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Message of the UNRWA Commissioner General and of the WHO Regional Director

Across UNRWA's five fields of operation, Palestine refugees have been increasingly affected by conflict and crisis. Fighting in Syria has entered its fourth year, internally displacing close to 270,000 Palestine refugees, and forcing many to flee to neighboring countries. More than 52,000 Palestine refugees from Syria have sought refuge and assistance in Lebanon, and over 12,000 in Jordan. Many of these refugees are now experiencing their third or even fourth displacement since 1948. Meanwhile, the ongoing Israeli occupation of the Gaza Strip and West Bank, including East Jerusalem, exacerbated by the blockade of the Gaza Strip, continues to have a profound impact on the population of more than two million Palestine refugees registered there with UNRWA and whom the Agency is mandated to assist. As well as increasing forced displacement and escalating injuries and fatalities as a result of operations conducted by Israeli security forces in the West Bank in 2013, this has also caused severe economic hardship throughout the territory, including high rates of poverty and a disturbing rise in food insecurity, which is particularly felt in Gaza.

In the context of increasing humanitarian crisis, UNRWA, has never been so important. In all Fields, the Agency's health programme continues to benefit from the support of its strategic partner, the World Health Organization (WHO). Health is a fundamental human right, but is also an intrinsic part of meaningful human development. UNRWA has provided comprehensive primary healthcare to Palestine refugees for over 60 years, with enormous success reducing communicable diseases, and infant and maternal mortality.

However, reform has been necessary in order to address the changing health needs of refugees, particularly the increasing prevalence of lifestyle related non-communicable diseases (NCDs), including diabetes and hypertension. Initiated in 2011, the new Family Health Teams and e-health system provide a patient-centric, holistic approach to service provision, and will enable the Agency to build on its past achievements to improve access to quality, relevant healthcare for Palestine refugees. With help of WHO and other partners, UNRWA is also in the process of developing a new Medium Term Strategy for 2016 to 2021. This report will serve to guide UNRWA's plans, including responding to the complex and evolving health needs of Palestine refugees.

UNRWA faces many challenges. Financial support to the Agency has not kept pace with an increased demand for services, caused by expanding needs and deepening poverty in a growing refugee population. In the absence of a just and durable solution to their plight, Palestine refugees are increasingly vulnerable in a chronically volatile regional environment. The 2013 Health Report attests to the commitment and dedication of UNRWA health staff, who - despite these extremely challenging conditions - continue to work on the front line to deliver vital services to Palestine refugee communities. Because of this commitment, reforms are making progress, leading to real improvements in the quality and efficiency of healthcare services, contributing to the Agency's mission to promote the human development of all Palestine refugees.

Pierre Krähenbühl
UNRWA Commissioner General

Dr Ala Alwan
Regional Director, WHO/EMRO

Foreword of the Director of Health

The year 2013 was a challenging year for the region, Palestine refugees, and UNRWA. The ongoing Syrian conflict and the worsening plight of Palestine refugees inside Syria, growing burden of health services in Jordan and Lebanon from fleeing Palestine refugees, and Polio outbreak in Syria warranting massive and repeated immunisation rounds, all added a huge burden on UNRWA's services. I however present the Annual Report of the Department of Health for 2013 completely humbled by the continuing resilience and dedication of all refugees in general, and our staff in particular, that allowed us, yet once again, to rise to the challenge and still deliver our services. As always my sincere gratitude is due to all staff in the Fields and in the Headquarters who untiringly continue to work hard, sometimes in life threatening circumstances, to improve the health status and quality of life of over 5 million Palestine refugees we serve. This report documents the results of this hard work of the staff, and once again confirms that we are moving in the right direction towards realizing our ultimate Human Development Goal, "A Long and Healthy Life" for all Palestine refugees.

First and foremost, the 2013 report reaffirms that health reforms based on the family-centred, Family Health Team (FHT) approach initiated since 2011, are slowly but surely working and gaining ground. FHT approach was adopted to improve the quality of care and to streamline the delivery of our primary health care services to all refugees. Significance and utility of FHT grew further as it is well suited to address the globally prevalent trends, being experienced by Palestine refugees – an ageing population and an increasing burden of NCDs. These palpable changes in health and demographic profiles of Palestine refugees and their likely impact, warranted a meaningful adjustment to service delivery. A health centre audit for Diabetes, conducted in a selected sample of patients under UNRWA health care last year, showed alarmingly high prevalence of NCD related life style risk factors – over 90% were either obese or overweight, and 1 in 5 were smokers. These numbers clearly underscore the application of full gamut of primary to secondary to tertiary prevention services to prevent new cases, diagnose earlier and treat sooner for better health outcomes, and to prevent life threatening complications through quality treatment and management. However and unfortunately, donor funding has failed to keep pace with the growing numbers of Palestine refugees seeking UNRWA health services, thir growing health needs, causing our helth services to spread further thin with the limited available resources.

Nevertheless FHT-based health reforms implementation and its expansion to additional health centres (excluding Syria), continued in 2013, flanked by the growing and encouraging evidence of improvements in service quality, client satisfaction, and efficiency. The enthusiasm and satisfaction expressed by Palestine refugee communities as well as our health centre staff over the adoption of FHT approach have been contagious; by the end of 2013, the FHT approach covered 69 health centres across the agency. Our vision is to expand the Family Health Team approach to all health centres by 2015.

Syria crisis continued to worsen the plight of over 500,000 Palestine refugees living in this country – over 50% have faced multiple internal displacements and are in need of urgent humanitarian assistance, while over 150,000 have fled to neighbouring countries, burdening health services there. Confirmed outbreak of Polio in Syria last year, only proved the incremental deterioration of public health infrastructure, health services availability, and access and utilization, thus threatening to reverse the health gains accrued over several years if not decades. All Fields also continued to take innovations in diverse and critical areas to suit Field realities. What is encouraging indeed is that such innovations are often initiated by our frontline health centre staff in collaboration/consultation with the community. Syria Field office undertook simple

yet far reaching adjustments to service delivery that allowed it to maintain health services utilization to levels as high as 70% of pre-crisis levels, a remarkable achievement by any standards of service delivery in conflict. With the number of health centres closed and access to those open marred by violence, Syria Field Office introduced outreach-based health points to plug access deficits. Similarly many other innovations that took place in 2013, punctuate this report.

Evidence abounds from health reforms experience in the developed world that substantiate the critical role health informatics can play in improving efficiencies and in increasing health reforms yield by many folds. UNRWA accordingly had electronic medical records (e-health) as one key objective of health reforms and had initiated e-health also since 2009, and it has been expanding steadily. During 2013, 55 health centres were fully equipped with e-health and are now paperless in their functioning, allowing them to collect and to analyze the data extensively and to generate real time evidence to guide decision making and service delivery interventions. It was only e-health that allowed UNRWA to introduce a cutting edge and innovative NCD monitoring and a health care audit tool for "cohort-analysis" of patients with diabetes and hypertension.

Syrian conflict and its deleterious regional reach, has once again moved the goal posts in terms of targets and achievable goals, has compounded ill health, and like Polio may slowly be chipping away at formidable health gains of years. Many other major challenges confront us: health services provision during active conflict, inequitable access to healthcare in general, increasing need and demand for cost-intensive specialized care particularly for non-communicable diseases, growing need and demand for mental health care, and dwindling financial resources. Nevertheless, Palestine refugees have endured setbacks for decades and have only used adversity to further cement their resolve for freedom, equal rights and protection, and better health and quality of life. I borrow a leaf from this unflinching resolve of Palestine refugees to remain optimistic and to nurture my belief that these challenges and crises also afford unique opportunities. We will expand our evidence-based health reforms, and strengthen our linkages with an increasing number of national and international partners, including donors as indicated in the relevant parts of the report.

But most importantly, it is the great staff that I have the privilege of working with, day in, day out and my respect for them has only grown in the past year. With their resolve, dedication and skills we will strive to improve the health of the Palestine refugees the best way we can.

Dr. A. Seita

WHO Special Representative
Director of the UNRWA Health Programme

Executive Summary and Introduction to the Report

United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) has the largest humanitarian operations in the region for over 6 decades, and has been the main provider of Primary Health Care (PHC) for Palestine refugees in the five fields of operations: Gaza, Jordan, Lebanon, Syria and West Bank. It is mandated to protect and promote the health of Palestine refugees so that they could achieve the highest attainable level of health as indicated in the first Human Development Goal, "A Long and Healthy Life" and in the UNRWA Medium Term Strategy 2010-2015. This report highlights the activities, progress and challenges of UNRWA health services during the course of 2013.

The year 2013 was a challenging year for Palestine Refugees and UNRWA. Ongoing Syrian conflict, growing burden of health services in Jordan and Lebanon from fleeing Palestine refugees, and Polio outbreak in Syria warranting massive and repeated immunisation rounds. At the same time, the year 2013 was the year to reaffirm that health reforms based on the family-centred, Family Health Team (FHT) approach and e-health initiated since 2011, are showing progress and results, slowly but steadily. The reform with FHT and e-health has expanded in 2013, flanked by the evidence of improvements in service quality, client satisfaction, and efficiency. By the end of 2013, FHT approach covered 69 health centres. The enthusiasm and satisfaction expressed by Palestine refugee communities as well as the staff have been contagious. Progress is steady towards the target of 100% FHT coverage of all helth centres by the end of 2015.

Syria crisis continued to affect 500,000 Palestine refugees in Syria. Over 50% of them are internally displaced, and 50,000 fled for Lebanon and 10,000 for Jordan, burdening health services there. Polio outbreak in 2013, after decades of polio-free, confirming deterioration of health services in Syria. Half of the 23 UNRWA health centres are non-functional. Regular supply of medicines is a challenge due to collapse of domestic production in Syria and the difficulty in bringing medicines from abroad. Still, UNRWA managed to provide primary health care through the use of functional health centres and opening health points in shelters for displaced. Medical consultations, once decreased to half of the pre-conflict level in 2012, recovered to 70% of the pre-conflict level in 2013. Essential medicines are now sufficiently delivered to the central warehouse, while in-country distribution still remains a challenge.

This report will highlight the progress and challenges in the health reform as a start, and will illustrate primary health care services in a comprehensive way, and then will indicate the data in detail that is self-explanatory in each Field of operations at the end, and at an Agency-wide level.

All Fields also continue to take innovations in diverse and critical areas to suit Field realities. What is encouraging indeed is that such innovations are often participatory, and are initiated by our frontline health centre staff in collaboration/consultation with the community. Syria Field office, as mentioned befor, undertook simple, yet far reaching adjustments to service delivery that allowed it to maintain health services utilization to levels as high as 70% of pre-crisis levels, a remarkable achievement by any standards of service delivery in conflict. With the number of health centres closed and access to those open marred by violence, Syria Field Office introduced outreach-based health points to plug access deficits.

New approaches to health services provision had thus to be found to meet the needs brought about by the changing demographics and the health profile of Palestine refugees in the 21st century. This report summarizes the main achievements of UNRWA's Health Programme in 2013, and is structured in three sections: Section 1 reports on the innovations being implemented to provide quality health services to Palestine refugees in response to the changing environment and the challenges of a changing health care context, Section 2 provides information on the performance of health service delivery programmes and activities in 2013, and Section 3 contains self-explanatory data tables and trends on major indicators for each service delivery area at both Field and Agency-wide levels.

Section 1 – UNRWA Health Reform and Innovations in a Changing Environment

This section reports the health reform based on Family Health Team (FHT) approach and e-health, supported by community engagement and innovations like Agency-wide diabetes campaign and specific ones in each field. It also describes the UNRWA health services in Syria.

UNRWA has been implementing an extensive health care reform since 2011 to respond to the changing health needs of Palestine refugees in the 21st century. Non-communicable diseases, including diabetes and hypertension, are the main health problems for Palestine refugees, accounting for 70 to 80% of causes of deaths. Family Health Team (FHT) and e-health was adopted as the core strategy of the reform. FHT is a family-centred, continuous and comprehensive primary health care delivery, focusing not only on curative care, but also on the promotion of health and healthy lifestyle. This is based on the family medicine models widely adopted in the industrialized countries since many decades. E-health is composed of the electronic medical records developed by UNRWA, to the improve patients' data management and then to contribute to improvement of patients' care and the improvment of the overall health services.

Family Health Team (FHT) has expanded to 69 out of 115 health centres (excluding 23 in Syria) by 2013, covering 60% of the refugee populations. FHT resulted in the improvement of quality of services. The daily medical consultation by a doctor (which was extremely high, more than 100 per doctor per day) was decreased (around 80 in some fields), and antibiotics prescription rates has also shown a decrease. At the same time, indicators for maternal and child health such as vaccination coverage and percentage of pregnant women making at least four visits remained at the high level. Satisfaction of staff and community remained high.

E-health was expanded to 55 health centres by 2013, and 44 health centres now have both FHT and e-health. E-health contributed to reducing the paper workload, and helped, in combination with e-health-based appointment system, in reducing the patients' waiting time. It also helped, through fail-safe mechanisms, to improve completeness and accuracy of patients' data entry. In the care of NCD, e-health helped introduce innovative monitoring mechanisms, called cohort analysis borrowed from tuberculosis control, to accurately assess patients compliance to the treatment, control status and complication rates over the time.
Such progress is supported the engagement of communities and innovations in the fields and in UNRWA at large. This includes diabetes campaign to address two important components in diabetes care, namely healthy diet and exercise. The campaign brought extraordinary engagement of the communities by providing opportunities like cooking and exercise classes. Preliminary data shows that, of 1260 diabetes patients joined such classes, 86% completed the entire campaigns with good rates of weight, waist-circumference and cholesterol levels reduction.

Each field also took innovations. Highlights from fields include: FHT & e-heath expansion and mentoring program in Gaza; health centre budget initiative to strengthen management capacity at health centres towards health-centres as cost-centres in the future in Jordan; Care for women with gender-based violence, partnerships for diabetes retinopathy care and Qalqilya hospital improvement in West Bank, and; initiation of extensive mental health care and psychosocial support in Lebanon.

Section 2 – Maintaining Quality Health Services Across the Life Cycle

The performance of UNRWA health services in 2013 is presented in this report according to the 2010-2015 Medium Term Strategy and to the health service priorities identified for each biennium by the Field Implementation Plans (FIP). This section is divided into three strategic objective areas: ensure universal access to quality and comprehensive primary health care, protect and promote family health, and prevent and control disease. In addition, a section is dedicated to cross-cutting services.

Services under the first strategic objective include outpatient care, inpatient care, community mental health, oral health and physical rehabilitation. Services under the second strategic objective include reproductive health and child health. Services under the third strategic objective include Non Communicable Diseases (NCDs), communicable diseases, and environmental health.

Highlights for 2013 include the continuing high health inflation and collapsing health services structure in Syria, high workloads primarily in Lebanon and to certain extent in Jordan in wake of Palestine refugee from Syria (PRS) in these countries, and the emergence of NCDs and mental health as public health priorities among Palestine refugees. UNRWA is expanding peripheral health services delivery to improve access for PR in Syria, strengthening primary prevention through health education and by improving the quality of food served in school canteens. The Agency is also intensifying its screening programmes and assistance through the patient-centred new Family Health Team approach. The implementation of e-Health and the introduction of a cohort monitoring system are also improving the quality of care in UNRWA health centres.

Crosscutting service areas support all three strategic objectives and include: nutrition, disability care, laboratory and radiology services, medicines and medical supplies, health communication, regional emergency preparedness, response, readiness and relief, human resources and gender mainstreaming.

Section 3 – Data

The data section is structured in five parts:

• Part 1: Agency-wide trends (graphs) for selected indicators for overall program management from 2006 to 2013.

• Part 2: Programme management indicators (tables) in each field from 2008 to 2013. Indicators are taken from UNRWA Field Implementation Plans (FIP) along with three health-related Strategic Objectives of UNRWA (SO1: Ensure universal access to quality and comprehensive primary health care, SO2: Protect and promote family health, and SO3: Prevent and control disease).

• Part 3: More detailed indicators (tables) for each activity of the programme in 2013 by field: started with demography, health infrastructure, SO1, SO2, SO3, and crosscutting (laboratory, human resources).

• Part 4: Indicators from the different surveys such as DMFS survey in 2010, currant practices of contraceptive use, and the prevalence of anaemia.

• Part 5: List of donors who provided health-specific (ear-marked) support to UNRWA: many donors supported UNRWA with un-earmarked General Fund (GF) contribution. This table shows only those who supported with ear-marked funds for the Health Programme.

Section 1 – UNRWA Health Reform and Innovations in a Changing Environment

Family Health Team (FHT)

For over six decades, UNRWA Health Programme has been delivering comprehensive primary health care services to Palestine refugees. Despite occupation, conflict, violence, insecurity and marginalized access, considerable health gains have been accrued in terms of marked improvements in maternal and child health, pregnancy related outcomes and disease burden from communicable

diseases. The Palestine refugee population is now experiencing health and demographic transitions. An increasing proportion of Palestine refugees are suffering from non-communicable diseases (NCDs), namely diabetes and hypertension. These changes have significant implications for health service delivery programs. The increase of NCDs is attributable to life style and health behaviours, and the chronicity of NCDs makes their prevention and control a complex, cost-intensive, and a lifelong process. Such growing burden of NCDs warrants a holistic and continuous care package of health services. It also necessitates timely and easy access to patients' health records - electronic medical records via e-health.

Such changes in the health needs of the Palestine refugee population, in conjunction with a comparative reduction of operating budget due to the global financial crisis, led UNRWA to take steps to reform its health services in 2011. The main notion was to recognize the benefits of a primary care model in which patients and their families develop long-term relationships with their "family doctor." UNRWA adopted the FHT model to provide primary health care through a team of health professionals. Each team is set up based on available resources, local health, and community needs, and focuses on chronic disease management, disease prevention, and health promotion. Families are divided evenly between health teams, generally consisting of a doctor, nurse and midwife. Other services, such as laboratory, pharmacy and dental care, continue to be shared.

The progress in FHT reform is encouraging. By the end of 2013, the FHT approach was operational in 69 health centres serving 60% of the served refugee population. During 2014, the FHT approach will be expanded to all health centres in Gaza and Lebanon and by end of 2015 to the remaining health centres in Jordan and West Bank.

Several assessments were conducted in health centres implementing FHT found a very positive response to the approach from both staff and patients' points of view. Equitable workload distribution, a consequence of the new teamwork structure, was one of the key positive factors perceived by all staff.

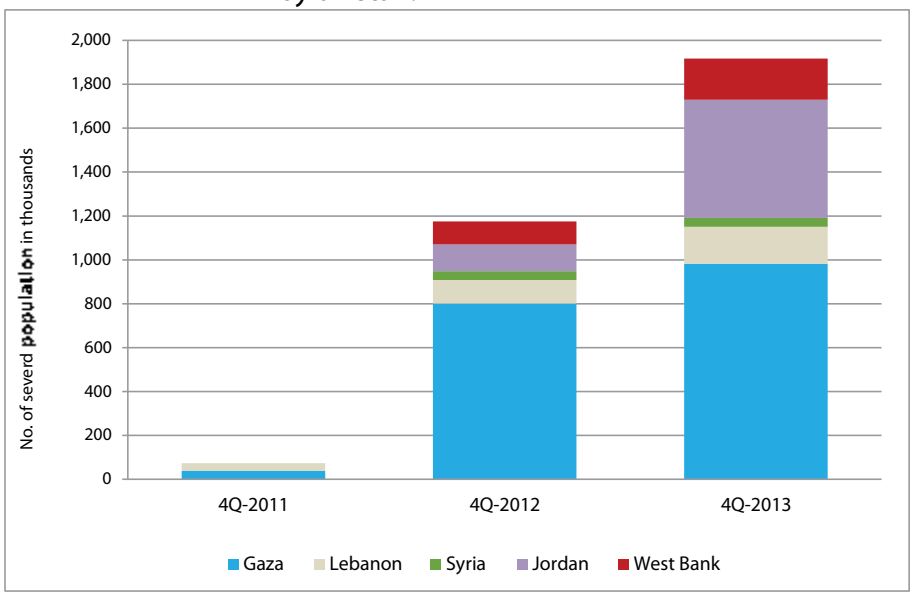

Figure 1 - The refugee population served by FHT approach Implemebting helth centres, 2011-2013

Staff also expressed improved professional satisfaction that resulted from having responsibility for the comprehensive health care of patients registered with their teams, as well as the opportunity to build relationships with patients over time. Patients appreciated having a "personal" doctor for their family and perceived the health centre to be more organized and less congested since the introduction of the FHT approach.

Improvements in the quality of services were observed: e.g. a decrease in the average number of daily medical consultations per doctor, an increase in consultation time, and a decrease in antibiotics prescription rates. Maternal and child health indictors, such as vaccination coverage, early registration to preventive care, and percentage of pregnant women attending at least four antenatal case visits, remained at high levels. Screening activities for NCD were strengthened and referrals to psychosocial counsellors increased.

Client Flow analysis, satisfaction surveys, and Focus Group Discussions (FGD) and Participatory Ranking Method (PRM) with the clients and staff revealed a clear perception of improvements in the relationship between clients and staff, better working environment and higher quality of care.

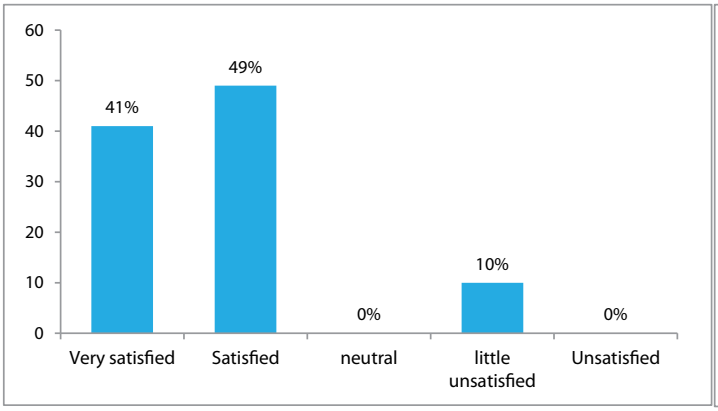

Figure2 - % of patients satisfied with the medicine prescribed

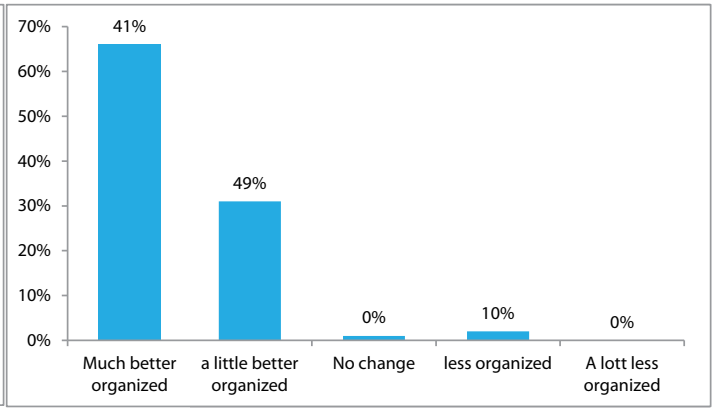

Figure3- % of patients' perception on health centre organization after FHT

In their opinion, FHT has significantly improved the daily life at the health centre, streamlining organization and reducing waiting times. It is possible that it will take several years for any cost effectiveness to become apparent, or for the decrease in the NCD burden to be statistically significant.

From the perspectives of the patients and staff the FHT model brought the following positive changes:

Table 1- Results of the Participatory Ranking Method(PRM) conducted at Askar health centre in the West Bank to identify positive changes brought by FHT listed based on priority

	Improvements as seen by women	Improvements as seen by men	Improvements as seen by staff
1	Better relationship with staff	Doctor is known to families	Employees are at ease
2	One FHT to care for all in family	Organization is better	Trust between client and staff
3	Doctor knows my disease and my family	Distribution of services is better	All families are in one team
4	Patients' rights are at the forefront	Over crowdedness is reduce	Contact time has increased
5	Organization of time is better	Doctor provides more care	Patient will take the right medicine
6	Less overcrowding in waiting room	Better relationship with staff	Workload is down
7	All services are available in one place	Better relationship with community	Waiting time is down

E-Health (Electronic Medical Records)

UNRWA started the use of electronic medical records (EMR), or e-health, since 2009 as an internal innovation. An advanced and comprehensive e-health package was developed in house to provide a synergized interface to accommodate all IT and information management needs for FHT. in January 2013, the newer version of e-health has been introduced at three health centres in West Bank and two health centres in Jordan.

By end of 2013, e-health has been expanded to 55 health centres: 27 in Lebanon, 14 in Jordan, 3 in West Bank and 11 in Gaza serving around 63% of Palestine refugee populations. Of the total, 44 health centres have both FHT and e-health.

UNRWA's e-health is based on the use of an EMR system for primary health care, with all patient records in electronic format, accessible from multiple service delivery points within the health centre, and are able to generate aggregate reports for management use. Through e-health, information on all aspects of the patient's care, including both curative and preventive services, is accessible at any stations in health centers. E-health consists of linked modules for non-communicable diseases, maternal health, child health and general outpatient services. Relevant modules are contained in a patient's individual electronic record within the comprehensive family health file.

The e-health system helped in reducing the workload of health staff, and is subsequently improving the quality of health services by avoiding wrong entry or incomplete entry of data, and proper monitoring. It also helped in decreasing the patient's waiting time, in increasing the doctor's-patients contact time, thereby in realizing the quality of evidence-based planning and management. E-health is thus an essential component of the health reform. Moreover, space in health centres was better utilzed, use of printed forms and stationary was rationalized, and staff were relieved from paper work.

In addition, an innovative e-health-based monitoring system ("cohort analysis") was developed in 2012. This cohort analysis allows the comprehensive monitoring of NCD care: incidence, prevalence, treatment compliance, control status of patients, treatment outcomes, outcomes over 3 years, and non-attendance follow-up. The results of this monitoring system were published in international peer-reviewed journals[1,2 ,3,4,5,6] and were featured by *the Lancet* .

E-health is a joint product with other departments in UNRWA, particularly the Information Systems Division (ISD) at the headquarters and in all fields. The United States of America has been the key supporter for e-health as well as the fa mily health team reform since it started.

[1] Khader A. et al. Cohort monitoring of persons with diabetes mellitus in a primary healthcare health centre for Palestine refugees in Jordan. Tropical Medicine and International Health, 2012

[2] Khader A. et al. Cohort monitoring of persons with hypertension: an illustrated example from a primary healthcare health centre for Palestine refugees in Jordan. Tropical Medicine and International Health. 2012, 17(9):1163-70

[3] Khader A. et al. Diabetes mellitus and treatment outcomes in Palestine refugees in UNRWA primary health care health centres in Jordan. Public Health Action (PHA). 2013, 3(4): 259–264

[4] Khader A. et al. Treatment outcomes in a cohort of Palestine refugees with diabetes mellitus followed through use of E-health over 3 years in Jordan. Tropical Medicine and International Health. 2014, 19(2):219-223

[5] Khader A. et al. What happens to Palestine refugees with diabetes mellitus in a primary health care centre in Jordan who fail to attend a quarterly health centre appointment? Tropical Medicine and International Health. 2014, 19(3): 308-312

[6] Mullins, J. Cohort reporting improves hypertension care for refugees. Lancet, 2012, 380(9841):552

Community Participation in the Health Reform Process

Community involvement in health is an essential element of the health reform in the FHT approach. As the disease burden due to life style related NCDs grows, community-based interventions become increasingly important. Hence, one of the key areas of focus under health reforms continues to be on health promotion outside the walls of health centres, and to build a strong culture of community involvement. Stronger patient-provider relationships with families inside the health centre through FHT provided inroads for the wider community engagement using households as advocates of FHT approach and quality NCD care. UNRWA is thus paying a special attention to community engagement for the success of its health reform. Prior to the start of FHT, health centers required an asset mapping of community-based organizations and civil societies which can then be engaged in health outreach. Similarly, community assets are also being identified through other UNRWA departments to capitalize upon pre-existing community relationships of other departments.

The interaction between the community and the health centre staff was strong throughout the implementation phase of the FHT. This link was cemented and institutionalized through the establishment of Health Centre Friendship Committees (HCFCs), and the utilization of other means of dialogue and communications. During the preparatory phase of FHT implementation, health centre staff benefited from the longstanding relationship with communities, and the fact that the staff itself was part of the community in which they worked. Health centre staff held further individual and group level discussions to explore the needs at individual, as well as in the wider community, that could be met better through implementing the FHT approach.

During the process of reform, the health teams informed the community about the health reform and the available health services, conducted regular meetings with the HCFCs, encouraged projects that involve the community with the health centre, coordinated with public and private sector, in addition to local and international NGOs. Moreover, health centre's staff involved the community in the organization of, preparation for, and participation in Health Days and other promotional activities. They also established lines of communication between the health centre and the community through switch boards, complaint boxes and other means of communication, responded to problems identified by community members with regards to health services, and advocated for positive behavioral change to improve health in the community and involvement in awareness campaigns.

Volunteers from the community participated in painting and cleaning the health centres, guided clients during early days of FHT implementation, and they helped in the remodeling of offices and reallocation of furniture. They also participated in placing signs and posters, helped in the distribution of pamphlets and educational materials, painted creative and informative drawings on the walls of the health centres, and donated paints and other materials to the health centre. Of particular importance was the participation of schools and school children in the preparation phase and during the launching ceremonies of FHT with plays and with the organization of ceremonies. Specialists and other doctors from the community volunteered to provide specialist consultations in their private clinics free of charge for patients, and particularly some performed eye examination for diabetics and others handled cases with heart problems.

Diabetes Campaigns

UNRWA, supported by the World Diabetes Foundation (WDF), conducted a health centre audit on diabetes care during 2012. The findings of this audit revealed problems in life style of patients: 64% were obese and another 26 % overweight, with many patients lacking opportunities to exercise with little knowledge about healthy nutrition, cooking practices and rational and timely use of medicine.

The findings of the audit have been instrumental in shaping the diabetes awareness campaigns under the slogan "Life is Sweeter with Less Sugar". The campaign was designed to tackle the main weaknesses revealed in the health centre audit, and it addressed three core components for improvement of the diabetes care programme:

1. Strengthening medical practice through refresher training courses, and improving patient education and follow up in the health centres.
2. Providing diabetes patients with enabling environments, in cooperation with local partners, to put their newly acquired knowledge about healthy life style into practice in community kitchens and exercise groups.
3. Increase partnership with local community stakeholders including the civil society and education facilities in organizing screening activities outside of the regular health centre setting.

The "Life is Sweeter with Less Sugar" campaign aimed to help Palestine refugees in the prevention and control of both diabetes and high blood pressure through four activities:

1. Training UNRWA health staff on patients' counselling skills;
2. Screening Palestine refugee patients at high risk for diabetes and high blood pressure;
3. Establishing community kitchens to practice healthy cooking;
4. Establishing exercise groups in the refugee community for diabetes patients.

The campaigns were implemented during April through November 2013 in 30 health centres in the four Fields (Gaza, Lebanon, West Bank and Jordan). The total number of patients screened outside UNRWA health centres was 31,340 patients, out of them 83.0% were Palestine refugees, and 55.0% were females. Those screening activities were conducted through 578 sessions in different locations inside and outside refugee camps. The total percentage of screened individuals with abnormal blood sugar and high blood pressure readings were at 11.0% and 10.8% respectively. Those individuals confirmed with diabetes and high blood pressure were 4.4% and 6.5% respectively. Those who were found to have both high blood sugar and high blood pressure (confirmed) were 1.6%.

As for the steps to conduct the campaign, UNRWA's health centre staff had randomly selected specific number of patients attending the largest 6-8 health centres in each Field to be part of focus groups on Diabetes Mellitus (DM). UNRWA staff in the selected health centres conducted educational sessions, healthy cooking sessions, and group exercise sessions on weekly basis. Process indicators such as anthropometric measurements, 2-hours postprandial glucose tests (2hr-PPGT), cholesterol, blood pressure, and number of sessions attended for different activities, were monitored on monthly basis with a specific code for every patient.

Out of 1260 patients enrolled at the beginning 1120 completed the campaign. The main findings revealed reduction in weight, improvement in blood sugar and blood pressure readings, and decrease in cholesterol levels, whereas the percentage of attendance among patients was 86.0% in average. The preliminary findings are highlighted in the Nutrition section of this report.

UNRWA Health Services in Syria

The Syrian conflict is over 3 years old, and the affected population with incremental erosion of coping capacities over three years now stands extremely vulnerable, and in dire need of humanitarian assistance. Out of around 500,000 Palestine refugees registered in Syria, over 250,000 are already internally displaced, while over 150,000 have fled to neighbouring countries, namely Lebanon (around 50,000) and Jordan (around 10,000). Out of 23 health centres in Syria, over 50% are almost constantly closed. This has affected the access to primary health care for the refugees. In the second half of 2012, when the conflicts had been intensified, the number of medical consultations dropped to almost half of the previous, pre-conflict average: from around 80,000 to less than 40,000 a month.

To address such access issue, in 2013, UNRWA reallocated the staff from the closed health centres to the functional centres and intensified medicine distributions to them. This has contributed to the recovery of medical consultations, reaching to around 60,000 a month. Moreover, peripheral health points were established in temporary shelters and in areas seeing clustering of displaced communities. Manned either by a doctor or a nurse, the 8 health points served to maintain health access and supply of critical (even life-saving) NCD medicines to displaced refugees. Such health points accommodated 4000 to 5000 patients a month.

Another challenge was the regular supply of and access to essential medicines. In the past, Syria relied on the domestic production of medicines. However such capacity has been seriously damaged during the conflict and UNRWA had to bring medicines from outside, namely on surface from Beirut/ Lebanon. Such transport had been extremely difficult, and in the 2nd quarter of 2013, UNRWA had almost run out of essential medicines. After intensified efforts by all parties, UNRWA managed to deliver sufficient quantities of essential medicines in the 3rd and 4th quarters of 2013. Even when the stocks were replenished at Damascus, within country distribution remained challenge due to extremely volatile security situations.

Access to hospitalization services also became a significant challenge. In the past, UNRWA relied on the contracted hospitals for such services, however such hospitals largely became unavailable or inaccessible due to the conflicts. In response, UNRWA started to allow Palestine refugees to visit any hospitals they could access, and to pay to the hospital with minimum copayment by patients. This has maintained hospital access for the refugees, but its cost has increased due to the limited availability of hospital services.

The difficulties in maintaining the core health services still remain significant in Syria. Many Palestine refugees now live in temporary shelters, and their basic daily needs are barely met with UNRWA's support. Yarmouk camp, that used to accommodate more than 100,000 refugees, is largely destroyed and inaccessible. Desperation for the future is negatively affecting the resilience of refugees. And as a matter of fact, the health staff members who have been heroically devoted their support to Palestine refugees are not free from such desperation and suffering.

Field Innovations

During 2013, UNRWA Health Programmes at the Fields introduced a number of innovations that aimed at strengthening and complementing the successes achieved by implementing the Family Health Team approach and e-health. Through these innovations, Fields are working in creative ways to improve the quality and efficiency of UNRWA's health services.

The Gaza Field

Successful implementation of the Family Health Team approach and e-health

Gaza Field started piloting the FHT approach in October 2011 in one of its health centres. During 2012, there were 10 additional health centres implementing the FHT approach, and in 2013 another 6 health centres has implemented it, thus increasing the total number of FHT approach implementing health centres to 17 by the end of 2013.

Through the systematic implementation of the FHT, families and staff satisfaction were higher than before and were well related to each other. Quality of the service has been improved due to the positive competition between the teams at the same health centre. Fair distribution of the workload among staff within the same category and between different staff categories was evident. Better opportunity for the successful implementation of the appointment system was realized. The reform also induced evidence-based practices by staff with higher levels of commitment and accountability.

At the same time, it resulted in better and more effective management of health services with better output in terms of quality. This has been achieved by the development of action plans to improve the quality of health services, setting criteria for ideal health centres that are based on implementing both FHT and e-health, and the use of a tool for qualitative evaluation of the quality of services at health centers with FHT approach. Moreover, it brought more efficient management of human resources which became more visible and controllable through FHT.

Concerning the implementation of e-health, by the end of 2013, it has been implemented in 11 health centres. This witnessed many challenges related to data entry of all records, training of staff at heath centres, and IT infrastructure. E-health has brought many improvements. These included the availability of accurate data that lead to effective and efficient management of resources, high levels of satisfaction of staff with less effort using e-health and easier access to the data in the patients' records, possibility of producing complete, and accurate reports and registrations with little effort. In addition, there became an effective management of all activities in health centres by the senior management team, better control over duplicated patients' records, and saving time and money, needed before, for producing printed forms.

The Mentoring Programme initiative

The mentoring program is an innovation in Gaza to improve the management capacity of medical officers through exchange of experiences and direct interaction of senior, well experienced medical officers in the health services. The programme was very successful in 2013. The initiative required the work of one mentor with 16 mentees. The mentees were Senior Medical officers (SMOs) and Medical Officers A (MOA) and potential Medical Officers B (MOB).

The main achievements and outcome of this initiative were managing health centres performance through the effective use of statistics; effective supervision of staff performance; utilizing the full capacity of the health centre's team; managing stock efficiently, and efficient reporting process.

The Jordan Field

Health Centre Budget Initiative: An efficiency exercise to monitor expenditure and empower managers at health centres

Background: The Health Centre Budget Initiative (HCBI) is an exercise for studying the expenditure at health centres, as a step to decentralization and empowerment of health centre managers to have their cost centres using different efficiency indicators. HCBI was started in February 2012. In June 2012, the first report was presented as an opportunity to review and provide feedback on information/data collection process, understand data analysis process, and to assess the results including possible causes. In October 2012, training on health centre management was conducted for more than 80 staff members.
In 2013, Virtual Budget was set as a tool to monitor expenses at health centres and to help in decentralize and in empowering health centre managers. Setting of this virtual budget was based on 2012 actual budget for each health centre as the preceding step for real health centre budgeting (actual cost centres). Data analysis in 2010 and 2012 showed some differences in expenditure at health centres by unit of activity and by beneficiary. Therefore, in 2013 the Health Department assigned a virtual budget for each health centre to monitor expenditure at health centre level against this budget.

Methods: The actual expenditure from HCBI in 2012 was considered as a reference, and a virtual budget for the subsequent year (2013) was assigned, with subsequently adding 7% for inflation and subtracting 10% from drug budget as reserve.

Results: The expenditure versus virtual budget was calculated over the first 4 quarters of 2013. The annual average expenditure for all health centres versus the virtual budget was 98.7%. The expenditure in the 4 Areas in Jordan was ranging from 100.1% at Irbid Area to 98.0% at South

Table 2- Annual expenditure against virtual budget for each health centre.

Area/Health Centre	Month Actual	Month Budget	Month Variance	Month variance (percent)	Year 2 date actual	Year 2 date budget	Year 2 date variance	Year 2 date variance (percent)
Amman North Area	352,046	4,323,489	3,880,443	8.32%	4,081,606	4,232,489	150,883	96.44
Amman Town	81,369	726,364	644,995	11.20%	724,411	726,364	1,953	99.73
Jabal Al Hussein	85,278	904,426	819,148	9.43%	912,468	904,426	-8,042	100.89
Nuzha	64,736	767,795	703,061	8.43%	689,694	767,795	78,101	89.83
Baqa'a	81,413	1,254,622	1,173,209	6.49%	1,191,501	1,254,622	63,121	94.97
South Baqa'a	36,252	579,282	540,030	6.78%	563,532	579,282	15,750	97.28
Amman South Area	260,453	2,504,809	2,244,356	10.4%	2,455,421	2,504,809	49,388	98.03
Amman new camp	156,037	1,308,021	1,151,984	11.93%	1,296,105	1,308,021	11,916	99.09
Taybeh	59,451	660,072	600,621	9.01%	644,534	660,072	15,538	97.65
Talbieh	27,243	278,113	250,870	9.80%	269,423	278,113	8,690	96.88
Aqaba	17,722	258,603	240,881	6.85%	245,359	258,603	13,244	94.88
Irbid Area	263,428	4,045,026	3,781,598	6.51%	4,048,815	4,045,026	3,789	100.09
Irbid Town	61,585	1,009,601	948,016	6.10%	1,025,823	1,009,601	-16,222	101.61
Itbid Camp	42,113	624,226	582,113	6.75%	635,483	624,226	-11,257	101.8
Husn	34,244	483,464	449,220	7.08%	512,667	483,464	-29,203	106.4
Jarash	37,344	560,916	523,572	6.66%	546,570	260,916	14,346	97.44
Suf	27,363	425,406	398,043	6.43%	391,208	425,406	34,198	91.96
North Shouneh	12,752	225,329	212,577	5.66%	203,447	225,329	21,882	90.29
Waqqas	15,441	219,343	203,902	7.04%	218,070	219,343	1,273	99.42
Kraymeh	15,240	207,407	192,467	7.35%	238,766	207,407	-31,359	115.12
Mashare'	17,346	289,334	271,988	6.00%	276,781	289,334	12,553	95.66
Zarka Area	412,984	4,678,913	4,265,929	8.83%	4,668,586	4,678,913	10,327	99.78
Zarka Town	111,352	1,120,196	1,008,844	9.94%	1,085,734	1,120,196	34,462	96.92
Zarka Town	36,239	544,036	507,797	6.66%	599,984	544,036	-55,948	110.28
Marka	79,898	842,689	762,791	9.48%	795,805			

Amman Area. The expenditure by health centre ranged from 115.1% at Kraymeh health centre to 89.8% at Al-Nuzha Health centre (table 2).

Interpretation: By studying the virtual budget we were able to define the outliers and study them thoroughly. It also raised the interest and knowledge of health centre managers about the pattern of expenditure. In our analyses, we found that the annual average expenditure in 2013 was 98.7%. This finding indicated that allocations were reasonable, and expenditures were within the standards of 100% of the assigned virtual budget, and thus supported the Health Department's decision towards decentralization and health centre costing to allocate real budget at health centre level.

Way forward: We have several meetings with the UNRWA's concerned departments including Enterprise Resource Planning (ERP) and Finance to make health centers as cost-centers, and to include the health centre budget indicator and the virtual budget in the ERP. Incentives for health centres that managed to make some saving with no encroachment of quality shall be offered based on preset criteria.

The West Bank Field

Integrating Gender-Based Violence (GBV) services into Health Services:

Violence against women affects reproductive health in different ways. One way is having unwanted pregnancies, unsafe and illegal abortions for unwanted pregnancies, complications from frequent, high-risk pregnancies, sexually transmitted infections, gynaecological problems, and psychological problems. Recognizing this, and to further integrate GBV services into UNRWA's health services, West Bank has included GBV screening questions in the family file for newly registered pregnant women. All newly registered pregnant women are required to visit the psychosocial counsellor for a quick screening on mental health and GBV issues.

Moreover, West Bank Family and Child Protection Programme works through support groups to protect and promote the health and well-being of vulnerable groups within the refugee community. Through support groups, the Programme provides health, nutrition, and psychosocial counselling, stress management, and communication techniques both to the individuals and their families. The programme currently targets two main vulnerable populations: mothers and UNRWA Environmental Health Sanitation Workers.

Preventing Diabetic Eye: Diabetic Retinopathy Project:

There are approximately 22,000 diabetic registered Palestinian refugees in the West Bank. These patients are at high risk of suffering from eye diseases which can lead to blindness. Based on current trends, approximately 25% of those patients will need medical interventions such as advanced screening, specialized treatment, and/or Vitreo Retinal surgeries in order to prevent visual disabilities or blindness. Diabetic Retinopathy is largely preventable if diagnosed and treated properly. Early detection of diabetes-related eye diseases is critical to preventing visual disability and blindness, and thus protecting refugees and their families from poverty.

UNRWA Health Department in partnership with St. John Eye Hospital in East Jerusalem has been working to screen diabetic patients for eye complications. Diabetic patients from the Northern and Central regions of the West Bank are referred to St. John's Eye Hospital and Anabta Health centre for screening. In addition, St. John's Hospital provides the refugees with the following treatments at considerable discounts: avastine, FFA, OCT and Laser. St. John Eye Hospital has also provided 2 Fundus Cameras to UNRWA to photograph the interior surface of the eye for screening purposes. One camera is rotated among health centres in the Southern Region, and the other in the Northern region.

In 2013, more than 3000 diabetes patients were screened for diabetic eye using the Fundus camera technology in the West Bank. Sixteen UNRWA staff members were trained on Diabetic Retinopathy screening by St. John's Hospital, building the capacity to follow up on diabetic cases to limit the complications that may result from this disease.

Reducing Maternal Morbidity and Improving Quality of Services in Qalqilya Hospital:

The West Bank Field Office (WBFO), in partnership with the Palestinian NGO Juzoor for Health and Social Development, undertook comprehensive efforts during 2013 to reduce maternal morbidity and improve the quality of services in Qalqilya Hospital. UNRWA integrated the updated Normal Childhood Protocol in the hospital's services by training and providing on-site mentorship to promote natural normal spontaneous vaginal delivery (NSVD), decrease invasive procedures, and decrease medical interventions in NSVD.
In addition, the Health Programme worked to improve the overall standards of service delivery in the maternity ward. The hospital adopted Advanced Life Support in Obstetrics (ALSO) and Emergency protocols, revised job descriptions, provided training in leadership, supportive supervision, and quality management. Further, the hospital worked to improve the appointment system, hygiene, cleanliness, communication, privacy, and hospitality.

A focus group discussion conducted with women who gave birth in the maternity ward revealed general satisfaction concerning the labour room with regards to cleanliness, communication, privacy, and the admittance of the husband and family for support. Staff members have communicated greater satisfaction following the implementation of the updated protocols, especially with regards to clear division of responsibilities, shared workload, and confidence following training.

The Lebanon Field

Mental Health Project

Lebanon Field Office has made preparations for the start of mental health project in collaboration with the European Union (EU). The project aims at enabling an estimated 50,000 Palestine refugees living with mental health conditions to benefit from psychosocial and mental health services. Because of the unfavorable living conditions, limited access to stable jobs and other harsh environment, psychological and mental health illnesses are rather prevalent among Palestine refugees in Lebanon. To date, the refugees do not have access to quality mental health services including psychosocial support.

The plan was to establish a referral system for mental health support within and outside UNRWA (via school counselors and social workers and UNRWA health centres). In addition, it included the provision of specialized consultations by psychiatrists and health centre psychologists. UNRWA staff (medical officers, nurses, midwives, social workers and specific school staff) will be equipped with enhanced capacity in mental health and psychosocial support. Special attention will be paid to children and youth with disabilities, providing them with appropriate installations and access to psychological and social support services that will enhance their chances of integration in the community.

The project will provide specialized services and connect with partners in Lebanon for external referrals and will build the capacity of UNRWA staff to enhance their understanding of mental health to provide the quality services. Frontline staff will be trained on the Mental Health Gap Assistance Programme (mhGAP-IG) developed by WHO. A total of 37 Medical Officers, 120 nurses and midwives, 73 social workers, 74 teacher counselors, and 21 school counselors will be trained on the mhGAP-IG. Medical officers, nurses, midwives, and social workers will be trained on all the modules of the mhGAP-IG, with tailored interventions regarding medications depending on the need of each target group.

In addition, there will be awareness campaigns to increase people's knowledge on awareness on mental health, as well as mental health services offered by UNRWA. The campaigns will address stigma in society concerning mental health, so that people may become more comfortable in seeking help. The awareness campaign will also shed light on the different activities within the project including specialized staff services and training for the frontline staff. This will be done in close collaboration with Community Based Organisations (CBOs) and NGOs.

SECTION 2: Maintaining Quality Health Services Across the Life Cycle

Strategic Objective 1 – Ensure Universal Access to Quality and Comprehensive Primary Health Care

Services under this objective include outpatient care, inpatient care, community mental health, oral health and physical rehabilitation.

Outpatient Care

Utilization

UNRWA currently provides comprehensive Primary Health Care through a network of 138 health centres of which 69(50%) are located inside refugee camps. In addition, UNRWA operates five mobile health centres in the West Bank to facilitate access to health services in areas affected by closures, checkpoints and the Barrier.
Utilization of outpatient services Agency-wide decreased by 3.8 % in 2013 compared to 2012, with a total of approximately 9.3 million medical consultations. Of these consultations, 172,376 were specialist consultations (Table 3).

This decrease in utilization was found in all Fields except Lebanon where Palestine refugees from Syria who utilize UNRWA's health services were included. As for the Fields other than Lebanon:

- In Syria, the utilization of outpatient services was still affected by the closure of a large number of health centres and limited access to health services caused by the prevailing security constraints.
- In Jordan, Gaza and West Bank this decrease could be attributed to implementing the appointment system, e-health system and FHT approach in some health centres. Moreover, in West Bank this decrease could be attributed to the interruption of services due to the strike that took place during December 2013 which resulted in the closure of health centres.

Within the UNRWA health system, outpatient medical consultations are classified as either first or repeat visits. First visits are defined as the first visit of an individual to the health centre in a calendar year.

Table 3- No. of medical consultations, 2012-2013

	Jordan	Lebanon	Syria	Gaza Strip	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

(*) Data represents the first five months of 2012

All other visits are considered repeat visits. The ratio of repeat to first visits was decreased from 3.4 in 2012 to 3.2 during 2013. This ratio varies among Fields and also among health centres within each Field. The highest ratio (4.1) was found in Lebanon, while the lowest (1.1) was in Syria during 2013.

Workload

The average number of medical consultations per doctor per day at UNRWA health centres decreased from 105 in 2012 to 99 in 2013. The highest workload was reported by West Bank Field with 116 patients per doctor per day and the lowest in Jordan with 81. In spite of the decrease of total medical consultations, the workload in West Bank increased due to the decrease in the number of medical officers recruited on the emergency basis Fields of operation - almost identical to 2012 (Table 4). Of all the patients hospitalized, 48.0% were between 15 and 44 years old, while 30.8 % were children below the age of 15. Almost 66.8% of the patients were women.

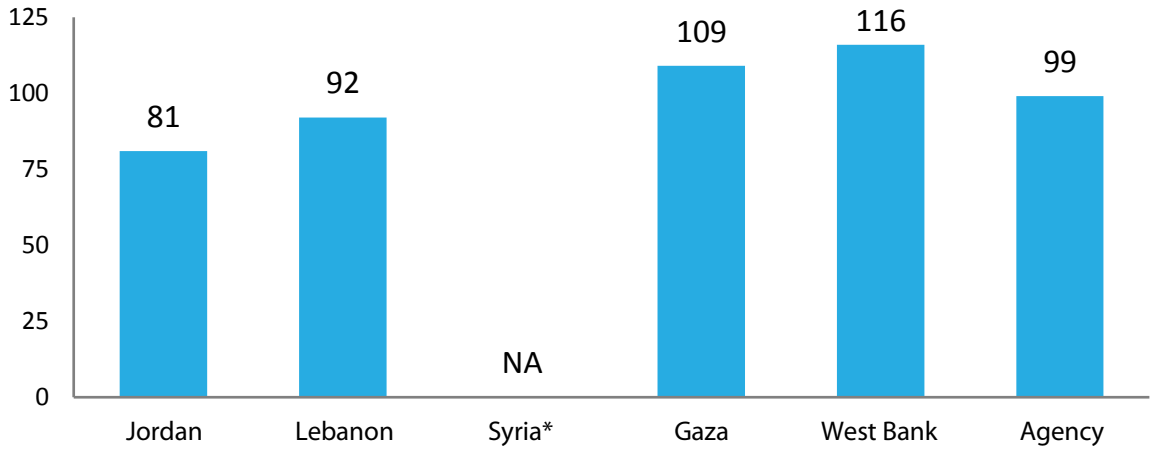

Figure 4 - Average daily medical consultations per doctor, 2013 (* Data not available)

under the Job Creation Project/ Limited Duration Contracts (JCP/ LDC). Although the workload was reduced, it is still high and far from UNRWA's intermediate target of 80 patients consultations per doctor per day

Inpatient Care

UNRWA assists refugees to obtain hospital care by contracting beds or by partially reimbursing costs incurred for inpatient care at public, non-governmental and private health care facilities. In addition, the Agency directly provides hospital care in one hospital at Qalqilia in the West Bank.

Outsourced Hospital Services

During 2013, a total of 72,914 refugees benefited from assistance for hospital services. There is a significant variation between Fields. The average length of stay was 2.0 days across UNRWA's five

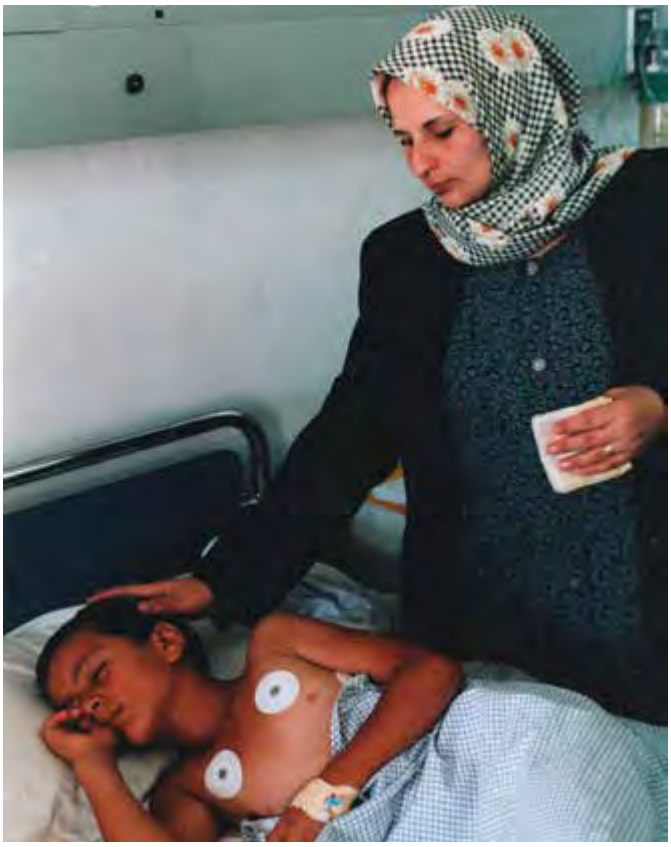

Table 4 - Patients who received assistance for hospitalization during 2012 and 2013

	Jordan	Lebanon	Syria	Gaza Strip	West Bank	Agency
2012	14,481	29,767	4,580	8,719	22,879	80,426
2013	12,908	30,832	NA	8,444	20,730	72,914

There is a significant variation among Fields concerning the number and type of hospital cases reimbursed by UNRWA. In Jordan and Gaza, deliveries represented the majority of the cases reimbursed, while in Lebanon and the West Bank the majority were internal medicine cases. The variation is not related to any significant morbidity variation, but is rather a consequence of differences in the reimbursement policies implemented in the various Fields. Table 5 shows the expenditure on hospital services in all Fields.

Table 5- Expenditure on hospital services (USD), 2013

Cost	Jordan	Lebanon	Syria	Gaza Strip	West Bank	Agency
GF	1,196,814	11,885,932	663,170	1,318,389	3,674,906	18,739,211
Projects	0	1,014,444	756,864	0	200,000	1,971,308
Total	1,196,814	12,900,376	1,420,034	1,318,389	3,874,906	20,710,519

Qalqilia Hospital

UNRWA manages a 63-bed secondary care facility in Qalqilia, West Bank. Qalqilia Hospital is the only hospital operated by the Agency and accommodates 14 surgical, 12 medical, 20 paediatric, 15 obstetric/gynaecologic, two intensive care beds, in addition to a five-bed emergency ward. The hospital serves both UNRWA refugees and non-refugees from the surrounding municipalities. A total of 5,399 patients were admitted to the hospital during 2013 compared to 6,118 in 2012. The average daily bed occupancy in Qalqilia Hospital was 39.6% in 2013, compared with 57.4% in the previous year. The average length of stay in 2013 was 1.7 days. The overall expenditure on Qalqilia hospital services during 2013 amounts to USD 2,588,524 all of which were secured through general funds (GF) (Table 6).

Table 6-Inpatient care at Qalqilia Hospital during 2012 and 2013

Year	Persons admitted	Average stay in days	Average daily bed occupancy	Expenditure (USD)
2012	6,118	2.2	57.4%	2,853,633
2013	5,399	1.7	39.6%	2,588,524

Community Mental Health

Palestine refugees have for decades suffered the trauma of displacement as well as repeated episodes of conflict and violence. In response to the situation, UNRWA provides a Community Mental Health Programme (CMHP). The Programme offers counselling and support, through a network of counsellors, established in UNRWA health centres and schools and in community based organizations.
psychological deterioration. Throughout 2013, the CMHP offered frontline counselling and group interventions through school, community and health centre UNRWA Health Department is working toward increased integration of mental health into primary health care, through the new Family Heath Team approach.

Gaza Strip Community Mental Health Programme

The year 2013 continued to be another difficult year for refugees in the Gaza Strip with the devastating effects of the cycles of violence and chronic siege-like conditions. In Gaza, the CMHP works through the main core programmes of UNRWA with 203 school counsellors, 13 community counsellors, 22 health centre counsellors and 22 managers, supervisors and support staff providing a wide range of services targeting children, youth, parents, elderly and disabled people as well as local committees, local organizations, professionals and students (Table 7).

Table 7 - Community mental Health Programme activities - Gaza, 2013

	Individual counselling	Group counselling	Group guidance (awareness)	Home visit
Sessions	50,052	10,522	10,522	1,247
Beneficiaries	15,237	14,989	90,113	5,424

The West Bank Community Mental Health Programme

In the West Bank, the programme provided individual counselling, group counselling, group guidance, family counselling, home visits, referrals, group intervention sessions, supportive group sessions, summer and winter camps and open days, reaching a total of 140,270 individuals.

Family and child protection programme reported 407 cases of Gender Based Violence (GBV), of whom 17 were referred to health counsellors, 22 to social counsellors and 15 to seek help from outside UNRWA.
Table 9 lists the most common behavioural and psychological problems reported among school children.

Table 8 - Community Mental Health Programme activities – West Bank, 2013

	Individual counselling	Group counselling	Family counselling	Home visits	Summer/winter camps	Supportive groups	Group interventions
Sessions	29,452	2,662	1,213	55	378	758	2,517
Beneficiaries	29,452	16,636	882	55	20,826	7,153	65,266

Table 9- The most common behavioral problems identified among school children in West Bank, 2013

Behavioural problem	No of cases,	%
Lack of discipline	1680	19%
Aggressiveness	1580	18%
Low achievement	1387	16%
Hyperactivity	576	7%
Lack of communication	485	7%
Family problems	466	5%
Emotional problems	456	5%
Fear/phobias	430	5%
Insomnia	420	5%
Others	1220	16%

Oral Health

During 2013 oral health services were provided through 108 fixed and 9 mobile dental clinics.

In addition, during 2013, the total number of curative oral health consultations decreased by 3.4% compared to 2012, reaching a total of 599,705.

Data from Syria was not reported. The decrease observed in other Fields could be explained by the change in UNRWA strategy to focus on oral health preventive interventions and on the reduction by two mobile dental units in Lebanon.

Moreover, the West Bank is facing difficulties in sustaining oral health services that are provided through the emergency programme.

Oral health screening activities were conducted Agency-wide for 222,734 individuals including pre-school children, school children, patients with non-communicable diseases , women at the first preconception care visit and pregnant women.

This decrease in utilization is mainly attributed to the absence of data from Syria Field and to the change in screening policy in Gaza Field where only first grade students are targeted with comprehensive care including oral health screening, treatment and pit and fissure sealant application.

During 2013, UNRWA continued to reinforce the preventive component of oral health. Oral health education was introduced as part of routine mother and child health care, with dental screening for women at the first preconception care visit and for all pregnant women.
Comprehensive oral health assessment was conducted for all children at the age of two years, in addition to the application of sealant.

A total of 53,014 assessments were conducted among pre-school children. Regular dental screening for new school entrants and for 7th and 9th grade students, along with oral hygiene education continued in all Fields except Gaza where they targeted only first graders with comprehensive dental care. The policy of providing root canal treatment was reviewed and treatment priorities were revised to allow more resources for community preventive dentistry.

Assessment of the workload, productivity and efficiency of oral health services is conducted annually in each of the five Fields. The assessment, based on a standardized protocol, is carried out as part of the periodic evaluation of system performance. It is also used to identify staffing requirements and the need for the re-organization of services.

The acceptable average productivity per dental surgeon per hour (45-55 WLUs/hour) was achieved in Jordan and Lebanon, but was exceeded in Gaza and West Bank Fields. Gaza continued to report the highest workload (60.3 WLUs/hour). No data was reported from Syria.

Table 10- No. of dental curative and preventive interventions and daily dental surgeon workloads, 2013

	Jordan	Lebanon	Syria	Gaza	West Bank	Agency
No. of curative interventions	160,692	74,700	NA	302,961	61,352	599,705
No. of preventive interventions	64,099	28,904	NA	104,340	25,391	222,734
Daily dental surgeon workloads	30.7	32.3	NA	60.3	51.7	42.9

Physical Rehabilitation

Physiotherapy services were provided to 17,445 patients through 18 physiotherapy units (eleven units in Gaza, six in the West Bank and one in Jordan).

The 3,491 patients in the West Bank received 28,477 sessions provided by 11 staff members. The 13,576 patients in Gaza received 165,964 sessions provided through 45 staff members. Lastly, 379 patients in Jordan received 387 sessions.

These units provided a wide range of physiotherapy and rehabilitation services including manual treatment, heat therapy, electrotherapy, and gymnastic therapy. They conducted an outreach programme using more than 50 units of advanced equipment that facilitated providing therapeutic exercise, manipulation massage, functional training, hydrotherapy, electrotherapy and self-training.

The outcome in Gaza was the discharge of 81.0% of treated patients without any disability (full recovery), 17.0% with mild disability and only 2.0% remained disabled due to the nature of injury or disorder. The outcome of the treatment sessions provided in the West Bank was the discharge of 88.0% of treated patients without any disability (full recovery), 11.2% with mild disability and only 0.8% remained disabled due to the nature of injury or disorder. The patients with permanent disability together with their family members were educated on how to handle the physical aspect of the disability in the daily lives.

Modalities and techniques of physiotherapy treatment included strengthening therapeutic exercise, therapeutic massage, Infrared and light radiation, electrical stimulation, therapeutic ultra sound, electromagnetic waves, heat and cold therapy, gait retraining and functional training sessions.

Community-based initiatives continued during 2013 and included several educational sessions to different target groups, home visits, cooperation with school supervisors, partnerships with non-governmental organizations, screening of school children for postural deformities and the distribution of assistive aid devices.

Sessions were conducted to raise the awareness of different target groups on physiotherapy services and physical rehabilitation related to types of disabilities, preventive measures of avoidable disabilities and on how to care for disabled people. The target groups included medical staff in the health centres, patients and patient's families, students, health educators, social health workers, community members, pregnant women, diabetic patients and mothers. Topics of awareness sessions included diabetic foot care, prevention and management of back problems, sport and recreation for diabetic patients, correct posture for school children, prenatal and postnatal care, exercises for patients with osteoarthritis and prevention of facial palsy.

The expenditure on physical rehabilitation amounted to USD 1,534,266, out of which USD 1,460,856 (95.2%) were secured through General Fund (GF) while the remaining, USD 73,410 (4.8%), were secured through projects and/or in-kind donations. The patient subsidies contributed to 23.2% (USD 355,386) of the total expenditure on physical rehabilitation and the remaining 76.8% (USD 1,78,880) represented the expenditure on physical rehabilitation services provided through the 18 UNRWA physiotherapy units

Strategic Objective 2 – Protect and Promote Family Health

Strategic Objective 2 includes reproductive health, child health and initiatives to address gender-based violence.

Reproductive Health Services

UNRWA's reproductive health services include family planning, preconception care, antenatal care, delivery care and postnatal care.

Family planning

Family planning services, include counselling and provision of modern contraceptive. Services are also provided through preconception care, antenatal, post-natal care and growth monitoring of children under-five years of age.

During 2013, similar to previous years, the demand for modern contraceptive methods continued to increase. A total of 21,911 new family planning users were enrolled. The Agency-wide total number of continuing users, excluding Syria, reached 142,760 representing an increase of 4.0% compared with 2012 (Table 11). The increase was consistent in all fields.

Table 11 - Utilization of UNRWA family planning services, 2013

	Jordan	Lebanon	Syria	Gaza Strip	West Bank	Agency
New users	7,067	1,736	NA	10,639	2,469	21,911
Total continuing users at year end	40,934	14,055	NA	62,648	25,123	142,760
Discontinuation rate (%)	6.0	5.4	NA	4.5	4.6	5.0

Couple Years of Protection (CYP), an output indicator used to estimate the number of clients (or couples) protected from pregnancy in one year by UNRWA dispensed contraceptives, increased in all fields. The distribution of family planning users according to contraceptive method remained stable.

The intra-uterine device continued to be the most popular method (50.4% of the users) followed by oral contraceptive (25.1%), condoms (21.4%), injectable (2.5%), and spermicidal suppositories (less than 1%).

Preconception care

The aim of preconception care is to prepare women at reproductive age to enter pregnancy in an optimal health status.

Preconception Care Programme consists of six main components: health promotion, counselling, screening, periodic risk assessments, intervention and follow-up and regular folic acid supplementation.

Couples receive counselling concerning the risks of "too many, too often, too early and too late pregnancies", and on how to prepare for a healthy pregnancy. Women are assessed for risk factors, screened for hypertension, diabetes, anaemia, oral health diseases, offered folic acid supplementation to prevent congenital malformation, and are provided with medical care where relevant. Where necessary, couples may be advised to avoid or delay pregnancy using a reliable contraceptive method. During 2013, a total of 13,681 compared to 13,427 women in 2012, had been enrolled in UNRWA's Preconception Care Programme in the four Fields . Data from Syria was not reported.

Antenatal care

UNRWA encourages pregnant women to receive their first antenatal assessment as early as possible, and to have at least four antenatal care visits throughout their pregnancy.

Pregnant women receive a comprehensive initial physical examination and then a regular follow-up care, including screening for pregnancy related hypertension, diabetes mellitus, anaemia, oral health problems and other risk factors. Women are classified according to their risk status. Iron and folic acid supplementation is provided to all pregnant women.

In 2010, UNRWA introduced the Maternal and Child (MCH) Handbook that serves as a health education tool, as a home based record for the mother during pregnancy and as a health record for the child until the age of five years.

UNRWA uses selected indicators of coverage and quality to monitor the performance of antenatal care services including: antenatal care coverage, percentage of registration for antenatal care in the 1st trimester, number of antenatal care visits, tetanus immunisation coverage, risk status assessment and diabetes mellitus and hypertension in pregnancy (Section 3).

Antenatal care coverage

During 2013, UNRWA primary health care facilities cared for 85,352 pregnant women which represented a coverage rate of 84.5 % of all expected pregnancies. The antenatal care coverage was calculated based on the expected number of pregnancies in the served refugee population (Table 12).

In contrast to the trend in previous years, since 2008 the UNRWA antenatal services has decreased constantly in all Fields. In 2013, the number of pregnant women registered for antenatal care decreased by 3.4% Agency-wide.

The reasons for the decrease require further investigation but could be at least in part explained by an increased utilization of services offered by other service providers.

Table 12 - UNRWA antenatal care coverage, 2013

	Jordan	Lebanon	Syria	Gaza Strip	West Bank	Agency
Served population	1,197,793	302,572	NA	1,271,568	481,570	3,253,503
Expected no. of pregnancies[7]	33,538	6,051	NA	46,921	14,495	101,006
Newly registered pregnancies	25,777	5,167	NA	41,856	12,552	85,352
ANC Coverage (%)	76.9	85.4	NA	89.2	86.6	84.5

[7] Calculated by multiplying the total number of served refugees (from the UNRWA registration system) by the crude birth rates published by host authorities (2.8% in Jordan, 2.0% in Lebanon, 2.8% in Syria, 3.7% in the Gaza Strip and 3.0% in the West Bank).

Registration for antenatal care in the 1st trimester

The proportion of pregnant women who registered during the 1st trimester of pregnancy in 2013 increased by 1.5% reaching 79.7%, while it was 18.1% for women registered during the 2nd trimester and 2.1% for those registered during the 3rd trimester. This increase in early registration in the 1st trimester could be attributed to the expansion of preconception care services and the introduction of the Family Health Team approach.

Number of antenatal care visits

WHO recommends that all pregnant women should attend at least four visits during the antenatal period.

Table 13 - Number of antenatal care visits during 2013

Indicator	Jordan	Lebanon	Syria	Gaza Strip	West Bank	Agency
% of pregnant women with four antenatal visits or more	83.4	90.7	NA	93.0	83.3	88.8
Average number of antenatal visits per pregnant women	6.3	6.5	NA	7.0	6.2	6.6

In 2013, Agency-wide percentage of pregnant women who paid ≥ 4 antenatal visits was 88.8% compared to 86.5% in 2012. The highest was in Gaza at 93.0 % and the lowest was in the West Bank at 83.3% (Table 13).

Tetanus Immunisation Coverage

Results of the annual rapid assessment survey for 2013 showed that 99.8% of registered pregnant women were adequately immunized against tetanus. No cases of tetanus have reported during the last two decades among mothers or new-borns attending UNRWA antenatal care services.

Risk Status Assessment

The new WHO model of antenatal care separates pregnant women into two groups: those likely to need only routine antenatal care (about 75% of pregnant women), and those with specific health conditions or risk factors that necessitate special care (25% of pregnant women)[8] . UNRWA currently uses a risk scoring classification based on three risk categories (high, alert, low). During 2013, and Agency-wide, 13.2% of women were classified as high risk, while 25.7% were considered alert risk cases. High and alert risk pregnancies receive more intensive follow-up than low risk cases and are referred to specialists as needed.

Diabetes mellitus and hypertension in pregnancy

Pregnant women are screened regularly for diabetes and hypertension all through pregnancy. Agency-wide, during 2013, the prevalence of diabetes mellitus during pregnancy (pre-existing and gestational) was 5.0 % as compared to 4.6% in 2012. The increase may reflect improved screening practices. Globally the reported rates of gestational diabetes range from 2% to 10% of pregnancies depending on the population studied and the diagnostic tests and criteria employed[8.] Hypertensive disorders affect 5-15% of pregnancies worldwide. The prevalence of hypertension during pregnancy (including pre-existing and pregnancy-induced hypertension) was 9.4% in 2013 similar to previous year, with wide variations among Fields.

Calculated by multiplying the total number of served refugees (from the UNRWA registration system) by the crude birth rates published by host authorities (2.8% in Jordan, 2.0% in Lebanon, 2.8% in Syria, 3.7% in the Gaza Strip and 3.0% in the West Bank).

[8] Centres for Disease Control and Prevention. National Diabetes Fact Sheet: national estimates and general information on diabetes and pre-diabetes in the United States, 2011. Atlanta, GA: U.S. Department of Health and Human Services Centres for Disease Control and Prevention, 2011.

Delivery Care

Place of delivery

Delivery in a health facility, where complications can be managed, substantially lowers the risk of complications and death for both mother and baby. UNRWA subsidizes hospital delivery for pregnant women classified as high-risk. During 2013, 98.5% of all reported deliveries Agency-wide took place in hospitals compared with 78.0% in 2002, 90.6% in 2005, and 97.7% in 2012. Deliveries in private health centres accounted for 1.4% of the total, while home deliveries represented 0.1%. Most home deliveries were attended either by a qualified midwife or by a physician. Agency-wide, 100.0% of women who delivered in 2013 were assisted by trained personnel

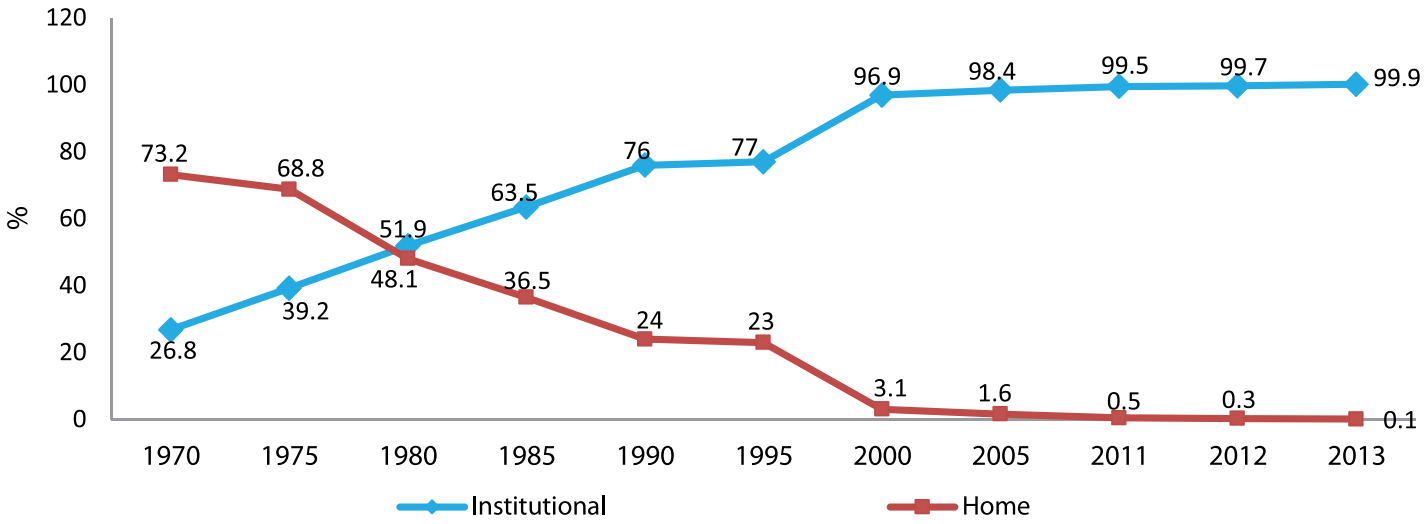

Figure 5 - Trends (%) of home versus institutional deliveries, 1970-2013

Caesarean sections

The proportion of deliveries by caesarean section among Palestine refugees served by UNRWA was 18.9% during 2013, compared to 20.8% during 2012. The substantial variation among Fields may reflect a combination of client preference and prevailing medical practice.

Monitoring the outcome of pregnancy

In 2002, UNRWA established a registration system to track the outcome of each pregnant woman in each health facility. During 2013, the total number of pregnant women who were expected to deliver was 85,364. Of these, the outcome of only 184 pregnancies (0.2%) remains unknown. The percentage of unknown outcomes dropped from 2.8% in 2002 to 0.2% in 2007, and had since that time remained constant. The highest proportion of unknown outcomes in 2013 was reported from the West Bank (1.4%).

Monitoring maternal deaths

During 2013, a total of 17 maternal deaths were reported by the four UNRWA Fields (Syria excluded). This is equivalent to an overall maternal death ratio of 21.9 per 100,000 live births.

Table 14 - Caesarean section rate among UNRWA reported deliveries, 2010-2013

Field	Total deliveries 2013	Caesarean section rate			
		% 2010	% 2011	% 2012	% 2013
Jordan	23,815	19.1	21.1	20.7	21.7
Lebanon	4718	28.8	31.0	33.8	34.0
Syria	NA	38.3	39.9	42.0	NA
Gaza Strip	39,031	12.7	13.8	14.6	13.6
West Bank	11,988	19.8	21.4	22%	22.9
Agency	79,552	19.0	20.5	20.8%	18.9

UNRWA health staff conducts a thorough assessment following each reported maternal death using a standardized verbal autopsy questionnaire. Five women died during pregnancy, one during labour and eleven deaths occurred in the post-natal period. All deaths occurred in hospitals. The main reported cause of death was haemorrhage in eight cases (47.1%), pulmonary embolism in four cases (23.5%), acute respiratory distress syndrome in two cases (11.8%), heart disease in one case(5.9%), septicemia in one case (5.9), and liver failure in the last case (5.9%). The majority of these deaths could have been prevented. The maternal mortality among Palestine refugees is similar to the rate in upper middle income countries and far low from the estimate for the Arab states at 140 and west Asia region at 71 per 100,000 live births[9] .

Post-Natal Care

UNRWA encourages all women to attend post-natal care as soon as possible after the delivery. Post-natal care services include a thorough medical examination of the mother and the new-born, either at UNRWA health centres or at home, counselling on family planning, breast feeding and newborn care. Of the 79,552 pregnant women who delivered during 2013, a total of 73,206 women received post-natal care within six weeks of delivery, representing postnatal coverage 94.4% [10].

Child Health Services

UNRWA provides care for children across the phases of the lifecycle. Both preventive and curative care is provided, with a special emphasis on prevention. Services include newborn assessment, well-baby care, periodic physical examinations, immunisation, growth monitoring and nutritional surveillance, micronutrient supplementation, preventive oral health, school health services and care of sick children, including referral for specialist care.

Care of Children Under Five Years of Age

Registration and follow up

Each UNRWA health centre maintains a system of registration for children less than five years of age. In the past, UNRWA registered only children up to the age of three years. The system is currently under transition to include children less than five years of age. During 2013, a total of 261,142 children below 60 months were registered. The observed decline in the following figure (Figure 6) could be explained mainly for the exclusion of Syria data and for the observed decline in the number of children attending child health care services.

[9] Trends in maternal mortality: 1990 to 2010 WHO, UNICEF, UNFPA and The World Bank estimates.
[10] Postnatal coverage calculated based on WHO definition

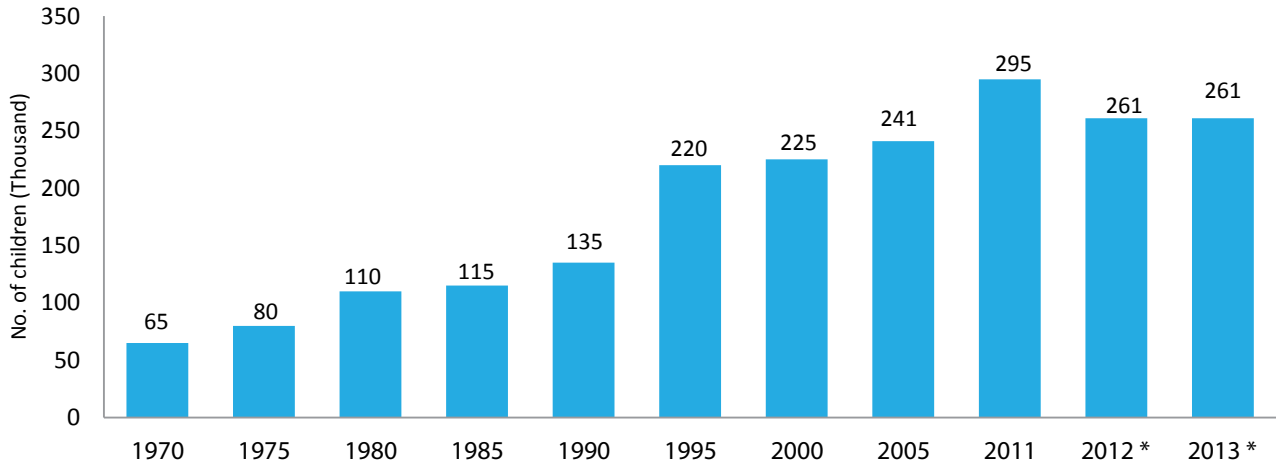

Figure 6 - Children 0-5 years registered at UNRWA health centres, 1970-2013 (* Data not available for Syria)

Child care coverage

Similar to the antenatal care, the number has decreased constantly since 2008 in all fields. During 2013, UNRWA primary health care facilities cared for 261,142 children who represent a coverage rate 79.7 % of all expected number of children.
This decrease could be explained by an increased utilization of other service providers and/or by access constraints due to movement restrictions in the West Bank or insecurity in Gaza.

Immunisation

UNRWA health services provide immunisation against ten diseases: tetanus, diphtheria, pertussis, tuberculosis, measles, rubella, mumps, polio, haemophilus influenza type B (Hib) and hepatitis. Pneumococcal vaccine is only provided in West Bank and Gaza. The percentage of children aged 12 months and 18 months who have received all required immunisations was more than 99.0% for both age groups during 2013.
Coverage has been close to 100% for more than a decade.

Growth monitoring and nutritional surveillance

Growth and nutritional status of under-five children is monitored at regular intervals. Breastfeeding is promoted and mothers are counselled on infant and child nutrition.

Data for 2013 reflect only the total number of children who were under-weight for the age group 0-3 years.

For this group, by the end of 2013, the incidence rate of under-weight was 1.8%, with a prevalence rate at 1.6%. There was no disparity between girls and boys. While under-weight does not represent a major health problem among refugee children, there is growing concern about obesity and micronutrient deficiencies.

Surveillance of Infant and Child Mortality

Infant mortality

During 2013, a total of 601 cases of death among infants below one year were reported from the four Fields (Syria excluded). Analysis revealed that congenital malformations ranked first (29.0%), followed by prematurity / Low Birth Weight (LBW) (27.6%), respiratory infections and other respiratory conditions (16.3%), gastroenteritis (2.0%), and unknown causes (7.7%).
Further analysis of the data showed that 39.1% of those children died during the early neonatal period (less than one week of age), 17.3% during the late neonatal period (8-28 days) and 43.5% between 29 days and one year of age.

Child mortality

During 2013, a total of 101 cases of death among children (1-5) year were reported. Congenital malformations and heart diseases ranked first (23.8%), followed by respiratory infections and accidents at 10.9%, and deaths due to other causes were at 25.7%. Among children (1– 5) years of age, 66.3% of deaths occurred during the second year of life, while 33.7% occurred during the third year.

School Health

During the school year 2012/2013, a total of 491,641 students were enrolled in UNRWA schools.

During 2013, the School Health Strategy has been launched jointly with Education Department. This strategy addresses four core areas to promote the healthy development of a student: comprehensive health services, a child-friendly, safe and healthy environment, health education, and healthy school nutrition and canteens.

The UNRWA School Health Programme includes medical and oral health prevention interventions and screening, assistance to children with special health needs, immunisation, vitamin A supplementation, and a de-worming programme. In 2013, a total of 4,754 students were referred to UNRWA health facilities, and an additional 3,366 were referred for specialist assessment. Furthermore, 10,067 students were assisted with the cost of eyeglasses, and 48 received assistance for hearing aids.

New school entrants medical examination

During the school year 2012/2013, UNRWA schools registered 56,925 new entrants (28,591 girls and 28,334 boys). Each new entrant received a complete medical examination, immunisation and follow-up or referral as required. The most frequently detected health problems were dental caries (16.4%) and vision defects (7.1%).
Health problems related to personal hygiene remain present at low levels: pediculosis was found in 1.8% and scabies in 0.1% of new entrants.

Medical screening

Medical screening activities, targeting 4th and 7th grade students, involve assessment for vision and hearing impairment, thyroid enlargement and oral health problems. Among 4th grade students, 49,332 were screened, achieving 98.5% coverage rate. The most common morbidities detected were vision defects (12.0%) and hearing impairment (1.4%). Among students in the 7th grade, 42,323 were screened, with 98.2% coverage rate.
The main morbidities were again vision defects (14.4%) and hearing impairment (1.0%).

Oral health screening

Oral health screening is conducted for 1st, 7th and 9th grade students, and for the 4th grade students in the West Bank.

A total of 64,710 students were screened. Screening is coupled with other dental caries prevention activities such as pit and fissure sealant for 1st graders, erupted molar for students at the 1st and 2nd grade, fluoride mouth rinsing, and tooth brushing campaigns.

For the 9th grade, 13,533 students were screened, with 70.1% coverage. In Gaza, 29,341 students in the 1st grade were screened with 100% coverage rate, with pit and fissure sealant application achieving 70.0% coverage rate.

Children with special health needs

During the school year 2012/2013, a total of 2,327 school children were identified with special health needs. Of these, 698 students were affected by juvenile diabetes mellitus, 178 had heart disease, 376 showed behavioural problems, 450 had asthma and 137 were living with epilepsy.
These children received special medical attention from teaching staff and the school health team and their school records are maintained separately to facilitate follow -up.

Immunisation

UNRWA Immunisation programme for school children is streamlined with the host country's requirements. During the school year 2012/2013, all new entrants in all Fields received a booster dose of tetanus-diphtheria (DT/Td) immunisation.

The Agency-wide coverage was 99.9%. Coverage of oral polio vaccine (OPV) for new entrants was 100% in the Gaza Strip and 99.9% in the West Bank, and coverage of Td vaccination among 9th grade school children was 97% in all Fields.

De-worming programme

In accordance with WHO recommendations, UNRWA maintains a de-worming programme for children enrolled at UNRWA schools. A single dose of a broad-spectrum anti-helminthic medication is applied for three successive years for new entrants.

During the 2012/2013 school year, a high coverage was achieved among children in first, second and third elementary classes.
During the school year 2012/2013, UNRWA jointly with the Global Network for Neglected Tropical Diseases at the Sabin Vaccine Institute and Dubai Care implemented a comprehensive de-worming project to distribute mebendazole, iron supplements and health education materials to all students in UNRWA schools in West Bank and Gaza.

Vitamin A supplementation

During the 2012/2013 school year, children from grades one to six at all UNRWA schools received two doses of Vitamin A (200,000 International Units (IU)) at six-month intervals.

Strategic Objective 3 – Prevent and Control Disease

Non Communicable Diseases (NCDs)

The burden of NCDs

NCDs are the major threat to Palestine refugees' health. The increased burden of NCDs represents a tremendous challenge for the Agency accounting 35.0% of the budget spent on all medications (USD 22.25 million). At the end of 2013, a total number of 199,418 patients with diabetes and/or hypertension were registered for UNRWA NCD services across the four Fields (Syria excluded).

More than 6,000 patients were newly registered during 2013. Figer 7 shows the number of NCD patients during the period from 2000 to 2013. Patients 40 years of age and above represented 91.0% of all NCD patients. During 2013, 62.0% of these patients were females. About 43.8% of the total registered patients had hypertension only, 38.6% had both hypertension and diabetes, while 17.3% had diabetes only. The number of patients with Type 1 Diabetes was 3,203 representing 2.9 % of all diabetic patients.

During 2013, the prevalence of diagnosed patients with diabetes mellitus and hypertension was 10.9% and 16.2% respectively among the served population at 40 years of age and above.

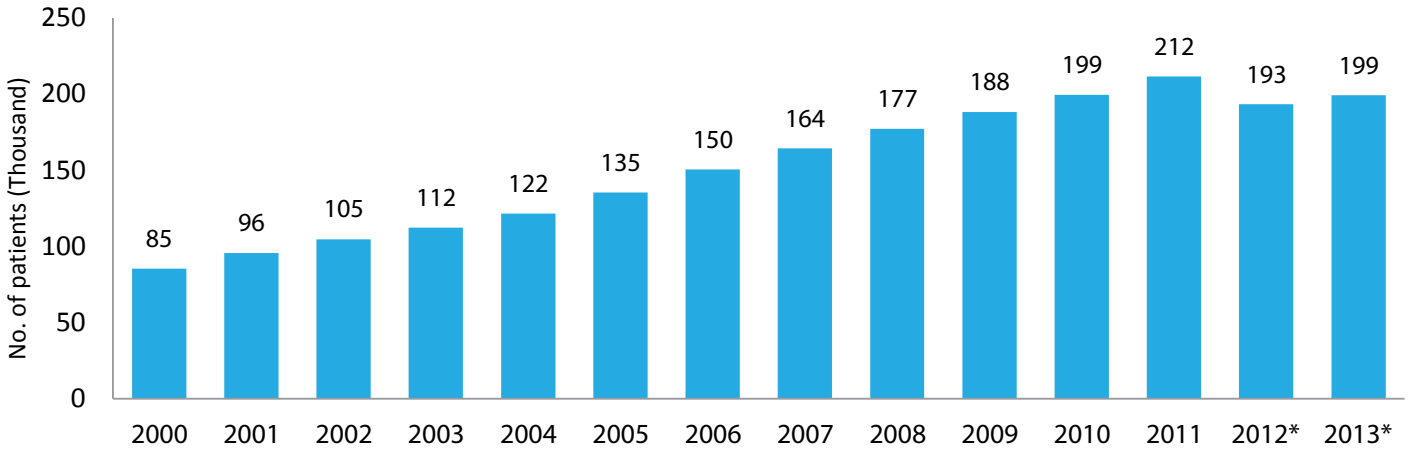

Figure 7-Patients with diabetes and /or hypertension under care Agency-wide, 2000-2013 (* Data not available for Syria)

Risk scoring

A risk assessment tool adopted by UNRWA, and based on WHO risk scoring system, is used to assess the risk status of NCD patients. The system assesses the presence of modifiable risk factors such as smoking, hyperlipidaemia, physical inactivity, blood pressure, and blood sugar, and non-modifiable risk factors such as age and family history of the disease.

Table 15- Patients with diabetes and/or hypertension by Field and by type of morbidity

Morbidity type	Jordan	Lebanon	Syria	Gaza Strip	West Bank	Agency
Diabetes mellitus type I	1,227	235	NA	1,091	650	3,203
Diabetes mellitus type II	10,845	2,419	NA	11,783	6,257	31,304
Hypertension	29,266	12,435	NA	31,938	14,217	87,856
Diabetes mellitus & hypertension	29,884	8,601	NA	23,176	15,394	77,055
Total	71,222	23,690	NA	67,988	36,518	199,418

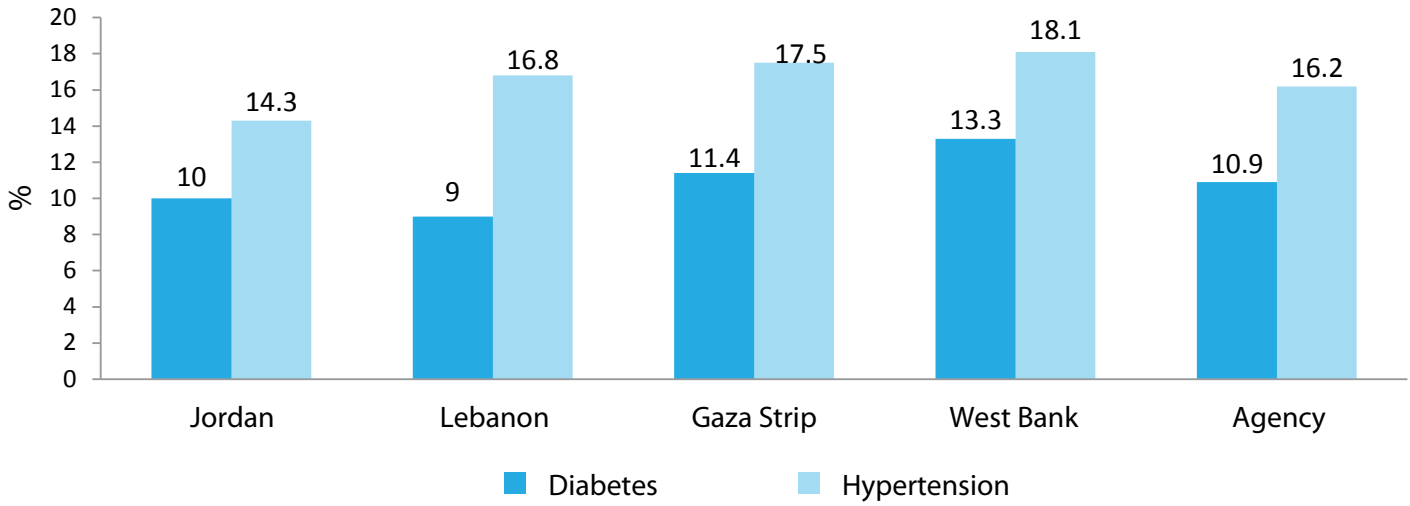

Figure 8- Prevalence (%) of patients diagnosed with diabetes and hypertension among served population ≥40 years of age, 2013

The risk scoring assessment revealed that 29.7% of patients who had hypertension, 28.7% of patients who had both diabetes and hypertension, and 16.8% of patients who had type II diabetes were at high risk.

Treatment

The highest percentage of non-pharmacological treatment among hypertensive patients was 9.0% in Lebanon Field, (5.0%), in Gaza Field, (2.0%) in Jordan and (1.0%) in West Bank. .

The proportion of patients with type I or type II diabetes who were treated with insulin as part of their management also varied among Fields; from 18.8% in Lebanon up to 40.4% in Gaza.

The control status of post prandial blood glucose levels was at 49.8% among diabetic patients based on the last 3 assessments, while the control rate was higher reaching 68.7%, among patients with hypertension.
These measurements cannot, however, reflect the control status over time. In 2011, UNRWA introduced the HbA1c testing in one Field (West Bank).

As mentioned earlier, and following the health centre clinical audit during 2012 (published in 2013), UNRWA Health Department, in cooperation with World Diabetes Foundation (WDF), conducted diabetes campaigns in 30 health centres in Gaza, Jordan , Lebanon and West Bank. The preliminary results are highlighted in the part on Nutrition in this report.

Late complications

Late complications of NCDs include: cardiovascular diseases (myocardial infarction and/or congestive heart failure), cerebrovascular disease (stroke), end-stage renal failure (ESRF), above-ankle amputation and blindness.
During 2013, late complications were reported in 9.6% of the NCD patients Agency-wide, while it was 9.1% for 2012.

The slight increase can be explained by the fact that the sample size of 10% differs from year to year, in addition to improved level of recording and reporting of late complications in some patients' files. It was found that patients having both diabetes and hypertension had the highest incidence of late complications of 15.3%, followed by patients with hypertension only at 6.8%, and patients with diabetes only at 5.5%. Some differences among the Fields were observed.

Defaulters

Defaulters are defined as patients who did not attend the health centre for NCD care at all during a calendar year.

The Agency-wide rate of defaulter NCD patients was 5.7 % (11,104 patients) in 2013, while it was 4.8 % in 2012. The Field specific defaulter rate ranged from 4.6% in West Bank to 7.3% in Jordan being the highest for the second year.

Case fatality

A total of 3,190 (1.7%) were reported to have died during 2013; deaths may however be under-reported.
Patients with both morbidities (hypertension and diabetes) comprised 54.0% of all deaths, while patients with only hypertension represented 35% and those with only diabetes represented 11.0% of all deaths.

The way forward for NCD care

The burden of NCDs and their complications is increasing. UNRWA is strengthening its approach to primary prevention through health education and by improving the quality of foods served at school canteens.
The Agency is also intensifying its screening programmes in order to detect more cases and to early manage those diagnosed. Outreach campaigns were conducted in four Fields (Gaza, Jordan Lebanon and Lebanon West Bank) during 2013 and a total of 31,340 persons were screened for diabetes and/or hypertension, which resulted in a detection rate of 4.4% new diabetic patients, 6.5% hypertensive patients, and 1.6% with both diseases.

The use of the cohort monitoring system is helping in the improvement of the quality of NCD care in UNRWA health centres. This system is now used for monitoring the NCD care at 6 health centres that implement e-health in Jordan. It is planned to implement it in all health centres that use the e-health.

Furthermore, UNRWA will continue to explore all possible options to introduce lipid-lowering agents and HbA1c testing.

UNRWA as well will continue to strengthen partnership with host authorities and other stakeholders to improve the quality of NCD care.

Communicable Diseases

Prevention and control of communicable diseases in 2013 faced new challenges that have not been faced since 1999. A total 24 cases of poliomyelitis were reported in Syria, besides increased reporting of new cases of H1N1 in Gaza and West Bank, and a Mumps outbreak in Gaza.
UNRWA continued its cooperation with host authorities and WHO, and participated in immunisation campaigns in all Fields, and in the sub-national campaign for mumps in Gaza.
In addition, focus on strengthening the surveillance of emerging and re-emerging diseases continued to be active.
Close coordination was maintained with the host countries' Ministries of Health for surveillance of communicable diseases, outbreak investigation, supply of vaccines, and exchange of information, in addition to the participation in national immunisation days and in the annual WHO/EMRO immunisation week.

H1N1 Influenza

During the 2013 year, a total of 139 cases with H1N1 (85 in Gaza and 54 in West Bank) were reported, with an incidence rate of 11.6 per 100,000 population.
Only 8 cases were confirmed to be positive and admitted to hospital and no deaths were reported. It is expected that many cases were treated at home and improved without being reported to health centres. No gender differences were reported.

Expanded Programme on Immunisation (EPI)

In each Field, UNRWA's immunisation services are linked to the host country's EPI
Agency-wide immunisation coverage, for both 12 month old and 18 month old children, continued to be close to 100% in all Fields except for Syria where the assessment was not possible during the year.
Factors contributing to UNRWA's success in immunisation coverage include a consistent supply of vaccines, the enforcement of an appointment system, and continuous follow-up of defaulters.

Although Polio was confirmed in Syria, no confirmed cases were reported among Palestine refugees. In addition, no cases of tetanus, diphtheria or pertussis were reported during 2013.

Other communicable diseases

Viral hepatitis

The Agency-wide incidence of suspected cases of viral hepatitis (mainly hepatitis A) continued to increase, from 31.6 per 100,000 populations in 2012 to 33.0 per 100,000 populations in 2013. The highest increase during 2013 was reported in Lebanon at 66.8 per 100,000, and Gaza at 57.2 per 100,000.

Typhoid fever

The Agency-wide incidence of suspected typhoid fever cases increased from 1.8 per 100.000 in 2012 to 4.6 per 100,000 in 2013. The highest incidence was observed in Gaza (7.2/100,000). Jordan and West Bank Field reported no cases.

Tuberculosis

Very obvious drop in reported cases of tuberculosis was noticed in 2013, and this is mainly due to the drop of reporting from Syria. This is might be due to the loss of follow up of known cases and the inability of patients to attend to health centres because of continued armed conflict. Only 23 cases were reported in 2013 compared to 75 in 2012.
Of those, 8 cases were smear-positive, 5 were smear-negative and 10 were extra pulmonary. Syria reported only 6 cases compared to 54 cases reported in 2012, Lebanon reported 11, Gaza reported 4, and both Jordan and the West Bank reported one case each.

With the exception of Syria, detection rates in all Fields remain below the WHO target of 70% of the expected number of cases for the country. During 2013, cure rates of 100% were achieved for UNRWA patients in all Fields.

Brucellosis

During 2013, 92 cases of Brucellosis cases were reported in Syria, 11 in West Bank and 2 cases in Jordan.

Environmental Health

UNRWA'S environmental Health Programme controls the quality of drinking water, provides sanitation, and carries out vector and rodent control in refugee camps.

Environmental health services are managed by different UNRWA Departments in different Fields: the Administration Department in Lebanon, the Procurement Department in Jordan, the Department of Infrastructure and Camp Improvement in Syria, and the Special Programmes Department in Gaza Field.

In the West Bank, these services are the responsibility of the UNRWA Health Department.

For West Bank, almost 48,400 tons of domestic, medical and commercial waste has been removed and disposed in the municipal dump sites in 2013.

The environmental health is also responsible for the operation and maintenance of two UNRWA water facilities: The slow-sand filtration water treatment plant at Aqbat Jaber and the water pump station at Far'a. Management of water supply to households, including the distribution and billing, is the responsibility of the water utilities and water committees inside camps.

Two campaigns annually to control the spread of Leshmaniasis in Jericho area and in the Jordan Valley are conducted every year.

Crosscutting Services

Crosscutting service areas support all three strategic objectives and include: nutrition, disability care, laboratory and radiology services, medicines and medical supplies, health communication, regional emergency preparedness, response, readiness and relief, human resources and gender mainstreaming.

Nutrition

During the year 2013, the Health Department conducted a six-month awareness campaign, entitled of "Life is Sweeter with Less Sugar".
The campaign had several phases, including the planning phase, the preparation phase, the implementation phase, and the monitoring and evaluation phase.

The preparation phase included the preparation of educational materials, data collection sheets and questionnaires, in addition to the training of staff on diabetes management, and the formation of focus groups that involved diabetic patients.

The Implementation phase was conducted by four Fields (Jordan, Gaza, West Bank, and Lebanon) with: health education and life-style counselling, cookin, and exercise for 6 months in West Bank, Gaza and Lebanon and 3 months in Jordan.

Out of 1400 patients who were registered with the campaign, 1170 completed the 3 months period (932 female, 238 male) and 799 completed the 6 months period (644 female, 155 male).

The average age of participants was 51.1 (19-69) years. Improvements observed included: weight reduction by 1.5 kg for the 3 months period including 39.4 % (n=461) of the participants and 3.0 kg for the 6 months period including 43.8% (n=350) of the participants.

Average waist circumference reduction was by 1.5 cm for 3 months period including 47.8% (n=508) of the participants, and 3.0 cm for the 6 months period including 43.4% (n=382) of the participants.
Average Body Mass Index (BMI) was reduced by 2.0 digits and was observed in 4.19 %(n=29) of the participants in the 3 months campaigns, and in 16.3% (n=29) of the 6 months campaign participants.

The average Post Prandial Blood Glucose (PPG) levels were decreased by 5.0 digits in 55.8% (n=653) of the participants in the 3months campaigns, and by 10.0 digits in 64.8% (n=513) of the patients participating in the 6 months campaign.
Average systolic/diastolic blood pressure was reduced by 5.0 digits in 40.3% (n=472)/ 29.2% (n=342) of the participants in the 3 months campaigns, and 10.0 digits in 37.8% (n=301)/ 22.4% (n=179) of the participants in the 6 months campaign.

Average cholesterol level was reduced by change by 5.0 digits in 43.4% (n=347) of the participants in the 3months, and 10 digits in 51.2% (n=599) of the participants in the 6 months campaign.

Improvement in the process indicators was also observed among the Fields. A significant weight loss was observed in 40.2% of the participants in Jordan, 42.0% in Gaza, 61.7% in West Bank and 55.5% in Lebanon.

A significant waist circumference reduction was observed in 49.9% of the participants in Jordan, 41.70% in Gaza, 63.8% in West Bank, and 49.0% in Lebanon.
In addition, a significant PPGT reduction was observed in 51.7% of the participants in Jordan, 54.0% in Gaza, 65.3% in West Bank, and 78.0% in Lebanon.

One of the best results was the high commitment and of attendance by the participating patients.

The average percentage of attendance based on the number of sessions conducted were: 83.0% in Jordan, 95.0% in Gaza, 81.0% in West Bank and 80.0% in Lebanon.

The level satisfaction of the patients and staff was high, and action plans are set for following up the patients and maintaining their results. The campaigns helped in strengthening the relationship between the health centres with the local community, NGOs, and donors through partnerships established between them.

Disability Care

UNRWA Programmes. UNRWA adopts the definition of disability stated in the UN Convention on the Rights of Persons with Disabilities, which states that "persons with disabilities include those who have long-term physical, mental, intellectual, or sensory impairments, which in interaction with various attitudinal and environmental barriers hinder their full participation in society on an equal basis with others."

During 2013, disability was addressed through a variety of activities to raise staff awareness about mainstreaming disability within all UNRWA activities.

Registered refugees identified by UNRWA's health centres as suffering from permanent physical disability and/or visual and hearing impairments are eligible for financial support from the Health Department to cover the cost of prosthetic devices.

During 2013, 48 students received assistance to cover the cost of hearing aids. Folic Acid supplementations are prescribed for the mothers in the pre-conception period. Technical instructions regarding eligibility for disability services were updated. The eligibility and the amount of financial contribution by UNRWA is outlined in these technical instructions. The UNRWA Health Programme implements a community mental Health Programme aimed at promoting the psychological and social wellbeing of Palestine refugees.

Laboratory Services

Comprehensive laboratory services were provided through 124 out of 139 health facilities. The remaining 15 facilities continued to provide basic laboratory support (blood glucose, blood haemoglobin and urine tests by dipstick) by competent nursing staff using basic laboratory equipment.

Utilization trend

The number of tests performed Agency-wide decreased from 4.6 million in 2012 to 4.3 million in 2013. The rates of decrease were 3.3% in Gaza, 1.1% in Jordan and 0.8% in the West Bank while there was an increase of 7.7% in Lebanon due to the provision of laboratory services to Palestinian refugees from Syria. No data was reported from Syria.

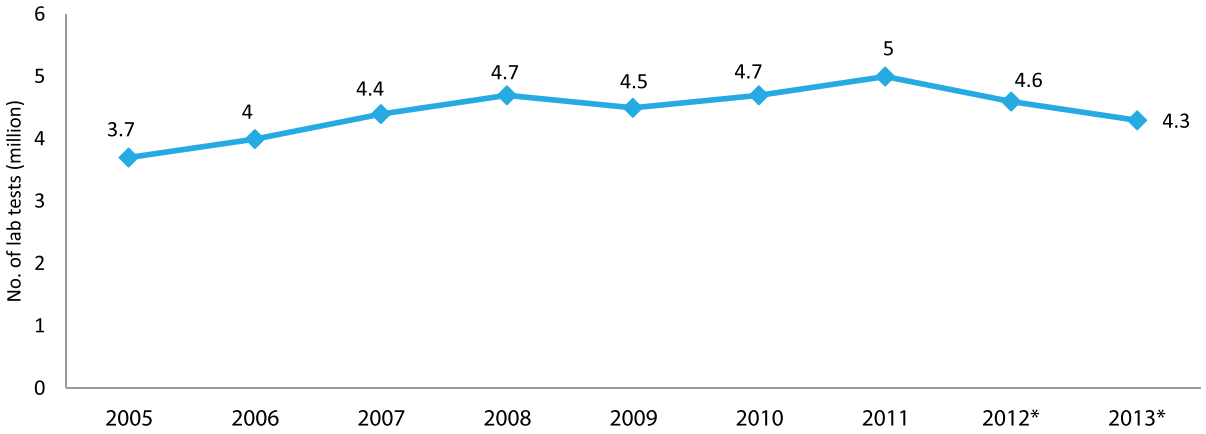

Figure 9 – Utilization trend of laboratory services, 2005-2013
(* Data not available for Syria)

Periodic self-evaluation

Based on the findings of the annual comparative study of workloads and efficiency of the laboratory services, the productivity target ranges from 45 to 55 (Work Load Units) WLUs/hour.

The productivity was 46.3 in Jordan, 35.7 in Lebanon, 67.2 in Gaza, and 53.0 in West Bank.
The high workload in Gaza was mainly due to the decrease in the number of staff recruited on the Job Creation Programme (JCP).

Laboratory costs

The overall cost of laboratory services USD 5.14 million, out of which USD 4.86 million (94.6%) were secured through GF and USD 0.27 million (5.4%) through in-kind donation or projects.

The cost of laboratory services continued to be far below the rates of the host countries for equivalent services at an average of USD 13.2 million. This suggests that UNRWA's experience in integrating laboratory services into its primary health care activities remains cost-efficient compared to referring patients to external services. The expenditure on laboratory equipment during 2013 was USD 511,145, out of which USD 315,441 (62%) were secured through General Fund whereas only USD 195,704 (38%) through emergency funds, project funds and/or donations

Table 16-Expenditure on laboratory services (USD), 2013

Cost	Jordan	Lebanon	Syria	Gaza Strip	West Bank	Agency
GF	1,086,112	691,704	449,146	1,562,040	1,077,404	4,866,406
Projects	0	39,025	128,964	60,820	46,564	275,373
Total	1,086,112	730,729	578,110	1,622,860	1,123,968	5,141,779

Table 17 - Comparative analysis on annual cost of laboratory services performed at UNRWA facilities and cost of same services if outsourced to host authorities (USD), 2013

Cost	Jordan	Lebanon	Syria	Gaza Strip	West Bank	Total
Public	3,251,601	1,392,850	NA	6,042,477	2,550,623	13,237,551
UNRWA	1,167,074	826,401	NA	1,707,301	1,254,554	4,955,330

Quality assurance

In order to ensure the quality of laboratory services, UNRWA laboratory supervisors continued to follow-up on the performance of laboratory personnel and on the proper provision and utilization of laboratory services through the following activities:

1. Training courses and in-service training for newly recruited laboratory technicians;
2. Implementation of internal quality control;
3. Implementation of External Quality Assurance System (EQAS) in Jordan, Gaza and the West Bank. It was not implemented in Lebanon and Syria due to logistics problem;
4. Conducting an annual assessment of the trends in utilization and productivity of laboratory services at health centre level;
5. On-going checking of the quality of laboratory supplies.

Radiology services

UNRWA operates 21 radiology units (9 units in the West Bank, 6 in Gaza, 4 in Lebanon and 2 in Jordan). These units provide plain x-ray services to patients attending the health centres.

During 2013 radiology services included 92,981 X-rays to 88,380 patients out of which, 73,380 were plain X-rays to 69,052 patients through UNRWA X-ray facilities, and 19,601 X-rays for 19,328 patients by contracted X-ray facilities.

Medicines and Medical Supplies

Total expenditure

In 2013, the total value of medical supplies and equipment from all funds (General Fund, in-kind contributions and emergency appeals) was approximately USD 23.74 million, representing a decrease of 10% compared with 2012 (USD 25.2 million).

Of the total, the General Fund covered USD 15.4 million (64.8%), while the in-kind and emergency funds covered approximately USD 8.4 million (35.2%). The emergency appeals covered USD 0.45 million. In Gaza, 36.0% of the expenditure was covered through donations. The expenditures by Field are: Gaza at USD 10.9 million (46.0%), followed by Jordan & West Bank at USD 3.1 million (17.0%) each, Lebanon at USD 2.82 million (12.0%) and Syria at USD 1.83 million (8.0%).

In 2013, the average expenditure on medical supplies per outpatient medical consultation was USD 2.56, representing a slight decrease as compared to 2012 (USD 2.7).

The average expenditure on medical supplies per served refugee was USD 7.3 Agency-wide, compared with USD 8.0 in 2012.

Expenditure on medicines

The total expenditure on medicines in 2013 was USD 22.25 million, of which 35% was spent on medicines for the treatment of diabetes and cardiovascular diseases (18% for diabetes, 17% for cardiovascular diseases) and 34% on antibiotics.

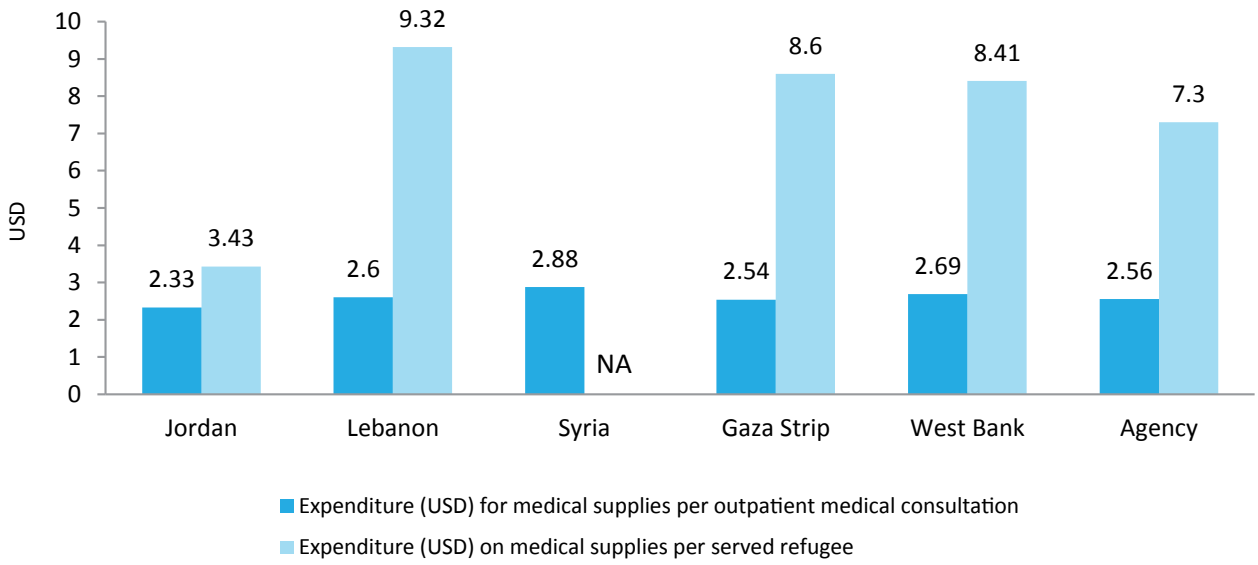

Figure 10 - Average expenditure (USD) for medicines and medical supplies, 2013

Expenditure on medical equipment and related supplies

During 2013, medical equipment and related supplies accounted for 8.0% (USD 1.89 million) of the total expenditure for medical supplies (USD 23.74 million).

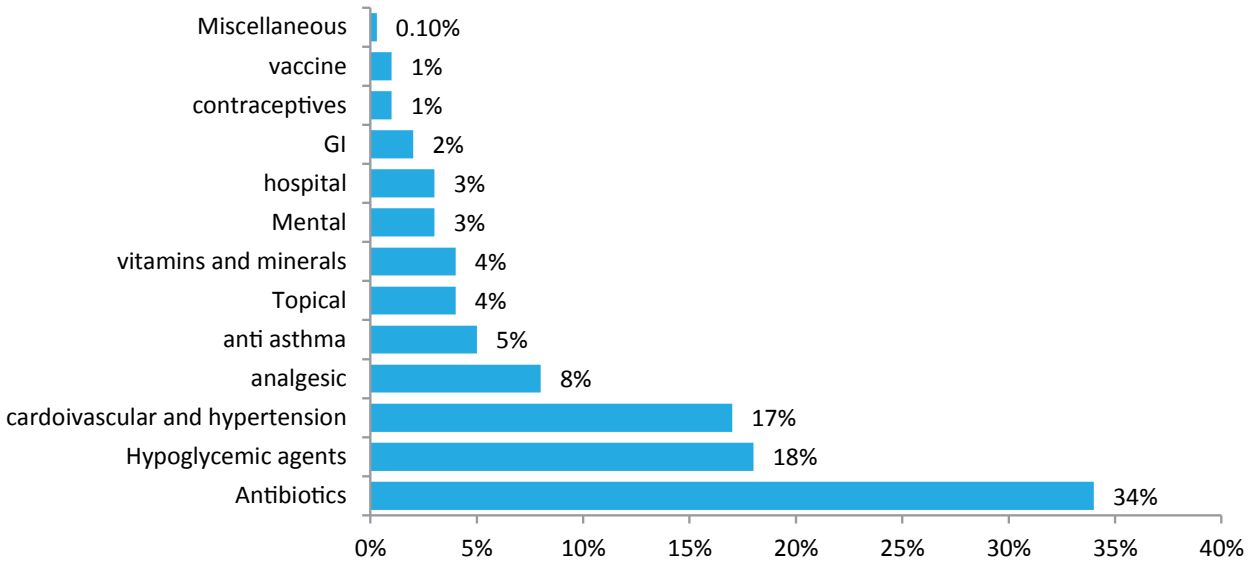

Figure 11 - Proportional expenditure on medicines per therapeutic group

The expenditure on medical equipment from all funds was USD 1.89 million and it includes all service contracts and maintenance. For detailed information on equipment and furniture expenditure see section 3.

Aantibiotic prescription rate

UNRWA aims for an antibiotic prescription rate below 25% in line with WHO recommendations. Antibiotic prescription rates ranged from 21% in Lebanon to 27% in Gaza in 2013.
It is worth mentioning that in January 2013, a new standard for calculating the antibiotic prescription rate was established and considered as a baseline for monitoring performance in this area in the coming years.

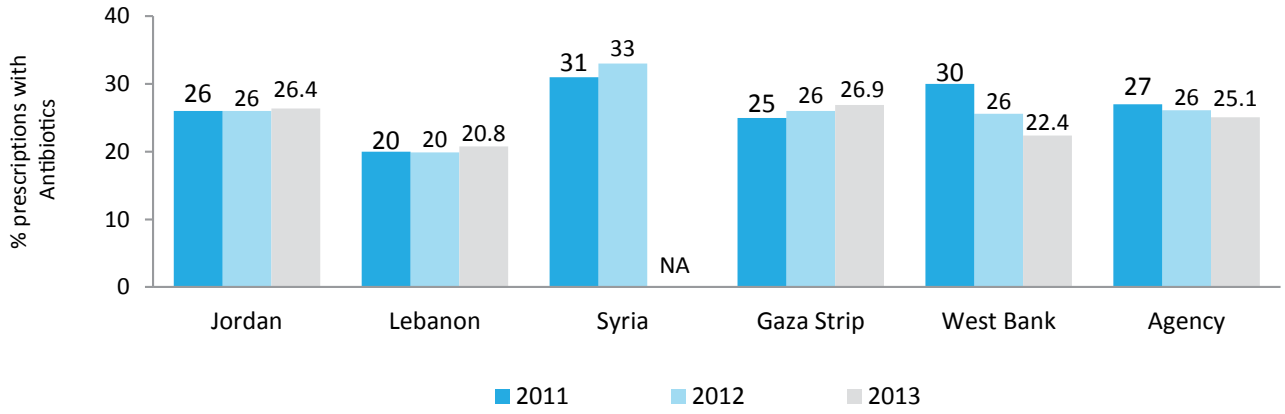

Figure 12 - Antibiotic prescription rate (%) by Field

Donations of medical supplies

In 2013, UNRWA received donations of medical supplies (medicines, medical equipment and others) equivalent to USD 9.64 million, of which Gaza Field received 40%, followed by Syria (21%), Lebanon (18%), Jordan (11%), and West Bank (10%).

The following medicines and consumables were donated during 2013:

1. The Ministry of Health of the Palestinian Authority and UNFPA provided the West Bank and Gaza with vaccines, iron drops and tablets as well as disposable syringes, needles and modern contraceptives;
2. The Ministry of Health in Jordan offered vaccines and contraceptives;
3. UNICEF and the Health Care Society (an NGO) provided Lebanon Field with vaccines, medications, disposable syringes and needles; and
4. Syria's Ministry of Health and UNICEF provided Syria Field with vaccines, tuberculosis treatment and other miscellaneous drugs.

Health Communication

During 2013, a variety of activities were conducted. Several major events were successfully organised and executed with wide participation of concerned UNRWA staff and other stakeholders. The most prominent was the celebration of the World Diabetes Day 2013 on 20 November at HQ (Amman) under the auspices of UNRWA's Deputy Commissioner General (DCG), and included many activities. Several health advocacy materials were produced and launched.

The Health Programme produced, in cooperation with two renowned Jordanian actors (Zaal and Khadra), a set of TV spots in Arabic with English subtitles to for broadcasting via UNRWA TV and UNRWA social media web pages.

In addition, the Health Programme produced a short video titled "Randa's Story" telling the story of a girl at one of UNRWA schools in Jordan who has diabetes type 1. Update of UNRWA website on the internet and on the intranet continued.
To support the diabetes campaign and participating patients, and as an advocacy tool, the Health Programme produced the UNRWA Healthy Plate and distributed them to DM patients participating in the DM campaign.

HD communications helped in the production for different publications based on UNRWA branding guidelines. Two key documents were the 2012 health centre audit report of diabetes care and the "Qalqilya hospital and UNRWA hospitalization programme in the WB" produced by the consultant.

Training on communication skills for health staff was delivered all clerks (72) in the Jordan Field, and training on SWOT analysis was delivered for 7 Senior Medical Officers in the same Field.

In addition, with the help of the Jordan Field Office, a survey on smoking for staff in general, and for medical officers in particular, was conducted at all health centres. During 2013, a training workshop and meeting on UNRWA Global Youth Tobacco Survey (GYTS 2013) study implementation was conducted, and Field started the implementation of the study at sample schools in all Fields except Syria.
Furthermore, a client satisfaction survey was conducted at Aqaba Health Centre during the period June 2013.

A partnership with King Hussein cancer Center (KHCC) in Amman/ Jordan was established and the implementation of a 100% smoke-free health centres' initiative to be piloted at one health centre in the Jordan Field.

Regional Emergency preparedness, Response Readiness and Relief

The region currently stands deeply affected by conflicts, economic downturn, human suffering, unemployment, etc. Palestine refugees in the region are unfortunately facing a double jeopardy; because they have to bear the impact of these recent adversities over and above their long standing pre-existing mard-ginalization as refugees for over 6 decades. They have the unique distinction of being paradoxically a refugee and an Internally Displaced Persons (IDP) at the same time (currently internally displaced in Syria). This double jeopardy has unique implications for UNRWA Health Programme.

The Occupied Palestinian Territory

The humanitarian situation in the occupied Palestinian territories brought about by the occupation, intermittent violence, displacement, severe movement restrictions, poor access, and intimidation continue to adversely affect physical, social and mental health of Palestine refugees and weaken their social determinants of health by aggravating poverty (especially in Gaza) and lack of economic growth opportunities.

According to 2012 survey, 71.0% of households in the Gaza Strip remained food insecure or vulnerable to food insecurity even after having received food assistance from UNRWA and other agencies. Approximately 46.0% of the population has "poor and borderline" diets, such as a reduced consumption of fruits and dairy products.

West Bank

The mobility of health teams including doctors and nurses continued to stand jeopardized by frequent closures and checkpoints. Communities in Area (C) continued to face difficulties in accessing health services due to road detours, road barriers, separation wall and higher transportation costs. Movement restrictions also prevented the access to 6 Palestinian NGO hospitals in East Jerusalem, the main providers of specialized care for the occupied Palestinian territory.

In the face of these challenges, UNRWA continued to provide health services to isolated communities through mobile health teams providing a full range of essential curative and preventive medical services to about 10,000 patients per month living in over 56 isolated locations, a community mental health program, and provided financial support to enable access to hospital care.

Gaza Strip

Continuing blockade fremained to seriously curtail UNRWA's ability to provide health services.
Electricity cuts, lack of construction materials, etc. continue to cripple construction and rehabilitation needs of health infrastructure.
Shortages of critical, life-saving medicines in Palestinian Authority health facilities is a problem; for example, a cancer patient can only expect to find half of the drugs required by chemotherapy protocols.[11]
Patients referred for treatment abroad continued to experience delays in obtaining permits to exit the Gaza Strip, delays which at times can prove fatal. Lingering effects from conflict in 2012 continue to negatively affect the mental health of the population, especially children.

There are reports on an increased number of domestic violence episodes, reportedly a negative externality of stress of occupation, the inability of men to provide security for their families and the consequent reversal of gender roles.

Syria

With conflict continuing in its 3rd year, key priorities of UNRWA's Health Programme were to ensure optimal health access to primary, secondary and tertiary care for all those in need and to mitigate life-threatening health risks.

Learning from the adversities faced in 2012, continued to adjust and innovate to the challenges. With over 50% of the health centres either fully or partially closed, remedial measures included the establishment and the expansion of health points in close proximity to shelters, temporary locations witnessing clustering of displaced populations, prioritizing care for children, pregnant women and NCD patients; providing NCD patients with sufficient medicines supplies for longer time periods, strategic propositioning and distribution of buffer stocks to the health centres.

Lebanon: Palestine refugees from Syria

Over 1.0 million Syrian refugees crossed the border into Lebanon to evade the conflict, roughly 10.0% of Lebanese population. Over 50,000 of PRS have crossed over into Lebanon and are using UNRWA health facilities in Lebanon.

At present, 1 out of 4 daily health consultations are for PRS, adding pressure on UNRWA health centres, staff, medicine and other supplies' stocks, and available funding in Lebanon, and to arrange for life saving secondary and tertiary care, including trauma care for wounded PRS.

[11] ICRC, Israel and the Occupied Territories: Another Year Without Change, February 2012

Human Resources

Field health staffing review

Post actions, related to 15 health posts at Field level, were approved by Department of Human Resources during 2013 as a result of the health staffing review which was conducted during 2011-2012 as part of the health reform.
The posts included Health Centre Clerk, Practical Nurse, Senior Practical Nurse, Midwife, Assistant Pharmacist and Laboratory Technician with Bachelor degree, Deputy Field Nursing Officer, Field Nursing Officer, Senior Dental Surgeon, Field Laboratory Services Officer, Field Pharmaceutical Services Officer, Deputy Field Pharmaceutical Services Officer, Field Physiotherapy Services Officer, Area Nursing Officer and Medical Officer B.
The aim of these post actions was to align the health staff functions with the health reform objectives and to ensure consistency and fairness to staff functioning with similar qualification requirements.

The Head Family Health Services post was reclassified to Senior Health Nutritionist which comes in line with the health reform objective and the Family Health Team approach to target individuals (patients) rather than Health Programmes (diseases)

Training and capacity building

Training and capacity building of health staff is the main investment in any health system.
To this effect, the following training activities were conducted:

- Jordan Field has conducted a training to include 84 medical officers.

The 1st phase of the training included sessions on the Family Health Team Approach, communication skills, Evidence Based Medicine, rationale drug use, and basic health centre skills.
The 2nd phase training included sessions on the approach to headache, URTI, dizziness, low back pain, psychosomatic disorder, and dyspepsia.
The 3rd phase included sessions on disease surveillance. DM, Hypertension, Gestational DM, Gestational Hypertension, Micronutrients, Anaemia in pregnancy, and preconception care.

- Gaza Field has conducted a mentoring exercise to establish, develop, and facilitate positive, stable, and mutually beneficial mentoring team relationships that allow mentees to plan, learn, collaborate, grow, renew, and to reward mentors through the experience of encouraging, motivating and inspiring others. (See Fields' innovations section).

Gender Mainstreaming

In accordance with the UNRWA Gender Policy adopted in 2007 and the Health Gender Mainstreaming Strategy (GMS) adopted in 2008, the Health Programme worked during 2013 on offering support to the Fields in the implementation of their prioritized interventions aiming at reducing the gender gaps, especially in the access to preconception care and family planning and in the health workforce, as well as addressing gender based violence (GBV).

Including men in family planning and preconception care

The Health Department continued to lead the work on technical guidance and management protocols on including men in pre-conception care and family planning. Training and workshops were organized in the Fields for health centres' staff. As there is still a need for improvement of attitudes and reporting skills of some staff members, training continued to take place during 2013, and will continue during the next year.
To that end, the Health Programmes at different Field offices continued their efforts to ensure the inclusion of men in preconception care and family planning by organizing community awareness and regular quarterly workshops for men.
The latter aimed to decrease the resistance to use of family planning methods, in addition to other relevant issues. The lack of allocated budgets and the heavy workload on the shoulders of health staff remain major constraints to overcome these challenges.

Gender Based Violence (GBV)

The Health Department continued its support to all the Fields as they build their GBV survivors referral system.

In Gaza and West Bank, the Health Programmes are leading the development of the referral system for GBV survivors. The overall project indicators for 2013 show a significant increase in the numbers of survivors detected who access UNRWA's health services compared to those in previous years. This increase is a result of the general expansion of the referral system into more geographical areas, staff trainings, awareness-raising activities within the community, and the increased knowledge and confidence of the survivors in the referral system. In the West Bank, UNRWA expanded its referral system to 16 camps, 1 village, and 1 city. In addition, West Bank implemented Health Protocols for GBV in 18 health centers. West Bank started the process of integrating GBV screening and detection into Family Health Team files (midwives and doctors). In Gaza, UNRWA has continued the process of consolidating the referral system through partnership with other UN agencies and local NGOs and Community Based Organisations (CBOs). Gaza consolidated its database and tracking system through a new web application with enhanced functionalities for case managers.

The Health Department and the Gender Unit at the UNRWA Headquarter (Amman) will continue to work together in the implementation of the gender mainstreaming strategy with a focus on the prevention, detection, and provision of health services to the survivors of GBV.

Achieving gender disaggregated data

The Health Department continued the collection of gender disaggregated data, including outpatient consultations, hospital admissions, oral health consultations, radiology service utilization and patients with diabetes and hypertension under care.

Addressing the gender gap in the workforce

UNRWA Health Department encouraged the recruitment of female staff. The percentage of women recruited within all categories and in all Fields varies from 30% in Jordan to 62% in the Gaza. However, the staffing structure in UNRWA health centres, similarly to what can be observed in the host countries reflects stereotypes in gender roles and jobs.

Nurses are primarily females and Medical Officers are mostly males. To tackle these gaps, UNRWA is working to ensure that recruitment procedures are gender-bias free. Advertised positions have been revised to adopt gender-neutral language. Male nurses' appointment is encouraged and women are encouraged to fill in senior positions.

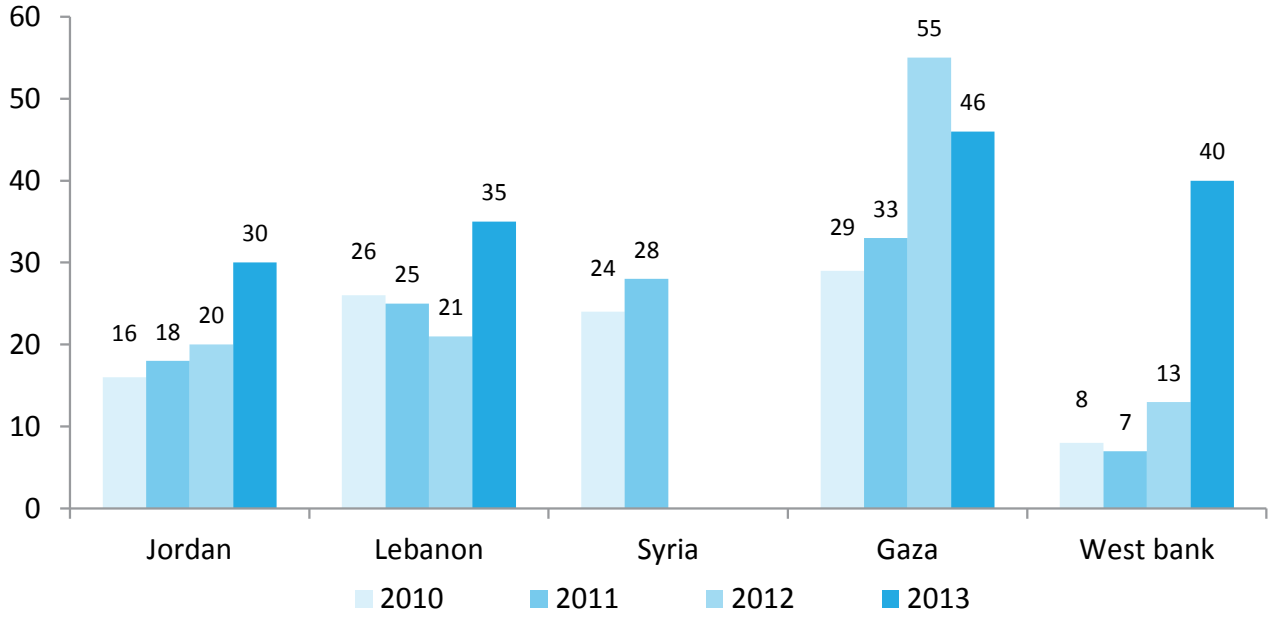

Figure 13 - Percentage of female medical officers at UNRWA health centres, 2010-2013


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Section 3 – Data

Part 1 - Agency-Wide Trends for Selected Indicators

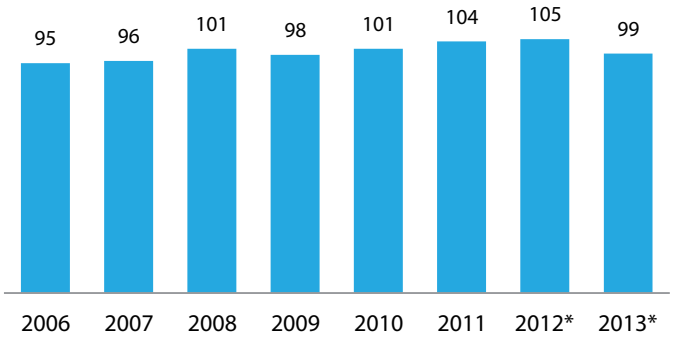


Figure 14- Average daily medical consultations per doctor

*Data from Syria is not included

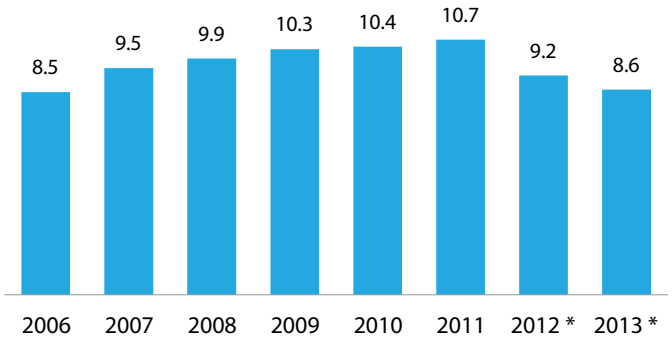


Figure 15- No. of outpatient consultations (millions)

* Data from Syria is not included

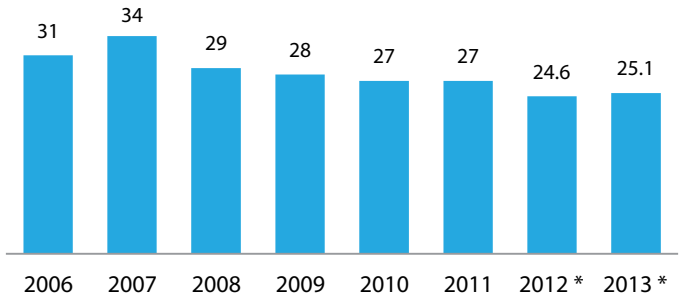


Figure 16- Antibiotics prescription rate

* Data from Syria is not included

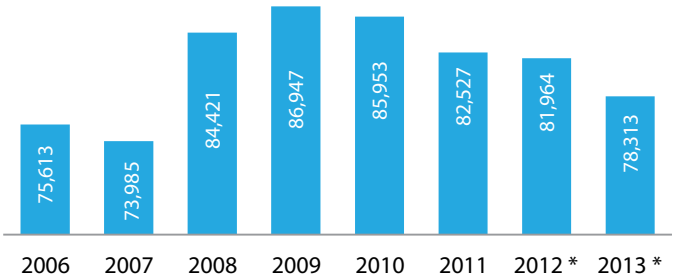


Figure 17- No. of hospitalizations (including Qalqilia hospital)

* Data from Syria is not included

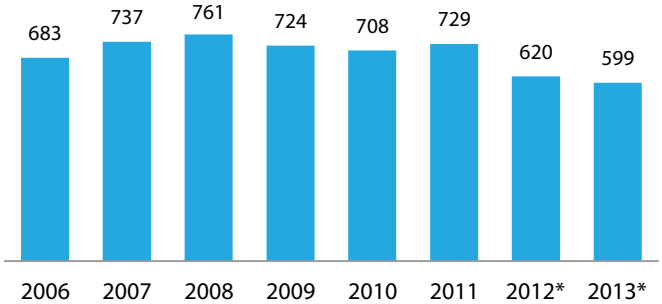


Figure 18- No. of dental consultations (thousand)

* Data from Syria is not included

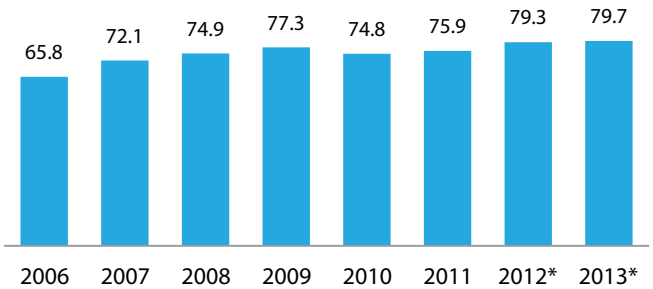


Figure 19- % of pregnant women registered during the 1st trimester

* Data from Syria is not included

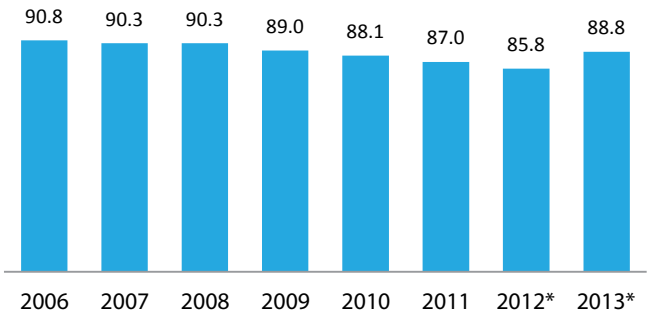


Figure 20- % of pregnant women attending at least 4 ANC visit

* Data from Syria is not included

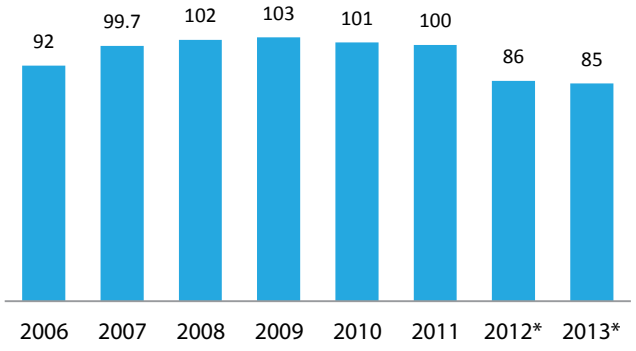


Figure 21- No. of newly registered pregnant women (thousand)

* Data from Syria is not included

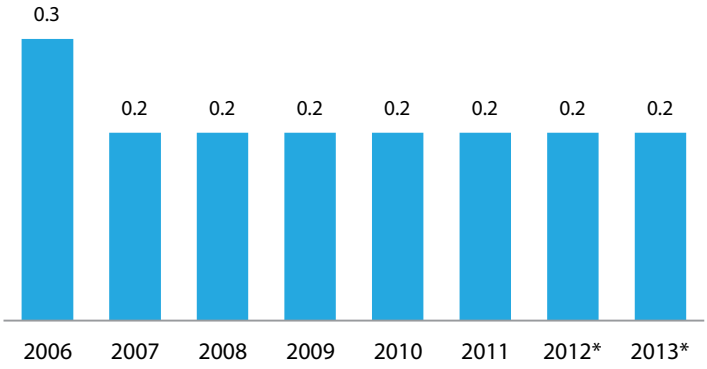


Figure 22- % of delivers with unknown outcome

* Data from Syria is not included

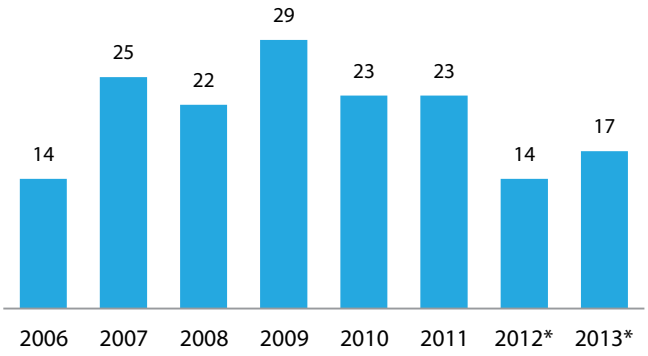


Figure 23- No. of maternal deaths

* Data from Syria is not included

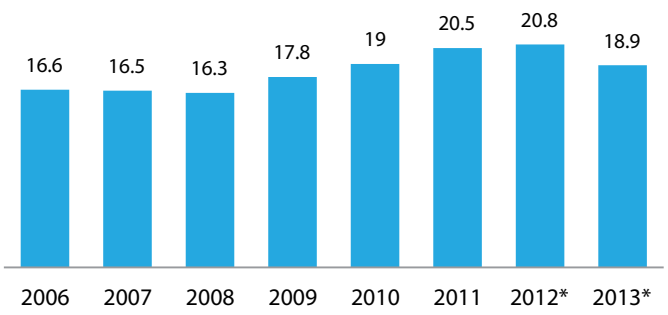


Figure 24- % of caesarean section deliveries

* Data from Syria is not included

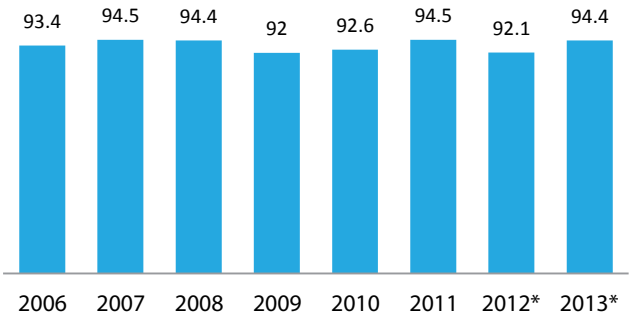


Figure 25- % of women attending PNC within 6 weeks of delivery

* Data from Syria is not included

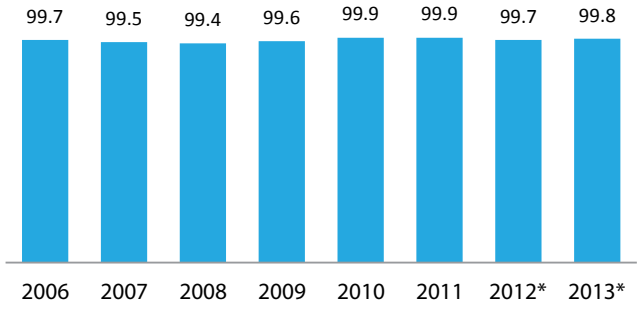


Figure 26- % of pregnant women protected against tetanus

* Data from Syria is not included

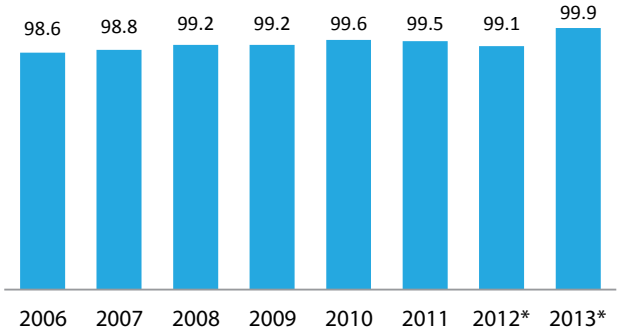


Figure 27- % of deliveries in health institutions

* Data from Syria is not included

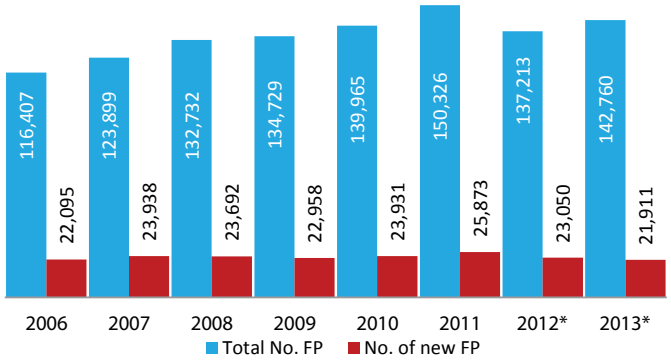


Figure 28- New & total no. of family planning acceptors

* Data from Syria is not included

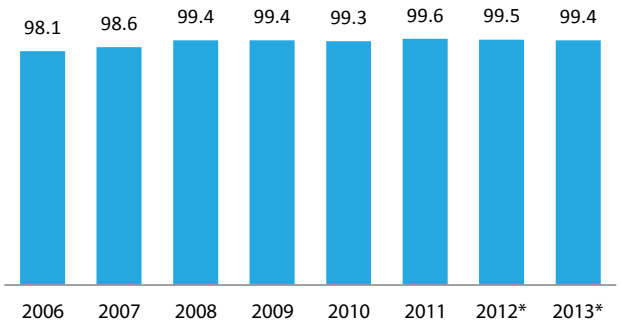


Figure 29- % of children 18 months old received all EPI booster

* Data from Syria is not included

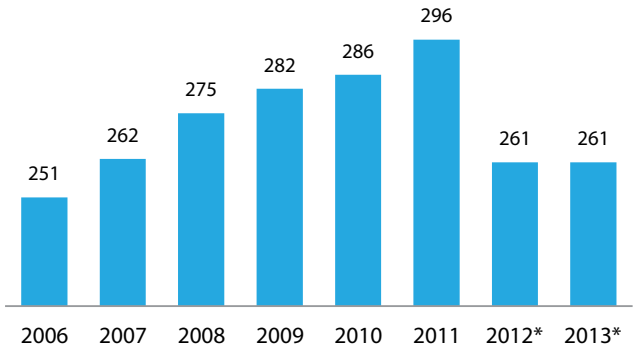


Figure 30-No. of children 0-5 years registered (thousand)

* Data from Syria is not included

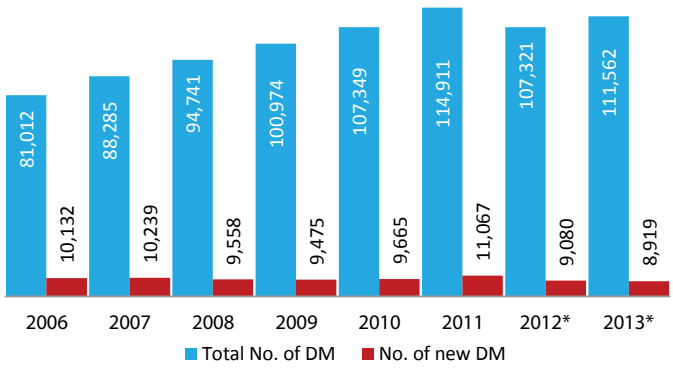


Figure 31- New & total no. of patients with diabetes

* Data from Svria is not included

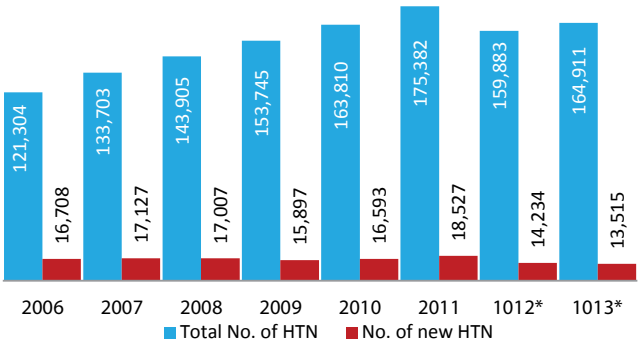


Figure 32- New & total no. of patients with hypertension

* Data from Syria is not included

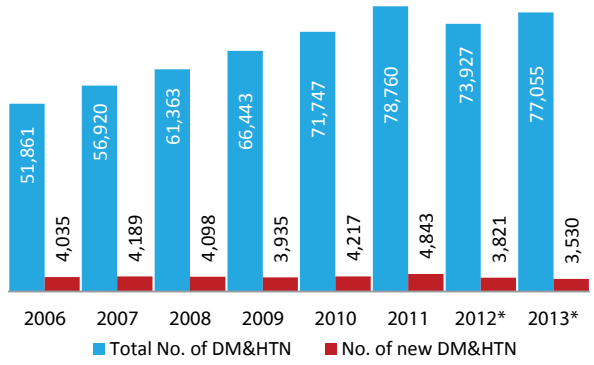


Figure 33- New & total no. of patients with diabetes & hypertension

* Data from Syria is not included

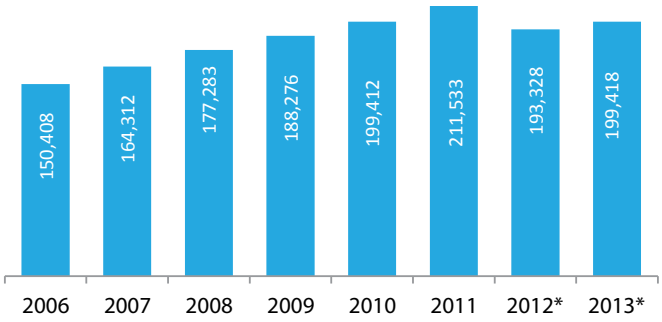


Figure 34- Total No. of all patients with diabetes and/ or hypertension

* Data from Syria is not included

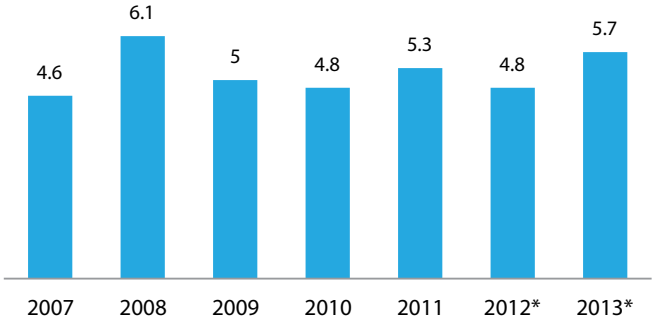


Figure 35- % of NCD patients defaulters

* Data from Syria is not included

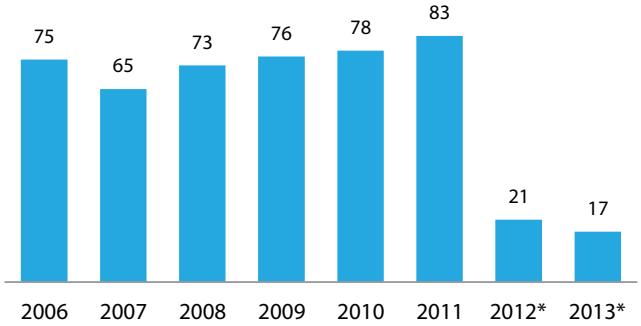


Figure 36- No. of new reported TB cases

* Data from Syria is not included

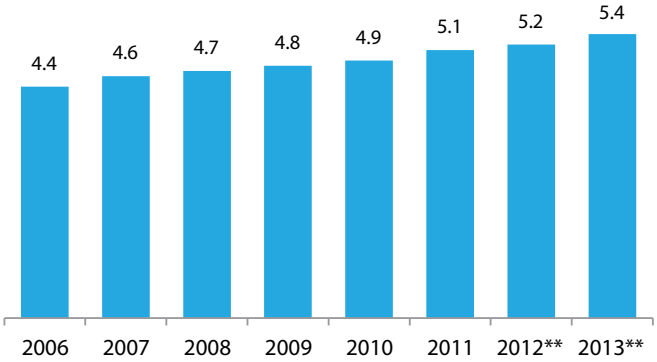


Figure 37- No. of registered populations (millions)

** Data from Syria is included

Part 2- Field Implementation Plans (FIP) 2012/2013 – Indicators Trends

Table 18- FIB 2012/2013 - Indicators Trends: Jordan Field

SO	Indicator	2008	2009	2010	2011	2012	2013
Strategic Objective 1	Average daily medical consultations per doctor	98.2	96.2	101.0	96.2	87	81
	Antibiotics prescription rate (%)	24.1	33.1	29	26	26	26.4
	% Preventive dental consultations of total dental consultations	29.6	21.8	25.5	30.3	31.4	30.4
	% 4th grade school children identified with vision defect - male	11.3	11	11.2	13.6	11.9	13
	% 4th grade school children identified with vision defect - female	15.4	15.1	16.7	19.4	19.3	17.9
	No. of hospitalizations(1)	22,917	24,114	19,859	16,069	14,481	12,908
	% Health centres implementing at least one E-health module	0	0	4.8	12.5	54.2	58
	% Health centres with no stock rupture of 15 tracer items (2)					93	100
	% Health centres with emergency preparedness plans in place (3)					_	100
Strategic Objective 2	% Pregnant women with at least 4 ANC visits	87.9	86.4	85.2	86.2	82.2	83.4
	% 18 month old children that received 2 doses of Vitamin A	98.7	98.9	98.6	98.9	99.0	98.8
	No. of women newly enrolled in preconception care programme(4)				3332	3267	3371
	% Women attending postnatal care within 6 weeks of delivery	91.0	85.7	87.5	88.0	83.5	87.8
	No. of continuing family planning acceptors	35,246	35,129	37,307	38,640	39,612	40,934
	%. of health centres with at least one staff member trained on detection and referral of GBV cases (2)					37.5	62.5
	Diphtheria and tetanus coverage among targeted students	100	100	99.6	97.8	98.1	95.3
Strategic Objective 3	% Target population ≥ 40 years screened for diabetes mellitus (2)					8.6	9.4
	% Patients with diabetes under control according to defined criteria (3)					27	52.8
	No. of new patients with diabetes mellitus	3,472	3,575	3,638	4,137	3,407	3,364
	Total no. of patients with diabetes mellitus	31,765	33,907	36,466	39,299	40,706	41,956
	No. of new patients with hypertension	5,733	5,749	5,533	6,544	5,082	4,805
	Total no. of patients with hypertension	46,084	49,531	52,794	56,480	57,940	59,150
	No. of new patients with diabetes & hypertension	1,535	1,643	1,591	1,919	1,506	1,466
	Total no. of patients with diabetes & hypertension	21,673	23,509	25,307	27,470	28,920	29,884
	No. of vaccine preventable disease outbreaks	0	0	0	0	0	0
	% Children 18 months old that received all booster doses of EPI vaccines	98.7	98.9	98.6	98.9	99.0	98.8
	No. of new TB cases detected	8	2	5	5	0	1

(1) Hospital admissions subsidized by UNRWA
(2) New indicators starting 2012
(3)Criteria will change in 2012, according to (HbA1c health centre audit)
(4) PCC programme established in 2011

Table 19 - FIB 2012/13 - Indicator Trends: Lebanon Field

SO	Indicator	2008	2009	2010	2011	2012	2013
Strategic Objective 1	Average daily medical consultations per doctor	101.6	107.1	104.0	117.3	103	92
	Antibiotics prescription rate (%)	22.1	19.9	20	20	20	20.8
	% Preventive dental consultations of total dental consultations	22.1	24.8	27.4	35	32	34.6
	% 4th grade school children identified with vision defect – male	15.8	11.9	12	12.6	9.9	10.4
	% 4th grade school children identified with vision defect female	18.9	15.2	12.3	9.9	13.2	10.3
	No. of hospitalizations(1)	20,978	21,912	25,763	26,030	29,767	30,832
	% Health centres implementing at least one E-health module		100	100	100	100	100
	% Health centres with no stock rupture of 15 tracer items (2)					91.9	100
	% Health centres with emergency preparedness plans in place (3)					100	100
Strategic Objective 2	% Pregnant women with at least 4 ANC visits	95.9	93.2	92.3	90.9	86.2	90.7
	% 18 month old children that received 2 doses of Vitamin A	99.7	98.6	99	100	99.2	99.5
	No. of women newly enrolled in preconception care programme(4)				1,680	1,432	1,239
	% Women attending postnatal care within 6 weeks of delivery	97.5	96.6	95.1	97.0	97.5	98.3
	No. of continuing family planning acceptors	12,598	12,942	13,269	13,597	14,057	14,055
	% of health centres with at least one staff member trained on detection and referral of GBV cases (2)					25	100
	Diphtheria and tetanus coverage among targeted students	100	100	100	100	100	100
Strategic Objective 3	% Target population ≥ 40 years screened for diabetes mellitus (2)					9.8	8.6
	% Patients with diabetes under control according to defined criteria (3)					33.8	65
	No. of new patients with diabetes mellitus	614	671	735	729	569	645
	Total no. of patients with diabetes mellitus	8,967	9,529	10,070	10,965	11,218	11,255
	No. of new patients with hypertension	1,463	1,587	1,643	1,795	1,366	1,355
	Total no. of patients with hypertension	17,807	18,657	19,481	20,713	21,090	21,036
	No. of new patients with diabetes & hypertension	231	274	338	343	214	283
	Total no. of patients with diabetes & hypertension	6,640	7,106	7,594	8,437	8602	8,601
	No. of vaccine preventable disease outbreaks	0	0	0	0	0	0
	% Children 18 months old that received all booster doses of EPI vaccines	99.7	98.6	99	100	99.2	99.5
	No. of new TB cases detected	14	11	13	19	11	11

(1) Hospital admissions subsidized by UNRWA
(2) New indicators starting 2012
(3)Criteria will change in 2012, according to (HbA1c health centre audit)
(4) PCC programme established in 2011

Table 20 - FIB 2012/13 - Indicator Trends: Syria Field

SO	Indicator	2008	2009	2010	2011	2012	2013
Strategic Objective 1	Average daily medical consultations per doctor	112.8	83.2	97.0	94.9	NA	NA
	Antibiotics prescription rate (%)	34	27	30	31	33	NA
	% Preventive dental consultations of total dental consultations	48.1	32	41.3	40.9	NA	NA
	% 4th grade school children identified with vision defect – male	4.5	4.5	2.7	2.9	9.2	NA
	% 4th grade school children identified with vision defect female	4	4	2.6	2.5	11.9	NA
	No. of hospitalizations(1)	11,012	9,963	8,543	6,926	4,580	NA
	% Health centres implementing at least one E-health module	0	0	0	0	0	NA
	% Health centres with no stock rupture of 15 tracer items (2)					NA	NA
	% Health centres with emergency preparedness plans in place (3)					NA	NA
Strategic Objective 2	% Pregnant women with at least 4 ANC visits	87.6	86.5	79.5	78.5	76.6	NA
	% 18 month old children that received 2 doses of Vitamin A	99.3	99.5	99.4	99.9	NA	NA
	No. of women newly enrolled in preconception care programme(4)				638	302	NA
	% Women attending postnatal care within 6 weeks of delivery	93.1	95.4	95.6	96.0	NA	NA
	No. of continuing family planning acceptors	18,267	18,751	18,778	19,313	8,436	NA
	No. of health centres with at least one staff member trained on detection and referral of GBV cases (2)					NA	NA
	Diphtheria and tetanus coverage among targeted students	99.6	99.6	97.9	99.2	86.7	NA
Strategic Objective 3	% Target population ≥ 40 years screened for diabetes mellitus (2)					NA	NA
	% Patients with diabetes under control according to defined criteria (3)					NA	NA
	No. of new patients with diabetes mellitus	1,089	951	984	1,033	NA	NA
	Total no. of patients with diabetes mellitus	11,428	11,985	12,618	13,360	NA	NA
	No. of new patients with hypertension	1,946	1,710	1,977	2,066	NA	NA
	Total no. of patients with hypertension	18,847	19,878	21,045	22,351	NA	NA
	No. of new patients with diabetes & hypertension	417	392	440	452	NA	NA
	Total no. of patients with diabetes & hypertension	7,739	8,203	8,780	9,598	NA	NA
	No. of vaccine preventable disease outbreaks	0	0	0	0	NA	NA
	% Children 18 months old that received all booster doses of EPI vaccines	99.3	99.5	99.4	99.9	NA	NA
	No. of new TB cases detected	45	59	50	52	54	6

(1) Hospital admissions subsidized by UNRWA
(2) New indicators starting 2012
(3)Criteria will change in 2012, according to (HbA1c health centre audit)
(4) PCC programme established in 2011

Table 21 - FIB 2012/13 - Indicator Trends: Gaza Field

SO	Indicator	2008	2009	2010	2011	2012	2013
Strategic Objective 1	Average daily medical consultations per doctor	102.6	97.0	98.1	102.7	113	109
	Antibiotics prescription rate (%)	29	25.7	26	25.2	26.0	26.9
	% Preventive dental consultations of total dental consultations	39.3	28.8	26.8	26.3	26.3	28.4
	% 4th grade school children identified with vision defect – male	9.3	16.3	12.9	12.1	12.6	7.7
	% 4th grade school children identified with vision defect female	11.8	18.1	18.2	17.8	16.4	13.1
	No. of hospitalizations(1)	4,763	4,590	4,575	4,810	8,719	8,444
	% Health centres implementing at least one E-health module	0	0	0	0	32	52
	% Health centres with no stock rupture of 15 tracer items (2)					98.8	100
	% Health centres with emergency preparedness plans in place (3)					100	100
Strategic Objective 2	% Pregnant women with at least 4 ANC visits	96.0	93.6	93.7	92.5	93.5	93
	% 18 month old children that received 2 doses of Vitamin A	100.0	99.9	99.8	100.0	100	100
	No. of women newly enrolled in preconception care programme(4)				6213	6773	7114
	% Women attending postnatal care within 6 weeks of delivery	99.3	97.4	98.7	99.2	99.3	99
	No. of continuing family planning acceptors	45,232	47,479	49,797	54,698	59,001	62,648
	%. of health centres with at least one staff member trained on detection and referral of GBV cases (2)					100	100
	Diphtheria and tetanus coverage among targeted students	99.8	99.9	99.8	100	100	100
Strategic Objective 3	% Target population ≥ 40 years screened for diabetes mellitus (2)					17.3	25.5
	% Patients with diabetes under control according to defined criteria (3)					29.5	42.5
	No. of new patients with diabetes mellitus	2,689	2,443	2,962	3,562	3,307	3,346
	Total no. of patients with diabetes mellitus	25,647	27,447	29,313	31,338	34,114	36,050
	No. of new patients with hypertension	5,120	4,273	5,460	5,770	5,646	4,997
	Total no. of patients with hypertension	38,376	41,298	44,988	48,551	52,485	55,114
	No. of new patients with diabetes & hypertension	1,023	844	1,304	1,496	1,514	1,196
	Total no. of patients with diabetes & hypertension	14,495	15,804	17,482	19,458	21,699	23,176
	No. of vaccine preventable disease outbreaks	0	0	0	0	0	0
	% Children 18 months old that received all booster doses of EPI vaccines	100.0	99.9	99.8	100.0	99.8	99.9
	No. of new TB cases detected	5	2	9	7	9	4

(1) Hospital admissions subsidized by UNRWA
(2) New indicators starting 2012
(3)Criteria will change in 2012, according to (HbA1c health centre audit)
(4) PCC programme established in 2011

Table 22 - FIB 2012/13 - Indicator Trends: West Bank

SO	Indicator	2008	2009	2010	2011	2012	2013
Strategic Objective 1	Average daily medical consultations per doctor	89.4	109.0	105.5	103.6	107	116
	Antibiotics prescription rate (%)	37	34	30	30	26.0	22.4
	% Preventive dental consultations of total dental consultations	15.5	12.7	19.5	21	27.3	27.2
	% 4th grade school children identified with vision defect – male	10.1	9.8	10.7	7.6	8.7	13.4
	% 4th grade school children identified with vision defect female	9.2	11.1	10.7	10.7	10.8	16.9
	No. of hospitalizations(1)	24,751	26,368	27,213	28,692	28,997	26,129
	% Health centres implementing at least one E-health module	0	0	0	0	0	7
	% Health centres with no stock rupture of 15 tracer items (2)					90.9	100
	% Health centres with emergency preparedness plans in place (3)					100	100
Strategic Objective 2	% Pregnant women with at least 4 ANC visits	83.6	83.3	83.6	77.2	81.5	83.3
	% 18 month old children that received 2 doses of Vitamin A	100	99.5	99.9	99.8	100	100
	No. of women newly enrolled in preconception care programme (4)				1,585	1,653	1957
	% Women attending postnatal care within 6 weeks of delivery	88.8	85.0	81.9	91.3	84.8	89.8
	No. of continuing family planning acceptors	19,519	20,428	20,814	24,078	24,543	25,123
	%. of health centres with at least one staff member trained on detection and referral of GBV cases (2)					100	100
	Diphtheria and tetanus coverage among targeted students	99.1	99.5	97.9	99	99.2	99.89
Strategic Objective 3	% Target population ≥ 40 years screened for diabetes mellitus (2)					21.1	24.6
	% Patients with diabetes under control according to defined criteria (3)					22.8	34.4
	No. of new patients with diabetes mellitus	2,051	1,835	1,346	1,606	1,797	1,564
	Total no. of patients with diabetes mellitus	16,934	18,106	18,882	19,949	21,334	22,301
	No. of new patients with hypertension	2,745	2,578	1,980	2,352	2,140	2,358
	Total no. of patients with hypertension	22,791	24,381	25,502	27,287	28,368	29,611
	No. of new patients with diabetes & hypertension	892	782	544	633	587	585
	Total no. of patients with diabetes & hypertension	10,816	11,821	12,584	13,797	14,706	15,394
	No. of vaccine preventable disease outbreaks	0	0	0	0	0	0
	% Children 18 months old that received all booster doses of EPI vaccines	100	99.5	99.9	99.8	100	100
	No. of new TB cases detected	1	2	1	0	1	1

(1) Includes Qalqilia Hospital admissions subsidized by UNRWA
(2) New indicators starting 2012
(3)Criteria will change in 2012, according to (HbA1c health centre audit)
(4) PCC programme established in 2011

Table 23 - FIB 2012/13 - Indicator Trends: Agency

SO	Indicator	2008	2009	2010	2011	2012	2013
Strategic Objective 1	Average daily medical consultations per doctor	101	98.5	101	104	105*	99*
	Antibiotics prescription rate (%)	29.3	28	27	27	26	25.1*
	% Preventive dental consultations of total dental consultations	32.4	24.5	27.3	29.5	28.8*	30.6*
	% 4th grade school children identified with vision defect – male	9.6	12.5	11.2	11.0	11.5	9.7*
	% 4th grade school children identified with vision defect female	11.8	14.2	14.7	14.5	15.5	14.6*
	No. of hospitalizations(1)	84,421	86,947	85,953	82,527	86,544	78,313*
	% Health centres implementing at least one E-health module	0	21	21	22.5	34.5	40*
	% Health centres with no stock rupture of 15 tracer items (2)					93*	90.8*
	% Health centres with emergency preparedness plans in place (3)					75	100*
Strategic Objective 2	% Pregnant women with at least 4 ANC visits	90.3	89	88.1	87.0	86.5	88.8
	% 18 month old children that received 2 doses of Vitamin A	99.4	99.4	99.3	99.6	99.5*	99.5*
	No. of women newly enrolled in preconception care programme (4)	-	-	-	13,448	13,427	13681*
	% Women attending postnatal care within 6 weeks of delivery	94.4	92.0	92.6	94.5	92.1*	94.4*
	No. of continuing family planning acceptors	132,732	134,729	139,965	150,325	145,649	142,760*
	% of health centres with at least one staff member trained on detection and referral of GBV cases (2)					65.6*	87.3*
	Diphtheria and tetanus coverage among targeted students	99.4	99.8	98.9	99.3	99.4	98*
Strategic Objective 3	% Target population ≥ 40 years screened for diabetes mellitus (2)					12.7*	15.8
	% Patients with diabetes under control according to defined criteria (3)					28.3*	47.6*
	No. of new patients with diabetes mellitus	9,915	9,475	9,665	11,067	9,080*	8,919*
	Total no. of patients with diabetes mellitus	94,741	100,974	107,349	114,911	107,372*	111,562*
	No. of new patients with hypertension	17,007	15,897	16,593	18,527	14,234*	13,515*
	Total no. of patients with hypertension	143,905	153,745	163,810	175,382	159,883*	164,911*
	No. of new patients with diabetes & hypertension	4,098	3,935	4,217	4,843	3,821*	3,530*
	Total no. of patients with diabetes & hypertension	61,363	66,443	71,747	78,760	73,927*	77,055*
	No. of vaccine preventable disease outbreaks	0	0	0	0	0	0
	% Children 18 months old that received all booster doses of EPI vaccines	99.4	99.4	99.3	99.6	99.5*	99.4*
	No. of new TB cases detected	73	76	78	83	57	23*

(1) Hospital admissions subsidized by UNRWA
(2) New indicators starting 2012
(3) Criteria will change in 2012, according to (HbA1c health centre audit)
(4) PCC programme established in 2011
(*) Syria Field data not available.

Part 3 – 2013 Data Tables

Table 24 – Aggregated 2013 data tables

Field	Jordan	Lebanon	Syria	Gaza Strip	West Bank	Agency
24.1 – Demographics						
Population of host countries in 2013[12]	6,508,887	4,140,289	22,530,746	1,763,387	2,676,740	37,620,049
Registered refugees (no.)	2,154,486	483,375	569,645	1,307,014	914,192	5,428,712
Refugees in host countries (%)	33.1	11.7	2.5	74.1	34.2	14.4
Refugees accessing (served population) UNRWA health services (%/no.)	55.6% (1,197,793)	62.6% (302,572)	NA	97.3% (1,271,568)	52.7% (481,570)	67% (3,253,503)
Growth rate of registered refugees (%)	2.6	2.0	7.7	3.5	2.1	3.2
Children below 18 years (%)	30.2	25.0	31.7	41.5	31.1	32.8
Women of reproductive age: 15-49 years (%)	28.0	27.3	25.4	25.1	24.9	26.5
Population 40 years and above (%)	27.8	27.0	27.8	27.3	25.0	27.0
Population living in camps (%)	32.2	39.0	32.3	22.7	32.6	30.6
Average family size	5.5	5.2	4.5	6.3	5.9	5.5
Aging index (%)	41.3	53.0	31.7	17.2	35.2	32.5
Fertility rate	3.5	3.2	2.5	4.3	3.9	3.5
Male/female ratio	1.0	1.04	0.96	1.03	1.01	1.02
Dependency ratio	52.2	45.1	53.7	71.1	52.2	55.8
24.2- Health Infrastructure						
Primary health care (PHC) facilities (no.):						
Inside official camps	12	14	12	11	20	69
Outside official camps	12	13	11	11	22	69
Total	24	27	23	22	42	138
Ratio of PHC facilities per 100,000 population	1.1	5.6	4.0	1.7	4.6	2.5
Services within PHC facilities (no.):						
Laboratories	24	17	21	21	41	124
Dental health centres:						
- Stationed units	29	19	18	19	23	108
- Mobile units	4	1	1	3	0	9
Radiology facilities	1	4	0	7	9	21
Physiotherapy health centres	1	0	0	11	6	18
Hospitals	0	0	0	0	1	1
Field	**Jordan**	**Lebanon**	**Syria**	**Gaza Strip**	**West Bank**	**Agency**
Health facilities implementing E-health	14	27	0	11	3	55

[12] Sources UNRWA Registration Statistical Bulletin of 2013, and CIA World Fact-book February 2014 population estimates *(https://www.cia.gov/library/publications/the-world-factbook/ last accessed on 15/2/2014*

STRATEGIC OBJECTIVE 1						
24.3 - Outpatient Care						
(a).Outpatient consultations medical officer (no.)						
First visits						
Male	140,007	83,512	148,819	363,242	185,382	920,962
Female	220,651	118,105	146,050	556,665	244,009	1,285,480
Repeat visits						
Male	482,358	326,061	159,277	1,308,110	423,193	2,698,999
Female	877,341	503,839	173,052	2,015,300	642,848	4,212,380
Sub-total (a)	1,720,357	1,031,517	627,198	4,243,317	1,495,432	9,117,821
Ratio repeat to first visits	3.8	4.1	1.1	3.6	2.5	3.1
(b) Outpatient consultations specialist (no.)						
Gyn. & Obst.	34,171	22,165	8,113	22,167	8,345	94,961
Cardiology	4,870	12,311	375	16,937	127	34,620
Others	5,937	16,434	68	18,216	2,140	42,795
Sub-total (b)	44,978	50,910	8,556	57,320	10,612	172,376
Grand total (a) + (b)	1,765,335	1,082,427	635,754	4,300,637	1,506,044	9,290,197
Average daily medical consultations / doctor	81	92	NA	109	116	99
24.4 - Inpatient Care						
Patients hospitalized -including Qalqilia (no.)	12,908	30,832	NA	8,444	26,129	78,313
Average Length of stay (days)	1.8	2.3	NA	2.2	2.1	2
Age distribution of admissions (%):-						
0-4 yrs	0.4	16.7	NA	0.0	15.3	11.7
5-14 yrs	3.5	10.9	NA	1.2	42.3	19.1
15-44 yrs	90.7	35.0	NA	86.2	29.9	48.0
< 45 yrs	5.4	37.4	NA	12.6	12.5	21.2
Sex distribution of admissions (%):						
Male	7.3	44.3	NA	32.3	33.3	33.2
Female	92.7	55.7	NA	67.7	66.7	66.8
Ward distribution of admissions (%):						
Surgery	4.4	22.3	NA	41.8	24.1	22.1
Internal Medicine	9.4	61.3	NA	5.1	42.1	40.3
Ear, nose & throat	2.5	3.8	NA	0.00	1.0	2.2
Ophthalmology	0.6	2.8	NA	0.0	3.2	2.3

Field	Jordan	Lebanon	Syria	Gaza Strip	West Bank	Agency
Obstetrics	83.1	9.9	NA	53.2	29.7	33.2
24.5 - Oral Health Services						
Dental curative consultation – Male (no.)	57,918	29,634	NA	132,387	24,301	244,240
Dental curative consultation – Female (no.)	102,774	45,066	NA	170,574	37,051	355,465
Total dental curative consultations (no.)	160,692	74,700	NA	302,961	61,352	599,705
Dental screening consultations – Male (no.)	19,072	9,739	NA	26,036	8,194	63,041
Dental screening consultations – Females (no)	45,027	19,165	NA	78,304	17,197	159,693
Total dental screening consultations (no.)	64,099	28,904	NA	104,340	25,391	222,734
% preventive of total dental consultations	30.4	34.6	NA	28.4	27.2	30.6
Productivity (workload units /hour)	49.0	50.0	NA	89.8	74.8	73.5
Average daily dental consultations / dental surgeon	30.7	32.3	NA	60.3	51.7	42.9
24.6 - Physical Rehabilitation						
Trauma patients	0	-	NA	4,654	495	5,149
Non-Trauma patients	379	-	NA	8,922	2,996	12297
Total	379	-	NA	13,576	3,491	17,446
STRATEGIC OBJECTIVE 2						
24.7 - Family Planning Services						
New family planning users (no.)	7,067	1,736	NA	10,639	2,469	21,911
Continuing users at end year (no.)	40,934	14,055	NA	62,648	25,123	142,760
Family planning discontinuation rate (%)	6.0	5.4	NA	4.5	4.6	5.0
Family planning users according to method (%):						
IUD	38.2	44.7	NA	55.9	59.6	50.4
Pills	34.0	24.7	NA	21.2	20.7	25.1
Condoms	24.1	29.7	NA	19.5	17.0	21.4
Spermicides	1.1	0.1	NA	0.3	0.4	0.5
Injectables	2.6	0.7	NA	3.0	2.2	2.5
24.8 - Preconception Care						
No. of women newly enrolled in preconception care programme	3,371	1,239	NA	7,114	1,957	31,681
24.9 - Antenatal Care						

Field	Jordan	Lebanon	Syria	Gaza Strip	West Bank	Agency
Served refugees (no.)	1,197,793	302,572	NA	1,271,568	481,570	3,253,503
Expected pregnancies (no.)[13]	33,538	6,051	NA	46,921	14,495	101,006
Newly registered pregnancies (no.)	25,777	5,167	NA	41,856	12,552	85,352
Antenatal care coverage (%)	76.9	85.4	NA	89.2	86.6	84.5
Trimester registered for antenatal care (%):						
1st trimester	75.2	89.8	NA	81.6	80.1	79.7
2nd trimester	20.7	7.4	NA	17.6	18.0	18.1
3rd trimester	4.1	2.8	NA	0.8	1.9	2.1
Pregnant women with 4 antenatal visits or more (%)	83.4	90.7	NA	93.0	83.3	88.8
Average no. of antenatal visits	6.3	6.5	NA	7.0	6.2	6.6
Pregnant women by no. of antenatal visits attended (%):						
1	3.8	1.2	NA	0.1	1.3	1.6
2 – 3	13.3	7.0	NA	6.0	14.7	9.9
4 – 6	53.9	45.1	NA	49.0	55.2	51.4
7 – 9	24.8	44.8	NA	39.6	25.5	32.8
10+	4.2	1.9	NA	5.2	3.3	4.4
24.10 - Tetanus Immunisation						
Pregnant women protected against tetanus (%)	99.7	98.9	NA	100.0	99.7	99.8
24.11 - Risk Status Assessment						
Pregnant women by risk status (%):						
High	16.9	8.3	NA	12.7	11.0	13.2
Alert	27.9	28.8	NA	25.5	22.0	25.7
Normal	55.2	62.8	NA	61.7	67.0	61.1
24.12 - Diabetes Mellutes a nd Hypertension During Pregnancy						
Diabetes during pregnancy (%)	7.6	4.8	NA	2.8	6.7	5
Hypertension during pregnancy (%)	11.7	6.1	NA	10.1	3.5	9.4
24.13 - Delivery Care						
Expected deliveries (no.)	25,840	5,213	NA	41,664	12,831	85,548
a - Reported deliveries (no.)	23,815	4,718	NA	39,031	11,988	79,552
b- Reported abortions (no.)	2,018	495	NA	2,632	667	5,812

[13] Expected no. of pregnancies =population X CBR

Field	Jordan	Lebanon	Syria	Gaza Strip	West Bank	Agency
a+b - Known delivery outcome (no.)	25,833	5,213	NA	41,663	12,655	85,364
Unknown delivery outcome (no. / %)	7 (0.03%)	0	NA	1 (0.002%)	176 (1.4%)	184 (0.2%)
Place of delivery (%):						
Home	0.1%	0.02%	NA	0.1%	0.2%	0.1%
Hospital	99.9%	99.98%	NA	97.2%	99.8%	98.5%
Private health centres	0.0%	0.0%	NA	2.77%	0.02%	1.44%
Deliveries in health institutions (%)	99.9%	98.0%	NA	99.9%	99.8%	99.7%
Deliveries assisted by trained personnel (%)	99.9%	100.0%	NA	100.0%	100.0%	100.0%
24.14 - Maternal Deaths	Jordan	Lebanon	Syria	Gaza	West Bank	Agency
Maternal deaths by cause (no.)						
Haemorrhage	2	2	NA	4	-	8
Pulmonary embolism	1	-	NA	2	1	4
Septicaemia	-	-	NA	1	-	1
Cardiac causes	-	-	NA	-	1	1
Liver failure	-	-	NA	1	-	1
Acute respiratory distress syndrome	-	2	NA	-	-	2
Total maternal deaths	3	4	NA	8	2	17
C-Section among reported deliveries (%)	21.7	34	NA	13.6	229	18.9
24.15 - Postnatal Care						
Post natal care coverage (%)	87.8	98.3	NA	99.0	89.8	94.4
24.16 - Care Of Children Under Five Years						
Served refugees (no.)	1,197,793	302,572	NA	1,271,568	481,570	3,253,503
Estimated surviving infants (no.) [14]	32,780	5,936	NA	45,959	14,213	98,888
Children < 1 year registered (no.)	25,014	5,036	NA	39,434	9,363	78,847
Children < 1 year coverage of care (%)	76.3	84.8	NA	85.8	65.9	79.7
Children 1- < 2 years registered (no.)	26,083	5,198	NA	38,251	10,147	79,679
Children 2- < 3 years registered (no.)	29,706	4,957	NA	46,116	21,837	102,616
Total children 0-3 years registered (no.)	80,803	15,191	NA	123,801	41,347	261,142

[14] No. of surviving infants = Population served X crude birth rate X (1-IMR)

24.17 - Immunisation Coverage						
Immunisation coverage children 12 months old						
Field	Jordan	Lebanon	Syria	Gaza Strip	West Bank	Agency
(%):						
BCG	99.4	99.8	NA	100.0	97.6	99.5
Poliomyelitis(IPV)	99.4	NA	NA	100.0	97.6	99.5
Poliomyelitis(OPV)	99.4	99.1	NA	100.0	100	99.8
Triple (DPT)	99.4	99.3	NA	100.0	100	99.8
Hepatitis B	99.4	99.5	NA	100.0	100	99.8
Hib	99.4	99.5	NA	100.0	100	99.8
Measles	99.4	98.8	NA	NA	NA	99.3
All vaccines	99.4	98.8	NA	100.0	97.6	99.3
Immunisation coverage children 18 months old - boosters (%)						
Poliomyelitis(OPV)	98.8	99.5	NA	99.7	100	99.4
Triple (DPT)	98.8	99.5	NA	99.7	100	99.4
MMR	98.8	99.5	NA	99.9	100	99.5
24.18- Growth Monitoring And Nutritional Surveillance						
Children 0 - 3 years underweight:						
New cases among registered children 0-3 yrs (%)	1.5	1.6	NA	2.1	1.3	1.8
Period prevalence 2013 (%)	2.4	2.7	NA	4.1	2.2	3.1
Prevalence year end 2013 (%)	1.3	0.9	NA	2.1	1.1	1.6
24.19 - School Health						
4th grade students screened for vision (No.) :						
Boys	5,898	1,611	NA	15,573	2,431	25,513
Girls	5,488	1,749	NA	13,315	3,267	23,819
Total	11,386	3,360	NA	28,888	5,698	49,332
4th grade students with vision impairment (%)			NA			
Boys	13.0	10.4	NA	7.7	13.4	9.7
Girls	17.9	10.3	NA	13.1	16.9	14.6
Total	15.4	10.3	NA	10.2	15.4	12.0
7th grade students screened for vision (No.) :						
Boys	5,764	1,533	NA	9,759	2,580	19,636
Girls	5,649	1,688	NA	11,881	3,469	22,687
Total	11,413	3,221	NA	21,640	6,049	42,323
7th grade students with vision impairment (%)						
Boys	15.7	11.4	NA	12.8	11.9	13.4
Girls	18.1	11.8	NA	14.9	13.3	15.2
Total	16.9	11.6	NA	13.9	12.7	14.4

STRATEGIC OBJECTIVE 3						
24.20 – Non - CommunicableDiseases (NCD) Patients Registered with UNRWA						
Field	Jordan	Lebanon	Syria	Gaza Strip	West Bank	Agency
Diabetes mellitus type I (no/%)	1,227 (1.7%)	235 (1%)	NA	1,091 (1.6%)	650 (1.8%)	3,203 (1.6%)
Diabetes mellitus type II (no/%)	10,845 (15.2%)	2,419 (10.2%)	NA	11,783 (17.3%)	6,257 (17.1%)	31,304 (15.7%)
Hypertension (no/%)	29,266 (41.1%)	12,435 (52.5%)	NA	31,938 (47.0%)	14,217 (39.9%)	87,856 (44.1%)
Diabetes mellitus & hypertension (no/%)	29,884 (42.0%)	8,601 (36.3%)	NA	23,176 (34.1%)	15,7394 (42.2%)	77,055 (38.6%)
Total	71,222	23,690	NA	67,988	36,518	199,418
24.21 - Prevalence of Hypertension and Diabetes						
Served population ≥ 40 years with diabetes mellitus (%)	10	9.0	NA	11.4	13.3	10.9
Served population ≥ 40 years with hypertension (%)	14.3	16.8	NA	17.5	18.1	16.2
24.22 – Management						
Hypertensive patients on lifestyle management only (%)	2	9	NA	5	1	4
Diabetes patients on insulin (%)	32.7	18.6	NA	40.4	31.8	33.6
24.23 - Risk Scoring						
Risk status - patients with diabetes mellitus type 1 (%):						
Low	67.2	44.7	NA	75.0	61.4	64.2
Medium	27.3	45.5	NA	23.7	34.5	31.3
High	5.5	9.8	NA	1.3	4.1	4.5
Risk status - patients with diabetes mellitus type 2 (%):						
Low	28.4	31.2	NA	28.2	33.7	29.9
Medium	54.0	49.4	NA	54.9	51.7	53.3
High	17.5	19.4	NA	16.9	14.5	16.8
Risk status - patients with hypertension (%):						
Low	22.1	16.7	NA	13.4	26.2	19
Medium	57.4	51.4	NA	48.0	51.5	51.3
High	20.5	32	NA	38.6	22.2	16.8
Risk status - patients with diabetes & hypertension (%):						
Low	6.7	27.4	NA	27.4	16.2	20.6
Medium	46.2	49.5	NA	53.0	50.5	50.7
High	47.2	23.2	NA	19.6	33.4	28.7
Risk factors among NCD patients (%):						
Smoking	17.4	39.4	NA	10.5	18.2	15.3

Field	Jordan	Lebanon	Syria	Gaza Strip	West Bank	Agency
Physical inactivity	46.8	16.0	NA	45	19.7	42.3
Obesity	43.9	42.3	NA	49.3	63.2	47.5
Raised cholesterol	34.8	40.8	NA	36.1	30.5	35.7
24.24 - Late Complications AmongNCD Patients (%)						
Diabetes mellitus type I	0.7	1.6	NA	0.9	2.7	1.0
Diabetes mellitus type II	4.4	4.9	NA	4.4	6.6	4.5
Hypertension	9.1	7.5	NA	5.2	7.7	6.8
Diabetes mellitus & hypertension	17.7	12.1	NA	13.8	15.2	15.3
All NCD patients	11.9	9.1	NA	8.0	10.6	9.6
24.25 – Defaulters						
NCD patients defaulting during 2013 (no.)	5103	1120	NA	3279	1602	11104
NCD patients defaulting during 2013/total registered end 2012 (%)	7.32	4.7	NA	5.1	4.6	5.7
24.26 - Fatality						
Reported deaths among registered NCD patients (no/%)	936 (1.3%)	503 (2.1%)	NA	1117 (1.7%)	634 (1.8%)	3190 (1.7%)
Reported deaths among registered NCD patients by morbidity (no):						
Diabetes mellitus	63	42	NA	160	84	349
Hypertension	279	209	NA	418	197	1103
Diabetes mellitus & hypertension	594	252	NA	539	353	1,738
24.27 - Communicable Diseases						
Registered refugees (no.)	2,154,486	483,375	569,645	1,307,014	914,192	5,428,712
Refugee population served (no.)	1,197,793	302,572	NA	1,271,568	481,570	3,253,502
Reported cases (no.):						
Acute flaccid paralysis[15]	0	0	0	0	0	0
Poliomyelitis	0	0	0	0	0	0
Cholera	0	0	0	0	0	0
Diphtheria	0	0	0	0	0	0
Meningococcal meningitis	0	0	0	2	0	2
Meningitis – bacterial	0	0	2	31	2	35
Meningitis – viral	0	0	0	51	15	66
Influenza A(H1N1)	0	0	0	85	54	139

[15] Among children <15 years

Field	Jordan	Lebanon	Syria	Gaza Strip	West Bank	Agency
Tetanus neonatorum	0	0	0	0	0	0
Brucellosis	2	0	92	0	11	105
Watery diarrhoea (>5years)	7,444	11,306	1,461	9,485	7838	37,534
Watery diarrhoea (0-5years)	8,338	10,095	2,431	20,890	9,494	51,248
Bloody diarrhoea	299	18	57	2,647	687	3,708
Viral Hepatitis	136	202	660	727	5	1,730
HIV/AIDS	0	2	2	0	0	4
Leishmania	0	2	24	0	1	27
Malaria*	0	0	0	0	0	0
Measles	1	2	0	1	0	4
Gonorrhoea	3	5	0	0	0	8
Mumps	9	5	1	1,401	18	1,434
Pertussis	0	0	0	1	0	1
Rubella	3	0	0	0	4	7
Tuberculosis, smear positive	0	3	0	4	1	8
Tuberculosis, smear negative	0	3	2	0	0	5
Tuberculosis, extra pulmonary	1	5	4	0	0	10
Typhoid fever	0	2	56	91	0	149
CROSSCUTTING SERVICES						
24.28 - Laboratory Services						
Laboratory tests (no.)	1,121,184	340,600	NA	2,043,048	842,617	4,347,449
Productivity (workload units / hour)	46.3	35.7	NA	67.2	53.0	53.0
24.29 - Radiology Services						
Plain x-rays inside UNRWA (no.)	1,709	19,123	NA	35,532	17,016	73,380
Plain x-rays outside UNRWA (no.)	2,442	7,452	NA	-	-	9,894
Other x-rays outside UNRWA (no.)	-	9,707	NA	-	-	9,707

24.30- Human Resources	HQ	Jordan	Lebanon	Syria	Gaza	West Bank	Agency
Health staff as at end of December 2013 (no.)							
(a) Medical care services :							
Doctors	3	102	52	NA	175	84	416
Specialist		10	15	NA	13	10	48
Pharmacists	1	2	2	NA	4	3	12
Dental Surgeons		30	17	NA	31	17	95

24.30- Human Resources	HQ	Jordan	Lebanon	Syria	Gaza	West Bank	Agency
Nurses		267	117	NA	330	273	987
Paramedical	2	131	61	NA	192	193	579
Admin./Support Staff	6	91	63	NA	109	89	358
Labour category		104	31	NA	147	111	393
Sub-total (a)	12	737	358	NA	1001	780	2888
(b)Environmental health services :							
Engineers						5	5
Admin/Support Staff						31	31
Labour category						195	195
Sub-total (b)	0	0	0	0	0	231	231
International	4						4
Grand total (a+b)	16	737	358	0	1001	1011	3123
Health personnel per 100,000 registered refugees:							
Doctors	-	4.7	10.8	NA	13.4	9.2	7.7
Dental surgeons	-	1.4	3.5	NA	2.4	1.9	1.9
Nurses	-	12.4	24.2	NA	25.2	29.9	18.6

Part 4 - Selected Survey Indicators

DMFS Survey, 2010

Table 25- Descriptive: total DS, FS, and DMFS sorted by age group

Age group	DS[16] Mean, SE (95%CI)	FS[17] Mean, SE (95%CI)	DMFS[18] Mean, SE (95%CI)8
11-12 year	3.27, 0.34 (2.61 – 3.94)	0.49, 0.13 (0.24 – 0.74)	3.83, 0.38 (3.08 – 4.58)
13year	3.20, 0.08 (3.04 – 3.36)	0.58, 0.03 (0.52 – 0.63)	3.92, 0.09 (3.74 – 4.10)
> 13 year	3.09, 0.49 (2.11 – 4.06)	0.94, 0.24 (0.46 – 1.42)	4.22, 0.54 (3.16 – 5.29)

[16] Decayed Surface
[17] Filling Surface
[18] Decayed, Missing, Filled Surface

Table 26 - DMFS, DS, and FS sorted by age group and gender

Age group	gender	DS Mean, SE (95%CI)	FS Mean, SE (95%CI)	DMFS Mean, SE (95%CI)	DS/ DMFS %	FS/ DMFS %
11-12 year	males	3.38 0.47 (2.43 – 4.32)	0.39 0.12 (0.14 – 0.64)	3.90 0.52 (2.86 – 4.94)	86.5	10.0
	females	3.16 0.48 (2.20 – 4.12)	0.59 0.23 (0.14 – 1.05)	3.75 0.56 (2.64 – 4.86)	83.0	14.1
13year	males	3.23 0.12 (3.00 – 3.47)	0.55 0.04 (0.46 – 0.63)	3.90 0.13 (3.65 – 4.15)	77.2	22.8
	females	3.16, 0.12 (2.93 – 3.40)	0.60 0.04 (0.52 – 0.68)	3.9 0.13 (3.67 – 4.20)	84.2	15.8
> 13 year	males	3.75 0.85 (2.03 – 5.48)	1.11 0.47(0.16 – 2.06)	4.87 0.90 (3.05 – 6.68)	80.4	15.3
	females	2.57, 0.57 (1.43 – 3.70)	0.81 0.22 (0.36 – 1.25)	3.72 0.65 (2.42 – 5.03)	69.0	21.8

Table 27 - DMFS, DS and FS sorted by Field

Field	DS Mean, SE (95%CI)	FS Mean, SE (95%CI)	DMFS Mean, SE (95%CI)	DS/ DMFS %	FS/ DMFS %
Jordan	2.48 0.15 (2.19 – 2.78)	0.55 0.05 (0.45 – 0.64)	3.23 0.17 (2.89 – 3.56)	76.9	17.0
Lebanon	2.99 0.21 (2.57 – 3.41)	0.77 0.08 (0.61 – 0.92)	3.78 0.23 (3.33 – 4.23)	79.2	20.3
Syria	3.37 0.18 (3.02 – 3.72)	0.7 0.09 (0.59 – 0.93)	4.22 0.20 (3.82 – 4.62)	80.0	18.0
Gaza	2.21 0.11 (1.99 – 2.42)	0.34 0.04 (0.25 – 0.42)	2.66 0.12 (2.38 – 2.87)	82.9	12.7
West Bank	5.02 0.21 (4.60 – 5.44)	0.54 0.06 (0.42 – 0.66)	5.88 0.23 (5.42 – 6.34)	85.4	9.2

Contraceptive use study, 2010

Current Practices of Contraceptive Use Among Mothers of Children 0-3 Years Survey, 2010

Table 28 - Selected reproductive health survey indicators

Indicators	Jordan	Lebanon	Syria	Gaza Strip	West Bank	Agency
Mean birth interval (months)	32.7	36.9	35.1	29.3	32.8	33.3
Percentage of women married by the age < 18 years	22.2	18.9	18.5	33	30.2	24.6
Percentage of women with birth intervals < 24 months	42.2	37.9	40.5	48.9	43.7	42.7
Prevalence of modern contraceptives among women of reproductive age utilizing UNRWA MCH services	60.6	47.7	67.4	47.1	59.1	61.7
Mean marital age (women)	20.5	21	21	19.2	19.4	20.2

Table 29 - Total fertility rates among mothers of children 0 to 3 years of age who attended the Maternal and Child Health at all health centres

Field	1995	2000	2005	2010
Jordan	4.6	3.6	3.3	3.5
Lebanon	3.8	2.5	2.3	3.2
Syria	3.5	2.6	2.4	2.5
Gaza Strip	5.3	4.4	4.6	4.3
West Bank	4.6	4.1	3.1	3.9
Agency	4.7	3.5	3.2	3.5

Anaemia study,2005

Prevalence of Anaemia among Pregnant Women, Nursing Mothers, School Childre, and Children 6-36 Months of Age Survey, 2005

Table 30 - Selected anaemia survey indicators

Indicator	Jordan	Lebanon	Syria	Gaza	West Bank	Agency
Percentage of infants breastfed for at least one month	75.9	87.2	78.3	65.0	87.1	78.9
Prevalence of exclusive breast feeding up to 4 months	24.0	30.2	40.3	33.3	34.5	32.7
Prevalence of anaemia among children < 3 years of age	28.4	33.4	17.2	54.7	34.2	33.8
Prevalence of anaemia among pregnant women	22.5	25.5	16.2	35.6	29.5	26.3
Prevalence of anaemia among nursing mothers	22.2	26.6	21.7	45.7	23.0	28.6
Prevalence of anaemia among school children						
• 1 st grade	14.4	22.3	9.1	36.4	14.6	19.5
• 2 nd grade	11.6	16.9	6.0	11.4	14.9	12

Part 5 - Selected Health Expenditure Indicators

Table 31 - Expenditure on medical equipment and furniture, 2013 (GF: General Fund, P: Project Fund) in USD

Equipment & Furniture		Jordan	Lebanon	Syria	Gaza	WB	Subtotal	Grand total
Administration	GF	0	0	0	0	76,972	76,972	86,932
	P	0	0	0	0	9,960	9,960	
Laboratory	GF	0	0	0	646	43,086	43,732	239,436
	P	0	2,250	53,300	54,220	85,934	195,704	
Out patient	GF	55,614	3,479	445	24,783	203,834	288,155	837,030
	P	172,367	133,026	51,024	86,500	105,958	548,875	
MCH	GF	20,904			0	46,656	67,560	93,760
	P	0			26,200	0	26,200	
DP&C	GF				0		0	404

Table 31 - Expenditure on medical equipment and furniture, 2013 (GF: General Fund, P: Project Fund) in USD (.../ Continued)

Equipment & Furniture		Jordan	Lebanon	Syria	Gaza	WB	Subtotal	Grand total
	P				404		404	
Physical Rehabilitation	GF				0	26,915	26,915	47,923
	P				13,008	8,000	21,008	
Oral Health	GF				10,482	5,029	15,511	34,083
	P				18,572	0	18,572	
School Health	GF					0	0	7,535
	P					7,535	7,535	
Qalqilia Hospital	GF					46,917	46,917	46,917
	P					0	0	
Environmental l Health	GF				28,047	17,940	45,987	335,235
	P				255,548	33,700	289,248	
Mental Health	GF					990	990	156,405
	P					155,415	155,415	
All	GF	76,518	3,479	445	63,958	468,339	612,739	1,885,660
	P	172,367	135,276	104,324	454,452	406,502	1,272,921	

Table 32 - Expenditure on Laboratory Services 2013

Expenditure (USD)	Jordan	Lebanon	Syria	Gaza Strip	West Bank	Agency
Staff	968,122	482,323	277,869	1,131,571	1,927,039	4,786,924
Non-staff	117,990	248,406	300,241	491,289	478,162	1,636,088
Total	1,086,112	730,729	578,110	1,622,860	2,405,201	6,423,012
Equipment-GF	89,993	54,254	23,275	88,499	59,420	315,441
Equipment-P	0	2250	53,300	54220	85,934	195,704
Equipment-Total	89,993	56,504	76,575	142,719	145,354	511,145
%	17.6	11.1	15.0	27.9	28.4	100


Family Health Team

Part 6 - Donor Support to UNRWA Health Programme During 2013

In 2013, in addition to un-earmarked contributions to the Agency's General Fund which supported the Health Programme, earmarked funds to core-services and projects were received from Japan, Austria, Italy, Luxembourg and Switzerland together with donations from the Saudi Fund for Development, the Spanish Local Government of Andalucía and Qatar Charity. In addition, generous support was provided by the United States government to ensure the continued implementation of the Agency's Health reform.

Table 33- Donor support to UNRWA›s General Fund for the Health Programme 2013

Donor	Amount (USD)	Health programme/field/activity
Government of Japan	10,000,000	Support to UNRWA's Health Programme in the West Bank and Gaza
Government of Austria	1,636,126	A Long and Healthy Life: UNRWA Life Cycle Approach to Health in Gaza and the West Bank
Government of Italy	1,324,503	"Support of UNRWA Health Reform in Lebanon (Secondary and tertiary hospitalization, Heart surgeries for elderly services, Emergency Room services, Staffing, Intensive care secondary services)"
Grand Duchy of Luxembourg	977,597	Healthy Life and Lifestyle for Youth in West Bank and Gaza -2013
Government of Switzerland	318,300	Solid Waste Removal from Gaza Camps Using Gaza Municipalities' Landfills
Kingdom of Saudi Arabia	7,787,915	Essential Support to Health Sector in West Bank and Gaza Strip
Spanish Local Government of Andalucía	1,326,260	UNRWA Lifecycle Approach to Health : Maternal Child Health Care in Gaza and West Bank
Qatar Charity	449,041	"Support to UNRWA's Health Programme in Gaza: Procurement of Medical Drugs and Pharmaceuticals"

Donor	Amount (USD)	Health programme/field/activity
USA	646,797.99	Expanding UNRWA's comprehensive E-health for the Family Health Team approach (all fields)

Annexes

Annex1 - Health Department Field Implementation Plan (FIP) 2012 / 2013

Table 34 - Agency-wide common log frame

Strategic Objective	Outcome	Outcome Indicators	Output	Output Indicators
1. Ensure access to quality comprehensive primary health care services	1.1 Quality of health services maintained and improved	• Average daily medical consultations per doctor	• General outpatient services maintained & improved	• Antimicrobial prescription rate (%)
				• % preventive dental consultations of total dental consultations
				• % 4th grade school children identified with vision defect
			• Access to hospital care ensured	• Total no. of hospitalizations (secondary and tertiary)
			• Health management support strengthened	• % Health centres implementing at least one E-health module
			• Drug management system in place	• % Health centres with no stock rupture of 15 tracer items
			• Emergency health services maintained and improved	• % Health centres with emergency preparedness plans in place
			• Health Centre Infrastructure improved	• % Upgraded health centres meeting UNRWA's infrastructure security, safety and accessibility standards*
2. Protect and promote family health	2.1 Coverage and quality of maternal & child health services maintained & improved	• % Pregnant women attending at least 4 antenatal care visits • % 18 month old children that received 2 doses of Vitamin A	• Comprehensive maternal and child health services delivered	• No. of women newly enrolled in pre-conception care program
				• % Women attending postnatal care within 6 weeks of delivery
				• No. of continuing family planning acceptors
				• % health centres with at least one health centre staff member trained on detection and referral of gender based violence cases
			• School health services strengthened	• Diphtheria and tetanus (dT) coverage among targeted students
3. Prevent and control diseases	3.1 Coverage and quality non-communicable disease (NCD) care improved	• % target population ≥40 years screened for diabetes mellitus • % patients with diabetes under control according to defined criteria	• Appropriate management of NCDs ensured	• No. of new NCD patients in programme(DM, HT, DM&HT disaggregated)
				• Total no. of NCD patients in programme(DM, HT, DM&HT disaggregated)
	3.2 Communicable diseases contained and controlled	• No. of vaccine preventable disease outbreaks	• Prevention and control of communicable diseases maintained	• % 18 month old children that have received all EPI vaccinations according to host country requirements
				• No. of new TB cases detected
			• Current level of environmental health services maintained	• % shelters connected to public water network*
				• % shelters connected to public sewerage network*

*Monitored by Infrastructure and Camp Improvement Program

Table 35 - Agency-wide Common Indicators

Average daily medical consultations per doctor	Total workload (All patients seen by all medical officers) No. of medical officers X working days
Antimicrobial prescription rate	No. of patients receiving antibiotics prescription x 100 All patients attending curative services (general outpatient health centre + sick babies + sick women + sick NCD)
% Preventive dental consultations of total dental consultations	No. of preventive dental consultations x 100 Total no. of preventive & curative dental consultations
% 4th grade school children identified with vision defect	No. of 4th grade school children identified with vision defect x 100 No. of 4th grade school children screened by UNRWA school health program
Total no. of hospitalizations (secondary and tertiary)	Total no. of hospitalizations
% Health centres implementing at least one e-health module	No. of health centres implementing at least one e-health module x 100 Total No. of health centres
% Health centres with no stock-outs of 15 tracer items	No. of health centres with no stock-outs of 15 tracer items x 100 Total no. of health centres
% Health centres with emergency preparedness plans in place	No. of health centre s with emergency preparedness plan in place x 100 Total no. of targeted health centres
% Pregnant women attending at least 4 ANC visits	No. of pregnant women attending at least 4 ANC visits x 100 No. of deliveries
% 18 months old children that received 2 doses of Vitamin A	No. of children 18 months old that received 2 doses of Vit A x 100 No. of registered children 1 - < 2 years
No. of women newly enrolled in Pre-Conception Care program	No. of women newly enrolled in Pre-Conception Care program
% Women attending PNC within 6 weeks of delivery	No. of women attending postnatal care within 6 wks of delivery x 100 Total no. of deliveries
No. of continuing family planning acceptors	No. of continuing family planning acceptors
% Health centres with at least one health centre staff trained on detection & referral of GBV cases	No. of health centre s with at least one health centre staff trained on GBV x 100 Total no. of health centres
Diphtheria and tetanus (dT) coverage among targeted students	No. of school children that received dT x 100 Total no. of school children targeted
% Targeted population 40 years and above screened for diabetes mellitus	No. of patients 40 years and above screened for diabetes x 100 (Total no. of served population 40 years and above) – (total no. of diabetes patients currently registered in NCD program)
% Patients with diabetes under control according to defined criteria	No. of DM patients defined as controlled based on HbA1C or postprandial glucose criteria x 100 Total no. of DM patients

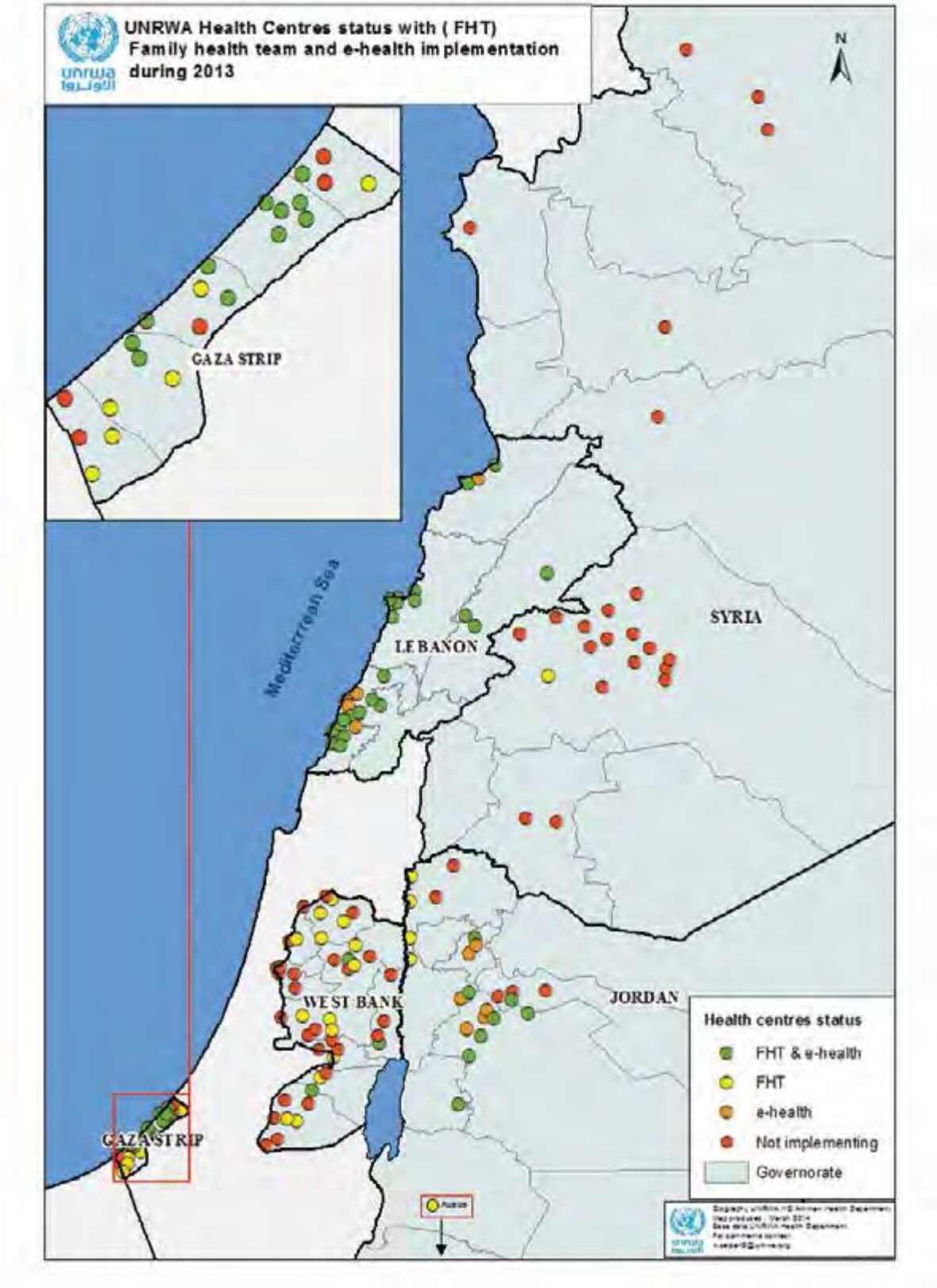
No. of new NCD patients in programme (Diabetes mellitus)	No. of new NCD patients in programme (Diabetes mellitus; Hypertension; Diabetes mellitus & Hypertension)
Total No. of NCD patients in programme (Diabetes mellitus)	Total No. of NCD patients in programme (Diabetes mellitus; Hypertension; Diabetes mellitus & Hypertension)
No. of EPI vaccine preventable diseases outbreaks	No. of EPI vaccine preventable diseases outbreaks
%18 month old children that have received all EPI vaccinations according to host country requirements	No. of children 18 months old that received all doses for all required vaccines x 100 Total no. of children 18 months old
No. of new TB cases detected	No. of new TB cases detected (smear positive + smear negative + extra pulmonary)

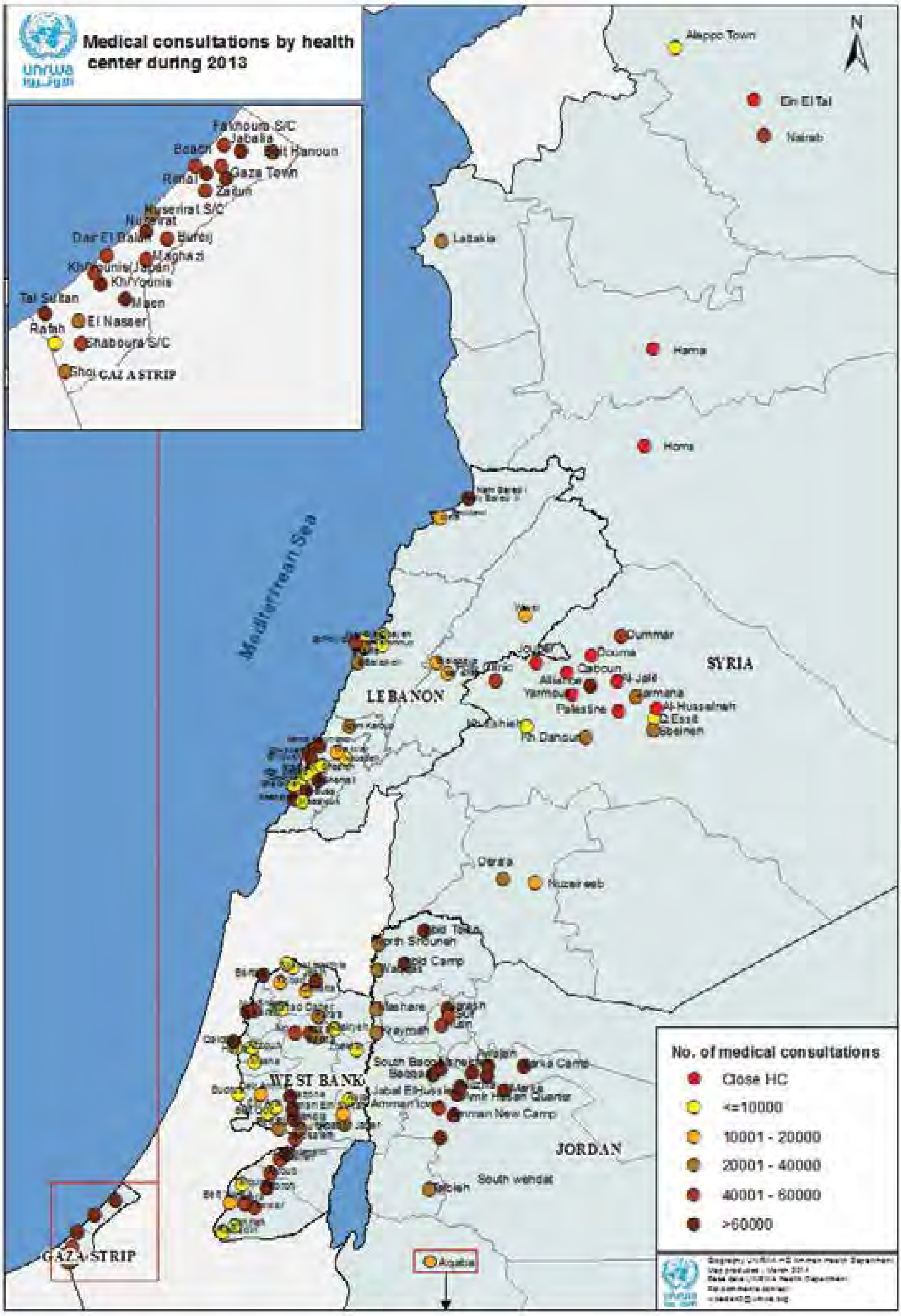
Annex 2 - Health Department Research Activities and Puplished Papers

Table 36-List of publication

S. No	Title of publication	Published in	Present as
1	Health centre Audit on Diabetes care for Palestinian refugees in UNRWA Health Centres, Jordan	Lancet Palestinian Health Alliance (LPHA)	Poster
2	Measuring the Impact of the "Family Health Team"(FHT) approach in two UNRWA primary-health care Health centres using Client Flow	Lancet Palestinian Health Alliance (LPHA)	Poster
3	Design of a monitoring and evaluation framework to measure efficiency and effectiveness of reforms to UNRWA health services	Lancet Palestinian Health Alliance (LPHA)	Poster
4	Anaemia Awareness Campaign in Palestinian Camps & Gatherings in Lebanon:	Lancet Palestinian Health Alliance (LPHA)	Poster
5	Assessment of Health Staffs Knowledge and Counselling Skills on Nutrition to Patients with Type II Diabetes Mellitus in Jordan refugee	Lancet Palestinian Health Alliance (LPHA)	Poster
6	Cohort reporting improves hypertension care for refugees	Lancet Palestinian Health Alliance (LPHA)	Scientific paper
7	Cohort monitoring of persons with diabetes mellitus in a primary healthcare health centre for Palestine refugees in Jordan	Tropical Medicine & International Health (TMIH)	Scientific paper
8	What happens to Palestine refugees with diabetes mellitus in a primary health care centre in Jordan who fail to attend a quarterly health centre	Tropical Medicine & International Health (TMIH)	Scientific paper
9	Cohort monitoring of persons with hypertension	Tropical Medicine & International Health (TMIH)	Scientific paper
10	Diabetes mellitus and treatment outcomes in Palestine in UNRWA primary health care health centres in Jordan	Public Health Action (PHA)	Scientific paper
11	Treatment outcomes in cohort of Palestine refugees with diabetes mellitus followed through use of E-health over 3 years in Jordan	Tropical Medicine & International Health (TMIH)	Scientific paper

Annex 3 - Health Maps, 2013




Medical consultations by health center during 2013
unrwa
N
Aleppo Town
Ein El Tal
Neirab
Lattakia
Hama
Homs
Mediterranean Sea
LEBANON
SYRIA
Dummar
Douma
Qaboun
Jaramana
Palestine
Al-Husseineh
Sbeineh
Kh Danoun
Deraa
Muzeireeb
WEST BANK
JORDAN
South Wehdat
Talbieh
Aqaba
Amman New Camp
Fakhoura S/C
Jabalia
Beit Hanoun
Beach
Gaza Town
Zaitun
Nuseirat S/C
Nuseirat
Deir El Balah
Bureij
Maghazi
Kh/Younis(Japan)
Kh/Younis
Tal Sultan
Maen
El Nasser
Rafah
Shaboura S/C
GAZA STRIP
No. of medical consultations
Close HC
<=10000
10001 - 20000
20001 - 40000
40001 - 60000
>60000

Annex 4 - Contacts of Senior Staff of the UNRWA Health Programme

Headquarters staff

Post Title	Incumbent	E-mail address
WHO Special Representative	Dr. Akihiro Seita	a.seita@UNRWA.org
Health Policy & Planning Officer	Dr. Irshad Shaikh	i.shaikh@UNRWA.org
Family Health Coordinator	Dr. Ali Khader	a.khader@UNRWA.org
E-health Project coordinator	Mrs. Ghada Ballout	g.ballout@UNRWA.org
Health Communication & Community Based Initiative Officer	Dr. Yassir Turki	y.turki@UNRWA.org
Health Statistics Officer	Ms. Wafa Zeidan	w.zeidan2@UNRWA.org
Division of Health Protection & Promotion		
Chief, Health Protection & Promotion	Dr. Majed Hababeh	m.hababeh@UNRWA.org
Health Nutrition Officer	Ms. Nada Abu-Kishk.	n.abu-kishk@UNRWA.org
Division of Disease Prevention & Control		
Chief, Disease Prevention & Control	Dr. Yousef Shahin	y.shahin2@UNRWA.org
Division of Medical Care Services		
Head Laboratory & Medical Diagnostics Services	Mr. Ahmad Al-Natour	a.alnatour@UNRWA.org
Head Pharmaceutical Services	Mrs. Rawan Saadeh	r.saadeh@UNRWA.org

Chiefs Field Health Programme

Jordan	Dr. Ishtaiwi Abu-Zayed	i.abu-zayed@UNRWA.org
West Bank	Dr. Umaiyeh Khammash	u.khammash@UNRWA.org
Gaza Strip	Dr. Mohammad Maqadma	m.maqadma@UNRWA.org
Lebanon	Dr. Najeh Elsadek	n.elsadek@UNRWA.org
Syrian Arab Republic	Dr. Tayseer Sabbagh	t.sabbagh@UNRWA.org

List of Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ALSO	Advanced Life Support in Obstetrics
BMI	Body Mass Index
CBR	Crude Birth Rate
CBC	Complete Blood Count
CIA	Central Intelligence Agency
CBOs	Community Based Organization
CMHP	Community Mental Health Programme
COOP	Continuity of Operations Planning
CYP	Couple Years of protection
DMFS	Decayed, Missing ,Filled Surface
DM	Diabetic Mellitus
DS	Decayed Surface
DT/Td	Tetanus – diphtheria
DOTs	Directly Observed Treatment, short-course
EMRO	Eastern Mediterranean Regional Office
EPI	Expanded Programme of Immunisation
ERP	Enterprise Resource Planning
ESRF	End Stage Renal Failure
EQAS	External Quality Assurance System
EU	European Union
FHP	Family Health Protection
FFA	Fundus Fluorescein Angiography
FHT	Family Health Team
FS	Filling Surface
FIP	Field Implementation Plan
FGD	Focus Group Discussion
GBV	Gender Based Violence
GF	General Fund
GYTS	Global Youth Tobacco Survey
HCBI	Health Centre Budget Initiative
HCFCs	Health Centre Friendship Committees
IDA	Iron Deficiency Anaemia
IDP	Internally Displaced Persons
IT	Information Technology
IU	International Unit
Hib	Haemophilus Influenza
IMR	Infant Mortality Rate
JCP	Job Creation Project
JFO	Jordan Field Office
KHCC	King Hussein Cancer Center
LBW	Low Birth Weight
LFO	Lebanon Field Office
LDC	Limited Duration Contract
LPHA	Lancet Palestinian Health Alliance
MCH	Maternal and Child Health
MO	Medical Officer
MTS	Medium Term Strategy
NCDs	Non-communicable Diseases
mhGAP	Mental Health Gap Assistance Program
NGOs	Non-Governmental Organizations
NSDV	Normal Spontaneous Vaginal Delivery
OCT	Optical Coherence Tomography
OPV	Oral Polio Vaccine
PEN	Package of Essential Non-communicable disease
PHC	Primary Health care
PRS	Palestinian refugees from Syria
PHA	Public Health Action
PLHA	People Living with HIV/AIDs
PPGT	Post Prandial Glucose Test
PLD	Procurement and Logistics Department
PRM	Participatory Rank Method

SMO	Senior Medical Officer
SMs	Staff Member Satisfaction
SPING	Support to partnership, Reform and Inclusive Growth Programme
TB	Tuberculosis
Td	Tetanus/Diphtheria
TMIH	Tropical Medical & International Health
TVET	Technical and Vocational Education and Training
UNICEF	United Nations Children's Fund
UNRWA	United Nations Relief & Works Agency for Palestine refugees in the Near East
UNOCHA	United Nations Office for the Coordination of Humanitarian Affairs
VB	Virtual Budget
WBFOs	West Bank Field Office
WDF	World Diabetes Foundation
WHO	World Health Organization

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1. Annual Report 2008 (pdf)
2. Annual Report 2009 (pdf)
3. Annual Report 2010 (pdf)
4. Annual Report 2011 (pdf)
5. Annual Report 2012 (pdf)
6. Annual Report 2013 (pdf)
7. Section – 3 Data tables for Annual Report 2013 (Excel)

II. Family Health Team Approach and Health Reform materials (Folder)

III. DM clinical audit report 2012 (pdf)

IV. DM campaign materials (Folder)

V. Healthy lifestyle promotion cartoons (Folder): Zaal and Khadra – 9 TV Spots

VI. Infant and Child Mortality Study Report 2009 (pdf)

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الاونروا

دائرة الصحة
عمان –الرئاسة العامة للأونروا
العنوان البريدي: ص. ب.: 140157 عمان 11814 الأردن
هـ: 5808301 (6 962)+ ف: 9/5808318 (6 962)+

health department
unrwa headquarters - amman
po box: 140157 amman 11814 jordan
t: +(962 6) 580 8301 f: +(962 6) 580 8318/9

www.unrwa.org