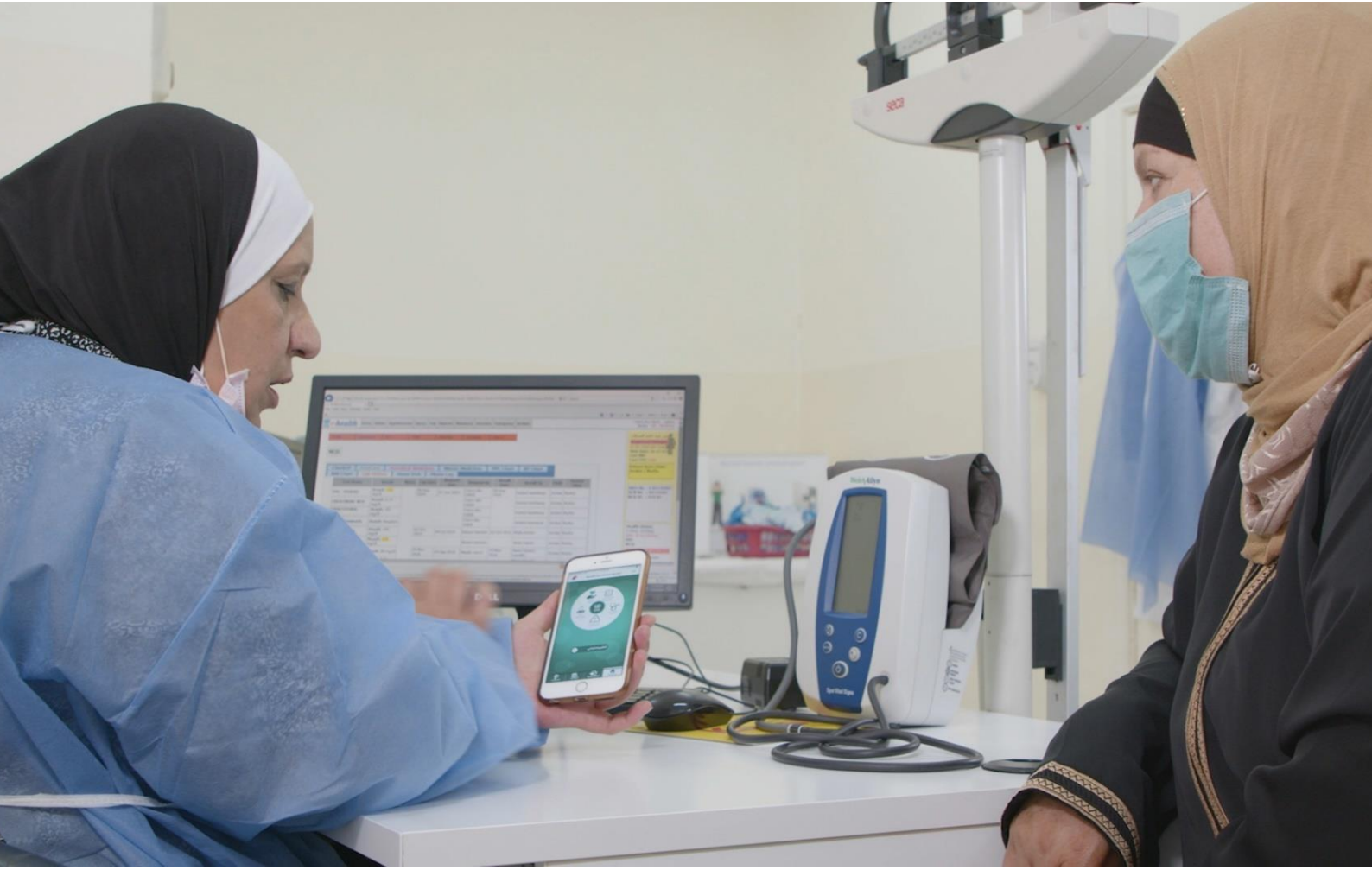

evaluation of the unrwa family health team reform

department of internal oversight services evaluation division

unrwa
الاونروا

october 2021

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

<u>Relevance and Coherence</u>

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 progamme 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.