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Message of the UNRWA Commissioner-General and the WHO Regional Director for the Eastern Mediterranean

The five geographical fields where UNRWA operates experienced a variety of challenging developments. The crisis in Syria entered its fifth year, internally displacing more than half of the country's Palestine refugee population, and forcing the other refugees to flee to the neighbouring countries of Jordan and Lebanon. In Gaza, conflict raged for 50 days in July and August, resulting in the deaths of almost 1,450 civilians, including over 500 children, and leading to rising tensions in the West Bank. Today, more than 100,000 people remain homeless including 10,000 Palestine refugees who remain displaced in UNRWA collective shelters and waiting for funds and resources to rebuild their homes.

Despite these challenging environments, UNRWA successfully maintained its operations on the ground, serving the five million registered Palestine refugees who depend on us more than ever before. Continued support from the World Health Organization (WHO) as a strategic partner remains indispensable and allows UNRWA to ensure that its beneficiaries receive the highest standards of life-saving health care services.

UNRWA's work has been enhanced by the almost completed transition to the Family Health Team: a person-centred, holistic, primary health care model that is now the new norm at its health centres. More than half of the health centres now operate without paper, using electronic medical records through our e-health information system. UNRWA also developed a new mid-term strategy for 2016-2021 which will serve as a roadmap for upcoming priorities, including aligning the Agency's protection strategy with international standards, and ensuring higher quality of health care for families.

UNRWA continues to face many challenges, however. An aging population suffering from noncommunicable diseases that require costly treatment has placed a growing burden on the agency, and current funding has been unable to keep up with increasing financial needs. Conflict, occupation and persecution have created an increasingly vulnerable population suffering from high levels of poverty and unemployment, and another year has passed without a just and durable solution to the plight of the Palestine refugees. Until such a solution is reached, UNRWA will continue to deliver the services on which its beneficiaries depend to survive. As conflict continues to plague our region, UNRWA's team of dedicated and hardworking staff remains on the front lines of health delivery to ensure that Palestine refugees receive the services they urgently need. Together, UNRWA and WHO are committed to ensuring the best possible health care is available to all.

Pierre Krähenbühl

UNRWA Commissioner-Genera

Ala Alwan

WHO Regional Director for the Eastern Mediterranean

Foreword of the Director of Health

2014 was not an easy year for the region and in particular for the Palestine refugees whom UNRWA serves. This past summer, Gaza experienced an armed conflict unprecedented in both scale and destruction. The crisis in Syria is now entering its fifth year, and with no peaceful solution on the horizon, we continue to strive to provide the highest quality care possible under incredibly difficult circumstances. Throughout the year, Lebanon and Jordan continued to absorb the bulk of the burden of the conflict's refugees, where resources in camps and health centres are already stretched beyond capacity.

However, despite these seemingly unsurmountable challenges, I present with great pride 2014's Annual Report from the Department of Health. The strides our department has made – throughout all five fields – in times of such intense turmoil, is a testament to the unwavering dedication and personal sacrifices made by our staff.

The Family Health Team reform has been expanded to over 85.0% of health centres (excluding Syria), with full implementation across the Four Fields expected by the end of this year, well within target. Expansion in Syria is planned to start in 2015. Our e-Health system has enabled over half of our health centres to simplify record keeping, and contains a wealth of data which will enable us to strengthen evidence based policies.

During the 50 day conflict in Gaza this past summer, UNRWA extended services to all IDPs, regardless of refugee status, a majority of UNRWA health staff continued to come to work, there were no interruptions in essential, lifesaving health services, health centre pharmacies had no stock ruptures, and shelters reported zero outbreaks of communicable diseases. While the crisis in Syria continues into its fifth year, because of the dedication of frontline staff, 2014 saw an increase in consultations to 92.7% of the pre-crisis level, up from 70.0% in 2013.

UNRWA continues its uphill battle in 2015; mental health and psychosocial needs, always a concern in a protracted crisis, have become more pronounced as a result of the active conflicts in Syria and Gaza and their spillover into Lebanon and Jordan. The ever-rising burden of non-communicable disease as a result of sedentary lifestyles, smoking and unhealthy diets is a massive cause for alarm today. These challenges exist in the face of the grim reality that our financial resources are never sufficient, and in fact are shrinking every year. However, I am confident that with increased evidence-based reforms that produce encouraging results, we will expand existing relationships with our national and international partners and donors – highlighted in the coming pages – and continue to attract more.

This year, I can confidently say that we would not be able to boast such successes against all odds, were it not for the staff that I have the privilege of working alongside. I eagerly anticipate what we will be able to achieve together over the coming year and I look forward to our further collaboration to improve the health of the Palestine refugees in the region.

Dr. A. Seita
WHO Special Representative
Director of the UNRWA Health Programme

Executive Summary

Report Overview and 2014 Highlights

UNRWA's Family Health Team (FHT) is now implemented in 99 of 115 health centres, excluding Syria, where the transition is scheduled to be made in six health centres during 2015. e-Health, the UNRWA's in-house electronic medical record system was developed in 2011 to address the administrative burden of millions of patient files. At the close of 2014, 54 health centres were implementing the traditional e-Health system, while 18 health centres were implementing the new FHT e-Health system, tailored to allow for seamless integration with the FHT approach.

Highlights from two diabetes campaigns, implemented in 2013 and 2014 are also featured in this report. A total of 1,300 patients with diabetes participated in each round of the campaign, during which they were provided with a number of educational materials and sessions, healthy cooking materials and classes and group exercise activities. In both rounds of the campaign, participants had significant reductions in body measurements, as well as improved blood pressure readings. Additionally, the comradery and sense of community ownership that developed as a result of the campaigns has inspired the Department of Health to expand the activities in the campaign to all health centres, integrating the health education and lifestyle support into regular activities.

A study assessing the infant and neonatal mortality rates (IMR, NMR) across Four Fields (Jordan, Lebanon, West Bank and Gaza) was conducted in 2013, and analysis completed in 2014. The results show that while Lebanon and the West Bank's rates declined in accordance with Millennium Development Goal (MDG) 4, Jordan's rates declined only marginally, and Gaza's IMR actually rose slightly, while NMR rose significantly. These results are troubling to the Department of Health, and plans are in place for 2015 to further supplement these findings.

Emergency response continued to be a pillar of the Department of Health's service delivery in 2014. Gaza experienced a 50 day conflict during July and August, 2014, which resulted in 1,450 civilian deaths. Despite challenging and often dangerous circumstances, UNRWA was able to provide lifesaving and essential care to all residents of the Gaza Strip and health centres suffered no stock ruptures. Shelters, which reached a peak of more than 290,000 Internally Displaced Persons (IDPs), were able to contain communicable disease, and no significant outbreaks were reported. The crisis in Syria entered its fifth year, internally displacing over 280,000 Palestine refugees from Syria (PRS), and causing more than 80,000 to flee to neighbouring countries, including Jordan and Lebanon. Nine health centres have been forced to close due to security concerns or damage; however, with the establishment of 12 health points, the number of consultations are back to 92.7% of pre-crisis levels. A focus on improving the quality of these consultations will be a priority for 2015.

Lebanon, Jordan and the West Bank continued to suffer the effects of instability in the region this year. In Lebanon and Jordan, PRS have been straining the system for years, competing for scarce resources in camps, schools and health centres, while in the West Bank, the occupation by Israel creates its own set of challenges in accessing health services.

While the Department of Health has made significant strides over the past 65 years, new challenges have emerged as priorities for 2015 and beyond. This year will bring an increased focus on improving the quality of health care delivered through the FHT model, which includes improving the quality of medical consultations, improving diabetes care quality and continuing to train staff on family health. Additionally, the Department of Health will focus on integrating health issues that have previously been unaddressed in a systematic fashion, including Mental Health and Psychosocial Support (MHPSS) and protection, and engaging the community in health prevention and promotion activities. Plans for 2015 include focusing on the improvement of hospitalization support in order to ensure financial protection is available for the most impoverished Palestine refugees, as well as fostering a better understanding of how UNRWA can prevent catastrophic health expenditure for families on the brink of poverty.

Section 1–Introduction and Progress to Date

This section includes an introduction to UNRWA as an Agency, and the Department of Health's activities over the past 65 years. It highlights the traditional model of health service delivery that has been provided in UNRWA's 137 health centres, and examines the demographic and epidemiological shifts in the served population that served as the reasoning behind reforming this model. It also gives an overview of the state of emergency response in each field, as well as priorities for 2015.

Section 2 – Maintaining Quality Health Services Across the Life Cycle

The performance of UNRWA's health services in 2014 towards the 2010-2015 Medium Term Strategy (MTS), as well as for the priorities identified in the biennium Field Implementation Plan (FIP) is presented in this section. The UNRWA Department of Health measures its performance on three strategic outcomes: ensure universal access to quality and comprehensive primary health care, protect and promote family health and prevent and control disease. A chapter highlighting cross cutting issues is also included in this section. Highlights from each of the Agency's Five Fields – Jordan, Lebanon, Syria, Gaza and the West Bank – are also featured throughout the report.

Section 3 – Data

Of note this year, for the first time since 2011, Syria Field is included in recorded indicators wherever possible. Such inclusions for 2012 and 2013 were not possible due to incomplete and inconsistent data collection and reporting as a result of the ongoing conflict. However, a focus on improved data collection techniques was emphasized in 2014, leading to this year's data.

Part One: Agency-wide trends (in graphic form) for selected indicators for overall programme performance from 2007 to 2014

Part Two: Field Implementation Plan (FIP) indicator trends by Field, and Agency-wide, sorted by Strategic Objective.

Part Three: 2014 data tables by Field and Agency-wide on more general details, including demographic information, health infrastructure, Strategic Outcomes one, two and three and cross-cutting indicators.

Part Four: Includes selected survey indicators, including the DMFS Survey (2010), current practices of contraceptive use among mothers and prevalence of anaemia.

Part Five: Includes a list of donors who provided health-specific (earmarked) support to UNRWA. Many donors supported UNRWA with non-earmarked, General Fund contributions, however this table only highlights those who supported the health department specifically with ear-marked funds.

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

UNRWA

UNRWA is a United Nations agency established by the General Assembly in 1949 following the first 1948 Arab-Israeli War, which became operational in 1950. It is mandated to provide assistance and protection to a population of over 5 million registered Palestine refugees. Its mission is to help Palestine refugees in Jordan, Lebanon, Syria, West Bank and the Gaza Strip to achieve their full potential in human development, pending a just solution to their plight. UNRWA's services encompass education, health care, relief and social services, camp infrastructure and improvement, microfinance and emergency assistance. UNRWA is funded almost entirely by voluntary contributions. UNRWA has its Headquarters (HQ) in Amman, Jordan, and the Gaza Strip, which coordinate the activities of the five Field Offices (FO).

Figure 1-UNRWA health facilities, 2014

UNRWA's health system has three tiers:

1- One Headquarters: handles policy and strategy development

2- Five Field Departments of Health: concerned with operational management

3- 137 Health Centres: provide service delivery
The Department of Health employees over 3,000 staff throughout the three tiers, 500 of whom are doctors. 3.7 million Palestine refugees utilize UNRWA health services, free of charge. UNRWA does not operate its own hospitals (except for one in the West Bank), but instead operates a reimbursement scheme for its beneficiaries, which varies by field.

Health Profile

UNRWA has contributed to sizeable health gains for Palestine refugees since the start of operations in 1950. The infant mortality rate, for example, declined from 160 per 1000 live births in the 1960s to less than 25 in the 2000s. Communicable diseases are largely under control thanks to high vaccination coverage, and the early detection and control of outbreaks using a health centre-based epidemiological surveillance system. 100% of births Agency-wide are attended by a skilled professional.

However, with a population that is now living longer as a result of improved health services, and whose main cause of mortality is no longer communicable diseases, the challenge of dealing with an aging population whose main cause of morbidity and mortality is now non-communicable diseases (NCD) has presented itself. Diabetes mellitus, cardiovascular diseases and other NCDs are now responsible for 70.0% of deaths in UNRWA's population. These chronic diseases are costly to treat, and often lifestyle and behavioural related, a result of sedentary lifestyles, obesity, unhealthy

diets and smoking. Coupled with a population growth of approximately 3.0% each year, demand on the health services has never been higher. In 2014, UNRWA had more than 231,000 registered Palestine refugee NCD patients.

Continuing insecurity, political instability, increasing poverty, and patchy access to potable water, are having a negative impact on the health status of Palestine refugees. Severe restrictions on the movement of people and goods within the West Bank and between the Gaza Strip, the West Bank and areas abroad remain a major obstacle to socioeconomic development and health-care provision.

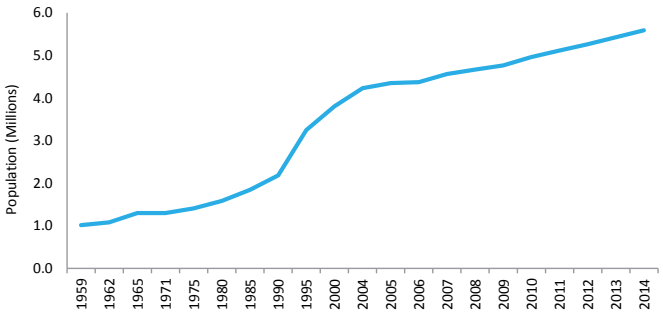


Figure 2- Number of registered Palestine Refugees (1949-2014)

The continuing protracted and acute conflicts, occupation, and the lack of a just and durable solution and their consequences continue to affect the physical, social and mental health of Palestine refugees. They remain severely affected by inequalities in health access and coverage, which are compounded by economic hardship, conflict and the consequences of conflict, which touch all Five Fields of UNRWA's operations, and which adversely affect Palestine refugees' right to achieve the highest attainable standards of health on a non-discriminatory and equal basis. The summer conflict in Gaza left tens of thousands homeless and in need of immediate fiscal assistance. However, UNRWA aims to mitigate the effects of conflict and socioeconomic disparities on health through the provision of the best possible comprehensive primary health care services.

Traditional Model of UNRWA Health Services

UNRWA has long been providing primary health services in three main programmes, divided into separate clinics within each health centre: maternal and

child health care (MCH), non-communicable disease (NCD) care, and general outpatient services. A health centre visit was characterized by long wait times for patients, short consultation times with doctors, and multiple stops within the health centre. A pregnant woman with diabetes and a common cold would potentially visit all three clinics during her visit, waiting for more than a half hour for each.

Doctors were seeing well over 100 patients per day, which meant that it was hard for a short consultation to sufficiently address patient concerns and dispense appropriate treatment and advice. Because patients often did not have consistency in which staff members they saw visit to visit, it was hard to develop a provider-patient relationship, and doctors, nurses and midwives often spent precious time collecting medical and family history during a visit. The most prevalent diseases among the Palestine refugee population – reflected in global trends – are more time consuming to treat, and require behavioural and lifestyle changes. Short consultation times that were manageable in the past became a risk factor for the misuse of medicines – particularly antibiotics – and an increased risk of hospitalization and referral to specialist care as a result of disease mismanagement,

both of which are leading cost drivers for UNRWA.

UNRWA health services were faced with the changing needs of its population. The structure of service provision that worked well for decades – largely disease or condition-specific and fragmented within the health centre between MCH, NCD (diabetes mellitus and hypertension) and general walk-in clinic – was no longer the best way to treat patients. A more holistic, lifestyle and behaviour-focused approach – one that required a relationship between the patient and their healthcare providers - was now required.

Health centre staff were also adversely affected by the processes between the clinics. The workload was uneven between doctors and other staff. Patients had files in each clinic, with fragmented history in each. Health centres were disproportionately full in the early mornings, and often near empty in the afternoons.

UNRWA Response: Health Reform

Family Health Team

In late 2011, a health reform package was introduced as part of the Agency-wide Organizational Development plan (OD). Family Health Team (FHT) is a primary care package focused on providing comprehensive and holistic primary health care for the entire family, emphasizing long-term provider-patient/family relationships. This person-centred approach has been successfully adopted in many developed and developing countries to address the growing problem

Many countries are struggling with conflict and have a double burden of health system challenges on top of the issue of insecurity. Although it was noted that implementing the family practice approach may be difficult, ***UNRWA provided a good example of how primary health care reform including the integration of a family practice approach could improve quality of care and patient satisfaction under difficult situations***

WHO-EM/PHC/165/E. Report on the Regional consultation on strengthening service provision through the family practice approach. Cairo, Egypt. November 2014

of NCDs and the increasing costs associated with their care. The FHT was designed to improve quality, efficiency and effectiveness of health services, particularly targeting NCDs. The FHT approach is supported by the concurrent introduction of electronic medical records (e-Health) and health centre upgrades to better accommodate the infrastructure needs of the new approach.

Under the Family Health Team, approach families are registered and assigned to a provider team which consists of a doctor, nurse and midwife. The provider team is responsible for all health care needs for the family through all stages of the lifecycle. The FHT was first introduced in two pilot health centres in Gaza and Lebanon. By the close of 2014, 99 of UNRWA's 115 health centres (excluding those in Syria) have successfully implemented FHT reform, impacting 80.0% of the served population. Improvements in wait times, health centre organization and patient satisfaction have already been seen, in addition to a decrease in daily consultation rates for doctors.

Several assessments have been conducted in health centres implementing the FHT approach since 2012, including focus group discussions, client flow analysis exercises and patient and staff satisfaction surveys. Such assessments have garnered with very positive responses to the approach from both staff and patients, as well as quantitative improvements to patient wait times and staff workload. Equitable workload distribution – a consequence of the new teamwork structure and switch from specialized services to general primary services – had been cited as one of the key positive factors perceived by all staff. In addition, improved professional satisfaction and the opportunity to build relationships with patients over time have also been cited by staff. Patients appreciate having a doctor who knows the health profile of the whole family. Moreover, they have indicated that the health centre is more organized and less congested since the transition to FHT.

Highlight from the Field: Jordan

Through a generous contribution from the US, the Department of Health completed construction of Irbid New Health Centre in 2014. The new two-story health centre has 2,500m^2 of service area, is disability accessible, and was designed to improve patient flow and cope with the FHT approach. More than 122,000 patients formerly attending Irbid Camp and Irbid Town Health Centres now seek services at Irbid New Health Centre. The merger of the two HCs also helped respond to the dire needs of the marginalized and poor refugees living in Jerash, Duleil and Sukhneh Camps. Excess staff resulting from the merger of the two HCs were redeployed to understaffed Jarash Health Centre and the newly established HCs at Sukhneh and Dulail.

Improvements in quality of services were observed, including a decrease in the average number of daily medical consultations per doctor, increase in consultation time, and decrease in antibiotics prescription rate. 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 a high level. As indicated in detail in their respective sections, screening activities for NCD were strengthened and referrals to psychosocial counsellors have increased.

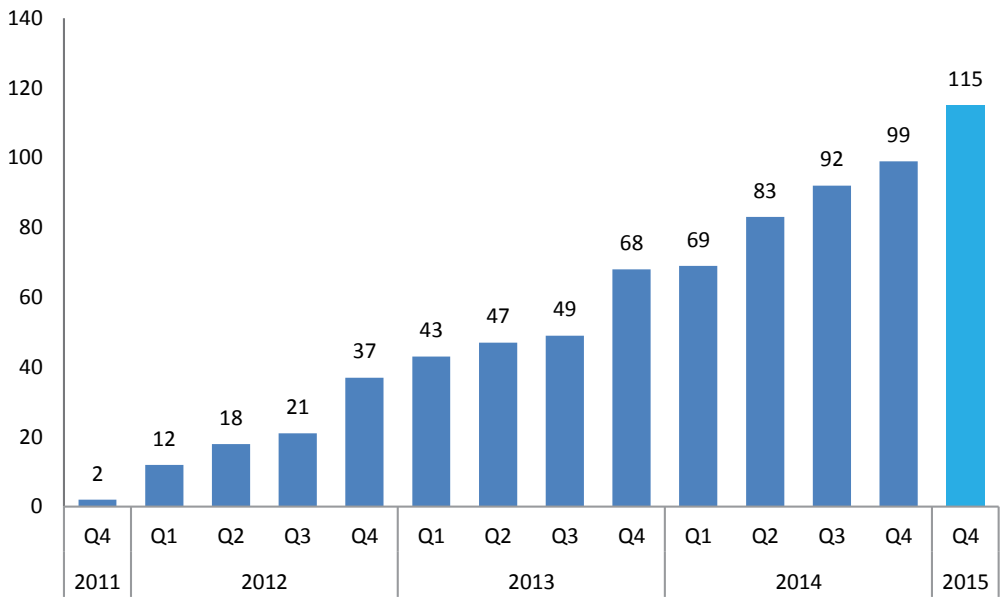


Figure 3- Family Health Team Transition Progress (2011-2014)

Progress towards implementation has been stalled in Syria, where ongoing conflict has prevented health reform; rather, the focus has been on continuing to provide essential care by any means possible. The goal for 2015 is to launch FHT in a total of six health centres in Syria, as the security situation and infrastructure capabilities allow.

e-Health

In order to streamline and improve the primary health care daily operations, recording and reporting at the service delivery and at the higher administrative layers, UNRWA developed an e-Health system. Traditionally, the manual system of data collection, processing, analysis and reporting has been paper based, resulting in a time consuming, costly, and labor intensive process.

With continued financial support from the United States of more than 1.8 million through 2014, UNRWA's e-Health system was developed in-house in 2011 to address the administrative burden of millions of patient files. The software initially contained four main modules: NCD, child health care, maternal health care, and outpatient, in addition to support modules such as pharmacy, laboratory, dental and specialists. This system has also served to streamline a patient's flow at the health centre level, including proper documentation and follow up of referrals. This has resulted in an improvement of health staff performance, which has enhanced their managerial and administrative capacity. It has also served to strengthen the decentralization of health centres and continuous quality improvement process. It is reducing the paper work, the workload on health staff, decreasing the patient's waiting time, and subsequently is improving the quality of health services by increasing the doctor's-patients contact time which impacted positively on the health education and prevention. In addition to that, it is improving the accuracy and reliability of statistical information, thereby the quality of evidence-based planning and management.

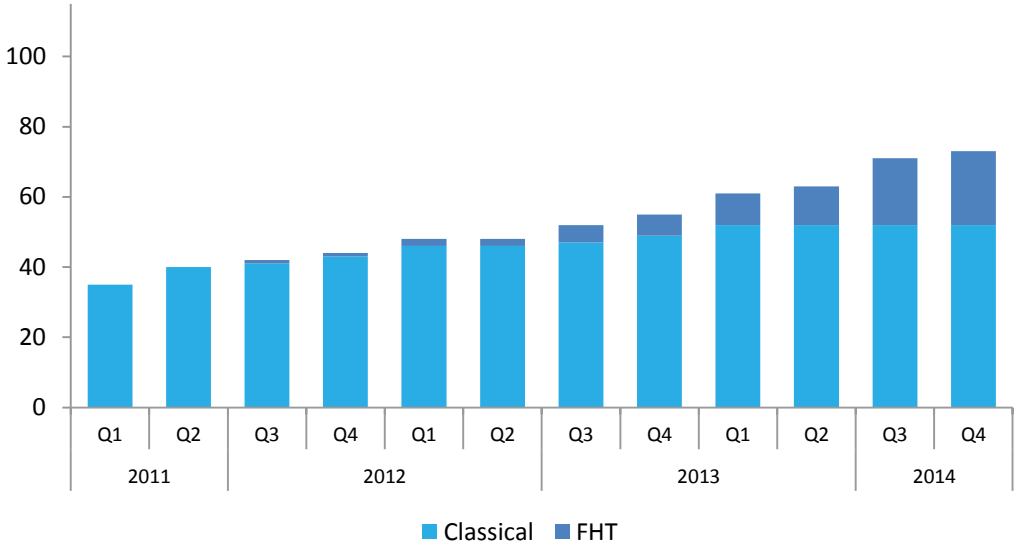


Figure 4- No. of health centres with Classic e -Health and e-Health FHT

This system allows for easy production and automatic generation of all standard reports, data compilation, and transferal and production of health indicators. Moreover, the e-Health system is encouraging and supporting the implementation of the health reform which aims to improve cost efficiency and effectiveness of the health programme .

In 2012, in line with the reform and the introduction of the FHT approach, the e-Health system was tailored to adopt this approach (FHT e-Health). Full implementation across the fields is anticipated by mid-2017. This new version is more advanced and comprehensive, allowing for a synergized interface to accommodate all IT and information management needs for FHT. However, challenges relating to securing sufficient resources are ongoing. Fifty four of UNRWA health centres have traditional e-Health, while 18 had the FHT version by the close of 2014.

While e-Health has not expanded to Syria at all to date, where logistically possible, UNRWA will explore the possibility of bringing compatible e-Health modules to Syria this year, though this is again dependent on external factors.

Non-Communicable Diseases

Diabetes Campaign

UNRWA, supported by the World Diabetes Foundation, conducted a health centre audit on diabetes care in 2012. The findings of this audit revealed problems in patient lifestyles: 64.0% were obese and another 26.0% overweight, with many patients lacking opportunities to exercise, with little knowledge about healthy nutrition and cooking practices, and even rational and timely use of medicine.

The findings of the audit were instrumental in shaping two rounds of diabetes awareness campaigns entitled Life is Sweeter with Less Sugar,

"الحياة أكثر سعادة بدون سكر زيادة "

The six month campaign took place in 2013 and 2014, and aimed to help Palestine refugees in the prevention and control of both diabetes mellitus and hypertension through three activities:

- Training UNRWA health staff on patients' counselling skills;
- Establishing community kitchens to practice healthy cooking;
- Establishing exercise groups in the refugee community for patients with diabetes.

A total of 1,300 patients were selected in the largest eight health centres in each field to participate in the pilot campaigns. Within each health centre, staff selected 50 willing patients with diabetes to participate in the duration of the campaign. Educational materials, including pill boxes, pedometers, plates with visual depictions of healthy meals, foot care kits, cook books, and pamphlets with proper insulin injection instructions were provided to participants. UNRWA staff in the selected health centres conducted educational sessions, healthy cooking sessions, and group exercise sessions on a weekly basis. Process indicators such as body measurements, blood tests, and number of sessions attended for different activities, were measured on monthly basis for each patient.

Of 1,300 included patients, 1,174 (951 female, 223 male) completed the campaign with 83.7% attendance; a significant reduction in the body measurement was seen in patients with significant improvements in blood tests. Of 1,600 patients who were registered in the 2nd campaign, 1,573 (female 1,150, male 423) have completed the campaign activities for 6 months period, with average age of 52.8 years. Preliminary results show improvements in the process indicators such as the body weight, waist circumference, 2hrs-PPG, blood pressure and cholesterol levels.

While these results are exciting, what is perhaps more so, was the ownership health centre staff took over the campaign activities, and the social bonding that resulted within the focus groups themselves. Based on these positive reactions to the campaign, the Department of Health will work to strengthen the health education and staff counselling portions of the campaign by conducting trainings with nurses and integrating the core educational messages into the daily routine of the health centres. UNRWA will continue to seek community partnerships to continue cooking and exercise activities.

Infant mortality rates among Palestine refugees in Gaza, West Bank, Jordan and Lebanon

UNRWA has periodically monitored infant mortality rates (IMR: number of deaths before one year per 1000 live births) and neonatal mortality rates (NMR: number of deaths in the first 28 days per 1000 live births) among Palestine refugees to guide future strategic approaches aimed at improving maternal and infant health. From 2013-2014, UNRWA HD conducted an IMR evaluation to estimate IMR and NMR and assess changes over time, as well as assess the main risk factors and causes of infant death. This survey was conducted previously in 2008. In Lebanon and the West Bank, IMR decreased according to MDG4 target. In Jordan, IMR and NMR declined only marginally. However, in Gaza, there was a slight increase of IMR (from 20.2 in 2008 to 22.4) and a significant increase in NMR from 12.0 in 2008 to 20.3. Reassessment of mortality rates in Gaza in 2015 is planned to supplement findings and further assess what is needed to reverse this trend. A more in-depth presentation of the results can be found in the Child Health section of this report.

Hospitalization

To support primary health care, the Department of Health will continue to strengthen coordination with host countries and other stakeholders to ensure access of Palestine refugees to a higher level of care. A renewed focus will be on giving more priority to financial protection for poor families, in addition to providing additional protection for lifesaving care or procedures that may represent a catastrophic expenditure for households. Currently, the hospitalization database system is active in Jordan and Lebanon. Throughout 2015, the Department of Health will expand the hospitalization database system to other fields.

The hospitalization database will allow in-depth analysis, to better understand the impact of the support provided, that is not captured through current data collection. Collecting data that is currently obtained through both electronic and manual techniques, the database will capture characteristics of the beneficiary population, utilization rates and expenses in contracted hospitals, and trends over time. Analysis on this data will provide a method to better tailor hospitalization support to meet the needs of Palestine refugees.

UNRWA's Response: Emergencies

2014 was particularly difficult for UNRWA. This past summer Gaza experienced a conflict unprecedented in both scale and destruction. The crisis in Syria entered its fourth year, with no peaceful solution on the horizon, while Lebanon and Jordan continued to absorb the bulk of the burden of the conflict's refugees. Gaza's conflict led to increased tension and upheavals in the West Bank. It is as if there is no safe, quiet, or stable place in any of our fields of operation. Life for Palestine Refugees, already difficult to begin with, was made more unstable and difficult in 2014.

Gaza

The 50 days of conflict during July and August resulted in significant destruction in Gaza; 1,450 civilians – including 482 children and 250 women – were killed, and more than 100,000 refugee homes or dwellings were damaged or destroyed. Eleven UNRWA staff members or associated personnel lost their lives due to conflict related reasons in 2014. The months leading up to the summer conflict were marked by a deterioration of the relative calm situation experienced in Gaza throughout 2013.

Existing emergency preparedness plans in UNRWA Gaza anticipated capacity to accommodate between 35,000 and 50,000 potential IDPs in schools often used as shelters during times of conflict. Within two weeks of the commencement of the conflict in July 2014, that number had doubled, reaching a peak of over 290,000 shelter residents in 92 UNRWA schools. Conditions in the shelters were difficult, with an average of >3,000 IDPs in each. While UNRWA strives to prevent conditions in which communicable diseases flourish, hygienic conditions in shelters were difficult, with inconsistent access to non-potable water and sanitary facilities. As of February, 2015 more than 10,000 displaced persons continued to live in one of 15 collective shelters.

In spite of these extremely challenging circumstances, an average of 68.0% of UNRWA health staff continued to come to work throughout the 50 days of conflict. There were no interruptions in essential, life-saving health services throughout the conflict and health centre pharmacies had no stock ruptures. In July, clinics reported only a 28.0% workload decrease, while August saw 127% of pre-conflict visits. Levels were reached despite the fact that only 65.0% of health centres were open for the majority of the conflict.

After a rapidly increasing IDP populations in shelters, UNRWA installed health points at each shelter consisting of three health staff. Population reports on shelter residents, and records detailing patients from shelters were collected daily. Lice cases peaked September 4th with 1,126 reported new cases; by September 7th that number was down to 46, after widespread health education campaigns and improved access to sanitary facilities. Despite being at 6.2 times capacity, UNRWA was able to prevent outbreaks of communicable disease common to areas with a high density of people living in difficult conditions.

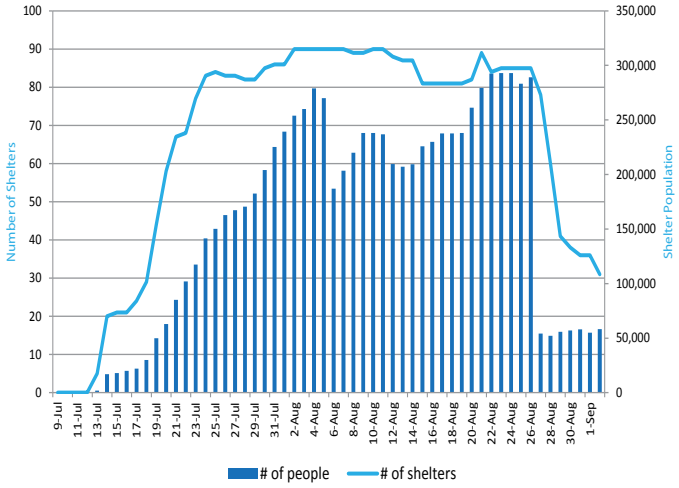


Figure 5 - No. of people living in shelters and No. of shelters open in Gaza during July 7-August 31, 2014

Syria

The crisis in the Syrian Arab Republic, now entering its fifth year, has internally displaced over 280,000 Palestine refugees and caused over 80,000 to flee to neighbouring countries, including Jordan and Lebanon. 95.0% of the remaining 460,000 Palestine refugees are estimated to be in continuous need of humanitarian support. In 2014, 75.0% of the Syrian population was estimated to be living in poverty, with 49.0% inflation. The unemployment rate in Syria is nearly 55.0% for adults and 70.0% for youth (up from 35.0% in 2011). Prior to the crisis, Palestine refugees in Syria were among the poorest in the country; it is reasonable to assume that these rates are higher for Palestine refugees. The worsening situation for Palestine refugees in the Syrian Arab Republic is indicative of the declining quality of life for Palestine refugees in the region as a result of conflict, displacement and occupation.

However, working under the assumption that this crisis and its implications will continue for the immediate and foreseeable future in both the Syrian Arab Republic and the region, UNRWA continues to provide the full spectrum of health services, to the greatest extent possible. Since 2012, UNRWA has opened 12 health points; in conjunction with the remaining 15 health centres in operation, Syria has seen consultations rebound to 92.7% of pre-crisis totals.

The humanitarian situation in Yarmouk continued to deteriorate throughout the course of 2014, with some 18,000 residents unable to access regular food, supplies, clean water, health care, electricity or heating fuel. Early in the year, the Department of Health opened a health point in Yarmouk, composed of a medical officer and assitant pharmacist. The health point provides essential medicine and consultations along with drugs for NCD patients, children women and the elderly inside Yarmouk during food basket distribution. The services are provided three days a week, with an average of 80 patients per day. Through surveillence, the Department of Health was also able to detect an epidemic of Typhoid in July 2014. Intensive contorl and prevention measures suceeded in controlling the epidemic. UNRWA HD was able to introduce 14,000 doses of the polio vaccine through participation in six vaccination rounds.

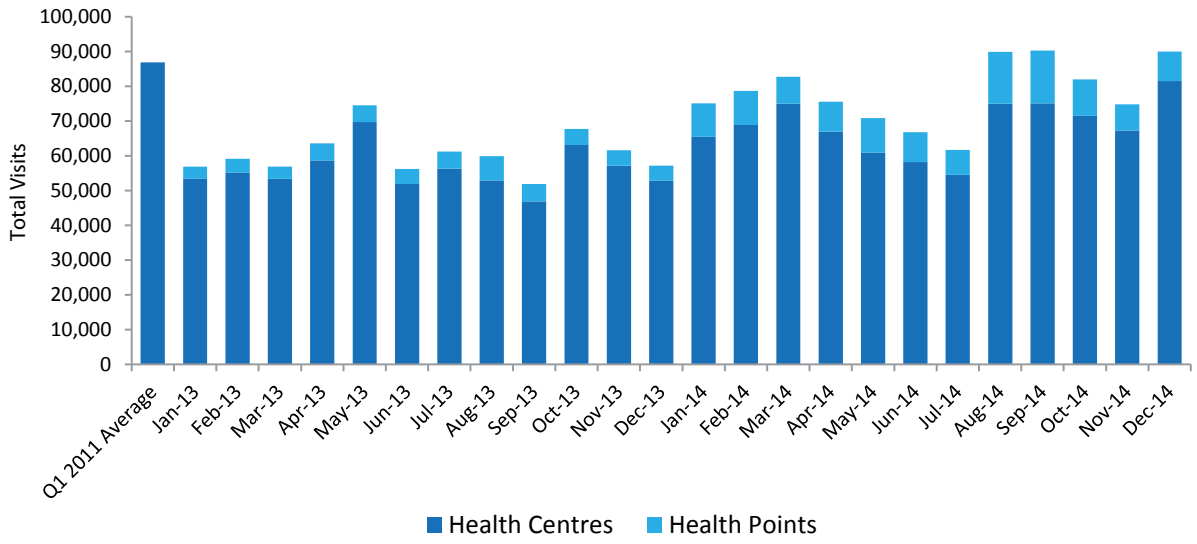


Figure 6 - Daily consultations at health centres and health points in Syria, from Jan. 2013-Nov. 2014 compared to Q1 2011 average

Lebanon

Lebanon continues to shoulder the bulk of Palestine refugees from Syria (PRS), putting further strain on an already strained health system. Doctors' daily workloads have increased, as health centres absorb over 50,000 Palestine refugees from Syria. Data relating to health centre use in Lebanon has indicated that not only do PRS use health services more frequently than their Lebanese counterparts, but they see medical doctors specifically on a more frequent basis, increasing the daily workload for doctors.

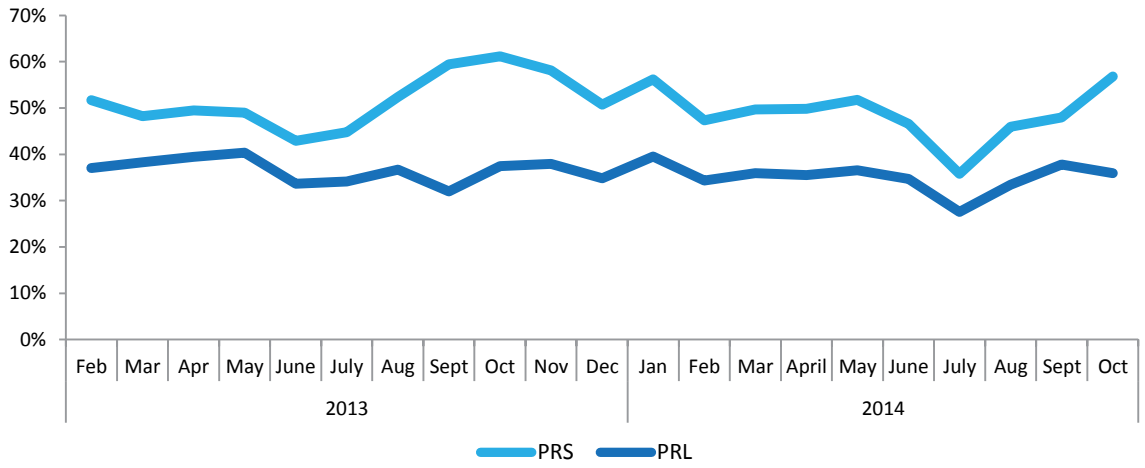


Figure 7 - Percent of PRL & PRS visits at UNRWA health centres in Lebanon, 2013 -2014

West Bank

The mobility of health teams, including doctors and nurses continued to be jeopardized by frequent closures and checkpoints. Communities in Area (C) continued to face difficulties in accessing health services due to road detours, road barriers, the West Bank Barrier and higher transportation costs. Movement restrictions also prevented Palestinians from accessing six 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 programme, and provided financial support to enable access to hospital care.

Jordan

The total number of Palestine refugees who fled to Jordan from Syria had reached 14,802 as of 30 December 2014. 30.0% are in Irbid Area, 28.0% in Zarqa Area, 24.0% in North Amman Area and 18.0% in South Amman Area. UNRWA support to PRS in Jordan includes basic primary care services provided to Palestine refugees from Jordan: free health care at 23 health centres across the country, one health point and four mobile dental clinics, in addition to hospital referrals for secondary and tertiary health care. The Agency also supports an onsite clinic in Cyber City Refugee Camp, run by the Jordanian Health Aid Society (JHAS), an international NGO, to serve approximately 185 PRS and the Syrian refugees hosted in the camp. In 2014, PRS accounted for close to 20,000 primary health care consultations in UNRWA clinics and more than 660 secondary and tertiary health care consultations and admissions. PRS have strained already scarce resources within the Agency, however emergency funding has been able to alleviate some of the burden.

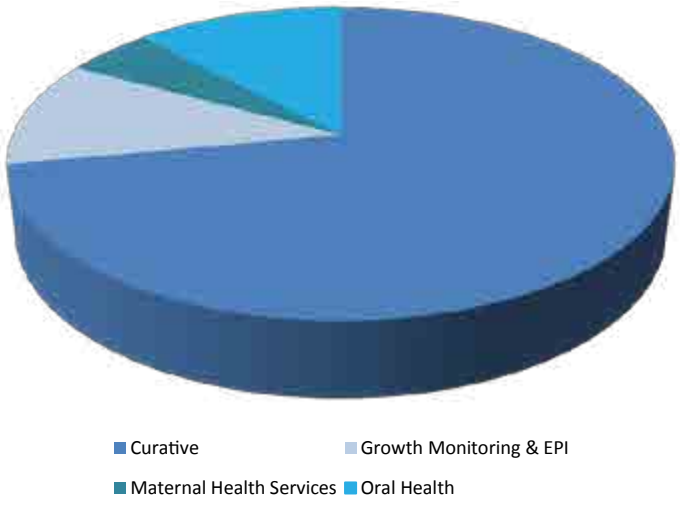


Figure 8 - Consultation type at UNRWA health centres among PRS in Jordan

Next Steps

Despite significant health reform successes in the past few years, several priorities emerged in 2014 which will help the Department of Health continue to improve the healthcare it provides to Palestine Refugees.

Improvement of the quality of health care delivered through FHT

While the FHT transition has shown improvement in efficiency and organizational indicators relating to daily operations at the health centre level, 2015 will bring a renewed focus on improving the quality of care provided in the health centre.

Improving the medical consultation quality

The average number of daily medical consultation has been used to estimate the time doctors spend with each patient, assuming that contact time with doctors is directly correlated with the quality of the medical consultation. Therefore, a reduction in consultations per day for doctors means more time with the patient and higher client satisfaction. However, this proxy measurement is quite inaccurate; e-Health allows for exact measurement of the contact time between doctor and patient. In addition, it will organize the patient flow through a flexible appointment system that ensures the optimal utilization of working hours and health staff time. It will also allow staff to retrieve data and review patient history quickly, sparing more time for the interaction with, and counselling of, clients.

Improving diabetes care quality

A focus within consultation quality improvement will specifically address NCD care quality. At all levels of health centre care, messages to patients regarding healthy lifestyles, behavioural changes and proper self-care must be reinforced. Health promotional outreach efforts such as the Diabetes Campaign will help educate patients about their disease, proper self-care, and ways to improve their health at home.

Staff training on family health

Most of the physicians working in UNRWA primary health care facilities are general practitioners, not family physicians, who are certified to work without further specialist training after graduating from medical school. UNRWA will work with local regional and international partners to take advantage of any training opportunity to develop the capacity of its general practitioners in the field of Family Medicine. Although on-the-job training for general practitioners and other supportive staff proved to be the most adequate model to UNRWA context, the Department of Health will exploit all available means and opportunities to build the capacity of the health staff through other training modalities and training.

Integrate unaddressed key health and health-related issues into FHT

Over the past 60 years, UNRWA Department of Health has addressed maternal and child care in an exemplary way, while the FHT model has successfully integrated NCD care and control into primary health care. However, there are still two important health priorities which have yet to be addressed in a comprehensive, systematic way.

Mental Health and Psychosocial Support and Protection

Addressing protection-related concerns emerged as a priority in 2014; in 2015 UNRWA will take steps to establish an Agency-wide protection framework, which will encompass mental health and psychosocial support, and gender based violence needs. This framework will be tailored as appropriate for health centre activities, ensuring that a systematic and

coordinated programmatic response, tailored to the particular needs of girls and boys, is provided.

Health prevention and promotion and community engagement

Community participation in health campaigns and activities is a crucial component of encouraging healthy populations. The “Life is Sweeter with Less Sugar” diabetes campaign conducted in 2013 and 2014 sought to incorporate community participation and investment in leading healthier lifestyles.

However, more robust and targeted campaigns are planned to be conducted in all aspects of health promotion in order for healthy lifestyles and behaviours to become a part of daily life of Palestine Refugees.

Improve hospitalization support

For those cases that are beyond the scope of UNRWA's primary care services, UNRWA provides assistances towards hospital services by contracting beds at non-governmental and private hospitals, or by partially reimbursing costs for treatment. Currently, UNRWA hospitalization costs approximately US$ 20million per year – the same budget allocated for medicines. An evaluation of the hospitalization policy review was conducted by an external consultant in 2014, with the purpose of exploring how efficiency can be maximized in the face of financial deficits. To that end, three priorities have emerged for 2015:

Hospitalization survey among social safety net (SSN) cases

As a result of the policy report, and a renewed focus on financial protection, plans to collect more data in order to determine if revising the Department of Health hospitalization strategy will improve efficiency are being developed. The focus for this work will be on expanding the financial services available to the SSN cases – that is, those who are classified as abject poor and therefore most in need of financial assistance by the Relief and Social Services department.

Improve hospitalization data sets

A database to monitor referrals, use of hospital services and patient expenditures is under development. This will allow better analysis and understanding of the population using hospitalization services most frequently, and for what reasons.

Improve hospitalization contracts by building in quality indicators

Quality indicators are being added in to existing contracts, allowing UNRWA to monitor the quality of care provided at contracted hospitals throughout the five fields. New contracts will have these indicators built in.

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

In the UNRWA health system, outpatient care encompasses all services that can be done in a health centre during a routine visit and which do not require an overnight stay at a hospital. At UNRWA health centres, these services include, but are not limited to, basic consultations, antenatal and prenatal care, infant and child care, NCD management, basic laboratory testing and medicine distribution.

Utilization

UNRWA currently provides comprehensive Primary Health Care through a network of 137 health centres of which 69 (50.0%) are located inside refugee camps. In addition, UNRWA operates six mobile health centres in the West Bank to facilitate access to health services in those areas affected by closures, checkpoints and the barrier.

Utilization of out-patient services in 2014 was higher than that in 2013 with a total of approximately 9.5 million medical consultations (Palestinian refugees from Syria is included) compared to 9.3 million in 2013. Of these consultations, 168,921 were specialist consultations.

Table 1 - No. of medical consultations, 2013-2014

	Jordan	Lebanon	Syria	Gaza Strip	West Bank	Agency
2013	1,765,335	1,082,427	635,754	4,300,637	1,506,044	9,290,197
2014	1,721,440	1,276,153*	983,635	4,181,967	1,293,960	9,457,155

(* PRS data is included)

In Syria, the utilization of outpatient services was still affected by the closure of health centres and limited access to health services caused by the prevailing security constraints. However, during 2014, medical consultations increased 54.0% compared to 2013, and reached 92.0% of pre-crisis levels. In 2015, a greater focus will be on improving the quality of services provided, as well as increasing the number of preventative consultations.

In Jordan, Gaza and West Bank, the utilization of outpatient services decreased. This decrease could be attributed to implementing the appointment system, e-Health system and FHT approach in some health centres. Moreover, in Gaza this decrease could be attributed to the interruption of services due to the conflict in Gaza during July and August 2014 that resulted in the closure of some health centres.

In the UNRWA system, out-patient medical consultations are classified in two groups: first and repeat visits. First visits reflect the number of persons attending a health centre during a calendar year, while repeat visits measure the frequency of service utilization. The ratio of repeat to first visits decreased from 3.2 in 2013 to 2.9 in 2014, with wide variation, both among Fields, and between health centres in the same Field. The highest ratio (4.8) was found in Lebanon, while the lowest (1.8) was in Syria. The variability of this ratio within and between fields reflects access to other health care providers. It is quite higher in health centres located inside camps where people can easily reach services, and in the fields with limited access to other health care providers – like Lebanon. The security situation in Syria may account for the low utilization rate in this field.

Workload

The average number of medical consultations per doctor per decreased from 99 in 2013 to 95 in 2014. The highest workload was reported by West Bank Field with 111 patients per doctor per day and the lowest in Syria with 80. Although the workload was reduced, it is still high and far from UNRWA's intermediate target of 80 patients consultations per doctor per day.

However, the introduction of the Family Health Team approach has begun to help reduce the workload, through the shifting of mainly preventive tasks from medical officers to nurses, such as authority to approve monthly refills of medicines for controlled NCD patients, and through the introduction of an appointment system to better manage demand. In addition, the individualized care provided through this approach may help to reduce irrational health care seeking behaviour.

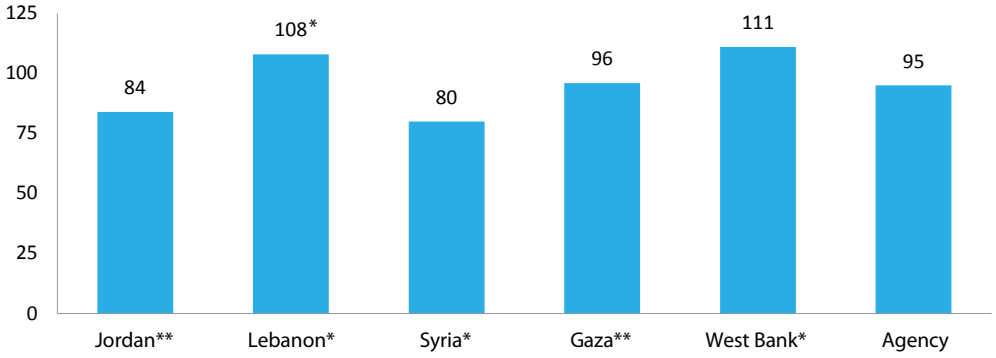


Figure 9 - Average daily medical consultations per doctor, 2014 (*HCs open 5 days/week, **HCs open 6 days/week)
* PRS average daily medical consultations per doctor is included

Inpatient Care

UNRWA continued to provide assistance towards essential hospital services either by contracting beds at non-governmental and private hospitals or by partially reimbursing costs incurred by refugees for treatment. In addition, the Agency directly provides hospital care in one hospital at Qalqilia in the West Bank.

Outsourced Hospital Services

During 2014, a total of 88,635 refugees benefited from assistance for hospital services. The average length of stay was 1.9 days across UNRWA's five Fields of operation

Table 2 - Patients who received UNRWA assistance for hospital services during 2013 and 2014

	Jordan	Lebanon	Syria	Gaza Strip	West Bank	Agency
2013	12,908	30,832	NA	8,444	20,730	72,914*
2014	21,902	29,269	7,130	9,615	20,719	88,635*

*Number excludes Qalqilia Hospital

Of all the patients hospitalized, 52.8% were between 15 and 44 years old, while 27.6 % were children below the age of 15. Almost 66.6% of the patients were women. There is a significant variation among Fields concerning the number and type of hospital cases reimbursed by UNRWA. In Jordan and the Gaza Strip, deliveries represented the majority of the cases reimbursed, and in Syria the majority of the cases were surgical cases while in Lebanon and the West Bank the majority were internal medicine cases. The variation is not related to any significant morbidity variations, but is rather a consequence of differences in access to public health services in host countries, and the resource allocation and reimbursement policies implemented in the various Fields.

Qalqilia Hospital

In addition to subsidizing outsourced hospital services, 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 5,175

patients were admitted to the hospital in 2014 compared to 5,399 in 2013. The average bed occupancy in Qalqilia Hospital was 47.5% in 2014, compared with 39.6% the previous year. The average length of stay in 2014 was 2.1 days

Table 3- In-patient care at the UNRWA hospital (Qalqilia, West Bank) in 2014

Indicators	(no.)/ (%)
Number of beds	63
Persons admitted	5,175
Bed days utilized	10,914
Bed occupancy rate	47.5
Average stay in days	2.1

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 of on-going and often severe psychological stress, particularly in the Gaza Strip and the West Bank, UNRWA launched a Community Mental Health Programme (CMHP). The Programme offers counselling and support, and ensures the long-term strategic incorporation of psychosocial wellbeing of refugees into the Agency's healthcare package.

West Bank Community Mental Health Programme

In 2014, 7,049 individuals received consultations and counseling services through a team of 21 psychosocial counselors in WBFO health clinics. Anxiety complaints (32.0%), gender-based violence/ domestic abuse and neglect (14.0%), and psychological disorders due to medical reasons (11.0%) are the most commonly detected.

More than 33,000 individuals and families were reached through public awareness and education activities and sessions. Topics included psychological first aid, crisis intervention, life skills (communication, leadership, time management, stress and tension management, self-awareness), youth and mental health, GBV, sexual and reproductive health and rights, sexual harassment and the internet, early marriage & STDs, sexual abuse, neglect, verbal abuse, and psychological abuse. The Programme also worked through support groups to promote prevention of GBV at the community level. WBFO established 18 mother-to-mother groups (consisting of 244 women), 22 peer groups (169 boys and 188 girls), and 15 support groups for UNRWA sanitation workers (162 males and 15 females).

In conjunction with the Child Protection Programme, interventions also focused on the specific needs of the elderly. In 2014, 430 home visits to neglected elderly refugees to provide necessarily medication, food and nutrition, social and economic support, counseling, and home cleaning were made. Counseling to the families of the neglected elderly in an effort to improve care was also provided.

Highlight from the Field: Lebanon

In 2014, five nurses were included in an extensive Psychosocial Support (PSS) training, which allowed them to set up a PSS group in each area. Each group consists of five to eight staff members and provides a platform for staff to learn to support each other in dealing with identification, assessment, intervention, and referral of clients in need of mental health (MH) services or PSS.

Additionally, staff are given a confidential space to give support to their peers and practice self-care, as it is often not recognized sufficiently that staff members themselves are often exposed to high levels of stress. The self-care component of the programme consists of debriefing sessions and peer support and has received positive feedback from the staff.

The presence of MH specialists in the clinics (clinical psychologists and psychiatrists), and the link between the specialists and the PSS groups has contributed to an increased awareness of MHPSS issues in the health centres. This has led to an improved referral pathway between staff and MH specialists.

In addition to the PSS groups, 11 Child Friendly Spaces (CFS) have been established, where animators carry out recreational activities with children and refer them to further PSS counseling, if the need arises.

In Aida, Jalazone, and Jenin refugee camps, 140 children (43 girls and 97 boys) 12-17 years of age participated in a summer camp for children and youth from refugee camps facing increased levels of conflict-related violence, including military and settler violence, incursions, arrests and detentions. This included creative and interactive psychosocial activities to safely discuss traumatic events, express emotions, cultivate skills and coping mechanisms and develop advocacy skills. Evaluations highlighted the need for systematic interventions specifically targeting victims of conflict-related violence and detention, including further and more in-depth summer camps.

The Programme works in close coordination with national governmental and non-governmental stakeholders, UN agencies, and international organizations. Key national partners included the Ministry of Health, Ministry of Social Affairs, Women's Centre for Legal Aid and Counseling (WCLAC), Juzoor for Health and Social Development, Palestinian Counseling Centre (PCC), and the Women's Studies Centre. The Programme also enjoys productive relationships with Save the Children, UNICEF, UNFPA, and the YMCA.

Gaza Strip Community Mental Health Programme (CMHP)

In Gaza, the CMHP works through the main core programmes of UNRWA with 203 school counsellors, 13 community counsellors, 25 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 4 - Community Mental Health Programme activities - Gaza, 2014

	Individual counselling	Group counselling	Group guidance (awareness)
Sessions	78,136	10,802	33,646
Beneficiaries	15,103	11,839	117,862

The CMHP intervention during the conflict in Gaza, July-August 2014

The summer 2014 hostilities have had a major psychosocial impact on individuals and communities in the Gaza Strip. High levels of fear pervaded the entire population, with particularly serious impacts on children. Tens of thousands of families fled their homes and took refuge at UNRWA schools. These families were affected by many tragedies including loss and grief as they try to cope with the shelter situation. To help these families; CMHP deployed counsellors to UNRWA shelters hosting these IDPs.

UNRWA staff members, working both during the conflict and during the recovery phase, were exposed to the impacts of trauma on Palestine refugees whom they serve, although they have not had formal training on how to respond in this type of situation. After the summer hostilities CMHP organized numerous workshops and short-term trainings for frontline staff addressing stress management and self-care.

Over the last quarter of 2014, 8,735 UNRWA staff benefited from these activities. Similarly, CMHP organized training courses for mental health counsellor and supervisors after the conflict where all counsellors and supervisors had stress counselling training to help them and other colleagues.

Oral Health

Oral health services during 2014 were provided through 100 fixed and 9 mobile dental clinics. During 2014, the total number of curative oral health consultations increased by 7.2% compared to 2013, reaching a total of 643,149 in 2014. Oral health screening activities including pre-school children, school children, patients with non-communicable diseases, women at the first preconception care visit and pregnant women increased by 17.0% compared to 2013, reaching a total of 260,770 in 2014.

During 2014, 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 one and two years, in addition to the application of sealant. A total of 35,907 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.

Assessment of workload, productivity and efficiency of oral health services is conducted annually in each of the five Fields. A workload unit method is a standardized counting method for measuring technical workload in a consistent manner. With this method, one work unit is equal to one minute of productive technical, clerical and aide time. 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 re-organization of services.

Highlight from the Field: Jordan

Early Childhood Caries (ECC) is a serious, painful dental disease affecting children. A form of tooth decay, it is a result of improper feeding and saliva sharing practices with inadequate hygiene and lack of fluoride exposure. The prevalence of tooth decay among children aged 40-48 months in Jordan field is 60%.

In preparation for a 2015 initiative to increase fluoride varnish application, the HD conducted five in-service training workshops in 2014 for 100 nursing staff in the North Amman area on the following topics; infant and mother oral health education, conducting a caries risk assessment, fluoride varnish application, and traumatized teeth and emergency dental treatment.

This initiative will target 5,200 preschool aged children attending five health centres in North Amman in the second quarter of 2015, and every child will begin receiving the fluoride varnish application every six months starting upon teeth eruption.

Table 5- No. of curative and preventive oral health interventions, 2014

	Jordan	Lebanon	Syria	Gaza	West Bank	Agency
No. of curative interventions	160,170	64,567	47,946	309,465	61,001	643,149
No. of preventive interventions	82,963	38,976	2,115	103,657	33,059	260,770
Average daily dental consultations/per dental surgeon (target 25)	32.3	30.5	32.4	78.6	33.1	49.3

Physical Rehabilitation

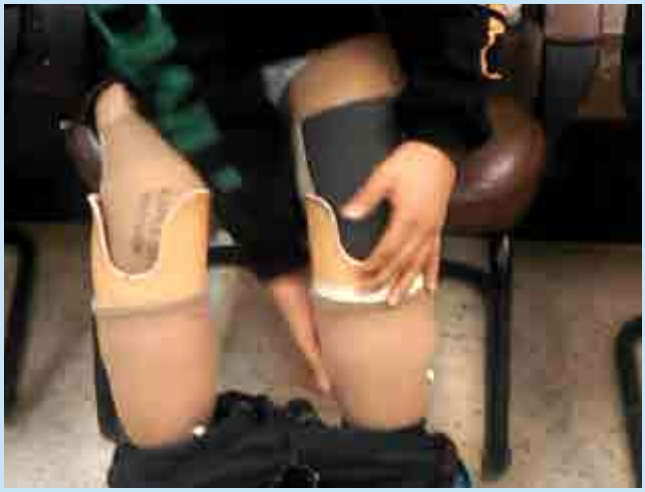
Physiotherapy services were provided to 3,778 patients through six physiotherapy units in the West Bank and to 11,181 patients through eleven units in Gaza and to 427 patients through one unit in Jordan. The patients received 33,733 sessions through 11 physiotherapists in the West Bank, 152,048 sessions through 43 physiotherapists in Gaza and 3,843 sessions through one physiotherapist in Jordan.

These units provided a wide range of physiotherapy and rehabilitation services including manual treatment, heat therapy, electro therapy, and gymnastic therapy with an outreach programme using advanced equipment which exceeded 50 in number and facilitated providing therapeutic exercise, manipulation massage, functional training, hydrotherapy, electrotherapy and self-training.

The outcome of the treatment sessions provided at UNRWA physiotherapy units and through home visits in West Bank Field was the discharge of 82.0% of treated patients without any disability (full recovery) and 15.0% with mild disability. Only 3.0% 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 their daily lives, which will lead to more independence and self-reliance. Consequently, it will release the professional staff to devote more time for other patients.

Highlight from the Field: Syria

Limb loss as a result of the ongoing crisis in Syria has increased at a rate UNRWA physiotherapy services are not able to keep pace with. Artificial limbs are very expensive, and the majority of patients are unable to afford their cost. In November 2014, a contract with Al Saleh Establishment was created between the HD and RSS in order to provide needed artificial limbs and training on their use to patients in Syria. As of December 2014, 75 patients had received a new limb as a result of this contract. The majority of patients had lost their limbs as a result of a conflict-related injury, and lower limb loss was most common. 70% of recipient patients were male. The average period between referral and fitting the limb was five days.



Strategic Objective 2 – Maternal and Child 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, including counselling and provision of modern contraceptives, are available at all times to women accessing UNRWA health centres.

Services are also provided as an integral part of the maternal and child health services through preconception care, antenatal, post-natal care and growth monitoring of children under-five years of age. Family planning services will be further strengthened with the increased males' participation through the Family Health Team approach.

During 2014, similar to previous years, the demand for modern contraceptive methods continued to increase. A total of 23,101 new family planning users were enrolled in the Family Planning Programme. The Agency-wide total number of continuing users reached 146,469 representing an increase of 2.6% compared with 2013.

Table 6 - Utilization of UNRWA family planning services, 2014 (*No. of discontinuers/total no. of remaining FP users)

	Jordan	Lebanon	Syria	Gaza Strip	West Bank	Agency
New users	6,978	1,651	2,311	9705	2,465	23,101
Total continuing users at year end	39,747	14,243	6,210	61,674	24,595	146,469
Discontinuation rate (%)*	6.5	5.2	4.5	6.3	3.9	5.3

The distribution of family planning users according to contraceptive method remained stable. The intra-uterine device continued to be the most popular method (50.7% of the users) followed by oral contraceptive (25.0%), condoms (21.2%), injectable (2.7%), and spermicides (0.4%).

Couple-Years of Protection (CYP) is an output indicator used by UNRWA to estimate the number of clients (or couples) that were protected from pregnancy in a year by an UNRWA dispensed contraceptive. The contraceptives dispensed during 2014 through the Agency's family planning services provided 134, 798 CYP with variations between the Fields. The data shows that the CYP indicator increased in all Fields (see section III for data).

Preconception care

To achieve further reduction in infant and maternal mortality, UNRWA introduced a preconception care programme in 2011 as an important component of the maternal health care and fully integrated within the primary health care system. The aim of preconception care is to prepare women of reproductive age to enter pregnancy in an optimal health status.

The Preconception Care Programme (PCC) 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 mellitus, anaemia, oral health diseases, given folic acid supplementation to prevent congenital malformation - in particular neural tube defects - 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 2014, a total of 15,670 women had been enrolled in UNRWA's Preconception Care Programme representing an increase of 14.5% compared with 2013 (13,681). This increase can be attributed to a 2014 focus on increasing women's enrolment in the PCC programme, which was done through health awareness sessions on preconception care which targeted women who were attending a health centre for medical, dental and NCD consultations. Additionally, the expansion of FHT to the majority of health centres may have had an impact on enrolment, given the increased focus on family health and patient/family relationship.

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 to promote early detection and management of risk factors and complications. Pregnant women receive a comprehensive initial physical examination and 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 for individualized management. Iron and folic acid supplementation is provided to all pregnant women. In 2010, with a generous donation from the Japan International Cooperation Agency (JICA), UNRWA introduced the Maternal and Child (MCH) Handbook. The handbook 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.

Antenatal care coverage

During 2014, UNRWA primary health care facilities cared for 88,615 pregnant women which represented a coverage rate of 79.0% of all expected pregnancies among the served refugee population (Syria data is excluded for this indicator). The antenatal care coverage was calculated based on the expected number of pregnancies in the served refugee population.

Compared to the antenatal coverage in 2013, coverage in 2014 increased in Jordan and West Bank by 1.1% and 8.9%, respectively, while it decreased in Lebanon and Gaza by 7.5% and 1.9%, respectively. This significant decrease in Lebanon is mainly attributed to the increased number of expected pregnancies in 2014, due to an increased population served as a result of the Palestine Refugees from Syria in utilizing UNRWA health services.

In Syria, the utilization of antenatal care 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. Data collected in 2014 reflects a 30.4% coverage rate, and is included in the Agency-average.

Table 7 - UNRWA antenatal care coverage, 2014

	Jordan	Lebanon	Syria	Gaza Strip	West Bank	Agency
Served population	1,218,979	331,461	422,664	1,227,156	475,600	3,676,060
Expected No. of pregnancies[1]	34,131	6,629	11,840	45,282	14,316	112,198
Newly registered pregnancies	26,634	5,165	3,600	39,546	13,670	88,615
ANC Coverage (%)	78.0	77.9	30.4	87.3	95.5	79.0

Registration for antenatal care in the 1st trimester

Early registration facilitates timely detection and management of risk factors and complications, thus improving the likelihood of positive outcomes for the mother and the baby. The proportion of pregnant women who registered during the 1st trimester of pregnancy in 2014 was 79.7%, while it was 18.2% 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

A key objective of the maternal health care programme is to ensure that women register for antenatal care as early as possible in pregnancy to allow ample time for risk identification follow up and management, and to meet the WHO recommended standard of at least four antenatal visits during the course of pregnancy. The average number of antenatal care visits per client decreased from 6.6 in 2013 to 5.7 in 2014, probably as a result of changes in UNRWA's technical guidelines in 2009/10. In an effort to rationalise care, the frequency of antenatal follow-up appointments for normal pregnancies was reduced from every four weeks to every six weeks.

Analysis of the 2014 data reveals that the Agency-wide percentage of pregnant women who paid ≥ 4 antenatal visits was 86.8%. The highest was in Gaza at 91.7% and the lowest was in Syria at 59.7%. The decrease in utilization in Syria is mainly due to accessibility problem caused by the prevailing security constraints, as well as inconsistent data collection.

Table 8 - Number of antenatal care visits during 2014

Indicator	Jordan	Lebanon	Syria	Gaza Strip	West Bank	Agency
% of pregnant women with four antenatal visits or more	83.1	89.4	59.7	91.7	81.5	86.8
Average number of antenatal visits per pregnant women	4.9	6.8	4.7	6.4	5.1	5.7

Tetanus Immunisation Coverage

Results of the annual rapid assessment survey of antenatal records for 2014 showed that 99.9% of registered pregnant women were adequately immunized against tetanus. As a result of the optimal immunisation coverage maintained, 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, and those with specific health conditions or risk factors that necessitate special care (39.0% in UNRWA). UNRWA currently uses a risk scoring classification based on three risk categories (high, alert, low). During 2014, and Agency-wide, 12.1% of women were classified as high risk, while 26.9% 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.

[1]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).

Diabetes mellitus and hypertension in pregnancy

Pregnant women are screened regularly for diabetes mellitus and hypertension all through pregnancy. Agency-wide, during 2014, the prevalence of diabetes mellitus during pregnancy (pre-existing and gestational) was 3.6% compared to 5.0% in 2013, with wide variation between fields. The lowest rate was 1.4% in Syria and the highest rate was 6.3% in West Bank. Globally the reported rates of gestational diabetes range from 2% to 10% of pregnancies (excluding pre-existing DM) depending on the population studied and the diagnostic tests and criteria employed[2]. Whereas some fields achieved the expected detection rate of DM, some did not. Therefore, efforts need to be exerted to improve the detection rate. The prevalence of hypertension during pregnancy (including pre-existing and pregnancy-induced hypertension was 8.0% in 2014, the lowest rate was 2.5% in Syria and the highest rate was 10.0% in Gaza.

Delivery Care

Place of delivery

UNRWA subsidizes hospital delivery for pregnant women classified as high-risk. During 2014, 99.9% of all reported deliveries Agency-wide took place in hospitals, while home deliveries represented 0.1%.

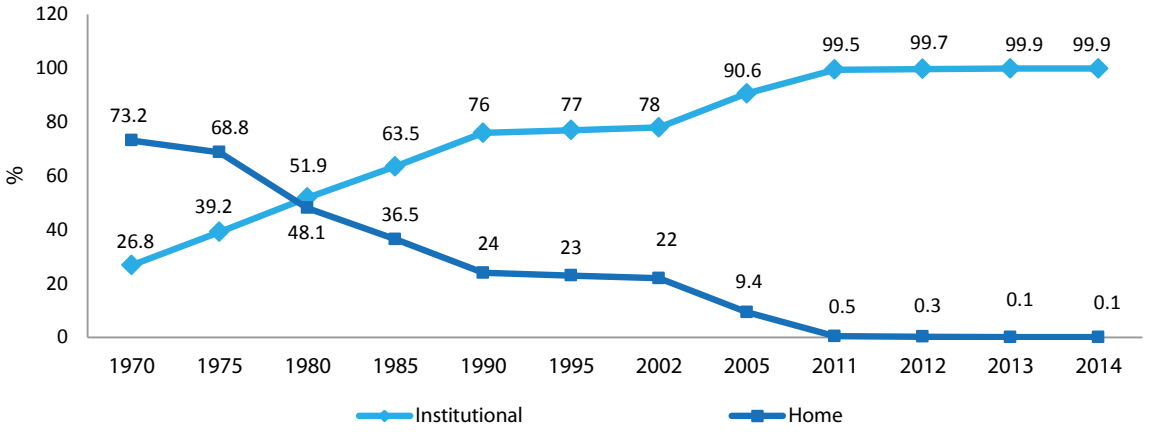


Figure 10 - Trends (%) of home versus institutional deliveries, 1970 -2014

Caesarean sections

The proportion of deliveries by caesarean section among Palestine refugees served by UNRWA was 22.4% during 2014, compared to 18.9% during 2013. The substantial variation among Fields may reflect a combination of client preference and prevailing medical practice. Globally, there is a wide variation among regions and countries, however, worldwide caesarean section rates are estimated at 33%[3] .

Table 9 - Caesarean section rate among UNRWA reported deliveries, 2013 -2014

Field	Total deliveries 2014	Caesarean section rate	
		% 2013	% 2014
Jordan	24,045	21.7	24.7
Lebanon	4,482	34.0	44.6
Syria	2,415	NA	34.0
Gaza Strip	37,592	13.6	17.4
West Bank	12,785	22.9	22.5
Agency	81,319	18.9	22.4

[2]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.

[3]Villar J, Valladares E, et al. Caesarean delivery rates and pregnancy outcomes: the 2005 WHO global survey on maternal and perinatal health in Latin America. The Lancet 2006; 367:1819-1825.

Monitoring the outcome of pregnancy

In 2002, UNRWA established a registration system (based on the expected date of delivery) to track the outcome of each pregnant woman in each health facility. During 2014, the total number of pregnant women who were expected to deliver was 87,012. Of those, 81,043 were delivered, 5,702 resulted in miscarriages or abortions and the outcome of only 267 pregnant women (0.31%) remained 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 was reported from Syria (7.1%). This could be attributed to the prevailing security constraints; health staff couldn't track and ascertain the outcome of pregnancy of registered women in the antenatal care due to the mobility of people to seek safe places inside and outside the country.

Monitoring maternal deaths

During 2014, a total of 18 maternal deaths were reported in four Fields (Jordan, Lebanon, the West Bank and Gaza). This is equivalent to an overall maternal death ratio of 22.0 per 100,000 births among women registered with UNRWA antenatal services. UNRWA health staff conducts a thorough assessment following each reported maternal death using a standardized verbal autopsy questionnaire. Five women died during pregnancy and thirteen deaths occurred in the post-natal period. Seventeen women died in hospitals while one died at home. The main reported cause of death was haemorrhage in five cases (27.8%), heart disease in four cases (22.2%), pulmonary embolism in three cases (16.7%), septicaemia in two cases (11.1%), acute respiratory distress syndrome in one case (5.6%), pre-eclampsia in one case (5.6%), severe anaemia in one case (5.6%) and cancer in one case (5.6%). The majority of these deaths could have been prevented.

Globally, the common medical causes for maternal death include bleeding, high blood pressure, prolonged and obstructed labour, infections and unsafe abortions.

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 and counselling on family planning, breast feeding and newborn care. Of the 81,897 pregnant women who delivered live births during 2014, a total of 75,947 women received post-natal care within six weeks of delivery, representing a coverage rate of 92.7%.[4] The highest rate was 99.1% in Gaza and lowest rate was 84.5% in West Bank.

Child Health Services

UNRWA provides care for children across the phases of the lifecycle, with specific interventions to meet the health needs of newborns, infants under-one year of age, children one to five years of age and school-aged children.

Both preventive and curative care is provided, with a special emphasis on prevention. Services include newborn assessment, 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

Before 2010, UNRWA registered only children up to the age of three years, however for the past five years has been maintaining a system of registration for children up to five years of age. This system enables the follow-up of children who have missed important appointments, for services such as immunisation, growth monitoring, and screening. During 2014, a total of 302,484 children below five years (60 months) were registered at UNRWA primary health care facilities.

[4]Postnatal coverage calculated based on WHO definition

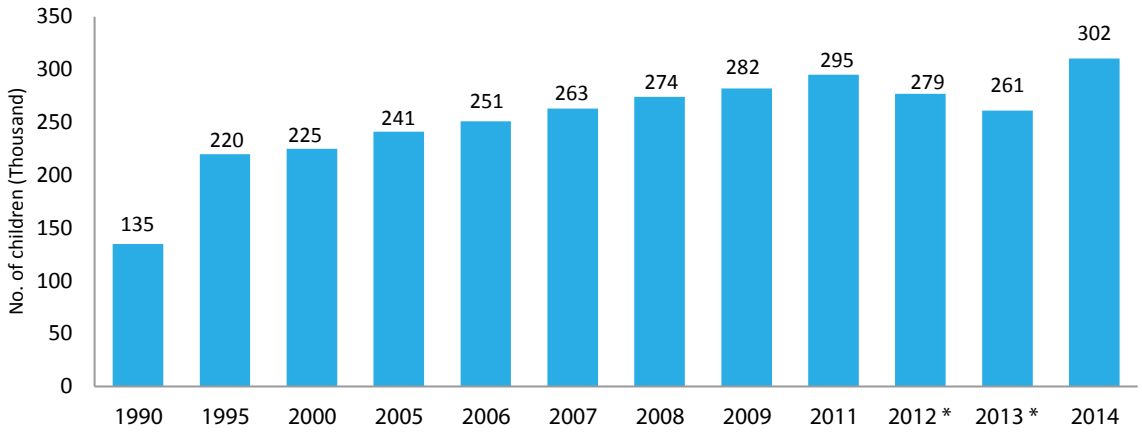


Figure 11 - Children 0-5 years registered at UNR WA health centres, 1990 -2014 (* Data not available for Syria)

Child care coverage

During 2014, UNRWA primary health care facilities cared for 302,484 children and children below one year, a coverage rate of 75.2% 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 and Syria. The expected number of children is calculated based on the crude birth rates in host countries.

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. Immunisation coverage is assessed annually through a review of a sample of records. The percentages of children aged 12 months and 18 months who have received all required vaccines among the served population in the Five Fields were 98.9% and 98.9%, respectively. In Syria, the immunization coverage for children aged 12 months and 18 months among the served population was 88.0% and 94.0%, respectively. This decrease in coverage in Syria is likely due to accessibility problems caused by the prevailing security concerns.

Growth monitoring and nutritional surveillance

Growth and nutritional status of under-five children is monitored at regular intervals through UNRWA health services. Breast-feeding is promoted and mothers are counselled on infant and child nutrition, including the appropriate use of complementary feeding and micronutrient supplements. A new electronic growth monitoring system based on the revised WHO growth monitoring standards, was integrated into e-Health. The system documents the four main growth and nutrition related problems among under-five children: underweight, wasting, stunting and obesity. UNRWA's documentation system is currently under transition to the new system, with different Fields at different stages of implementation. At the end of 2014, the incidence rate of under-weight Agency-wide was 1.6%, while the prevalence rate was 2.9%. There was no disparity between girls and boys. At the end of 2014, the prevalence reported rate from Four Fields (Jordan, Lebanon, Gaza and West Bank) for under-weight was 2.9%, stunting was 3.9%, wasting was 1.8% and the overweight/obesity rate was 2.3%.

Surveillance of Infant and Child Mortality

Cross-sectional survey: Measuring infant and neonatal mortality in Lebanon, Jordan the West Bank and Gaza

UNRWA has periodically monitored the infant mortality rate (IMR) and neonatal mortality rate (NMR) among Palestine refugees to guide future strategic approaches aimed at improving mortality rates. From 2013-2014, such an evaluation was conducted to estimate IMR and NMR and to assess the main causes and risk factors of infant death. As in former surveys, the preceding-birth technique survey was used, in which mothers with more than one child who came to HCs to register their last-born child for immunization were asked if their preceding child was alive or dead. This indirect method for estimating IMR is a valuable tool in populations with a high fertility rate and short birth intervals. Since the use of newborn immunization services is high (above 95% for more than two decades, Agency-wide, the IMR estimation can be considered representative of the total population served by UNRWA. The survey was conducted in all 115 UNRWA Health Centres (HCs) in Gaza, West Bank, Jordan and Lebanon. Enrolment of respondents started July 2013 and ended in May 2014 when the target sample size (10,812) was reached in all fields.

A total of 10,894 multiparous mothers were interviewed, and information was collected on 10,951 preceding children. The mean age of last-born child at registration was 16.7 (±21.4) days, the mean number of pregnancies was 4.3 (±2.2), and the mean birth-interval was 37.4 (±24.5) months. The reference year of survey rates was 2011, based on the following formula: start of the study – 0.67 x mean birth interval + mean age of the newborn child at registration (in months).

Table 10 -Infant and neonatal mortality rates among Palestine refugees, survey conducted in 2013

	Gaza	West Bank	Lebanon	Jordan	All fields
IMR per 1000 live births	22.4	11.9	15.0	20.0	18.0
NMR per 1000 live births	20.3	7.8	11.1	13.3	13.7

The main results are presented here, but for details we refer to the UNRWA Infant Mortality Report (in progress). In Gaza, there was a slight increase of IMR and a significant increase of NMR when compared to the survey conducted in 2008. In Lebanon and the West Bank, IMR decreased according to MDG4 target. In Jordan, IMR and NMR declined only marginally. The main causes of the 181 infant deaths reported by mothers Agency-wide were: preterm birth (44.0%), congenital malformations or metabolic disorders (27.0%), infection (16.0%), birth complications (6.0%), and sudden infant death syndrome (6.0%). Risk factors for infant death were: less maternal education, high number of pregnancies, alert and high-risk pregnancies, consanguinity, birth interval <24 months, preterm birth and low birth weight.

The rise of IMR and NMR in Gaza is multifactorial, and may include social, cultural and economic factors, as well as possible deterioration of quality of health services in hospitals due to the longstanding blockade. Some of these aspects are beyond the capacity of UNRWA's Department of Health. Reassessment of mortality rates in Gaza in 2015 is planned to supplement our findings and to further assess what is needed to reverse this trend. Throughout 2015, evaluations of current family planning services will take place to identify if these services are successful in reducing "too early, too late, too many and too close" pregnancies, which are commonly considered to be risk factors for maternal and infant mortality. Current antenatal care services provided by UNRWA should also be evaluated to identify if services for alert- and high-risk pregnancies need improvement.

School Health

During the school year 2013/14, a total of 476,443 pupils were enrolled in UNRWA schools. Collaboration between the UNRWA Health and Education Departments continued through meetings of school health committees, training of health tutors and provision of screening materials and first aid supplies.

UNRWA's existing School Health Programme consists of a number of health services provided in cooperation between the Health and Education Departments. The health services provided are: new

school entrants medical examination, immunizations, hearing and vision screening, dental screening, de-worming and vitamin A supplementation. Additionally, the School Health Programme follows up on children with special health needs and conducts school environment and canteen inspection.
As a result of the School Health Programme activities during 2014, a total of 6,165 students were referred to UNRWA health facilities for further care, and an additional 6,262 were referred for specialist assessment. Furthermore, 9,315 students were assisted with the cost of eyeglasses, and 190 received assistance for the cost of hearing aids.

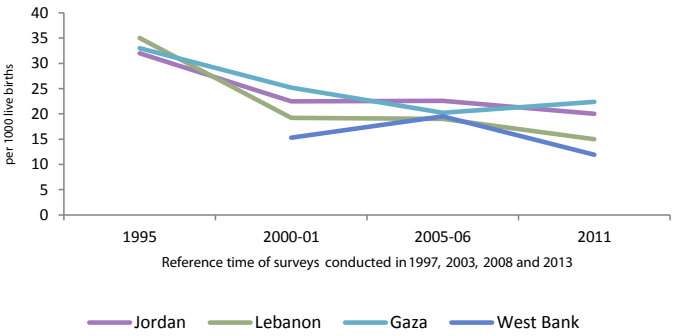


Figure 12 - Infant mortality rates of previous and current UNRWA surveys

New school entrants medical examination

During the school year 2013/14, UNRWA schools registered 56,283 new entrants. They received a thorough medical examination, immunization and follow-up. Morbidity conditions detected among new students included: dental caries (15.5%), vision defects (5.8%), heart disease (0.9%), bronchial asthma (0.9%) and type 1 diabetes mellitus (0.1%). Health problems related to personal hygiene remain present at low levels: pediculosis was found in 2.2% and scabies in 0.3% of new entrants. Children with disabilities were assisted towards provision of eyeglasses, hearing aids and other prosthetic devices according to their condition and available resources.

Screening

UNRWA screening activities during the school year 2013/14 targeted pupils in the 4th and 7th grades in all Fields and involved assessment for vision and hearing impairment and for oral health problems.

Among 4th grade students, 53,142 were screened, achieving 95.7% coverage rate. The main morbidity conditions detected were vision defects (10.3%) and hearing impairment (0.5%). Among students in the 7th grade, 47,057 were screened, with 95.4% coverage rate. The main morbidities were again vision defects (12.6%) and hearing impairment (0.5%).

Oral health screening

Oral health screening is conducted for 1st, 7th and 9th grade students in all Fields, and for 4th grade students in the West Bank. A total of 77,945 students were screened at different grade levels. 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 teeth brushing campaigns. In Gaza Strip 29,633 students in the 1st grade were screened with 100% coverage rate. Pit and fissure sealant application achieved 51.5% coverage rate. Improvement in oral health screening for school children is the result of the reorientation of the Oral Health Programme towards a preventive approach and investment in staff training on this concept.

Children with special health needs

During the school year 2013/2014, a total of 3,843 school children were identified with special health needs. Of these, 986 students were affected by type 1 diabetes mellitus, 474 had heart disease, 443 showed behavioural problems, 492 had asthma and 155 were living with epilepsy. These children receive 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 host country requirements. During the school year 2013/2014, new entrants in all Fields received a booster dose of tetanus-diphtheria (DT/Td) immunisation. The Agency-wide coverage was 98.2%. Coverage of oral polio vaccine (OPV) for new entrants was 98.2%, and coverage of Td vaccination among 9th grade school children in the five Fields was 98.1%.

De-worming programme

In order to improve the health status of school children, UNRWA in accordance with WHO recommendations, maintains a de-worming programme for children enrolled at UNRWA schools. The de-worming programme targeted school children in 1st, 2nd and 3rd grade. During the 2013/14 school year, a high coverage was achieved.. In addition, health awareness campaigns were carried out to emphasize the importance of personal hygiene in preventing transmission at all schools.

During the school year 2013/14, UNRWA jointly with the Global Network for Neglected Tropical Diseases at the Sabin Vaccine Institute and Dubai Care continued implementation of 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 2013/2014 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

The burden of NCDs

The number of patients with Non-Communicable Diseases (NCDs) is increasing consistently by approximately 5.0% per year. This has resulted in both a greater workload for health centre staff and a financial challenge for the Agency. Patients 40 years of age and older represented 91.0% of all patients under NCD care in 2014, which is consistent with 2013's proportion. The percentage of male patients diagnosed with NCDs has been increasing steadily, from 25.0% in 2012, 38.0% in 2013 to 39.0% in 2014. Distribution by morbidity showed that 38.7% of patients have both hypertension and diabetes mellitus; 15.1% had diabetes mellitus only, and 44.7% had hypertension only. Data is only available for type I and II diabetes mellitus and hypertension. The number of patients with type I diabetes mellitus was 3,572 as of 31 December 2014, representing 1.6% of all NCD patients, and 2.8% of all patients with diabetes mellitus.

The expenditure on NCD drugs in 2014 was US$ 8.92 million, representing 51.0% of Category A drug costs (US$ 17.37 million), and representing 41% of total drug expenditure[5]. At the end of 2014, a total number of 231,127 patients with diabetes mellitus and/or hypertension were registered for UNRWA NCD services across the five Fields of UNRWA operations (Included NCD Palestinian refugees from Syria). The graph below shows the number of NCD patients during the period from 2004 to 2014, taking into consideration that data in 2012 and 2013 did not include Syria. During 2014, the Agency-wide prevalence of diagnosed patients with diabetes mellitus and hypertension of those who were 40 years of age and older was 10.5% and 15.9%, respectively. These rates are also consistent with 2013's prevalence.

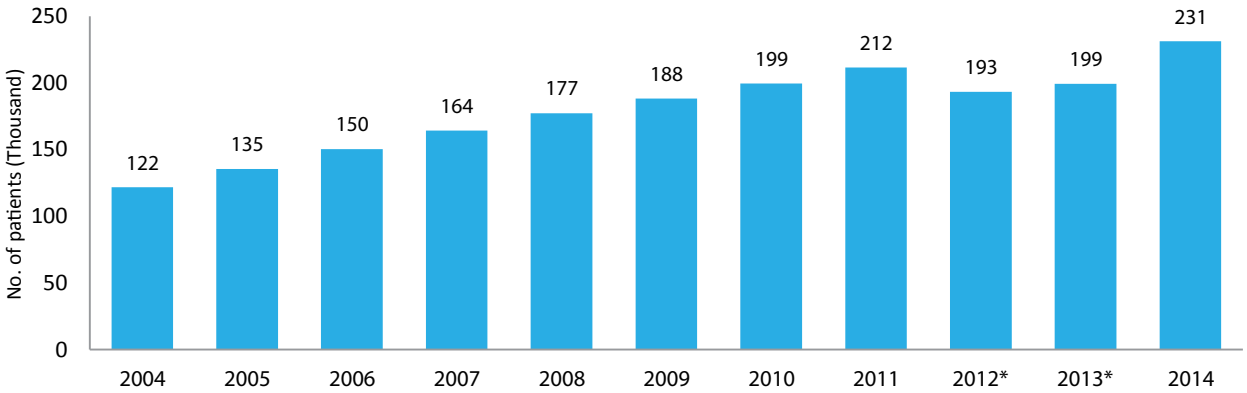


Figure 13 - Patients with diabetes mellitus and /or hypertension under care Agency-wide, 2000-2014 (*data not available from Syria)

[5]See Medicines & Medical Supplies section for drug cost calculations

Table 11- Patients with diabetes mellitus and/or hypertension by Field and by type of morbidity

Morbidity type	Jordan	Lebanon*	Syria	Gaza Strip	West Ban	Agency
Type I diabetes mellitus	1,223	288	263	1,122	676	3,572
Type II diabetes mellitus	11,269	3,055	2,667	11,974	5,923	34,888
Hypertension	30,169	14,480	10,004	33,945	14,723	103,321
Diabetes mellitus & hypertension	30,896	10,235	7,276	24,392	16,547	89,346
Total	73,557	28,058	20,210	71,433	37,869	231,127

(* PRS data is included)

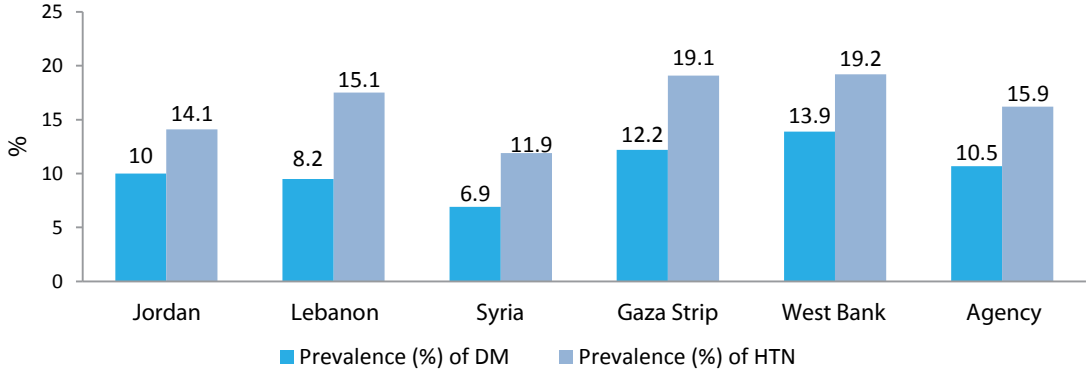


Figure 14 - Prevalence (%) of patients diagnosed with type I and II diabetes mellitus and hypertension among served population ≥40 years of age, 2014

Risk scoring

A risk assessment 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. The score helps health staff to manage a patient according to their risk score and to refer the patients for specialist care if necessary. All patients registered at the NCD programme at an UNRWA health centre were assessed using risk scoring during 2014. The risk scoring assessment revealed that 27.0% of patients with hypertension, 26.6% of patients with both diabetes mellitus and hypertension, and 14.1% of patients with type II diabetes mellitus were considered to be high risk. This represented an average of 24.3% among all NCD patients who were considered to be high risk in 2014.

Treatment

Although all Fields should implement the same guidelines for NCD case management, there were significant variations in relation to the management of patients with type II diabetes mellitus and hypertension, which can be attributed to Medical Officer judgement and differences in case management. Additionally, technical instructions – currently under revision – do not meet the most recent updates in management of hypertension, mainly the priority for using antihypertensive drugs. New technical instructions will reflect these updates. The highest percentage of non-pharmacological treatment among hypertensive patients was 7.0% in Lebanon, 5.0% in Gaza and 1.0% in each of Jordan, Syria and the 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. The proportion ranged from 18.5% in Syria, to 21.2% in Lebanon, followed by 32.3% in West Bank, and 33.0% in Gaza. The highest range was 34.4% in Jordan, which represented an average of 30.9% Agency wide.

The control status of post prandial plasma glucose (PPG) levels was at 49.7% among patients with type II diabetes mellitus and 46.0% among patients with type I diabetes mellitus based on the last three assessments (when two PPG readings from the last three visits are less than or equal to 180mg/dl), while the control rate was higher reaching 66.9% among patients with hypertension (when two blood pressure readings of the last three visits pending the last is less than 140/90). These measurements cannot, however, reflect the control status over time. UNRWA has been using HbA1c testing in all health centres in the West Bank since 2011. This method is able to provide information on blood glucose levels over the preceding three months, thus providing a more accurate view of the control status of patients with diabetes mellitus. Hba1c is planned for Agency-wide implementation in 2016, as well as the introduction of microalbuminuria test.

As mentioned earlier, and following the health centre clinical audit during 2012[6], UNRWA's Department of Health, in cooperation with World Diabetes Foundation (WDF), conducted diabetes campaigns in 62 (30 during 2013 and 32 during 2014) health centres in Gaza, Jordan, Lebanon and West Bank. Results are presented in Section I.

Table 12 - Patients with DMI&II only, 2014

	Jordan	Lebanon	Syria	Gaza Strip	West Bank	Agency
Lifestyle Control Only No. (%)	493 (4)	261 (8)	27 (1)	540 (4)	125 (2)	1446 (4)
Insulin Only No. (%)	2239 (18)	417 (12)	347 (12)	2137(16)	1215 (18)	6355 (17)

Table 13 - Patients with hypertension only, 2014

	Jordan	Lebanon	Syria	Gaza Strip	West Bank	Agency
Lifestyle Control Only No. (%)	452 (1)	1059 (7)	82 (1)	1694 (5)	127 (1)	3414 (3)
Antihypertensive Agents Only (%)	29,194 (97%)	13,416 (93)	99,22 (99)	32,251 (95)	14,595 (99)	99,378 (96)

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 2014, the records of 10.0% of all registered NCD patients were analysed for the presence of late complications through a rapid assessment. The rapid assessment technique is used to determine the indicators among NCD patients that impact late complication rates (risk factors such as obesity, smoking and control status). The NCD files are selected randomly from each health centre and analysed to come up with health centre, Field, and Agency-wide indicators.

Of the 10.0% of cases analysed, late complications were reported in 9.1% of the NCD patients Agency-wide, while it was 9.6% in 2013. Patients with both diabetes mellitus and hypertension had the highest incidence of late complications of 13.9%, followed by patients with hypertension only at 6.9%, and patients with diabetes mellitus only at 4.9%. There were some differences found in the distribution of late complications of diseases between the Fields. These variations can be attributed in part to following lifestyle advice, enforcement of the appointment system and proper case management, as well as Medical Officer variations in treatment mentioned previously.

Defaulters

Defaulters are defined as patients who did not attend the health centre for NCD care at all during a calendar year, neither for follow-up, nor for collection of medicines (in person or via relatives for those unable to travel to the HC). To reach patients who miss follow-up appointments, health staff use all means possible, including home visits, telephone calls and notifications via family members.

[6]2012 clinical audit of diabetes care among Palestine refugees

The Agency-wide rate of defaulter NCD patients was 6.0% (12,022 patients) in 2014, which is higher than the 5.7% recorded in 2013. The Field-specific defaulter rate ranged from a low of 4.3% in Gaza to a high of 6.8% in Lebanon. Jordan's defaulter rate was 6.5 %, while the West Bank was 5.8%. Defaulters in Syria Field were not reported for 2014, though the continued conflict and displacement of patients has likely led to an increased defaulter rate.

During 2013 and 2014, UNRWA, in collaboration with the World Diabetes Foundation, embarked on a diabetes campaign titled "Life is Sweeter with Less Sugar." The campaign was conducted in a total of 30 health centres agency-wide; eight in Jordan, the West Bank and the Gaza Strip and six in Lebanon with a total of 1,300 participants, respectively. The campaign consisted of education, cooking and exercise sessions conducted in UNRWA health centres and schools and local partner facilities. Of the 1,174 participants who completed all six months of the campaign agency-wide, 33% lost ≤3% of their weight, and 16% lost ≥5%. BMI and waist-height ratio was reduced among both genders and improvements were seen in both 2hrPPG and cholesterol. UNRWA hopes to continue implementing this campaign on a broader scale in the coming year.

The campaign also included an outreach screening programme. The total number of patients screened outside UNRWA health centres in 2013 was 31,340 patients. 31,000 patients were targeted to be screened in 2014. The total percentage of screened individuals with abnormal blood sugar and high blood pressure readings in 2013 were at 11.0% and 10.8% respectively; 2014 readings totals are currently under analysis. Those individuals confirmed with diabetes and high blood pressure were 4.4% and 6.5% respectively. Those who were confirmed to have both high blood sugar and high blood pressure were 3.1% and 1.6% respectively.

Case fatality

A total of 3,442 (1.7%) of UNRWA's NCD patients were reported to have died during 2014; deaths may, however, be under-reported. Patients with co-morbidities (hypertension and diabetes mellitus) comprised 56.0% of all deaths, while patients with only hypertension represented 33% and those with only diabetes mellitus 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 raising the awareness among refuges on risk factors for diabetes mellitus and hypertension. Outreach campaigns were conducted in four Fields (Gaza, Jordan, Lebanon and West Bank during campaigns) during 2014 as well as in 2013 and a total of 31,000 persons were screened for diabetes mellitus and/or hypertension. The use of an e-Health-based cohort monitoring system is helping in the improvement of the quality of NCD care in UNRWA health centres. It allows for comprehensive monitoring of NCD care, including incidence, prevalence, treatment compliance and control status of patients. The system has been featured in an international peer-review journal[7] [8]and also by the Lancet.[9] It is now integrated in monitoring the NCD care – now integrated into the FHT approach – at health centres that implement e-Health. Furthermore, UNRWA is in the final stages of updating the guidelines and technical instructions, which will be finalized and distributed by the end of 2015.

[7]Khader A et al., Cohort monitoring of persons with diabetes mellitus in a primary healthcare clinic for Palestine refugees in Jordan. Trop Med Int Health. 2012 Oct 11. (also in accompanying CD-Rom with hard copy of report)

[8]Cohort monitoring of persons with hypertension: an illustrated example from a primary healthcare clinic for Palestine refugees in Jordan. Khader A, et al. Trop Med Int Health. 2012 Sep;17(9):1163-70 (also in accompanying CD-Rom with hard copy of report)

[9]Cohort reporting improves hypertension care for refugees. Mullins J. Lancet. 2012 Aug 11; 380(9841):552

UNRWA will continue to explore options to introduce life-saving lipid-lowering agents into the UNRWA essential drugs list. In 2015/2016, statins and the Primary Essential Package (PEN) scoring system will be introduced for around 13.0% of high risk NCD patients according to WHO experts' recommendations. The PEN scoring system will allow the Department of Health to follow one standardized criteria for prescription of statins to NCD patients Agency-wide. UNRWA as well will continue to strengthen partnership with host authorities and other potential stakeholders to explore the means to improve the quality of NCD care.

As a result of the positive outcomes demonstrated during the two rounds of diabetes campaigns, the Department of Health will work to integrate elements of the campaign into daily health centre activities, specifically:

- Encouraging behaviour change of both patients and staff through:
  a. Conducting health awareness sessions in the waiting room during rush hour periods
  b. Improving health education and consultation quality for those in special groups (i.e. patients with type I diabetes mellitus and late complications) through special group sessions held during the slower afternoon hours
  c. training of nurses on proper diabetes care through the Micro-Clinic-UNRWA project
- Improve NCD prevention and outreach outside of the health centres through awareness sessions in collaboration with NGOs, the local community and other UNRWA installations

In 2015, a joint project was launched with Micro-Clinic International (MCI), supported by World Diabetes Foundation. The project aims to scale up UNRWA and the Micro-Clinic's models for diabetes prevention and management within the Palestine refugee population, through training of nursing staff at all UNRWA health centres.

While smoking within health centres has been prohibited for years, the prohibition has not specifically extended to the surrounding premises. In 2014, Jordan Field's Talbeih Health Centre became the first UNRWA health centre to become 100% smoke free, meaning smoking is allowed neither in the building, nor within the gates. Expansion of this initiative is planned throughout the Five Fields.

Communicable Diseases

Prevention and control of communicable diseases in 2014 did not face big challenges, no cases of polio or other emerging diseases were reported among Palestine refugees, UNRWA continued its cooperation with host authorities and WHO, and participated in immunisation campaigns for polio, in all Fields, 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, UNRWA also collaborated with host authorities for laboratory surveillance of HIV/AIDS and other communicable diseases that require advanced laboratory investigations which cannot be performed by UNRWA facilities.

Ebola Virus Disease (EVD)

An outbreak of Ebola Virus Disease (EVD) in some countries in the western part of Africa occurred in 2014. While the spread to surrounding countries was minimal, UNRWA – as a part of the regional and global efforts to control EVD, and in coordination with WHO and host countries – issued general staff circulars and distributed WHO posters on how to prevent transmission, and to recognize symptoms. The posters were circulated to all Fields and UNRWA installations. Medical officers were given updated case definitions, diagnostic criteria and information on prevention of the disease.

Communicable diseases during the conflict in Gaza, July – August 2014

During the 2014 conflict in Gaza, EPI and surveillance of communicable diseases and diseases related to personal hygiene and sanitation were given priority in the shelters. A daily monitoring and reporting system was in place with close supervision and regular feedback to headquarters. UNRWA reports indicated an increase in the number of diarrheal disease, scabies and lice infections. However, no outbreaks were identified, despite an increase in cases.

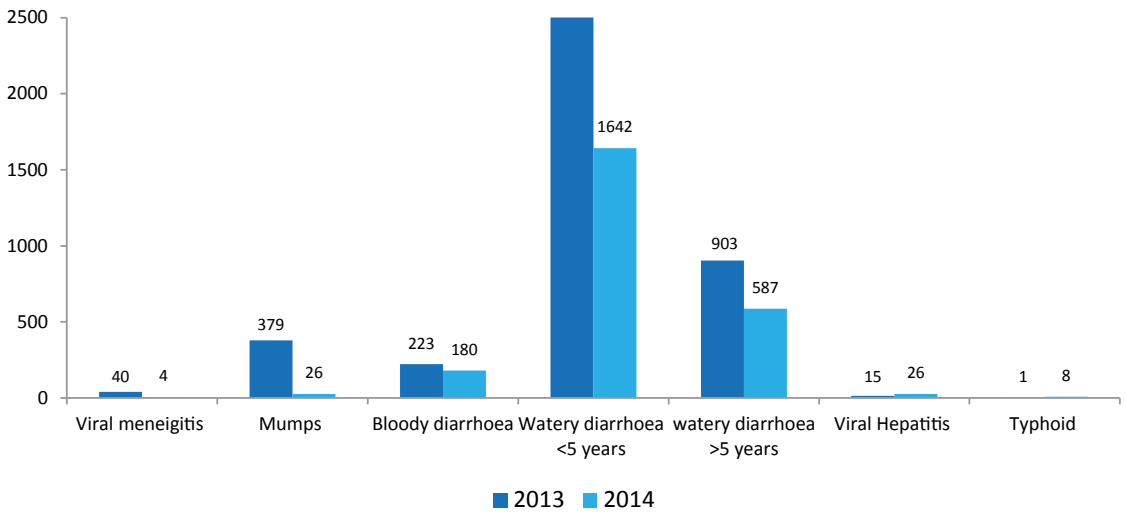


Figure 15 - Reported diseases in Gaza during the 50 days of conflict, 7 July - 26 August, 2014 in comparison with with the similar period in 2013

Expanded Programme on Immunisation (EPI): vaccine-preventable diseases

In each Field, UNRWA's immunisation services are linked to the host country's Expanded Programme on Immunisation (EPI). Agency-wide immunisation coverage, for both 12 month old and 18 month old children registered with UNRWA, continued to be above WHO target of 95.0% in all Fields. Factors contributing to UNRWA's success in immunisation coverage include a consistent supply of vaccines, the enforcement of an appointment system for vaccination, and continuous follow-up of defaulters by health centre staff. Although polio was confirmed among Syrians in different parts of the country, no confirmed cases of polio were reported among Palestine refugees. In addition, no cases of tetanus or diphtheria were reported during 2014.

Other communicable diseases

Viral hepatitis

The Agency-wide incidence of suspected cases of viral hepatitis (mainly hepatitis A) continued to increase, from to 33.0 per 100,000 population in 2013 to 38.5 per 100,000 population in 2014. The highest increase during 2014 was reported by Syria at 154.4 per 100,000 population; this increase is attributable to the difficult and non-hygienic living conditions of the Palestine refugees in Syria.

Lebanon's incidence was 49.5 per 100,000 population in 2014, while Gaza's was 44.4 per 100,000 population, which can be attributed to the low quality of water and poor hygienic conditions for PRS. This issue needs to be addressed and to be reflected in the promotion of good hygiene practices in schools and homes.

Typhoid fever

The Agency-wide incidence of suspected typhoid fever cases increased from 4.6 per 100,000 in 2013 to 5.5 per 100,000 population in 2014. No cases were confirmed. The highest and main incidence was observed in Syria (36.7 per 100,000 population) which is also explained by poor quality of water and hygienic conditions in addition to very difficult environmental conditions caused by on-going armed conflict and displacement of refugees. Jordan and West Bank Fields reported no cases as in 2013.

Tuberculosis

Reported cases of tuberculosis increased to 48 in 2014, compared with 23 reported in 2013. Syria Field reported 26 cases in 2014 compared to six cases in 2013. Reasons for the drop in cases in Syria may be explained by improved patients' improved access to UNRWA HCs and better follow up and detection. Lebanon had 18 reported cases, while both Gaza and West Bank had two.

Jordan had zero reported cases. Of the 48 reported cases, 20 cases were smear-positive, four were smear-negative and 24 were extra pulmonary. Syria reported only 16, Lebanon reported 7 and the West Bank reported one.

With the exception of Syria, detection rates in all Fields remain below the WHO target of 70.0% of the expected number of cases for the country. Patients diagnosed with tuberculosis are managed through national tuberculosis programmes using the directly observed treatment, short course (DOTS) strategy. During 2014, except for Syria where 3 patients could not be followed up, the cure rates of 100% were achieved for UNRWA patients, two patients in Lebanon and one in Syria died of different reasons rather than TB after cure.

Brucellosis

During 2014 out of 156 total cases, 146 were reported from Syria, eight in West Bank and one case in each of Jordan and Lebanon. Gaza had no reported cases.

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, human resources and gender mainstreaming.

Nutrition

During 2014, the Department of Health has produced number of nutritional interactive educational materials, namely, five flip charts that address five different topics of diabetes care (1) general information about the disease and insulin treatment, (2) late complications of diabetes mellitus, (3) foot care, (4) risk factors of diabetes and its prevention, and (5) nutrition therapy for patients with diabetes mellitus. Each of the flip charts is meant to provide the most important key messages about diabetes care management, and are to be used by the health staff at our HCs as an educational tool during individual and/or group counselling sessions. A series of educational magnets were produced to educate mothers of anaemic children about the different sources of iron in food, enhancers of iron absorption, and inhibitors of iron absorption.

Highlight from the Field: West Bank

A recent survey of 2000 school aged children in the West Bank indicated that one in 10 children is anemic, one in 17 is stunted, and one in four children skip breakfast, resulting in short term hunger. Around 12% of school children are overweight and 5% are obese. Poor eating habits are enforced in schools, where more than 70% of products sold in school canteens are of low nutritional value.

In 2014, funded by Mitsubishi, the HD, in conjunction with Education and RSS, launched the "Healthy Canteen" project in three schools in the Jordan Valley, West Bank: Aqbat Jaber Girls' School, Aqbat Jaber Boys' School and the Ein-Sultan CoEd School. The project aimed at improving the availability of good quality, diversified and affordable nutritious foods at school canteens, enhancing students', teachers' and parents' knowledge of an engagement in making nutritious and healthy lifestyle choices.

Disability Care

Disability is a crosscutting issue relevant to the work of all UNRWA Programmes. UNRWA adopts the definition of disability 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 2014, disability awareness was addressed among staff through a variety of activities related

to incorporating disability awareness within all UNRWA operations. Current Health Programme initiatives relating to disability take a comprehensive approach, addressing physical, mental, and social aspects. There is a strong focus on the prevention of disability, including family planning services, growth monitoring, immunization, disease prevention and control, early detection and screening services. Folic Acid supplementations are prescribed for mothers in the pre-conception period, which can help prevent certain birth defects, such as neural tube defects. The Health Programme also implements a number of specific interventions related to disability care. UNRWA health centres record data on children under the age of five years who have permanent physical or mental impairments such as hypothyroidism and phenylketonuria in order to facilitate appropriate medical follow-up.

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 Department of Health to cover the cost of prosthetic devices. During 2014, 162 students received assistance to cover the cost of hearing aids.

While UNRWA physiotherapy centres (operating in Gaza and the West Bank) and Community Mental Health Programme do not specifically target persons with disabilities, however, it is recognized that a significant proportion of the beneficiaries of these services are likely to be considered "persons with disabilities" under the definition contained in the UNRWA Disability Policy.

Laboratory and Radiology Services

Comprehensive laboratory services were provided in 119 of 137 health facilities. Of the remaining 18 facilities, 15 continued to provide basic laboratory support (blood glucose, blood haemoglobin and urine tests by dipstick) through competent nursing staff using basic laboratory equipment. The remaining three are in Syria Field, and not currently functioning, due to the ongoing conflict.

Utilization trend

The number of tests performed in 2014 increased from 4.56 to 4.84 million. The increase of tests was 38.8% in Syria, 7.6% in Lebanon, 7.5% in West Bank, 3.8% in Jordan and 3.4% in Gaza Field. The remarkable increase of 38.8% in Syria is due establishing new health points providing laboratory services in Damascus Training Centre, Jdaidah, Rukn/Addin and Qudsaia. The slight increase in Lebanon is due to providing laboratory services to Palestine Refugees from Syria. The increase in the remaining three Fields is due to natural population growth.

Periodic self-evaluation

The annual comparative study of workloads and efficiency of the laboratory services was carried out based on 2014 data as part of UNRWA's periodic self-evaluation of the programmes using the WHO approach for workload measurement. The productivity target ranges from 45 to 55 WLUs/hour. The productivity was 48.4 in Jordan, 37.2 in Lebanon, 66.7 in Gaza, 61.2 in the West Bank and 41.2 in Syria.

Laboratory costs

The overall cost of laboratory services provided by UNRWA is US$ 6.3 million, out of which US$ 4.86 million (76.9%) were secured through General Fund and US$ 1.46 million (23.1%) through in-kind donations, projects or emergency funds. The cost of laboratory services continued to be far below the rates of the host countries for equivalent services at (US$ 19.1 million). This suggests that UNRWA's experience in integrating laboratory services into its primary health care activities remains very cost-efficient vis-a-vis referring patients to external services.

Table 14 - Expenditure on laboratory services US$

Cost	Jordan	Lebanon	Syria	Gaza Strip	West Bank	Agency
GF	1,265,028	736,790	429,115	802,956	1,632,498	4,866,387
Non-GF	149,028	129,355	194,529	525,197	463,011	1,461,120
Total	1,414,056	866,145	623,466	1,328,153	2,095,509	6,327,507

Table 15 - Comparative analysis on annual cost of laboratory services performed at UNRWA facilities and cost of same services if outsourced to host authorities (USD), 2014

Cost	Jordan	Lebanon	Syria	Gaza Strip	West Bank	Agency
Public	3,413,000	1,324,248	694,027	9,255,243	4,376,161	19,062,679
UNRWA	1,441,056	866,145	623,666	1,328,153	2,095,509	6,327,507

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:

- Training courses and in-service training for newly recruited laboratory technicians were conducted in all Fields according to a standard training package
- Implementation of internal quality control system at all UNRWA laboratories and for all tests
- Implementation of External Quality Assurance System (EQAS) at all UNRWA laboratories in Jordan, Gaza and in some laboratories in Syria. It was not implemented in Lebanon Field due to logistical problems
- Conducting an annual assessment of the trends in utilization and productivity of laboratory services at health centre level in each Field as part of self-internal assessment policy according to UNRWA standard assessment protocol
- Conducting annual assessment of the laboratory services according to standard checklist by Field Laboratory Services Officers
- Conducting quarterly follow up checklist assessment on laboratory services by the Senior Medical Officer or Medical Officer in-charge
- On-going checking of the quality of laboratory supplies in coordination with relevant staff at the procurement division
- Arrangements were made with the public health laboratories of the host countries with respect to referral of patients or samples for surveillance of diseases of public health importance

Radiology services

UNRWA operates 19 radiology units (seven units each in Gaza and the West Bank, four in Lebanon and one in Jordan). These units provide plain x-ray services to patients attending the health centres. Other plain x-rays and specific types of diagnostic radiology services such as mammography, urography, ultrasounds, etc... are provided through different contractual agreements with hospitals and private radiology clinics to patients, to newly recruited UNRWA staff, during periodic medical examinations of UNRWA local staff and as part of medical board examinations.

During 2014, radiology services included: 101,114 X-rays to 95,026 patients. Out of those, 81,012 were plain X-rays to 74,924 patients through UNRWA X-ray facilities. 20,102 X-rays for 20,102 patients were conducted at contracted X-ray facilities.

Medicines and Medical Supplies

Total expenditure

In 2014, the total value of medical supplies and equipment from all funds (General Fund, in-kind contributions and emergency appeals) was approximately US$ 23.09 million, representing a slight decrease compared with 2013 (US$ 23.74 million).

In 2014, the average expenditure Agency-wide on

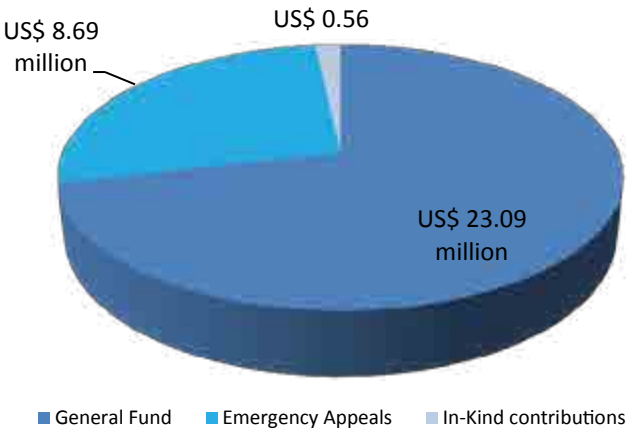


Figure 16 - Total value of medical supplies and equipment, 2014

medical supplies per outpatient medical consultation was US$ 2.44, representing a slight decrease over 2013 (US$ 2.56). The average annual expenditure on medical supplies per served refugee was US$ 6.28 Agency-wide, compared with US$ 7.3 in 2013. The high cost per served refugee in Lebanon (US$ 9.92) is due to the necessity of frequent local procurement of drugs, at a higher cost, as a result of stock ruptures.

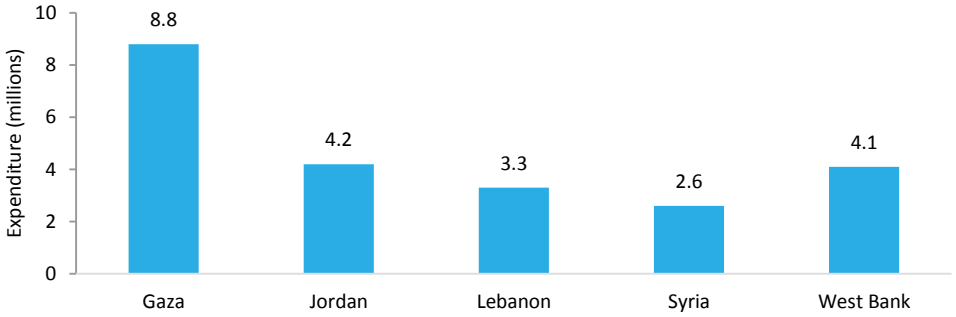


Figure 17 - Expenditure on medicines by Field 2014

Table 16- Average medical products expenditure (USD) for medical supplies per outpatient medical consultation and per served refugee, 2014

	Jordan	Lebanon	Syria	Gaza Strip	West Bank	Agency
Expenditure (US$) for medical supplies per medical consultations	2.46	2.58	2.63	2.12	3.14	2.44
Expenditure (US$) for medical supplies per served refugee	3.48	9.92	6.13	7.24	8.55	6.28

Expenditure on medicines

The total expenditure on medicines in 2014 was US$ 21.63 million. ABC costing analysis is an inventory control method by which items are grouped according to annual cost, in an attempt to identify the small number of items (20%) that will account for the majority of the cost (80%) and which are therefore most important to control for effective inventory management. Those accounting for 80% of the cost are classified as Category A, while those comprising 15% of the cost are classified as Category B. The remaining 5% are classified as Category C drugs. ABC analysis for Category A drugs revealed 51.0% was spent on medicines for the treatment of NCDs (31.0% for diabetes mellitus, 20.0% for cardiovascular diseases, 9% for antihypertensive) and 17.0% on antibiotics.

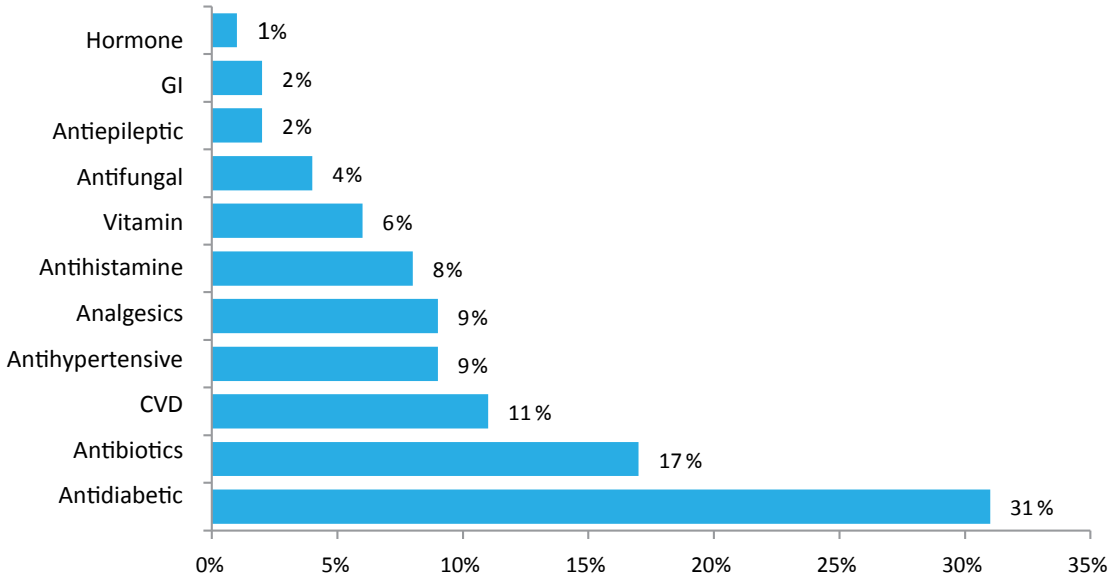


Figure 18- Proportion expenditure on medicines per therapeutic group

During 2014, medical equipment and related supplies accounted for 9.0% (US$ 2.11 million) of the total expenditure for medical supplies (US$ 23.09 million). The expenditure on medical equipment from all funds was US$ 1.89 million and includes all service contracts and maintenance.

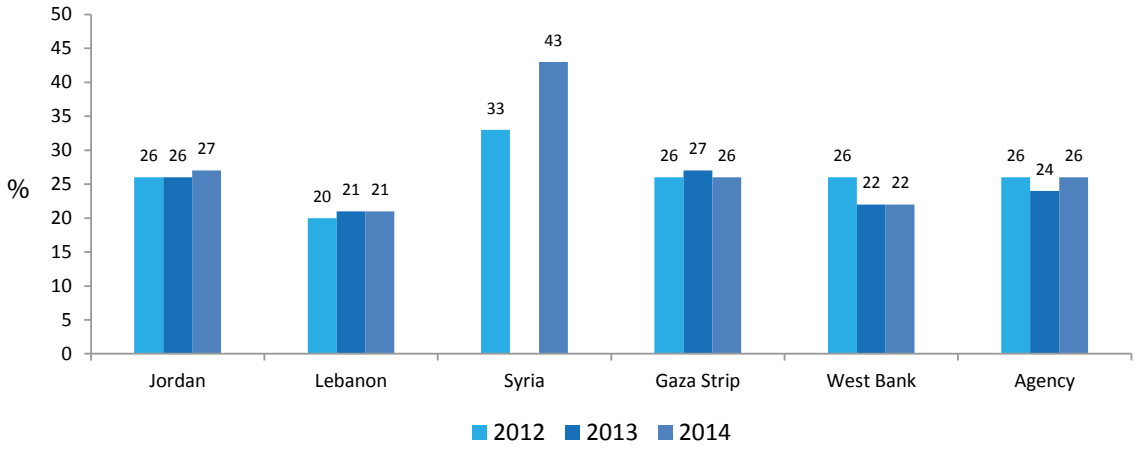


Figure 19 - Antibiotic prescription rate (%) by Field, 2012 – 2014 (Syria data n/a for 2013)

Antibiotic prescription rate

UNRWA aims for an antibiotic prescription rate below 25.0% in line with WHO recommendations. Antibiotic prescription rates ranged from 21.0% in Lebanon to 43.0% in Syria in 2014. It is worth mentioning that in Syria Field the rate increased tremendously in 2014 compared to 2012 (33.0%), due to the ongoing conflict and where the need for antibiotics to manage the increased cases of infections has increased.

Donations of medical supplies

In 2014, UNRWA received in-kind donations of medical supplies (medicines, medical equipment and others) equivalent to US$ 8.69 million, of which Gaza Field received 31.0%, followed by Syria (28.0%), Lebanon (25.0%), Jordan (10.0%), and West Bank (6.0%). The following medicines and consumables were donated during 2014:

- The Ministry of Health of the Palestinian Authority and UNFPA provided the West Bank and Gaza Fields with vaccines, iron drops and tablets as well as disposable syringes, needles and modern contraceptives
- The Ministry of Health in Jordan provided UNRWA with vaccines and contraceptives
- UNICEF and the NGO Health Care Society provided Lebanon Field with vaccines, medications, disposable syringes and needles
- Syria's Ministry of Health and UNICEF provided Syria Field with vaccines, tuberculosis treatment and other miscellaneous drugs.

Health Communication

A variety of health communication activities were conducted in 2014 to inform and promote the health of Palestine refugees both individually, and at community levels, and to support their enjoyment of a long and healthy life. Effective communication modalities to advocate for the achievements of the Department of Health were implemented. Several visits to UNRWA facilities by external delegates from different countries and interests were coordinated and conducted successfully.

Major Activities

- The participation of UNRWA in the Lancet Palestinians Health Alliance (LPHA) yearly conference was coordinated by the communications officer. A total of nine abstracts were accepted for presentation, including three oral presentations and six posters.
- During the Annual Meeting 2014, a press release and launching activity for the Diabetes Audit Report, along with 10 short videos on healthy lifestyles was held in the presence of the Deputy Commissioner-General.
- Advocacy materials were produced and distributed at two major global health related meetings: the Geneva Health Forum and the World Health Assembly.
- Several conferences were attended locally and regionally on tobacco use and NCDs. In addition, the Global Youth Tobacco Survey (GYTS) 2013/2014 was implemented in the fields and results were received for analysis and reporting. Two surveys about smoking among health staff at all HCs in Jordan and another for HQ staff were also conducted.
- Several Department of Health key documents were produced and distribute widely including the 2013 Annual Report, the Diabetes Mellitus Audit Report 2013, and The Qalqilya Hospital and Hospitalisation audit.

Educational Materials

- Innovative packages and educational materials for the DM campaigns were produced and distributed to health centres and patients participating in the DM campaign.
- A complied set of videos was produced for the fields to be displayed at health centres with TV/ DVD players.
- The observation of the World Days relevant to health – including World Health Day, World Diabetes Day, World No Tobacco Day and World AIDS Day – were successfully organized, with excellent participation by staff at UNRWA HQ and field offices, in addition to Palestine refugees attending UNRWA HCs and schools.
- Two videos about UNRWA health services, requested by The Spanish Committee for UNRWA (UNRWAce), were prepared. In addition, one video and four posters about youth smoking were produced in collaboration with the Education department to be used at UNRWA schools.
  Partnerships
- Channels for collaboration with King Hussein Cancer Centre in Jordan and the American University of Beirut in Lebanon on tobacco use were strengthened.

Human Resources

Health staffing review

The Commissioner-General approved changes to the grading of 16 health posts starting January 2014: Health Centre Clerk, Practical Nurse, Senior Practical Nurse, Midwife, Assistant Pharmacist and Laboratory Technician with Bachelor Degrees, 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, Deputy Field Nursing Officer and Area Nursing Officer. In January 2015, the changes in the grading for Medical Officers were approved. The aim of these post actions was to align health staff functions with the health reform objectives, and to ensure consistency and fairness to staff functioning with similar qualification requirements.

Training and Capacity Building:

Training and capacity building of health staff is the main stay in any health system, especially in the revolution of evidence based medicine and the rapid development and change in clinical sciences. This investment in the training and capacity building of available health staff is especially important in the face of a challenging local market, where finding replacement personnel is difficult.

In 2014, HQ staff, field office staff and health centre staff participated in a variety of training activities, ranging from professional development to skill acquisition and refresher courses. Examples of trainings in each field include:

- ***Headquarters:*** Tobacco Dependence Treatment, Intercultural Communication & Effective Management, Health Planning, Monitoring and Evaluation and PRINCE2 online courses on Practitioner Management
- ***Jordan:*** Training for medical officers on Family Health Team, maternal health care, rational drug use, disease surveillance, NCD treatment and management, and basic clinical skills. Nurses were given training on oral health care, dental treatment, micronutrient disorders and child growth indicators. In addition, two training courses were conducted in cooperation with the National Centre for Diabetes, Endocrine & Genetics, Jordan
- ***Syria:*** Training was conducted for the polio campaign, oral health, TB detection, Gender Based Violence, ethics and first aid.
- ***Gaza:*** Through its Mentoring Programme initiative, the field conducted in-service training on topics ranging from NCD, pharmacy and laboratory reports, FHT and dental daily workload, and stock management. Training was also given to medical officers on surveillance of infectious diseases.
- ***West Bank:*** Training on Family & Child Protection, comprehensive maternal health care services, FHT implementation, disability inclusion and External & Internal Quality Control.
- ***Lebanon:*** In conjunction with the American University of Beirut (AUB) select staff were trained on outbreak investigation and nutrition in emergencies while other key staff received training on Thalassemia and Sickle Cell anaemia

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 2014 to offer support to the Fields in the implementation of their prioritized interventions aimed at reducing gender gaps, particularly in the workforce. Efforts also addressed gender based violence (GBV) and focused on improving men's access to the pre-conception care and family planning.

Addressing the gender gap in the workforce

To address the gender gap in the workforce, the UNRWA Department of Health encouraged the recruitment of female staff while remaining mindful of the need for a competitive and transparent selection process. The percentage of women recruited within all categories and in all Fields varies from 30.8% in Jordan to 44.0% in Gaza. However, the staffing structure in UNRWA health centres, similar 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. For example, actions were taken to enhance the capacity of interview panels to carry out gender sensitive interviews. Advertised positions have been revised to adopt gender-neutral language. Male nurses appointments are encouraged and women are encouraged to apply for senior positions.

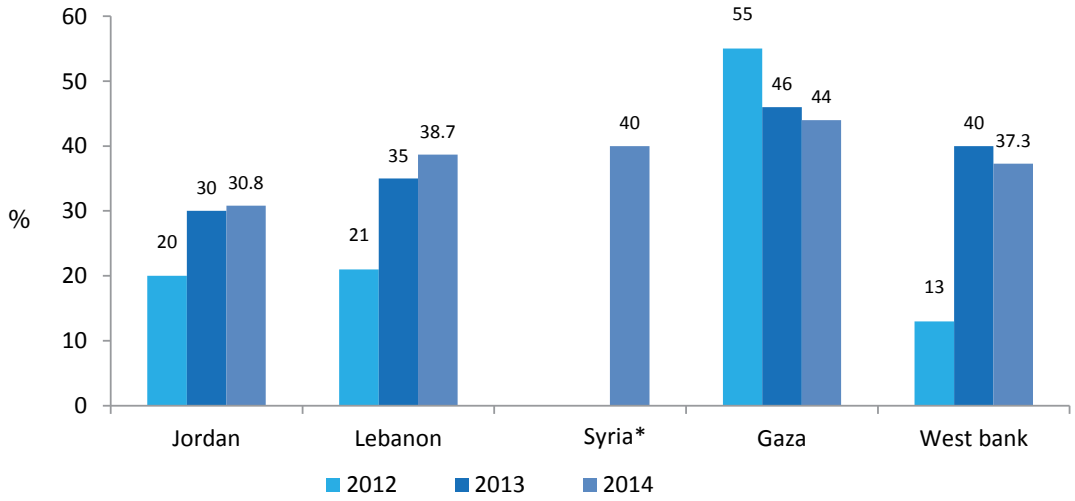


Figure 20 - Percentage of female medical officers at UNRWA health centres, 2012 -2014 (*Data N/A for 2012 and 2013)

Gender Based Violence (GBV)

In line with the international effort to combat GBV, in 2009, UNRWA systemized its work to address GBV and started building a referral system to increase survivors' access to services in each of the Five Fields. In 2014, the Department of Health developed protocols and technical guidelines on GBV to be implemented within the Agency to better systemize the detection and referral of GBV survivors by UNRWA health staff. These protocols and technical guidelines offer health-care providers evidence-based guidance on appropriate care, including clinical interventions and emotional support. They also seek to make healthcare providers and policy makers in UNRWA more aware of violence against women, and improve their capacity to respond.

Including men in family planning and preconception care

Through different Field Offices, the Department of Health continued their efforts to ensure the inclusion of men in preconception care and family planning by organizing community awareness and quarterly workshops for men. However, staff continue to report cultural obstacles as major challenges to involving men in pre-conception care. Nevertheless, in Gaza, 1,141 men participated in 2 awareness sessions and couple sessions during 2014. In Jordan, 212 out of 3,757 women newly enrolled in preconception care were counseled with husbands.

Section 3 – Data

Part 1 - Agency Wide Trends for Selected Indicators

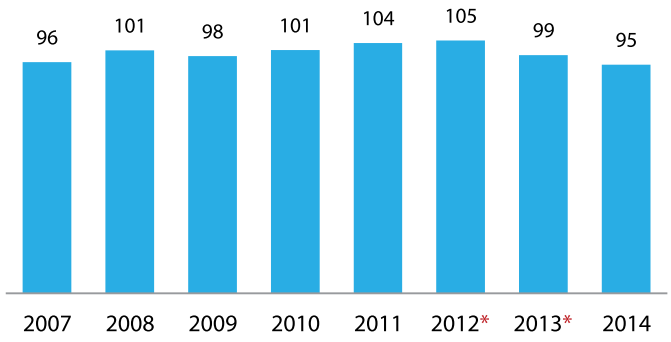


Figure 21- Average daily medical consultations per doctor

*Data from Syria is not included

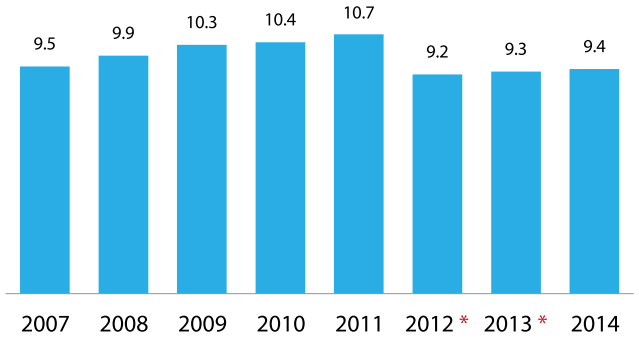


Figure 22- No. of outpatient consultations (million)

* Data from Syria is not included

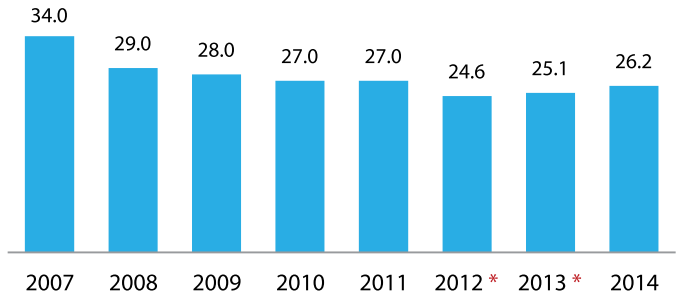


Figure 23- Antibiotics prescription rate (%)

* Data from Syria is not included

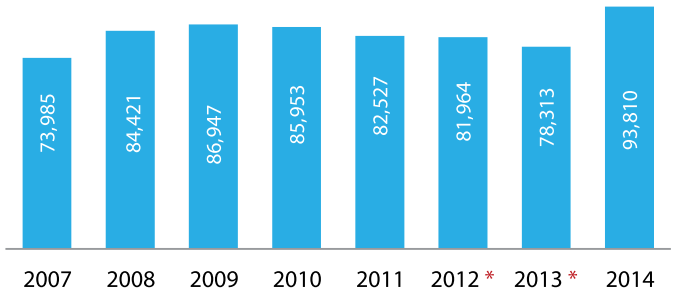


Figure 24- No. of hospital admissions (including Qalqilia hospital)

* Data from Syria is not included

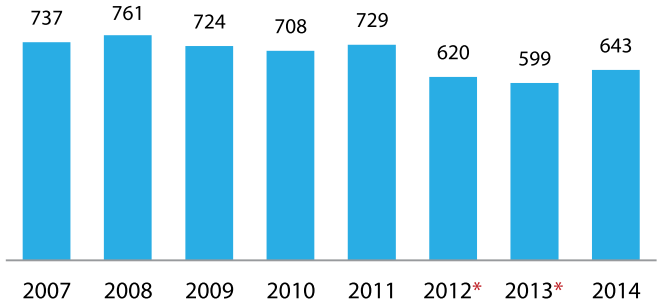


Figure 25- No. of dental consultations (thousand)

* Data from Syria is not included

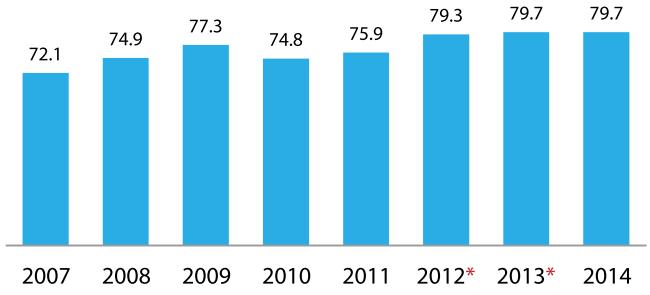


Figure 26- Percentage of pregnant women registered during the 1st trimester

* Data from Syria is not included

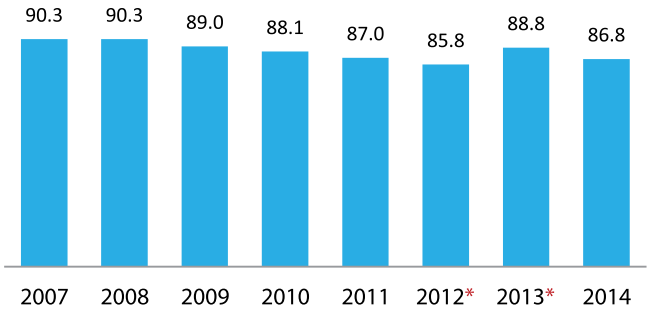


Figure 27- Percentage of pregnant women attending at least 4 ANC visit

* Data from Syria is not included

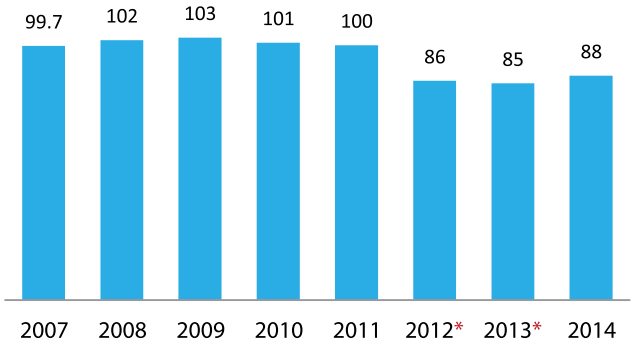


Figure 28- No. of newly registered pregnant women (thousand)

* Data from Syria is not included

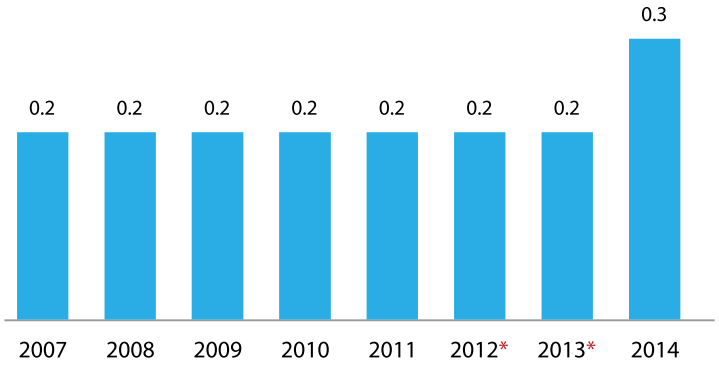


Figure 29- Percentage of deliveries with unknown outcome

* Data from Syria is not included

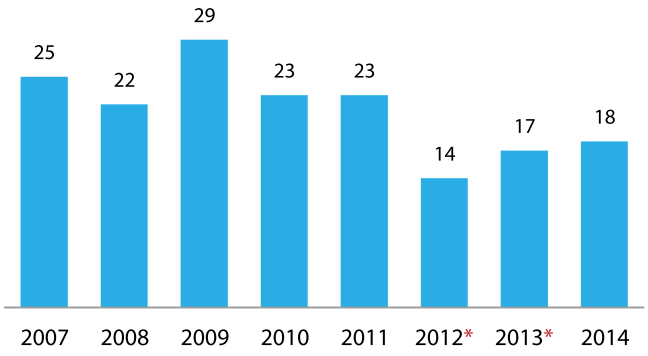


Figure 30- No. of maternal deaths

* Data from Syria is not included

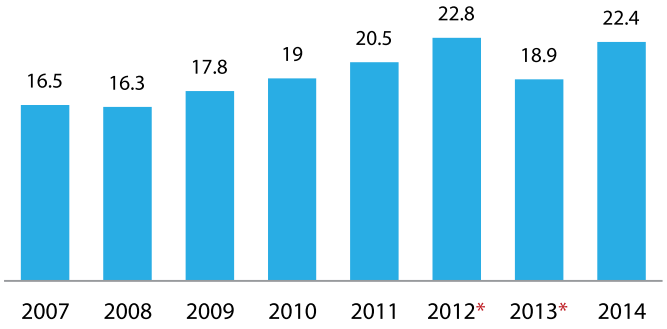


Figure 31- Percentage of caesarean section deliveries

* Data from Syria is not included

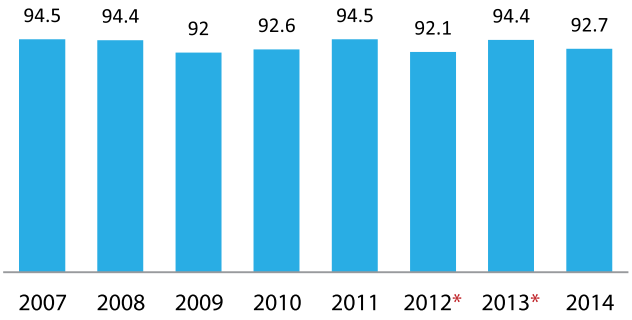


Figure 32- Percentage of women attending PNC within 6 weeks after delivery

* Data from Syria is not included

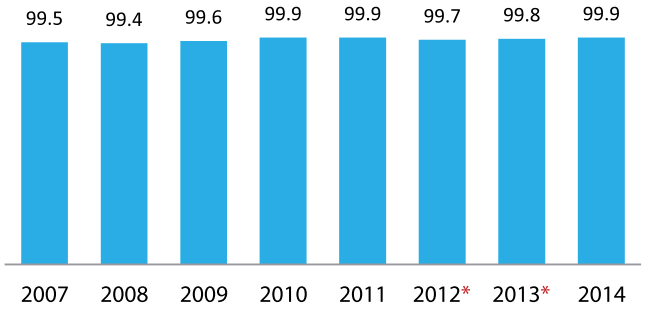


Figure 33 - Percentage of pregnant women protected against tetanus

* Data from Syria is not included

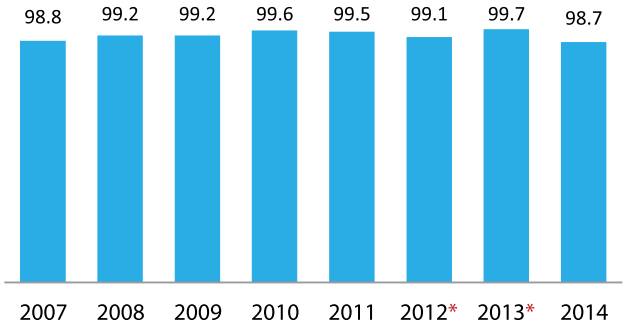


Figure 34 - Percentage of deliveries in health institutions

* Data from Syria is not included

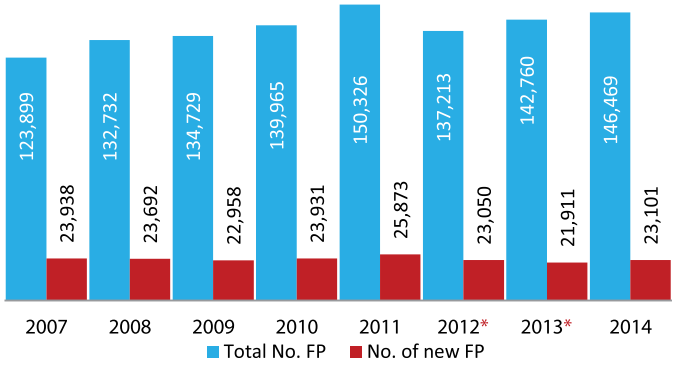


Figure 35- New & total no. of using modern family planning method

* Data from Syria is not included

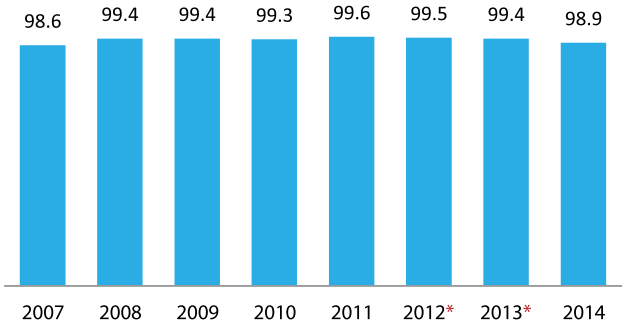


Figure 36 - % of children 18 months old received all booster doses of EPI vaccines

* Data from Syria is not included

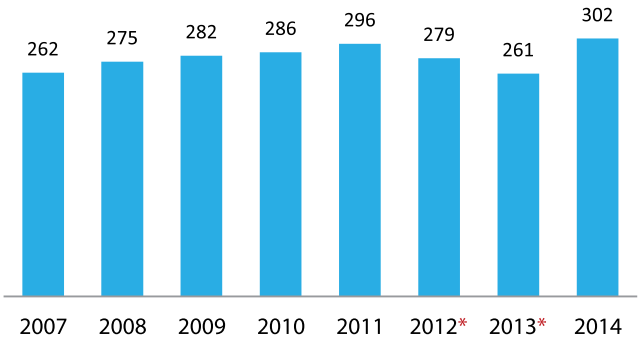


Figure 37- No. of children 0-5 years registered (thousand)

* Data from Syria is not included

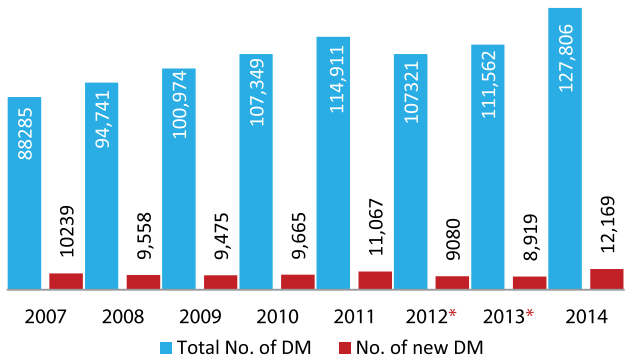


Figure 38 - New & total no. of patients with diabetes mellitus

* Data from Syria is not included

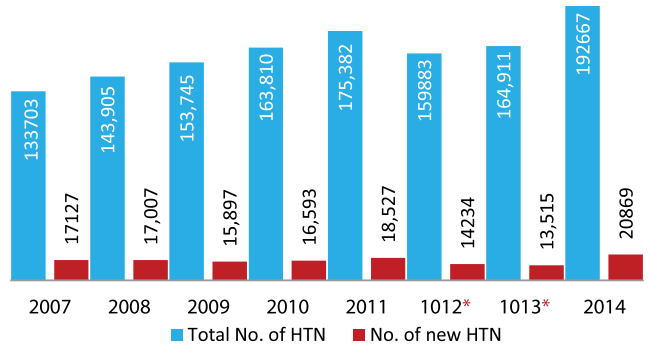


Figure 39- New & total no. of patients with hypertension

* Data from Syria is not included

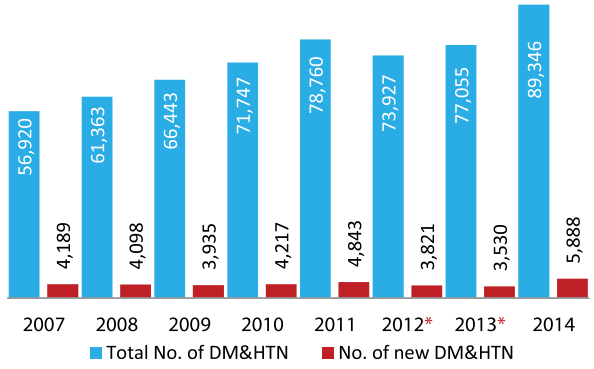


Figure 40- New & total no. of patients with diabetes mellitus & hypertension

* Data from Syria is not included

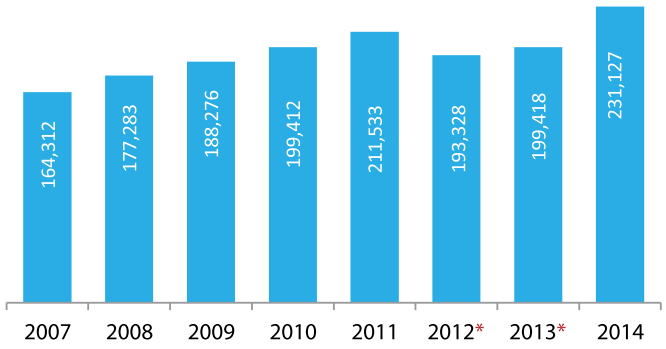


Figure 41- Total No. of all patients with diabetes mellitus and/ or hypertension

* Data from Syria is not included

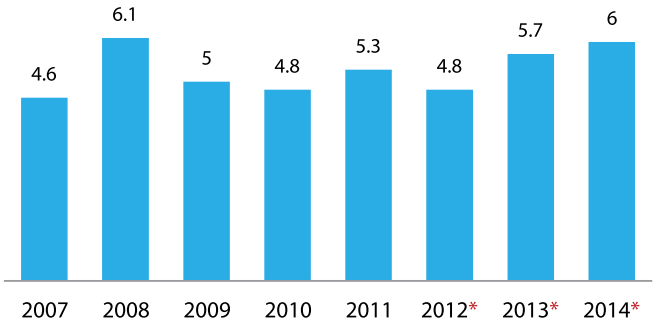


Figure 42- Percentage of NCD patients defaulters

* Data from Syria is not included

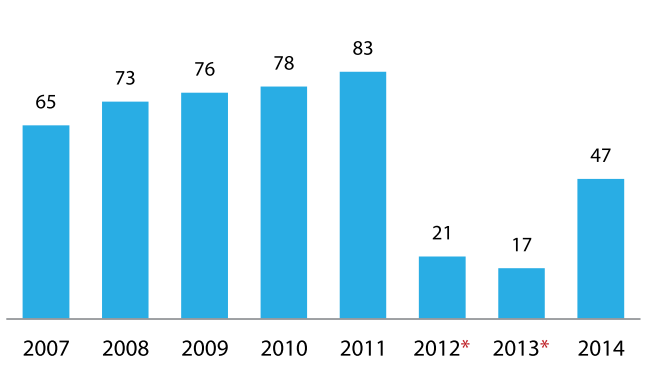


Figure 43- No. of new reported TB cases

* Data from Syria is not included

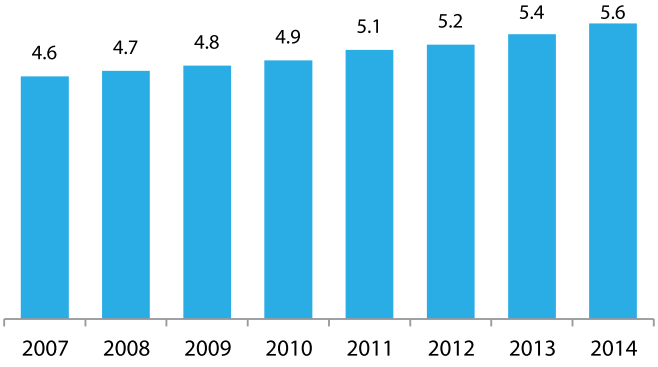


Figure 44- No. of registered populations (millions)

part 2- field implementation plans 2014/2015 indicator trends

Table 17 - Field Implementation Plan 2014/2015 - Indicator Trends: Jordan Field

SO	Indicator	2009	2010	2011	2012	2013	2014
Strategic Objective 1	Average daily medical consultations per doctor	96.2	101.0	96.2	87	81	84
	Antibiotics prescription rate (%)	33.1	29	26	26	26.4	26.5
	% Preventive dental consultations of total dental consultations	21.8	25.5	30.3	31.4	30.4	34.1
	% 4th grade school children identified with vision defect - male	11	11.2	13.6	11.9	13	10.4
	% 4th grade school children identified with vision defect - female	15.1	16.7	19.4	19.3	17.9	15.3
	No. of hospitalizations	24,114	19,859	16,069	14,481	12,908	21,902
	% Health centres implementing at least one E-health module	0	4.8	12.5	54.2	58	70
	% Health centres with no stock rupture of 15 tracer items (1)				93	100	100
	% Health centres with emergency preparedness plans in place (1)				_	100	100
Strategic Objective 2	% Pregnant women with at least 4 ANC visits	86.4	85.2	86.2	82.2	83.4	84.1
	% 18 month old children that received 2 doses of Vitamin A	98.9	98.6	98.9	99.0	98.8	98.2
	No. of women newly enrolled in preconception care programme (3)			3332	3267	3371	3,757
	% Women attending postnatal care within 6 weeks of delivery	85.7	87.5	88.0	83.5	87.8	86.3
	No. of continuing family planning acceptors	35,129	37,307	38,640	39,612	40,934	39,747
	%. of health centres with at least one staff member trained on detection and referral of GBV cases (1)				37.5	62.5	-
	Diphtheria and tetanus coverage among targeted students	100	99.6	97.8	98.1	95.3	100
Strategic Objective 3	% Target population ≥ 40 years screened for diabetes mellitus (1)				8.6	9.4	8
	% Patients with diabetes mellitus under control according to defined criteria (2)				27	52.8	45
	No. of new patients with diabetes mellitus	3,575	3,638	4,137	3,407	3,364	3,374
	Total no. of patients with diabetes mellitus	33,907	36,466	39,299	40,706	41,956	43,388
	No. of new patients with hypertension	5,749	5,533	6,544	5,082	4,805	5,171
	Total no. of patients with hypertension	49,531	52,794	56,480	57,940	59,150	61,065
	No. of new patients with diabetes mellitus & hypertension	1,643	1,591	1,919	1,506	1,466	1,435
	Total no. of patients with diabetes mellitus & hypertension	23,509	25,307	27,470	28,920	29,884	30,896
	No. of vaccine preventable disease outbreaks	0	0	0	0	0	0
	% Children 18 months old that received all booster doses of EPI vaccines	98.9	98.6	98.9	99.0	98.8	98.2
	No. of new TB cases detected	2	5	5	0	1	0

(1) New indicators starting 2012
(2) Criteria will change in 2012, according to (HbA1c clinical audit)
(3) PCC programme established in 2011

Table 18 - Field Implementation Plan 2014/15 - Indicator Trends: Lebanon Field

SO	Indicator	2009	2010	2011	2012	2013	2014
Strategic Objective 1	Average daily medical consultations per doctor	107.1	104.0	117.3	103	92	108
	Antimicrobial prescription rate (%)	19.9	20	20	20	20.8	20.9
	% Preventive dental consultations of total dental consultations	24.8	27.4	35	32	34.6	37.6
	% 4th grade school children identified with vision defect – male	11.9	12	12.6	9.9	10.4	13.3
	% 4th grade school children identified with vision defect female	15.2	12.3	9.9	13.2	10.3	13.1
	No. of hospitalizations	21,912	25,763	26,030	29,767	30,832	29,269
	% Health centres implementing at least one E-health module	100	100	100	100	100	100
	% Health centres with no stock rupture of 15 tracer items (1)				91.9	100	100
	% Health centres with emergency preparedness plans in place (1)				100	100	100
Strategic Objective 2	% Pregnant women with at least 4 ANC visits	93.2	92.3	90.9	86.2	90.7	89.4
	% 18 month old children that received 2 doses of Vitamin A	98.6	99	100	99.2	99.5	99.5
	No. of women newly enrolled in preconception care programme (3)			1,680	1,432	1,239	1,442
	% Women attending postnatal care within 6 weeks of delivery	96.6	95.1	97.0	97.5	98.3	97.6
	No. of continuing family planning acceptors	12,942	13,269	13,597	14,057	14,055	14,243
	% of health centres with at least one staff member trained on detection and referral of GBV cases (1)				25	100	100
	Diphtheria and tetanus coverage among targeted students	100	100	100	100	100	97.6
Strategic Objective 3	% Target population ≥ 40 years screened for diabetes mellitus (1)				9.8	8.6	11.3
	% Patients with diabetes under control according to defined criteria (2)				33.8	65	51.6
	No. of new patients with diabetes mellitus	671	735	729	569	645	1,108
	Total no. of patients with diabetes mellitus	9,529	10,070	10,965	11,218	11,255	13,578
	No. of new patients with hypertension	1,587	1,643	1,795	1,366	1,355	2,169
	Total no. of patients with hypertension	18,657	19,481	20,713	21,090	21,036	24,715
	No. of new patients with diabetes & hypertension	274	338	343	214	283	524
	Total no. of patients with diabetes & hypertension	7,106	7,594	8,437	8602	8,601	10,235
	No. of vaccine preventable disease outbreaks	0	0	0	0	0	0
	% Children 18 months old that received all booster doses of EPI vaccines	98.6	99	100	99.2	99.5	99.5
	No. of new TB cases detected	11	13	19	11	11	18

(1) New indicators starting 2012
(2) Criteria will change in 2012, according to (HbA1c clinical audit)
(3) PCC programme established in 2011

Table 19 - Field Implementation Plan 2014/15 - Indicator Trends: Syria Field

SO	Indicator	2009	2010	2011	2012	2013	2014
Strategic Objective 1	Average daily medical consultations per doctor	83.2	97.0	94.9	NA	NA	80
	Antimicrobial prescription rate (%)	27	30	31	33	NA	42.5
	% Preventive dental consultations of total dental consultations	32	41.3	40.9	NA	NA	33.8
	% 4th grade school children identified with vision defect – male	4.5	2.7	2.9	9.2	NA	4.1
	% 4th grade school children identified with vision defect female	4	2.6	2.5	11.9	NA	4.4
	No. of hospitalizations	9,963	8,543	6,926	4,580	NA	7,130
	% Health centres implementing at least one E-health module	0	0	0	0	NA	NA
	% Health centres with no stock rupture of 15 tracer items (1)				NA	NA	NA
	% Health centres with emergency preparedness plans in place (1)				NA	NA	NA
Strategic Objective 2	% Pregnant women with at least 4 ANC visits	86.5	79.5	78.5	76.6	NA	59.7
	% 18 month old children that received 2 doses of Vitamin A	99.5	99.4	99.9	NA	NA	NA
	No. of women newly enrolled in preconception care programme (3)			638	302	NA	150
	% Women attending postnatal care within 6 weeks of delivery	95.4	95.6	96.0	NA	NA	92.3
	No. of continuing family planning acceptors	18,751	18,778	19,313	8,436	NA	6,210
	No. of health centres with at least one staff member trained on detection and referral of GBV cases (1)				NA	NA	NA
	Diphtheria and tetanus coverage among targeted students	99.6	97.9	99.2	86.7	NA	78.4
Strategic Objective 3	% Target population ≥ 40 years screened for diabetes mellitus (1)				NA	NA	3
	% Patients with diabetes under control according to defined criteria (2)				NA	NA	48.1
	No. of new patients with diabetes mellitus	951	984	1,033	NA	NA	3,340
	Total no. of patients with diabetes mellitus	11,985	12,618	13,360	NA	NA	10,206
	No. of new patients with hypertension	1,710	1,977	2,066	NA	NA	5,770
	Total no. of patients with hypertension	19,878	21,045	22,351	NA	NA	17,280
	No. of new patients with diabetes & hypertension	392	440	452	NA	NA	2,264
	Total no. of patients with diabetes & hypertension	8,203	8,780	9,598	NA	NA	7,276
	No. of vaccine preventable disease outbreaks	0	0	0	NA	NA	0
	% Children 18 months old that received all booster doses of EPI vaccines	99.5	99.4	99.9	NA	NA	94
	No. of new TB cases detected	59	50	52	54	6	26

(1) New indicators starting 2012
(2) Criteria will change in 2012, according to (HbA1c clinical audit)
(3) PCC programme established in 2011

Table 20 - Field Implementation Plan 2014/15- Indicator Trends: Gaza Field

SO	Indicator	2009	2010	2011	2012	2013	2014
Strategic Objective 1	Average daily medical consultations per doctor	97.0	98.1	102.7	113	109	96
	Antimicrobial prescription rate (%)	25.7	26	25.2	26.0	26.9	25.9
	% Preventive dental consultations of total dental consultations	28.8	26.8	26.3	26.3	28.4	30.7
	% 4th grade school children identified with vision defect – male	16.3	12.9	12.1	12.6	7.7	7.7
	% 4th grade school children identified with vision defect female	18.1	18.2	17.8	16.4	13.1	13.1
	No. of hospitalizations	4,590	4,575	4,810	8,719	8,444	9,615
	% Health centres implementing at least one E-health module	0	0	0	32	52	71
	% Health centres with no stock rupture of 15 tracer items (1)				98.8	100	92
	% Health centres with emergency preparedness plans in place (1)				100	100	100
Strategic Objective 2	% Pregnant women with at least 4 ANC visits	93.6	93.7	92.5	93.5	93	91.7
	% 18 month old children that received 2 doses of Vitamin A	99.9	99.8	100.0	100	100	100
	No. of women newly enrolled in preconception care programme (3)			6,213	6,773	7,114	8,240
	% Women attending postnatal care within 6 weeks of delivery	97.4	98.7	99.2	99.3	99	99.1
	No. of continuing family planning acceptors	47,479	49,797	54,698	59,001	62,648	61,674
	%. of health centres with at least one staff member trained on detection and referral of GBV cases (1)				100	100	100
	Diphtheria and tetanus coverage among targeted students	99.9	99.8	100	100	100	100
Strategic Objective 3	% Target population ≥ 40 years screened for diabetes mellitus (1)				17.3	25.5	16.8
	% Patients with diabetes mellitus under control according to defined criteria (2)				29.5	42.5	46
	No. of new patients with diabetes mellitus	2,443	2,962	3,562	3,307	3,346	2,617
	Total no. of patients with diabetes mellitus	27,447	29,313	31,338	34,114	36,050	37,488
	No. of new patients with hypertension	4,273	5,460	5,770	5,646	4,997	5,139
	Total no. of patients with hypertension	41,298	44,988	48,551	52,485	55,114	58,337
	No. of new patients with diabetes mellitus & hypertension	844	1,304	1,496	1,514	1,196	970
	Total no. of patients with diabetes mellitus & hypertension	15,804	17,482	19,458	21,699	23,176	24,392
	No. of vaccine preventable disease outbreaks	0	0	0	0	0	0
	% Children 18 months old that received all booster doses of EPI vaccines	99.9	99.8	100.0	99.8	99.9	99.5
	No. of new TB cases detected	2	9	7	9	4	2

(1) New indicators starting 2012
(2) Criteria will change in 2012, according to (HbA1c clinicalaudit)
(3) PCC programme established in 2011

Table 21 - Field Implementation Plan 2014/15 - Indicator Trends: West Bank

SO	Indicator	2009	2010	2011	2012	2013	2014
Strategic Objective 1	Average daily medical consultations per doctor	109.0	105.5	103.6	107	116	111
	Antimicrobial prescription rate (%)	34	30	30	26.0	22.4	21.7
	% Preventive dental consultations of total dental consultations	12.7	19.5	21	27.3	27.2	35.1
	% 4th grade school children identified with vision defect – male	9.8	10.7	7.6	8.7	13.4	22.9
	% 4th grade school children identified with vision defect female	11.1	10.7	10.7	10.8	16.9	19.4
	No. of hospitalizations(1)	26,368	27,213	28,692	28,997	26,129	25,894
	% Health centres implementing at least one E-health module	0	0	0	0	7	31
	% Health centres with no stock rupture of 15 tracer items (2)				90.9	100	100
	% Health centres with emergency preparedness plans in place (3)				100	100	100
Strategic Objective 2	% Pregnant women with at least 4 ANC visits	83.3	83.6	77.2	81.5	83.3	81.5
	% 18 month old children that received 2 doses of Vitamin A	99.5	99.9	99.8	100	100	100
	No. of women newly enrolled in preconception care programme (4)			1,585	1,653	1,957	2,081
	% Women attending postnatal care within 6 weeks of delivery	85.0	81.9	91.3	84.8	89.8	84.5
	No. of continuing family planning acceptors	20,428	20,814	24,078	24,543	25,123	24,595
	%. of health centres with at least one staff member trained on detection and referral of GBV cases (2)				100	100	100
	Diphtheria and tetanus coverage among targeted students	99.5	97.9	99	99.2	99.89	99.6
Strategic Objective 3	% Target population ≥ 40 years screened for diabetes mellitus (2)				21.1	24.6	29.4
	% Patients with diabetes under control according to defined criteria (3)				22.8	34.4	37.7
	No. of new patients with diabetes mellitus	1,835	1,346	1,606	1,797	1,564	1,730
	Total no. of patients with diabetes mellitus	18,106	18,882	19,949	21,334	22,301	23,146
	No. of new patients with hypertension	2,578	1,980	2,352	2,140	2,358	2,620
	Total no. of patients with hypertension	24,381	25,502	27,287	28,368	29,611	31,270
	No. of new patients with diabetes & hypertension	782	544	633	587	585	695
	Total no. of patients with diabetes & hypertension	11,821	12,584	13,797	14,706	15,394	16,547
	No. of vaccine preventable disease outbreaks	0	0	0	0	0	0
	% Children 18 months old that received all booster doses of EPI vaccines	99.5	99.9	99.8	100	100	100
	No. of new TB cases detected	2	1	0	1	1	2

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

Table 22 - Field Implementation Plan 2014/15 - Indicator Trends: Agency

SO	Indicator	2009	2010	2011	2012	2013	2014
Strategic Objective 1	Average daily medical consultations per doctor	98.5	101	104	105*	99*	95
	Antimicrobial prescription rate (%)	28	27	27	26	25.1*	26.2
	% Preventive dental consultations of total dental consultations	24.5	27.3	29.5	28.8*	30.6*	37.1
	% 4th grade school children identified with vision defect – male	12.5	11.2	11.0	11.5	9.7*	9.9
	% 4th grade school children identified with vision defect female	14.2	14.7	14.5	15.5	14.6*	14.1
	No. of hospitalizations(1)	86,947	85,953	82,527	86,544	78,313*	93,810
	% Health centres implementing at least one E-health module	21	21	22.5	34.5	40*	63
	% Health centres with no stock rupture of 15 tracer items (2)				93*	90.8*	82
	% Health centres with emergency preparedness plans in place (3)				75	100*	100
Strategic Objective 2	% Pregnant women with at least 4 ANC visits	89	88.1	87.0	86.5	88.8	86.8
	% 18 month old children that received 2 doses of Vitamin A	99.4	99.3	99.6	99.5*	99.5*	99.5
	No. of women newly enrolled in preconception care programme (4)	-	-	13,448	13,427	13,681*	15,670
	% Women attending postnatal care within 6 weeks of delivery	92.0	92.6	94.5	92.1*	94.4*	92.7
	No. of continuing family planning acceptors	134,729	139,965	150,325	145,649	142,760*	146,469
	% of health centres with at least one staff member trained on detection and referral of GBV cases (2)				65.6*	87.3*	90.1
	Diphtheria and tetanus coverage among targeted students	99.8	98.9	99.3	99.4	98*	98.2
Strategic Objective 3	% Target population ≥ 40 years screened for diabetes mellitus (2)				12.7*	15.8	12.8
	% Patients with diabetes under control according to defined criteria (3)				28.3*	47.6*	45.6
	No. of new patients with diabetes mellitus	9,475	9,665	11,067	9,080*	8,919*	12,169
	Total no. of patients with diabetes mellitus	100,974	107,349	114,911	107,372*	111,562*	127,806
	No. of new patients with hypertension	15,897	16,593	18,527	14,234*	13,515*	20,869
	Total no. of patients with hypertension	153,745	163,810	175,382	159,883*	164,911*	192,667
	No. of new patients with diabetes & hypertension	3,935	4,217	4,843	3,821*	3,530*	5,888
	Total no. of patients with diabetes & hypertension	66,443	71,747	78,760	73,927*	77,055*	89,346
	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	99.3	99.6	99.5*	99.4*	98.9
	No. of new TB cases detected	76	78	83	57	23*	48

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

part 3 - 2014 data tabels

Table 23 – Aggregated 2014 data tables

Field	Jordan	Lebanon	Syria	Gaza Strip	West Bank	Agency
23.1 – DEMOGRAPHICS						
Population of host countries in 2014[11]	7,930,491	5,882,562	22,087,048	1,816,379	2,731,052	40,447,532
Registered refugees (no.)	2,212,917	493,134	591,780	1,349,473	942,184	5,589,488
Refugees in host countries (%)	27.9	8.4	2.7	74.3	34.5	13.8
Refugees accessing (served population) UNRWA health services (%/no.)	1,218,979 (55.1%)	331,461 (67.2%)	422,864 (71.5%)	1,227,156 (90.9%)	475,600 (50.5%)	3,676,060 (65.8%)
Growth rate of registered refugees (%)	2.7	2.0	3.9	3.2	3.1	3.0
Children below 18 years (%)	29.5	24.2	31.1	41.1	30.5	32.2
Women of reproductive age: 15-49 years (%)	27.9	26.8	27.7	25.0	27.5	27.0
Population 40 years and above (%)	32.9	40.2	32.8	22.9	33.0	31.1
Population living in camps (%)	17.4	50.6	30.2	41.6	24.3	28.7
Average family size	5.5	5.2	4.5	6.3	5.9	5.5
Aging index (%)	43.3	58.6	32.0	17.6	37.1	33.9
Fertility rate	3.5	3.2	2.5	4.3	3.9	3.5
Male/female ratio	1.0	1.03	0.96	1.02	1.00	1.01
Dependency ratio	51.9	45.6	52.8	71.1	51.8	55.6
23.2 - HEALTH INFRASTRUCTURE						
Primary health care (PHC) facilities (no.):						
Inside official camps	12	14	12	11	20	69
Outside official camps	11	13	11	11	22	68
Total	23	27	23	22	42	137
Health point			12			12
Ratio of PHC facilities per 100,000 population	1.0	5.5	5.9	1.6	4.4	2.6
Services within PHC facilities (no.):						
Laboratories	23	17	17	21	41	119
Dental clinics:						
- Stationed units	29	18	12	18	23	100
- Mobile units	4	1	1	3	0	9
Radiology facilities	1	4	0	7	7	19
Physiotherapy clinics	1	0	0	11	6	18
Hospitals	0	0	0	0	1	1
Health facilities implementing E-health	16	27	0	15	13	71
STRATEGIC OBJECTIVE 1						

[11] Sources UNRWA Registration Statistical Bulletin of 2014, and CIA World Fact-book February 2014 population estimates (https://www.cia.gov/library/publications/the-world-factbook/ last accessed on6/2/2015

Field	Jordan	Lebanon	Syria	Gaza Strip	West Bank	Agency
23.3 - OUTPATIENT CARE						
(a).Outpatient consultations medical officer (no.)						
First visits	383,699	213,146	345,850	1,112,782	334,365	2,389,842
Male	152,349	86,105	165,917	445,852	141,881	992,104
Female	231,350	127,041	179,933	666,930	192,484	1,397,738
Repeat visits	1,293,920	1,012,919	608,739	3,033,372	949,442	6,898,392
Male	472,065	405,186	283,030	1,205,289	374,759	2,740,329
Female	821,855	607,733	325,709	1,828,083	574,683	4,158,063
Sub-total (a)	1,677,619	1,226,065	954,589	4,146,154	1,283,807	9,288,234
Ratio repeat to first visits	3.4	4.8	1.8	2.7	2.8	2.9
(b) Outpatient consultations specialist (no.)						
Gyn.& Obst.	36,185	18,510	23,484	12,755	8,670	99,604
Cardiology	5,040	13,913	5,562	10,674	241	35,430
Others	2,596	17,665	0	12,384	1,242	33,887
Sub-total (b)	43,821	50,088	29,046	35,813	10,153	168,921
Grand total (a) + (b)	1,721,440	1,276,153	983,635	4,181,967	1,293,960	9,457,155
Average daily medical consultations / doctor[12]	84	108	80	96	111	95
23.4 - INPATIENT CARE						
Patients hospitalized -including Qalqilia (no.)	21902	29269	7,130	9,615	25894	93810
Average Length of stay (days)	1.8	2.3	1.7	1.6	1.9	1.9
Age distribution of admissions (%):-						
0-4 yrs	0.2	17.2	12.6	0.4	15.3	10.6
5-14 yrs	2.5	9.3	14.6	3.9	43.4	17.0
15-44 yrs	93.4	35.3	46.1	82.4	29.1	52.8
< 45 yrs	3.9	38.2	26.7	13.4	12.1	19.6
Sex distribution of admissions (%):						
Male	5.7	44.0	45.0	30.2	33.4	30.8
Female	94.3	56.0	55.0	69.8	66.6	69.2
Ward distribution of admissions (%):						
Surgery	2.3	21.9	46.5	47.2	22.4	21.9
Internal Medicine	7.2	62.4	21.1	0.7	42.0	34.4
Ear, nose & throat	1.5	3.2	15.1	0.0	0.9	2.7

[12] The working days in Jordan and Gaza are six days/week, and in Lebanon, Syria and West Bank Fields are five days/week

Field	Jordan	Lebanon	Syria	Gaza Strip	West Bank	Agency
Ophthalmology	0.4	2.9	1.1	2.8	4.9	2.7
Obstetrics	88.6	9.6	16.2	49.2	29.7	38.2
23.5 - ORAL HEALTH SERVICES						
Dental curative consultation – Male (no.)	56,879	26,063	20,377	136,778	24,143	264,240
Dental curative consultation – Female (no.)	103,291	38,504	27,569	172,687	36,858	378,909
Total dental curative consultations (no.)	160,170	64,567	47,946	309,465	61,001	643,149
Dental screening consultations – Male (no.)	26,470	15,752	1,023	28,665	11,560	83,470
Dental screening consultations – Females (no)	56,493	23,224	1,092	74,992	21,499	177,300
Total dental screening consultations (no.)	82,963	38,976	2,115	103,657	33,059	260,770
% preventive of total dental consultations	34.1	37.6	33.8	30.7	35.1	37.1
Average daily dental consultations / dental surgeon	32.3	30.5	32.4	78.6	33.1	49.3
23.6 - PHYSICAL REHABILITATION						
Trauma patients	-	-	-	3,785	508	4,293
Non-Trauma patients	427	-	-	7,396	3,270	11,093
Total	427	-	-	11,181	3,778	15,386
STRATEGIC OBJECTIVE 2						
23.7 - FAMILY PLANNING SERVICES						
New family planning users (no.)	6,978	1,651	2,311	9,705	2,456	23,101
Continuing users at end year (no.)	39,747	14,243	6,210	61,674	24,595	146,469
Family planning discontinuation rate (%)	6.5	5.2	4.5	6.3	3.9	5.3
Family planning users according to method (%):						
IUD	40.5	45.2	31.2	56.3	61.2	50.7
Pills	32.9	22.4	38.6	21.1	20.3	25.0
Condoms	23.1	31.7	26.9	19.1	16.2	21.2
Spermicides	0.9	0.0	0.2	0.1	0.1	0.3
Injectables	2.5	0.6	3.1	3.4	2.1	2.7
23.8 - COUPLE YEARS OF PROTECTION (CYP)						
Couple years of protection	29,437	10,215	14,888	62,098	18,158	134,796
23.9 - PRECONCEPTION CARE						
No. of women newly enrolled in preconception care programme	3,757	1,442	150	8,240	2,081	15,670
23.10 - ANTENATAL CARE						

Field	Jordan	Lebanon	Syria	Gaza Strip	West Bank	Agency
Served refugees (no.)	1,218,979	331,461	422,864	1,227,156	475,600	3,676,060
Expected pregnancies (no.)[13]	34,131	6,629	11,840	45,282	14,316	112,198
Newly registered pregnancies (no.)	26,634	5,165	3,600	39,546	13,670	88,615
Antenatal care coverage (%)	78.0	77.9	30.4	87.3	95.5	79.0
Trimester registered for antenatal care (%):						
1st trimester	82.5	92.0	56.9	78.9	75.3	79.7
2nd trimester	14.8	6.4	35.4	19.7	23.0	18.3
3rd trimester	2.8	1.6	7.6	1.5	1.7	2.1
Pregnant women with 4 antenatal visits or more (%)	84.1	89.4	59.7	91.7	81.5	86.8
Average no. of antenatal visits	4.9	6.8	4.7	6.4	5.1	5.7
23.11 - TETANUS IMMUNIZATION						
Pregnant women protected against tetanus (%)	99.9	99.1	100	100	99.8	99.9
23.12 - RISK STATUS ASSESSMENT						
Pregnant women by risk status (%):						
High	16.4	10.2	7.6	15.3	11	12.1
Alert	26.4	29.4	30	24.8	24	26.9
Low	57.2	60.4	62.4	59.9	65	61.0
23.13 - DIABETES MELLUTES AND HYPERTENSTION DURING PREGNANCY						
Diabetes during pregnancy (%)	3.2	4.5	1.4	2.7	6.3	3.4
Hypertension during pregnancy (%)	6.5	6.5	2.5	10.0	4.1	7.5
23.14 - DELIVERY CARE						
Expected deliveries (no.)	26,608	4,966	2,623	40,758	12,057	87,012
a - Reported deliveries (no.)	24,653	4,483	2,330	38,096	11,481	81,043
b- Reported abortions (no.)	1,955	483	107	2,662	495	5,702
a+b - Known delivery outcome (no.)	26,608	4,966	2,437	40,758	11,976	86,745
Unknown delivery outcome (no. / %)	0.0	0.0	7.1	0.0	0.7	0.31
Place of delivery (%):						
Home	0.1%	0.07%	2.8%	0.0%	0.1%	0.1%
Hospital	99.9%	99.93%	97.2%	100.0%	99.9%	99.9%
Deliveries in health institutions (%)	99.98	100.0	98.2	100.0	100.0	99.6

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

Field	Jordan	Lebanon	Syria	Gaza Strip	West Bank	Agency
Deliveries assisted by trained personnel (%)	99.9	99.9	95.2	98.5	99.9	98.7
23.15 - MATERNAL DEATHS	Jordan	Lebanon	Syria	Gaza	West Bank	Agency
Maternal deaths by cause (no.)						
Haemorrhage	2	1	-	2	-	5
Cardiac causes	1	-	-	2	1	4
Pulmonary embolism	1	-	-	2	-	3
Septicaemia	-	-	-	2	-	2
Pre-eclampsia	1	-	-	-	-	1
Severe anaemia	1	-	-	-	-	1
Cancer	-	-	-	1	-	1
Acute respiratory distress syndrome	-	-	-	1	-	1
Total maternal deaths	6	1	0	10	1	18
Maternal mortality ratio per 100,000 live births	24.9	22.1	0	26.4	7.8	22.0
C-Section among reported deliveries (%)	24.7	44.6	34	17.4	22.5	22.4
23.16 - POSTNATAL CARE						
Post natal care coverage (%)	86.3	97.6	92.3	99.1	84.5	92.7
23.17 - CARE OF CHILDREN UNDER FIVE YEARS						
Registered refugees (no.)	2,212,917	493,134	591,780	1,349,473	942,184	5,589,488
Estimated surviving infants (no.) [14]	60,561	9,675	16,103	48,775	27,807	162,921
Children < 1 year registered (no.)	25,111	5,082	3,672	38,584	10,135	82,584
Children < 1 year coverage of care (%)	75.3	78.1	31.9	87.0	72.2	75.2
Children 1- < 2 years registered (no.)	24,980	4,801	2,576	38,414	9,491	80,262
Children 2- < 5 years registered (no.)	26,039	5,065	2,647	85,209	20,678	139,638
Total children 0-5 years registered (no.)	76,130	14,948	8,895	162,207	40,304	302,484
23.18 - IMMUNIZATION COVERAGE						
Immunization coverage children 12 months old (%):						
BCG	99.0	99.8	99.3	99.8	100.0	99.6
Poliomyelitis(IPV)	99.0	NA	88.6	99.8	100.0	99.1
Poliomyelitis(OPV)	99.0	99.8	88.6	99.8	100.0	99.1
Triple (DPT)	99.0	99.8	88.2	99.8	100.0	99.1

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

Field	Jordan	Lebanon	Syria	Gaza Strip	West Bank	Agency
Hepatitis B	99.0	99.8	86.5	99.8	100.0	99.0
Hib	98.9	99.8	88.2	99.6	100.0	98.9
Measles	99.0	99.8	70.7	NA	0.0	96.1
All vaccines	99.0	99.8	88	99.8	100.0	98.9
Immunization coverage children 18 months old - boosters (%)						
Poliomyelitis(OPV)	98.2	99.5	94.2	99.5	100.0	98.9
Triple (DPT)	98.2	99.5	94.2	99.5	100.0	98.9
MMR	98.2	99.5	93.8	99.4	100.0	98.9
23.19- GROWTH MONITORING AND NUTRIONAL SURVEILLANCE						
Children 0 - 5 years underweight:						
New cases among registered children 0-5 yrs (%)	1.1	1.5	NA	2.0	1.6	1.6
Period prevalence 2014 (%)	2.1	2.3	NA	3.7	2.7	2.9
Prevalence year end 2014 (%)	1.2	0.7	NA	2.1	1.2	1.6
23.20 - SCHOOL HEALTH						
4th grade students screened for vision (No.) :						
Boys	5,834	1,891	1,006	16,283	2,282	27,296
Girls	5,672	2,099	880	13,822	3,373	25,846
Total	11,506	3,990	1,886	30,105	5,655	53,142
4th grade students with vision impairment (%)						
Boys	10.4	13.3	4.1	5.7	22.9	8.9
Girls	15.3	13.1	4.4	19.1	19.4	12.0
Total	12.8	13.2	4.2	7.3	20.8	10.3
7th grade students screened for vision (No.) :						
Boys	5,954	1,744	966	12,565	2,482	23,711
Girls	5,537	1,928	910	11,576	3,395	23,346
Total	11,491	3,672	1,876	24,141	5,877	47,057
7th grade students with vision impairment (%)						
Boys	14.2	11.5	4.5	7.2	21.6	10.6
Girls	20.1	13.4	4.8	11.0	21.6	14.7
Total	17.0	12.5	4.6	9.0	21.6	12.6
STRATEGIC OBJECTIVE 3						
23.21 – NON COMMUNICABLE DISEASES (NCD) PATIENTS REGISTERED WITH UNRWA						
Diabetes mellitus type I (no/%)	1,223 (1.7%)	288 (1%)	263 (1.3%)	1,122 (1.6%)	676 (1.8%)	3,572 (1.5%)
Diabetes mellitus type II (no/%)	11,269	3,055	2,667	11,974	5,923	34,888

Field	Jordan	Lebanon	Syria	Gaza Strip	West Bank	Agency
	(15.3%)	(10.9%)	(13.2%)	(16.8%)	(15.6%)	(15.1%)
Hypertension (no/%)	30,169 (41.0%)	14,480 (51.6%)	10,004 (49.5%)	33,945 (47.5)	14,723 (38.9%)	103,321 (44.7%)
Diabetes mellitus & hypertension (no/%)	30,896 (42.0%)	10,235 (36.5%)	7,276 (36.0%)	24,392 (34.1%)	16,547 (43.7%)	89,346 (38.7%)
Total	73,557	28,058	20,210	71,433	37,869	231,127
23.22 - PREVALENCE OF HYPERTENSION AND DIABETES						
Served population ≥ 40 years with diabetes mellitus (%)	10.0	8.2	6.9	12.2	13.9	10.5
Served population ≥ 40 years with hypertension (%)	14.2	15.1	11.9	19.1	19.2	15.9
23.23 – MANAGEMENT						
Hypertensive patients on lifestyle management only (%)	1%	7%	1%	5%	1%	3%
Diabetes patients on insulin (%)	34.4%	21.2%	18.5%	33.0%	32.3%	30.9
23.24 - RISK SCORING						
Risk status - patients with diabetes mellitus type 1 (%):						
Low	66.6%	36.6%	56.3%	77.3%	60.9%	62.1%
Medium	29.2%	48.1%	37.5%	21.3%	34.8%	32.1%
High	4.2%	15.3%	6.3%	1.5%	4.3%	5.8%
Risk status - patients with diabetes mellitus type 2 (%):						
Low	27.8%	27.4%	36.3%	35.1%	34.9%	33.0%
Medium	54.9%	52.3%	47.5%	52.8%	51.7%	52.9%
High	17.3%	20.2%	16.2%	12.1%	13.4%	14.1%
Risk status - patients with hypertension (%):						
Low	20.2%	23.9%	25.2%	14.0%	32.7%	20.8%
Medium	55.4%	52.9%	55.3%	50.3%	52.4%	52.2%
High	24.5%	23.1%	19.5%	35.7%	14.9%	27.0%
Risk status - patients with diabetes & hypertension (%):						
Low	10.3%	24.7%	13.9%	28.7%	13.2%	20.9%
Medium	49.3%	51.0%	49.6%	54.4%	51.9%	52.5%
High	40.4%	24.3%	36.5%	17.0%	34.8%	26.6%
Risk factors among NCD patients (%):						
Smoking	15.6	38.1	27.0	11.8	18.9	15.1
Physical inactivity	55.9	20.2	31.1	45.6	17.9	46.1
Obesity	36.2	44.3	47.6	43.6	64.7	42.2
Raised cholesterol	30.9	36.1	29.1	33.5	30.1	32.5

Field	Jordan	Lebanon	Syria	Gaza Strip	West Bank	Agency
23.25 - LATE COMPLICATIONS AMONG NCD PATIENTS (%)						
Diabetes mellitus type I	2.0	2.1	4.1	1.4	2.9	1.8
Diabetes mellitus type II	4.6	4.7	13.5	4.4	9.4	4.9
Hypertension	8.1	5.5	9.8	6.1	9.2	6.9
Diabetes mellitus & hypertension	13.2	11.8	15.7	14.3	15.5	13.9
All NCD patients	9.6	7.3	12.2	8.6	11.8	9.1
23.26 – DEFAULTERS						
NCD patients defaulting during 2014 (no.)	4,638	1,609	689	2,954	2,132	12,022
NCD patients defaulting during 2014/total registered end 2013 (%)	6.5	6.8	NA	4.3	5.8	6.0
23.27 - FATALITY						
Reported deaths among registered NCD patients (%)	1.3	2.0	NA	1.6	1.9	1.7
Reported deaths among registered NCD patients by morbidity (no):						
Diabetes mellitus	77	28	27	164	90	386
Hypertension	275	185	102	400	183	1,145
Diabetes mellitus & hypertension	606	249	111	539	406	1,911
23.28 - COMMUNICABLE DISEASES						
Registered refugees (no.)	2,212,917	493,134	591,780	1,349,473	942,184	5,589,488
Refugee population served (no.)	1,218,979	331,461	422,864	1,227,156	475,600	3,676,060
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	1	1	0	2
Meningitis – bacterial	0	0	3	12	1	16
Meningitis – viral	0	0	2	54	22	78
Influenza A(H1N1)	0	0	3	0	0	3
Tetanus neonatorum	0	0	0	0	0	0
Brucellosis	1	1	146	0	8	156
Watery diarrhoea (>5years)	7,459	11,554	4,025	11,946	7,953	42,937
Watery diarrhoea (0-5years)	8,041	9,841	5,978	27,229	9,897	60,986

[15] Among children <15 years

Field	Jordan	Lebanon	Syria	Gaza Strip	West Bank	Agency
Bloody diarrhoea	484	39	195	2,314	463	3,495
Viral Hepatitis	47	164	653	545	6	1,415
HIV/AIDS	0	1	2	0	0	3
Leishmania	0	0	58	0	1	59
Malaria*	0	0	0	0	0	0
Measles	0	8	2	0	0	10
Gonorrhoea	11	2	4	0	0	17
Mumps	3	57	23	15,825	28	15,936
Pertussis	0	1	1	0	0	2
Rubella	2	0	0	0	5	7
Tuberculosis, smear positive	0	10	7	2	1	20
Tuberculosis, smear negative	0	1	3	0	0	4
Tuberculosis, extra pulmonary	0	7	16	0	1	24
Typhoid fever	0	6	162	36	0	204
CROSSCUTTING SERVICES						
23.29 - LABORATORY SERVICES						
Laboratory tests (no.)	1,163,965	366,549	299,442	2,112,124	906,161	4,848,241
Productivity (workload units / hour)	48.4	37.2	41.2	66.7	61.2	54.8
23.30 – UTILIZATION TREND OF LABORATORY SERVICES						
No. of Laboratory tests / 1000 served populations	955	1,106	708	1,721	1,905	1,319
% of Children 1-<2 years tested for Hb	107	89	141	99	103	0
% of Pregnant Women tested for Hb at registration	104	106	148	104	97	105
% of Pregnant Women tested for Hb at 24 weeks of gestation	79	82	107	89	83	85
% of Pregnant Women tested for urine nitrite (Urinary Tract Infection)	101	4	166	157	99	123
% of Pregnant Women tested for Fasting Plasma Glucose (gestational diabetes) at registration	74	90	141	69	73	75
% of Pregnant Women tested for Fasting Plasma Glucose (gestational diabetes) at 24 weeks of gestation	84	80	96	89	81	86
% of diabetic patients tested for PPG/FPG at least 4 times a year	103	50	55	124	135	106
% of NCD patients tested for Cholesterol	88	63	90	106	90	91
No. of individuals screened for diabetes/1000 population	85	54	36	178	275	125
23.31 - RADIOLOGY SERVICES						
Plain x-rays inside UNRWA (no.)	3,046	20,940	0	33,861	23,165	81,012

Field	Jordan	Lebanon	Syria	Gaza Strip	West Bank	Agency
Plain x-rays outside UNRWA (no.)	1,112	6,982	0	0	0	8,094
Other x-rays outside UNRWA (no.)	4	12,004	0	0	0	12,008

23.32- HUMAN RESOURCES	HQ	Jordan	Lebanon	Syria	Gaza	West Bank	Agency
Health staff as at end of December 2014 (no.)							
(a) Medical care services :							
Doctors	3	103	41	87	175	93	502
Specialist		10	10	7	13	9	49
Pharmacists	1	2	11	1	4	2	21
Dental Surgeons		30	16	17	31	17	111
Nurses		267	120	127	330	275	1,119
Paramedical	5	131	52	80	192	190	650
Admin./Support Staff	5	93	53	47	109	92	399
Labour category		103	32	65	147	104	451
Sub-total (a)	14	739	335	431	1,001	782	3,302
(b)Environmental health services :							
Engineers						1	1
Admin/Support Staff						26	26
Labour category						194	194
Sub-total (b)	-	-	-	-	-	221	221
International	2	-	-	-	-		2
Grand total (a+b)	16	739	335	431	1,001	1,003	3,525
Health personnel per 100,000 registered refugees:							
Doctors		4.7	8.3	14.7	13.0	9.9	9.0
Dental surgeons	-	1.4	3.2	2.9	2.3	1.8	2.0
Nurses	-	12.1	24.3	21.5	24.5	29.2	20.0

part 4 - selected survey indicators DMFS survey, 2010

Table 24 - 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)

Table 25- 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 26 - 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

Current practices of contraceptive use among mothers of children 0-3 years survey, 2010

Table 27 - 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 28 - Total fertility rates among mothers of children 0 to 3 years of age who attended the Maternal and Child Health clinics

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

prevalence of anaemia among pregnant women, nursing mothers and children 6-36 months of age survey, 2005

Table 29 - 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						
• 1st grade	14.4	22.3	9.1	36.4	14.6	19.5
• 2nd grade	11.6	16.9	6.0	11.4	14.9	12

part 5 - donor support to UNRWA health programme during 2014

Table 30 - Donor support to UNRWA health programme

Funding Portal	Donor	USD Amount	Title
General Fund	American Friends of UNRWA	10,000	Eliminating Anemia in Gaza
	Austria	2,013,628	A Long and Healthy Life: UNRWA Life Cycle Approach to Health. Health Programme
	Japan	635,128	Support to UNRWA's Health Programme in West Bank
	Japan	5,796,117	Support to UNRWA's Health Programme in Gaza Strip
	Japan	3,244,453	Providing Emergency Assistance and Ensuring Health in Syria
	Local Government of Andalucia, Spain	1,054,018	Supporting Maternal-Child Healthcare Progarm in the Palestinian Refugees' Camps
	Luxembourg	457,433	Healthy Life and Lifestyle for Youth in West Bank and Gaza
	Saudi Arabia	11,024,868	Essential Support to Health and Education in Gaza
	Switzerland	346,834	Support Gaza Municipal Sanitation Services
	Japan	876,953	Providing Assistance to Palestine Refugees from Syria in Lebanon
Emergency Appeal oPt	Germany	326,814	Assistance to Support Health in the Transition from Emergency Relief to Reconstruction, Gaza Strip
	Human Appeal International	177,600	Provision of Fuel for Operating Hospitals and Municipalities in the Gaza Strip
	IDB	2,500,000	Providing Fuel to Operate the Water Wells, Sewage Treatment Plants, Hospitals, Health Centres and Public Clinics in Gaza Strip
	IDB	100,000	Providing Fuel to Cover the Needs of Hospitals and Medical Institutions Operating in the Gaza Strip
	Local Council of Zaragoza, Spain	95,299	Mobile Clinics for Improving Access to Basic Health Services in Isolated Localities in West Bank
	Qatar Red Crescent	350,000	Provision of Fuel for MOH Hospitals inh the Gaza Strip
	Turkey (TIKA)	499,730	Providing Fuel for Health Centres in Gaza
Projects	Australia	38	Support to UNRWA's E-health and Education Reform Evaluations
	Australia	54,317	Support to UNRWA's E-health and Education Reform Evaluations
	Ibdaa Humanitarian Foundation	1,059	Introducing UNRWA's E-health System and Family Health Team Approach at Jarash Camp Health Centre , Jordan
	IDB	4,000,000	Providing Fuel to Operate the Water Wells, Sewage Treatment Plants and Hospitals in Gaza Strip
	Japan	1,578,747	Support to UNRWA's Health Programme in West Bank: Interventions to Support the Delivery of Health Services
	Japan	1,990,008	Support to UNRWA's Health Programme in West Bank: Reconstructing, Furnishing and Equipping Qalqilia Health Centre
	Monaco	136,054	Improving Diabetes Care for Palestine Refugees in Lebanon
	Saudi Arabia	1,844,280	Reconstruction of Fawwar Health Centre, West Bank
	Saudi Arabia	2,072,232	Reconstruction of Aqbat Jaber Health Centre, West Bank
	Saudi Arabia	8,000,000	Reconstruction, Equipping, and Furnishing of Four Health Centres in Gaza Strip
	Saudi Arabia	1,030,795	Expanding UNRWA's Comprehensive E-health for the Family Health Team Approach
Syria Appeal	Extremadura Regional Government, Spain	101,764	Syria Response Plan: Provision of Hygiene Kits for Improving Displaced People Health Conditions, Syria
	Spain, Aragon	52,701	Hygiene Kits, Syria
	Spain, Bilbao	32,938	Syria Response Plan: Improving Hygienic Conditions of the Displaced Persons through the Distribution of Family Kits, Syria
	Spain, Castilla y León	61,958	Hygiene Kits in Syria
	Spain, Navarra	158,103	Syria Response Plan: Improving Displaced Persons' Survival through the Distribution of Hygiene and Baby kits, Syria

Annexes

annex 1 - department of field implementation plan (FIP) 2014/2015

Table 31 - 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 Ehealth 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 programme
				• % Women attending postnatal care within 6 weeks of delivery
				• No. of continuing family planning acceptors
				• % HCs with at least one clinical 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 Programme

Table 32 - ency-wide Common Indicators

Indicator	Calculation
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 clinic + 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 programme
Total no. of hospitalizations (secondary and tertiary)	Total no. of hospitalizations
% Health centres implementing at least one Ehealth module	No. of HCs implementing at least one Ehealth module x 100 Total No. of HCs
% Health centres with no stock-outs of 15 tracer items	No. of HCs with no stock-outs of 15 tracer items x 100 Total no. of HCs
% Health centres with emergency preparedness plans in place	No. of HCs with emergency preparedness plan in place x 100 Total no. of targeted HCs
% 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 programme	No. of women newly enrolled in Pre-Conception Care programme
% 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 clinical staff trained on detection & referral of GBV cases	No. of HCs with at least one clinical staff trained on GBV x 100 Total no. of HCs
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 programme)
% Patients with diabetes under control according to defined criteria	No. of DM patients defined as controlled according to HbA1C or postprandial glucose criteria x 100 Total no. of DM patients

Indicator	Calculation
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)

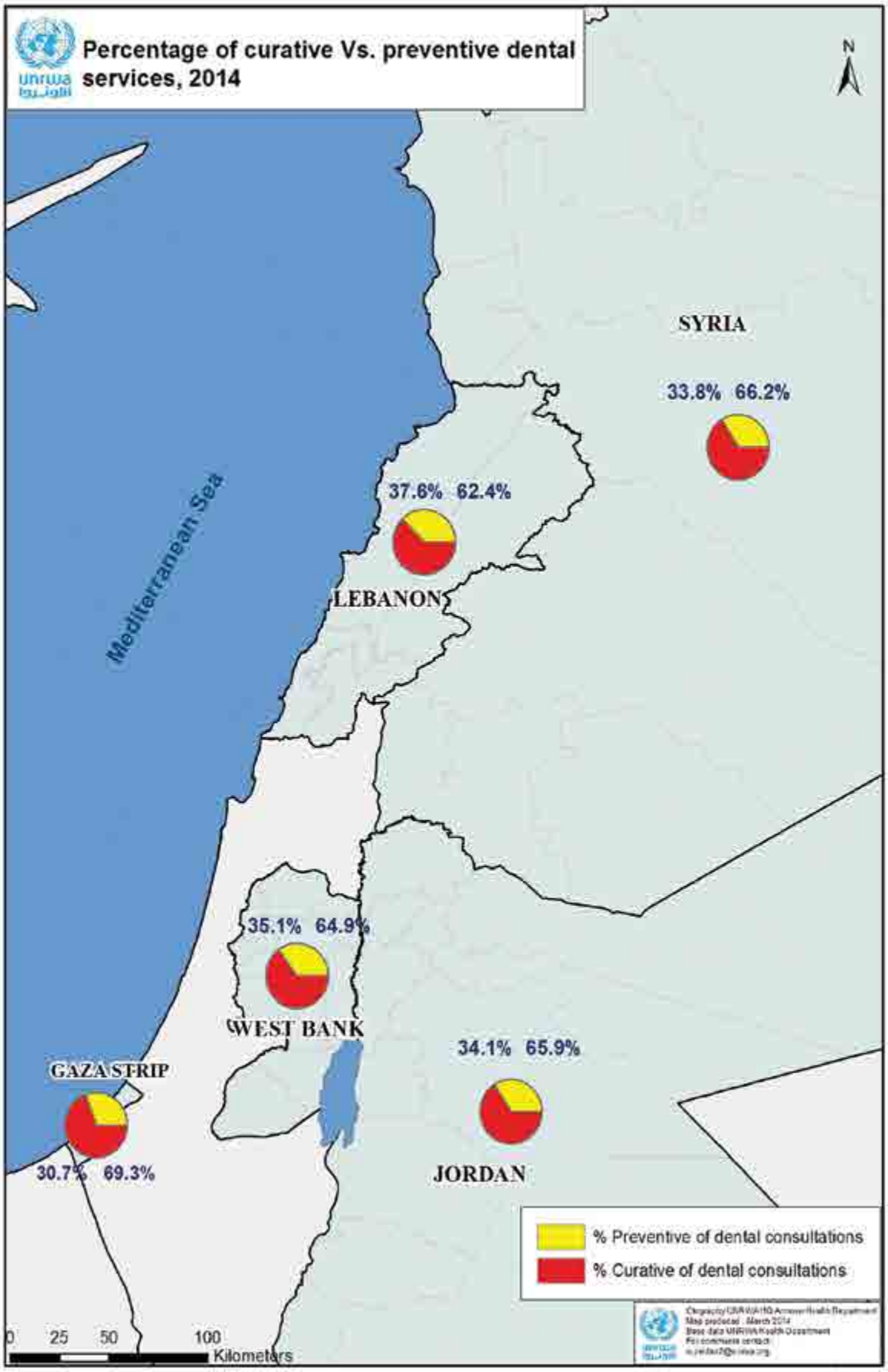
annex 2 - health department research activies and puplished papers

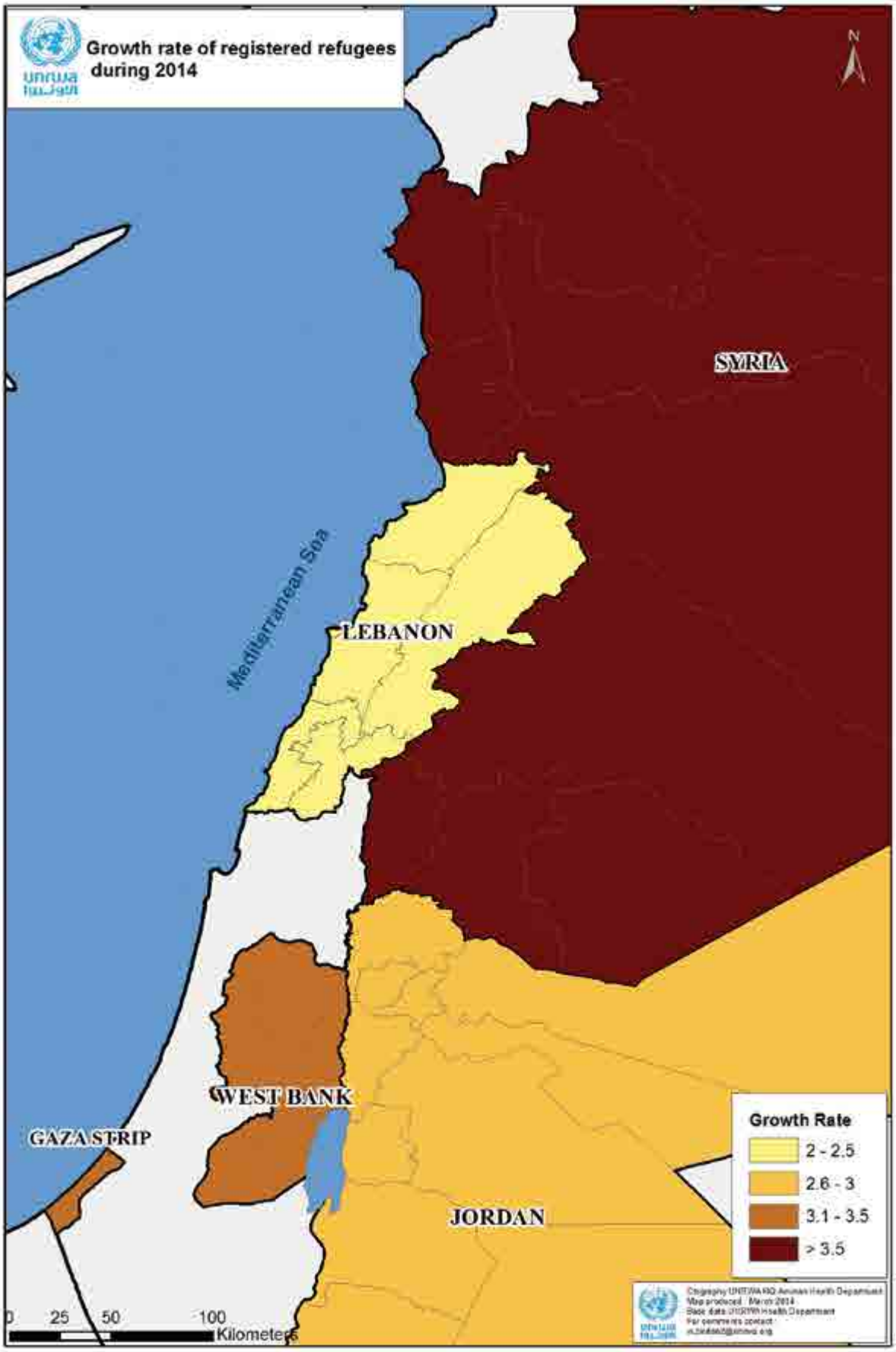
Table 33 – List of abstracts presented at the (LPHA) Lancet Palestinian Health Alliance Conference in Amman, Jordan in March, 2014

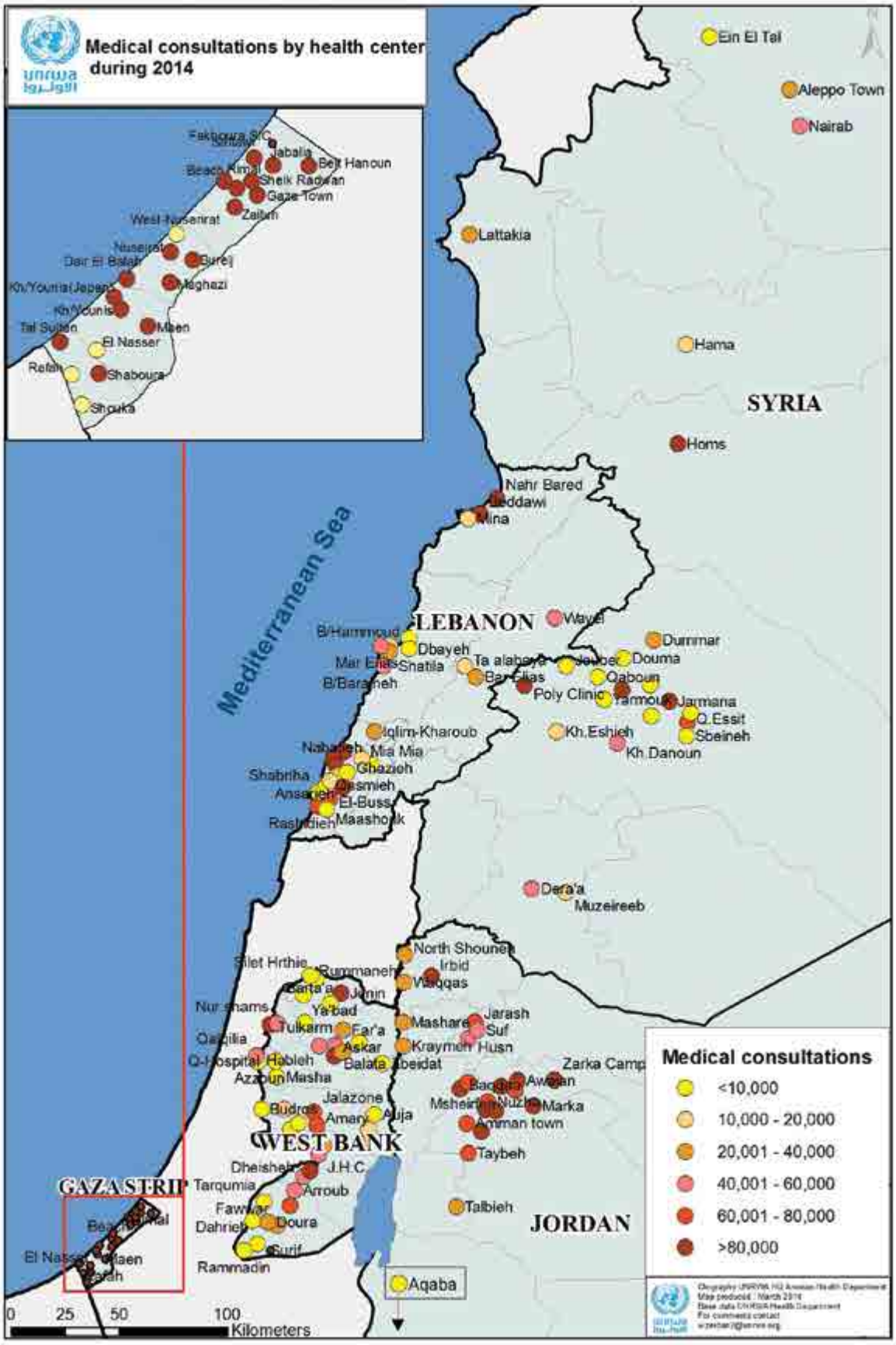
	Title	Present
1	Primary Health Care Utilization Pattern amidst Conflict: Case Study of Palestine Refugees in Syria	Oral
2	Health status and Morbidity pattern among Palestine refugees who have fled from Syria to Jordan	Oral
3	Quality of diabetic care and patients' satisfaction at Shouka Health Centre, Gaza Strip, Occupied Palestinian territory	Oral
4	Infant mortality among Palestine refugees in Gaza	Poster
5	Outreach screening for diabetes among Palestine refugees	Poster
6	Disparities in health seeking behaviours and out of pocket payments in the Gaza Strip in 2013: Results from a household survey	Poster
7	Utilization of Antihypertensive Medications Among the UNRWA Palestinian Refugee Population in Jordan	Poster
8	Drug prescription pattern at UNRWA clinics in Jordan	Poster
9	Health status and Morbidity pattern among Palestine refugees fled from Syria to Jordan	Poster

	Title	Present
1	Cohort analysis of antenatal care and delivery outcomes in pregnancy: a basis for improving maternal health	Scientific Paper
2	Comparative assessment of medicine procurement prices in the United Nations Relief and Work Agency for Palestine Refugees in the Near East (UNRWA)	Scientific Paper
3	Hypertension and treatment outcomes in Palestine refugees in United Nations Relief and Works Agency primary health care clinics in Jordan	Scientific Paper
4	What happens to Palestine refugees with diabetes mellitus in a primary healthcare centre in Jordan who fail to attend a quarterly clinic appointment?	Scientific Paper

annex 3 - health maps, 2014




Growth rate of registered refugees during 2014
SYRIA
LEBANON
Mediterranean Sea
WEST BANK
GAZA STRIP
JORDAN
Growth Rate
2 - 2.5
2.6 - 3
3.1 - 3.5
> 3.5
0 25 50 100
Kilometers


Medical consultations by health center during 2014
Ein El Tal
Aleppo Town
Nairab
Lattakia
Hama
SYRIA
Homs
Nahr Bared
Beddawi
Mina
Mediterranean Sea
LEBANON
Wavel
Dummar
Douma
Qabboun
Jarmana
Q.Essit
Sbeineh
Kh.Danoun
Kh.Eshieh
Poly Clinic
Dbayeh
Shatila
Ta alabaya
Bar Elias
B/Hammoud
B/Barajneh
Iqlim-Kharoub
Mia Mia
Ghazieh
Qasmieh
El-Buss
Maashouk
Shabriha
Dera'a
Muzeireeb
North Shouneh
Irbid
Wahqas
Jarash
Suf
Husn
Mashare
Zarka Camp
Awajan
Nuzha
Marka
Amman town
Taybeh
Talbieh
JORDAN
WEST BANK
GAZA STRIP
Jalazone
Budros
Amary
Aqaba
Medical consultations
<10,000
10,000 - 20,000
20,001 - 40,000
40,001 - 60,000
60,001 - 80,000
>80,000
0 25 50 100
Kilometers

annex 4 - contacts of senior staff of the UNRWA health programme

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annex 5 - abberviations

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
ECC	Early Childhood Caries
EPI	Expanded Programme of Immunisation
ERP	Enterprise Resource Planning
ESRF	End Stage Renal Failure
EQAS	External Quality Assurance System
EU	European Union
FCP	Family Health Protection
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
HCs	Health centers
IDA	Iron Deficiency Anaemia
IDP	Internally Displaced Persons
IDA	Iron Deficiency Anaemia
IT	Information Technology
IU	International Unit
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 Care Health
MO	Medical Officer
MTS	Medium Term Strategy
MHGAP	Mental Health Gap Assistance Program
NCDs	Non-communicable Diseases
NGOs	Non-Governmental Organizations
NMR	Neonatal mortality rate
NSDV	Normal Spontaneous Vaginal Delivery
OPV	Oral Polio Vaccine
OD	Organizational Development
PHA	Public Health Action
PLHA	People Living with HIV/AIDs
PPGT	Post Prandial Glucose Test
PLD	Procurement and Logistics Department
PRM	Participatory Rank Method

PEN	Package of Essential Non-communicable
PHC	Primary Health care
PRS	Palestinian refugees from Syria
SMO	Senior Medical Officer
SMs	Staff Member Satisfaction
SPING	Support to partnership, Reform and
STDs	Sexually Transmitted Disease
TB	Tuberculosis
Td	Tetanus/Diphtheria
TMIH	Tropical Medical & International Health
TVET	Technical and Vocational and Training
UNICEF	United Nations Children's Fund
UNRWA	United Nations Relief & Works Agency for Palestine refugees in
UNOCH	United Nations Office for the Coordination of Humanitarian
VB	Virtual Budget
WBFOs	West Bank Field Office
WCLAC	Women's Center for Legal Aid and Counseling
WDF	World Diabetes Foundation
WHO	World Health Organization

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